



FULL RIGHTS, WHOLE CHILDREN

A Case Study of Child Survival
and Human Rights in Mexico

July 2001



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Founded in 1983, Minnesota Advocates for Human Rights is the largest Midwest-based, non-governmental organization engaged in international human rights work. The organization has approximately 4,000 members, including more than 800 active volunteers who contribute an estimated \$1.4 million annually of in-kind services. Minnesota Advocates also has Special Consultative Status with the United Nations.

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TABLE OF CONTENTS

I.	PREFACE	1
II.	INTERNATIONAL OBLIGATIONS AND CHILD MORTALITY	4
III.	FINDINGS AND RECOMMENDATIONS	8
	A. Summary of Findings.....	8
	B. Recommendations and Suggested Actions	11
IV.	CHILD MORTALITY IN CONTEXT	14
	A. Reduction in Child Mortality	14
	B. Discrepancies in Vital Statistics	17
	C. Preventability of Child Deaths	21
V.	CAUSES OF UNDER-FIVE CHILD DEATH IN MEXICO	22
	A. Causes of Infant Death	23
	1. Perinatal Illnesses	24
	2. Congenital Anomalies	25
	B. Causes of Death in Children Aged One through Four	26
	Intentional and Unintentional Injury	26
	C. Causes of Death Common to Infants and Children	27
	1. Respiratory Infections	27
	2. Intestinal Infections	28
	3. Malnutrition	28
VI.	STRUCTURAL BARRIERS TO CHILD SURVIVAL IN MEXICO	29
	A. The Right to an Adequate Standard of Living	29
	1. Regional Disparities in Living Conditions	29
	2. Discrimination Against Indigenous Peoples	35
	3. Discrimination Against Girls	38
	B. The Right to an Adequate Level of Health Care	41
	1. Mexico's National Health System	42
	a. Mexican Social Security Institutions	42
	b. The Secretariat of Health	44
	c. Private Health Care	45
	d. The Uninsured "Open" Population	45
	e. Other Health and Social Assistance Institutions	46
	2. Lack of Access to Quality Health Care	47
	C. Mexico's Macroeconomic Policies and Social Sector Spending	50
	1. Mexico's Social Sector Spending	51
	2. Mexico's Structural Adjustments and Reductions in Social Sector Spending	52
	3. Free Trade Policies and Reduced Economic Opportunities	54
	4. Mexico's Minimum Wage Structure	56

VII.	OTHER CONDITIONS THAT PLACE CHILDREN AT RISK	59
A.	Maternal Factors	59
1.	Maternal and Infant Health Care	61
2.	Working Conditions	63
3.	Education	66
B.	Domestic Violence	67
1.	Violence Against Women	68
2.	Violence Against Children	70
3.	Government Response to Family Violence	71
C.	Militarization and Armed Conflict	73
D.	Natural Disasters	76
E.	Migration and Displacement	77
VIII.	MEXICAN GOVERNMENT PROGRAMS THAT ADDRESS CHILD WELFARE	78
A.	Legislation to Protect Children’s Rights	78
B.	Social Welfare Programs	81
1.	Poverty Alleviation and PROGRESA.....	81
2.	Food Subsidies	85
C.	Health Reform Efforts	86
1.	Health Sector Reform Program 1995-2000	86
a.	Decentralization of Health Services	87
b.	Program for Expansion of Coverage (PAC)	87
2.	System to Register Complaints about Health Care Services	89
D.	President Fox and the Future of Child Welfare Programs	90
IX.	ASSESSMENT OF MEXICO’S COMPLIANCE WITH INTERNATIONAL LEGAL OBLIGATIONS	92
A.	Economic, Social and Cultural Rights	93
1.	The Right to an Adequate Standard of Living.....	93
2.	The Right to the Highest Attainable Standard of Health	94
3.	Non-governmental Efforts to Protect Economic, Social and Cultural rights.....	95
B.	The Convention on the Rights of the Child	96
C.	The Indigenous and Tribal Peoples Convention	97
X.	CONCLUSION	98
	APPENDICES	
A.	Map of the United Mexican States.....	100
B.	Excerpts from the International Covenant on Economic, Social and Cultural Rights	101
C.	Excerpts from the Convention on the Rights of the Child	104
D.	ILO Convention 169: Indigenous and Tribal Peoples Convention	109
E.	Excerpts from the Political Constitution of Mexico.....	115
F.	Law for the Protection of the Rights of Children and Adolescents.	116

LIST OF FIGURES AND TEXT BOXES

Figure 1	Decline in Under-five Child Mortality Rates in Mexico 1980 – 1998 ...	15
Figure 2	National Child Mortality Rates in Relation to GNP Per Capita and Other Social Indicators	16
Figure 3	Reported Under-five Child Mortality Rates by Source	18
Box 1	Under-reporting of Child Death in the State of Guerrero	19
Figure 4	Leading Causes of Under-five Child Death in Mexico, 1998.....	21
Figure 5	Distribution of Deaths in the Under-five Population in Mexico.....	23
Figure 6	Leading Causes of Infant Death in Mexico, 1998.....	24
Figure 7	Leading Causes of Death among Children Aged One through Four in Mexico, 1998	26
Figure 8	Rates of Child Death from Malnutrition by State	31
Figure 9	Rates of Child Death from Intestinal Infections by State	32
Box 2	Child Malnutrition among the Tarahumara	37
Box 3	The Case of Baby H	49
Box 4	Example of Food Scarcity and Allocation Policies	55
Figure 10	Minimum Wage Buying Power	58
Figure 11	National Child Mortality Rates in Relation to Selected Indicators of Maternal Health	60
Figure 12	Child Mortality Rate Correlated to Maternal Education	66
Box 5	The Women and Children of Loxicha, Oaxaca	75
Box 6	International Instruments that Protect Children’s Rights, Applicable to Mexico	92

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The obligation of the state from a human rights point of view is to dismantle or rectify the social relations and civil, political, legal and economic institutions that deny poor people the freedom from hunger and want, the freedom from fear of avoidable morbidity and premature mortality, the freedom to support one's family, the freedom to be able to read – in short, the freedom to live lives of dignity.²

I. PREFACE

Almost 11 million children die in the world each year, most from preventable causes.³ These needless deaths constitute a human rights crisis because every child has a right to life and healthy development. When a child dies from a preventable condition, it is usually because a number of his or her human rights have been violated, such as the right to health care, the right to food, the right to safe drinking water and the right to shelter. These rights violations are occurring on multiple levels, from poor quality health treatments available in rural health clinics to national economic policies that perpetuate poor survival outcomes for children. In order to understand how these rights can be promoted and enforced, it is necessary to see that a single child's death is the result of complex processes on many levels. Through an analysis that examines these levels of causation, Minnesota Advocates for Human Rights (Minnesota Advocates) presents this case study regarding children's rights in Mexico.

Mexico is a country of great diversity, consisting of 31 states and the Federal District (also known as Mexico City).⁴ Mexico's geography varies greatly and includes deserts, subtropical areas and mountainous regions. While the current population of the country is over 97 million⁵, approximately one quarter of the entire population lives in the Federal District and the surrounding areas, making it more densely populated than

¹ This case study is an elaboration on an earlier case study of child survival in Mexico published by Minnesota Advocates for Human Rights, *Global Child Survival: A Human Rights Priority*, (1999).

² Alicia Ely Yamin, *Reflections on Defining, Understanding, and Measuring Poverty in Terms of Violations of Economic and Social Rights Under International Law*, 4 GEO. J. ON FIGHTING POVERTY 273, 280 (1997).

³ UNITED NATIONS CHILDREN'S FUND, STATE OF THE WORLD'S CHILDREN 68 (2001) [hereinafter STATE OF THE WORLD'S CHILDREN].

⁴ See Appendix A, map of the United Mexican States.

⁵ INSTITUTO NACIONAL DE ESTADÍSTICA, GEOGRAFÍA E INFORMÁTICA [NATIONAL INSTITUTE OF STATISTICS, GEOGRAPHY AND INFORMATICS] [hereinafter INEGI], XII CENSO GENERAL DE POBLACIÓN Y VIVIENDA, 2000 [XII GENERAL CENSUS OF POPULATION AND LIVING CONDITIONS], available at <http://www.inegi.gob.mx/estadistica/espanol/sociodem/fsociodemografia.html>.

any state. It is estimated that over ten million indigenous people live in Mexico, many of whom speak only their native language.⁶ Indigenous people live in every state, but the largest number of indigenous live in the south. Mexico is characterized by economic disparities between the northern and southern states. The northern states account for a large share of Mexico's Gross Domestic Product (GDP) per capita,⁷ in part due to disproportionate foreign investment in the manufacturing industry. The southern states are generally agricultural and less industrialized. According to recent demographic studies, the Mexican population has become increasingly divided; the rural population is thinly dispersed across thousands of small localities while large numbers of people are concentrated in the country's few large urban centers.⁸ This distribution of the Mexican population helps to explain why remote rural populations continue to have little access to state-sponsored services, such as health care, sanitation services and education, while the growing population of urban poor is also under-served by government programs.

In the last decade, Mexico has significantly reduced the child mortality rate for Mexican children aged one through four. The Mexican government has achieved this success, in part, through improvements to the National Health System and by increasing the population's access to health care. Nevertheless, Mexico's child mortality rate remains significantly higher than the mortality rate in other Latin American countries with comparable and even lower Gross National Products (GNP).⁹ The high child mortality rate in Mexico can be partly explained by the fact that the Mexican government allocates a smaller percentage of its budget to health care programs, as compared to other countries.¹⁰ Furthermore, the leading causes of child death in Mexico continue to be largely preventable, such as low birth weight, respiratory infections, intestinal infections,

⁶ Instituto Nacional Indigenista, [National Institute on Indigenous Peoples] *Información Básica Sobre Los Pueblos Indígenas de México* [Basic Information About the Indigenous Peoples of Mexico]. available at www.ini.gob.mx/infbas.html.

⁷ According to the World Bank, "[a] country's Gross Domestic Product represents the sum of value added by all producers in that country." 2000 WORLD DEVELOPMENT INDICATORS 189. Likewise, GDP can be measured for each state within Mexico. Of all the Mexican states, Guerrero, Oaxaca, and Chiapas had the lowest Gross Domestic Product per capita in 1999. The states that border the United States (except Tamaulipas) were within the top third of states according to the Gross Domestic Product per capita in 1999. Statistics by state available at <http://www.inegi.gob.mx/entidades/espanol/entidades.html>.

⁸ CONSEJO NACIONAL DE POBLACIÓN, III INFORME DE AVANCES DEL PROGRAMA NACIONAL DE POBLACIÓN (1995-2000) 23 (1998).

⁹ According to the World Bank's definition "Gross National Product (GNP) is the sum of value added by all resident producers plus any taxes (less subsidies) not included in the valuation of output plus net receipts of primary income (compensation of employees and property income) from abroad." More simply stated "GNP comprises GDP plus net receipts of primary income from nonresident sources." GNP is the broadest measure of national income, measuring the total domestic and foreign value added claimed by residents. 2000 WORLD DEVELOPMENT INDICATORS 13.

¹⁰ See Figure 2, page 16 *infra*, for comparison of Mexico's government expenditures versus other similarly wealthy Latin American countries.

nutritional deficiencies and injuries. An increase in government investment in effective health care programs is only one means of decreasing preventable child death.

In Mexico, many child deaths can be traced to the fact that a large segment of the Mexican population lives in conditions of marginalization, where they lack access to and participation in state-sponsored programs. In Mexico, factors such as employment, income level, education level, level of urbanization and access to electricity, clean water and sewage services determine the level of marginalization of a particular population. By some estimates, as many as 75 million people in Mexico live in poverty, over three-quarters of the population.¹¹ A high percentage of the poor are indigenous and are children, living in both rural and urban areas. The leading causes of child death in Mexico are directly related to the lack of access to basic services. Notably, states with high GDP per capita have child mortality rates that are significantly lower than the national rate while states with low GDP per capita experience child mortality rates considerably higher than the national rates.

The high child mortality rate and the disproportionate number of indigenous and poor children who die from preventable causes before reaching age five demonstrate that large segments of the Mexican population are being deprived of their fundamental human rights. Such human rights violations in Mexico result from both governmental action and inaction. Despite economic growth, Mexico's health care expenditures for the past years have remained stagnant at two to three percent of the federal budget. Moreover, governmental cuts to the federal budget, due to a sharp fall in oil prices from 1997 to 2000, have further affected expenditure on health.

Restrictive macroeconomic policies have arguably led to further impoverishment of Mexico's marginalized populations and made them more vulnerable to early child death. At the same time, the Mexican government has undertaken a number of initiatives designed to assist under-served populations. Such programs, directed toward poverty alleviation, expansion of health care coverage and sanitation, nevertheless, continue to fall short in the communities that are suffering the most. For example, Mexico's principal poverty alleviation program, PROGRESA, only targets rural communities which already have an infrastructure adequate to receive social services, thus ignoring both very marginalized rural communities and the urban poor populations. The government programs are also not directly addressing the inter-related causes of and factors that contribute to child death, such as family violence, low maternal education and migration. Therefore, even though it has made progress, the Mexican government is not fulfilling its human rights obligations to all of the people of Mexico.

¹¹ Miriam Posada García, *Viven en México 75 millones de pobres, asegura Boltvinik*, [75 million Mexicans live in poverty, affirms Boltvinik], LA JORNADA, Aug. 18, 2000.

II. INTERNATIONAL OBLIGATIONS AND CHILD MORTALITY

Preventable child mortality is an abuse of the most basic human right, the right to survive, and it also demonstrates the interdependence of all human rights. In order to eliminate preventable child death, nations must fulfill their international legal obligations to protect and promote the full range of rights necessary for the survival and development of children. The Universal Declaration of Human Rights, adopted by the United Nations, defines universal human rights to which all individuals are entitled and which are to be protected by governments. These fundamental rights include basic necessities, such as the right to food, clothing, housing, medical care, favorable work conditions, education and nationality. Although the Universal Declaration is not a treaty, it represents the foundation upon which other legally binding instruments are based.

The International Covenant on Economic, Social and Cultural Rights¹² (Economic Rights Covenant) is the principal international treaty that recognizes and protects a broad range of economic and social rights and describes these rights in a more comprehensive manner than the Universal Declaration. The Economic Rights Covenant also represents the consensus of the world community as to a government's obligations to protect the well being of its population, particularly those who are vulnerable, such as children. For this reason, the treaty both describes basic economic, social and cultural rights in detail and specifies the appropriate measures governments should take to achieve them. Because guaranteeing the full enjoyment of economic, social and cultural rights is demanding and requires a government to reallocate resources and redesign state programs, the Economic Rights Covenant allows state parties to "progressively" implement the treaty.¹³ In ratifying the Economic Rights Covenant, a state undertakes the obligation to achieve the rights guaranteed in the treaty "to the maximum of its available resources."¹⁴

Aside from treaties that outline basic human rights, the United Nations has also adopted treaties that mandate the specific protection of the rights of children, women and indigenous people. Although children are protected under international law generally, the Convention on the Rights of the Child¹⁵ (Children's Convention) is an explicit recognition that children are subjects of human rights themselves and are to be protected.

¹² International Covenant on Economic, Social and Cultural Rights, G.A.res.2200 (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, *entered into force* January 3, 1976. Ratified by Mexico on March 23, 1981. [hereinafter Economic Rights Covenant] *See* Appendix B, *infra*.

¹³ Mexico is also a state party to the American Convention on Human Rights, Nov. 22, 1969, O.A.S. Treaty Series No. 36, at 1, OEA/Ser.L./V/II.23 doc. Rev. 2, *entered into force* July 18, 1978; ratified by Mexico March 2, 1981. State parties to the American Convention on Human Rights undertake the obligation to adopt measures to progressively achieve the full realization of economic, social and cultural rights.

¹⁴ Economic Rights Covenant, *supra* note 12, Article 2.

¹⁵ Convention on the Rights of the Child, G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), *entered into force* September 2, 1990. Ratified by Mexico on September 21, 1990 [hereinafter Children's Convention]. *See* Appendix C, *infra*.

States that have ratified the Children's Convention undertake the obligation to protect children's civil and political rights as well as economic, social and cultural rights. Likewise, the Convention on the Elimination of All Forms of Discrimination Against Women¹⁶ (Women's Convention) seeks to eliminate discriminatory treatment of women that prevent them from enjoying their human rights, but also obligates state parties to guarantee women's equal enjoyment of social, economic and cultural rights. The Women's Convention recognizes women's important role in raising children and ensuring the welfare of their families. The Convention recognizes that women living in situations of poverty, lack access to food, health care, education and employment opportunities.¹⁷ Thus, the Women's Convention includes government responsibilities related to maternal nutrition, health care and education that directly impact a child's right to survive.

The Convention concerning Indigenous and Tribal Peoples in Independent Countries¹⁸ (Indigenous Rights Convention) outlines the economic, social and cultural rights that indigenous people are entitled to as well as the state's obligation to develop systems of protection in cooperation with indigenous communities. Under the Indigenous Rights Convention, state parties are obligated to assist in the elimination of socio-economic gaps between indigenous and non-indigenous groups, to improve conditions of life, work, health and education in conjunction with indigenous tribes.¹⁹ The convention emphasizes that a concerted effort must be made by governments to educate indigenous people of their rights and that proper legal proceedings must be made available to them to report incidences of abuses of these rights. Finally, by ratifying the International Convention on the Elimination of All Forms of Racial Discrimination, Mexico undertook the obligation to ensure that no public authorities or public institutions, such as health care providers, engage discrimination based on race.²⁰ Likewise, Mexico is obligated to review all governmental policies, at the national and state level, to ensure that they do not create racial discrimination.

Most preventable child deaths can be traced to inadequate nutrition, substandard living conditions and lack of proper health care. Therefore, a government that fails to provide the population with an adequate standard of living has violated basic human rights. Article 11 of the Economic Rights Covenant guarantees the "right of everyone to

¹⁶ Convention on the Elimination of All Forms of Discrimination Against Women, G.A. res. 34/180, U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/180, *entered into force* September 3, 1981. Ratified by Mexico on March 23, 1981 [hereinafter Women's Convention].

¹⁷ *Id.*

¹⁸ Convention (No. 169) concerning Indigenous and Tribal Peoples in Independent Countries, Adopted on 27 June 1989 by the General Conference of the International Labor Organization at its seventy-sixth session, *entered into force* 5 September 1991. Ratified by Mexico May 9, 1990 [hereinafter Indigenous Rights Convention]. See Appendix D, *infra*.

¹⁹ *Id.*, Article 2, concerning Indigenous and Tribal Peoples in Independent Countries.

²⁰ International Convention on the Elimination of All Forms of Racial Discrimination, 660 U.N.T.S. 195, *entered into force* January 4, 1969. Ratified by Mexico on February 20, 1975.

an adequate standard of living for himself and his family, including adequate food, clothing, housing, and to the continuous improvement of living conditions.” State parties must take measures to “to improve methods of production, conservation and distribution of food” Article 27 of the Children’s Convention, likewise obligates states to recognize “the right of every child to a standard of living adequate for the child’s physical, mental, spiritual, moral and social development” and that state parties must “take the appropriate measures to assist parents and others responsible for the child to implement this right and shall . . . provide material assistance and support programs, particularly with regard to nutrition, clothing and housing.” The Women’s Convention, in Article 14, recognizes that women in rural areas “play a significant role in the economic survival of their families” yet also face many hardships. Thus, state parties are required to ensure that rural women “enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply”

A child who dies because of lack of access to health services has been denied her right to the highest attainable standard of physical and mental health, as guaranteed by Article 12 of the Economic Rights Covenant. Article 12 obligates states to take measures to reduce infant mortality and to “assure to all medical service and attention in the event of sickness.” The Convention on the Rights of the Child, in Article 24, also guarantees children the right to “the highest attainable standard of health and to facilities for the treatment and rehabilitation of health. State parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.” In particular, states are obligated to (1) take measures to decrease infant and child mortality; (2) improve primary health care services, to combat disease and malnutrition “through the provision of adequate nutritious foods and clean drinking water”; (3) ensure appropriate pre-natal and post-natal health care for mothers; (4) “ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents.”

The Women’s Convention, in Article 12, states that women are to enjoy equal access to health care services and that state parties “shall ensure to women appropriate services in connection with pregnancy . . . and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.” Finally, Article 25 of the Indigenous Rights Convention requires governments to ensure that “adequate health services are made available to the [indigenous] peoples concerned . . . so that they may enjoy the highest attainable standard of physical and mental health” and that health services shall be “community-based, planned and administered in cooperation with the peoples concerned and take into account their economic, geographic, social and cultural conditions as well as their traditional preventive care, healing practices and medicines.”

Apart from the fundamental rights to an adequate standard of living and access to health care, preventable child mortality also implicates other basic rights that affect a family’s ability to provide for and protect its children. For example, both the Economic Rights Covenant (Article 9) and the Children’s Convention (Article 26) recognize the

right to social security, including social insurance, which offers children protection from poverty and improves access to basic services, such as health care. The Economic Rights Covenant (Article 7) guarantees the right to favorable working conditions, which includes a fair wage that allows for a decent living for themselves and their families and safe and healthy working conditions. Article 11 of the Women's Convention also addresses labor rights, including the right to protection of health and safety at work. Article 11 obligates state parties to take measures to provide for maternity leave, social services that enable parents to work, such as child-care facilities, and protection of women during pregnancy. Article 18 of the Children's Convention, likewise, requires governments to "take all appropriate measures to ensure that children of working parents have the right to benefit from child-care services" Both the Economic Rights Covenant (Article 10) and the Children's Convention (Article 32) protect children against economic exploitation. The Economic Rights Covenant (Article 13), the Children's Convention (Article 28), the Women's Convention (Article 10) and Article 26 of the Indigenous Rights Convention define the right of all people to acquire an education. Education is of critical importance to the parents' ability to provide for a child's needs and also to realize one's other human rights.

Ensuring a child's right to survive requires that the government guarantee and respect the other fundamental human rights of the child and the child's family. The state can protect these rights by: (1) ensuring that the population has access to basic necessities, adequate nutrition, sanitation and adequate economic resources; (2) maintaining a functioning health care system that provides equal and essential services to the entire population; and (3) promoting practices, such as universal education and safe workplace conditions for mothers, that are required for a child's full development.

III. FINDINGS AND RECOMMENDATIONS

A. Summary of Findings

Despite some governmental efforts to reduce the under-five child mortality rate in Mexico, young children continue to die from preventable causes, in contravention of their most basic human rights. Minnesota Advocates for Human Rights specifically finds the following:

- 1. Child mortality in Mexico has been reduced but is still at a disproportionately high level in marginalized communities.**
 - The poor in Mexico are concentrated in the southern states, such as Oaxaca, Chiapas and Guerrero, which have the lowest Gross Domestic Products per capita in the country. The rates of child death from malnutrition are highest in the economically poorest regions of the country.
 - Mortality rates for both indigenous infants and children are almost double the rates for Mexico as a whole.
 - Infants in Mexico suffer the greatest proportion of preventable child deaths. More than 83 percent of the deaths of children under age five in 1998 occurred within the first year of life.
 - The under-five child mortality rates in both Chile and Cuba are less than half the rate for Mexico.
- 2. There is significant variation in government statistics on under-five mortality in Mexico, in part, due to under-registration of children's births and deaths. Current data-collecting methodologies are not adequate to fully understand child mortality in Mexico.**
 - Five to ten million children in Mexico have incomplete birth certificates, which includes one million children whose births have not been registered at all.
 - Studies of specific rural communities in the state of Guerrero alone indicate that close to three-quarters of under-five child deaths are not registered there.
- 3. The leading causes of child death in Mexico are largely preventable and are directly related to the lack of access to basic services such as health care, sanitation and food assistance programs.**
 - Perinatal illnesses, such as complications related to short gestation and low birth weight, are the leading cause of death for infants (under age one) in Mexico.
 - Injuries are the leading cause of death for children age one through four.

- Of the 17 countries with the highest Gross National Products in the world, which includes Mexico, Mexico has the fourth highest child mortality rate.
- Among the 29 member-countries of the Organization for Economic Co-Operation and Development, Mexico has the second highest child mortality rate from injuries (both intentional and unintentional).
- Infants and children in poor, rural and indigenous communities die from respiratory infections, intestinal infections and malnutrition at rates considerably higher than the rates for the country as a whole. For instance, in the states of Chiapas and Oaxaca, which are primarily rural and have large numbers of indigenous peoples, intestinal infections are the leading cause of death of children aged one through four.
- Although Mexico has reduced its national malnutrition rate in the last decade, the reduction was less than that achieved in other developing countries in the same period. By some estimates, it will therefore take 15 years for the prevalence of malnutrition in Mexico to become comparable to countries considered to have a healthy state of nutrition.
- The national system for filing complaints regarding poor health services received in public or private clinics, the National Medical Arbitration Commission (CONAMED), has no authority to enforce the recommendations it issues.

4. In Mexico, girls and women experience discrimination in the form of barriers to health care, barriers to education, higher poverty rates and violence. Such discriminatory treatment has a detrimental impact on the health of children.

- The World Bank has documented a higher overall mortality rate for girls from age one to five in Mexico than for boys of the same age.
- In the Federal District of Mexico, the homicide rate for the population of girl children is three times higher than for boys. Girls die eleven times more often from physical abuse than boys.
- Studies suggest that over 65 percent of women in Mexico suffer some form of abuse. Stated another way, each year more than one million women seek emergency medical treatment for injuries sustained due to domestic violence, which is a leading cause of death for women.
- Thirty-five percent of women in Mexico have no education or have not completed primary school. Illiteracy among indigenous women in Mexico is even higher, at 49 percent.
- Women make up 37 percent of Mexico's labor force but only half of them are insured through their employer for health care.

- Compared to urban women, twice as many rural women receive no prenatal care and the majority of rural women receive no post-delivery care.
- There has been an increase in the number of migrant women to Mexico City by about 15 to 20 percent each year and such women are often single parents with no source of income.
- Women living in militarized zones experience violence, and the presence of the military in specific communities greatly limits women's access to health services.
- Compared to Chile, Costa Rica and Cuba, Mexican women access health care less frequently and have higher levels of illiteracy.

5. The rights of children are not given priority at the macroeconomic policy level.

- Since the World Bank's inception, Mexico has received the second largest share of the disbursed portfolio, totaling US \$31.5 billion, but almost 18 million people are still living on less than US \$1 per day.
- The Mexican government allocates a smaller percentage of its budget to health care programs, as compared to other countries with similar resources.
- Although major health care reforms have been instituted in Mexico, 60 percent of children age 14 and under remain uninsured.
- To comply with the requirements of international lenders, the government ended various farm subsidy programs, which has made it more difficult for families to feed themselves. As a result, poor families have shouldered the burden of the economic changes.
- In implementing agricultural policies required by international organizations, the Mexican government made no provisions for food security or economic security of small-scale farmers.
- Policies that create barriers to healthy living continue to be proposed, even under the new administration, for example placing a 15 percent Value Added Tax on food and medicines.

6. Mexico's steps to improve child survival have not risen to the standard required by either federal law or by international law.

- The National System for the Follow-up and Monitoring of the Implementation of the Children's Convention is not operating in every Mexican state.
- A number of Mexican states still grant parents and teachers the legal "right to discipline" children, which permits the use of corporeal punishment, in

contravention of an express prohibition in the Children's Convention and recommendations by the UN Committee on the Rights of the Child.

- Infants and children constitute 82 percent of all victims of physical or emotional violence.
- Government assistance programs have been used for political ends and have not been designed to improve self-sufficiency of rural communities.

B. Recommendations and Suggested Actions

Based on its findings, Minnesota Advocates for Human Rights recommends the following:

1. The Government of Mexico should ensure that all children in the country enjoy a high standard of health and have equal access to government health services and programs.

- The Government should ensure that existing health services for women include adequate prenatal and neonatal care.
- The Government should ensure that all people have access to quality health care regardless of employment status.
- The Government should support and facilitate the initiatives of NGOs in Mexico that provide health services to local populations. The Government should cooperate with such organizations as well as community members, particularly regarding the assessment of the health needs of the community.
- The Government should review whether existing mechanisms that allow people to bring claims concerning the accessibility and adequacy of the health care system are effective. Where there are deficiencies, the Government should act to ensure that an effective mechanism for redress exists.

2. The Government of Mexico should collect reliable and relevant data on the situation of children in Mexico.

- The Government should evaluate whether existing procedures for registering the births and deaths of children in Mexico conform to guidelines set forth by the World Health Organization.
- The Government should maintain accurate statistics on causes of child mortality and it should reduce the number of child deaths classified as "unspecified." Further, the government should classify child deaths by injury as "intentional" or "unintentional."

- The Government should maintain accurate statistics on child mortality by sex and for all demographic groups, by socioeconomic status, ethnicity and race.

3. The Government of Mexico should take measures to ensure that children are provided with adequate food and clean drinking water.

- The Government should allocate additional resources to health care, sanitation and education, and in the implementation of any policy decisions, should ensure that access to these basic services are not denied or impaired.
- The Government should ensure that food assistance programs are equally available to all segments of society, including indigenous and non-indigenous, both in rural and urban areas, and that they respond to the unique needs of each population.
- The Government should evaluate state food assistance programs and increase effectiveness in preventing maternal and child malnutrition by targeting communities with the highest levels of marginalization.
- The Government should take active steps to redress economic deprivation of the indigenous people in rural areas.
- Government aid programs should cooperate with rural communities to develop their capacity for self-sufficiency.

4. The Mexican Government should address child injuries as a preventable cause of death.

- The Government should undertake educational programs within the judicial, health care and educational systems to improve understanding of injury as the leading cause of death of children aged one through four.
- The Government should conduct public education campaigns against family violence generally and should also specifically address the negative impact domestic violence against women has on children.
- The Government should evaluate the health impact on children of the “right to discipline” provision in domestic law and reform the laws as indicated.
- The Government should enact child safety legislation in order to reduce the number of accidental deaths from injury.

5. The Mexican Government should ensure that the rights of all women and girls are protected.

- The Government should ensure that existing health care services address reproductive, prenatal and postnatal health and are available to all segments of society, including the rural and poor populations. The government should also evaluate whether existing state assistance programs adequately address the needs of women in these populations.
- The Government should evaluate whether existing vaccination programs are adequate in providing pregnant women with immunization against tetanus.
- The Government should ensure that women and girls have the same access as men and boys to all state programs, including compulsory and post-secondary education.
- The Government should analyze the conditions that lead to displacement and migration of specific populations within the country and focus reform efforts at communities of origin.
- The Government should ensure that women and girls who are victims of violence are provided with specialized state-sponsored assistance, including: health services, temporary shelters or housing assistance and welfare benefits.
- The Government should evaluate whether the criminal justice system offers effective remedies for victims of family violence.

6. The Mexican Government should ensure that the rights of women and children are taken into consideration in determining government spending policies.

- In implementing macroeconomic policies, the Government should consider whether such policies could adversely affect women and children, in particular whether they will contribute to the impoverishment of women and children.
- In creating and implementing domestic policies, including fiscal reform, the Government must not reduce families' access to food, medicine and education.
- The Government should ensure that budget and deficit reduction policies do not result in reduced public spending on basic services.
- The Government should ensure that public spending is equitably distributed between rural and urban areas.
- The Government should analyze the impact of trade agreements on children while such trade agreements are negotiated. Specifically, the Government should protect children from unsafe or exploitative labor situations.

- The Government should analyze the impact of trade agreements on women in the labor force while such trade agreements are negotiated. Specifically, the Government should develop and enforce a policy of equal pay for equal work for men and women and prohibit gender-based discriminatory practices, such as pregnancy testing.
- In reforming the National Health System, the Government should evaluate how new policies might impact women's and children's access to health care services.
- In all areas of policy, including health reform, tax reform and international trade agreements, there should be improved transparency, improved mechanisms for accountability and opportunities for civil society to participate in the development of the policies.

7. The Government of Mexico should review its legislation to ensure that all laws are consistent with the Convention on the Rights of the Child.

- The federal Government of Mexico should require all states to pass legislation that implements the standards set forth in the Convention on the Rights of the Child.
- The federal Government of Mexico should specifically ensure that state law that is inconsistent with the Convention on the Rights of the Child is amended, for example, the "right of discipline."
- The Government should vigorously enforce election laws to ensure that receipt of welfare benefits is not contingent on political party affiliation.
- The Government should ensure that child mortality and all the rights implicated in child mortality are addressed in the next State Party report to the Committee on the Rights of the Child, which is due on October 19, 2002.

IV. CHILD MORTALITY IN CONTEXT

A. Reduction in Child Mortality

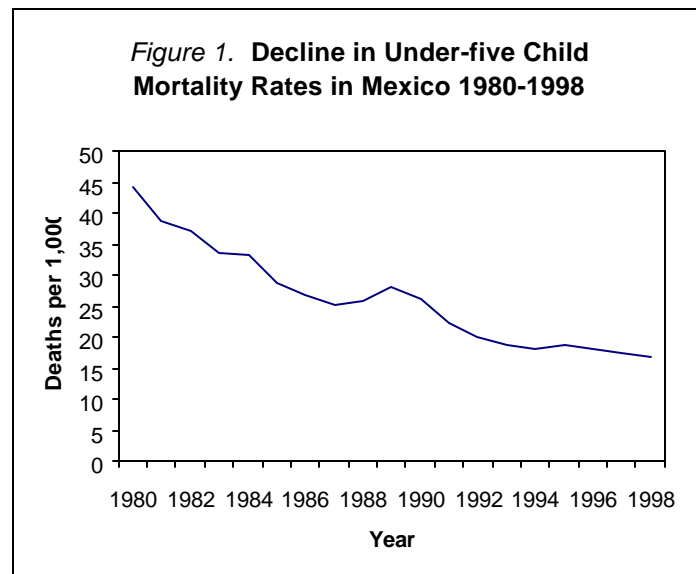
Child mortality rates are a general indicator of a country's level of development. The United Nations Children's Fund (UNICEF) uses the under-five mortality rate as the principal indicator of a country's human and economic progress for several reasons.²¹ First, the under-five child mortality rate is affected by a number of inputs, such as the availability of clean water to the family, the health knowledge of mothers and the child's level of immunization. Second, because of the various factors that contribute to child mortality, the rate of under-five child death represents "the end result of the development

²¹ STATE OF THE WORLD'S CHILDREN, *supra* note 3 at 107.

process” rather than the influence of any single input. For instance, child mortality is influenced by factors such as maternal education, availability of health services, and availability of nutritious food.²² Finally, because the under-five mortality rate is not calculated as an average, as is GNP per capita, it is less likely to be affected by extremes. As UNICEF explains, “it is much more difficult for a wealthy minority to affect a nation’s [under-five mortality rate], and it therefore presents a more accurate, if far from perfect, picture of the health status of the majority of children (and of society as a whole).”²³ Likewise, the under-five mortality rate gives an indication of a government’s respect for both children’s rights and for human rights generally.

Mexican government statistics show a decrease in under-five child mortality from 148 deaths per 1,000 births in 1960 to 16.8 in 1998.²⁴ Figure 1 depicts the decline in mortality rates for children under age five based on official government data from the period of 1980 to 1998.²⁵ Although Mexico’s overall under-five child mortality rate has shown a steady downward trend, rates continue to vary by region and state.

Despite the apparent decline in child mortality in Mexico, overall rates remain disproportionately high for the country’s development level. Compared to Chile, Panama and Venezuela (countries with a GNP per capita similar to Mexico), Mexico’s under five-mortality rate is considerably higher.²⁶ Furthermore, Mexico’s child mortality rate is higher than that of both Cuba and Costa Rica, countries with considerably lower GNP per capita and fewer resources than Mexico, as illustrated in Figure 2. Child mortality is correlated to a



Source: Data from Secretariat of Health, Mexico

²² *Id.*

²³ *Id.*

²⁴ SECRETARIAT OF HEALTH, MORTALIDAD 1998, at 11 (2000) [hereinafter MORTALIDAD 1998].

²⁵ Figure 1 was created from data from MORTALIDAD 1998, *Mortalidad según grupos de edad, [Mortality Rates by Age Group]*, Secretaría de Salud, [Secretariat of Health, Mexico], available at <http://www.ssa.gob.mx/unidades/dgied/sns/vitales/cuadro12.htm>. For a further discussion of discrepancies in reporting of vital statistics, however, see Section IV B, *infra* at 17.

²⁶ While recognizing that GNP is merely one factor in determining a country’s development level, it does provide a useful point of comparison between countries.

country's economic resources,²⁷ but, more significantly, is affected greatly by how those resources are allocated.²⁸ Cuba, Costa Rica and Panama have fewer economic resources than Mexico but have allocated a larger proportion of the state budget to health services. Cuba and Costa Rica have lower maternal mortality rates than in Mexico, indicating that their additional spending results in improved health for women.²⁹ The countries with lower child mortality rates share other common characteristics as well, such as a larger percent of the population with access to potable water and sanitation services and higher female literacy rates.³⁰

Figure 2. National Child Mortality Rates in Relation to GNP Per Capita and Other Social Indicators

	Latin American Countries	Under-5 mortality rate 1999 ^b	GNP per capita (US\$) 1999	% of central government expenditure allocated to health 1992-1999	% of under-fives who are underweight (1995-2000)	% of population urbanized 1999 ^c
Lower-Middle Income ^a	Cuba	8	1170	23	6	76
	Costa Rica	14	2740	22	5	48
Upper-Middle Income ^a	Chile	12	4740	12	1	85
	Venezuela	23	3670	10	5	87
	Panama	27	3070	19	7	56
	Mexico	33	4400	3	8	74

^a The World Bank Group classifies countries according to GNP per capita for lending purposes. 2000 WORLD DEVELOPMENT INDICATORS 13. Countries chosen for this figure were in the Lower-Middle Income (US \$761- \$3,030) or Upper-Middle Income (US \$3,031- \$9,360) groups in 1998.

^b The under-five mortality rate is the probability that a child will die between birth and exactly five years of age, expressed per 1,000 live births.

^c The urban population is described according to the national definition used in the most recent population census.

Source: STATE OF THE WORLD'S CHILDREN.

²⁷ Of the twenty-five countries with the highest under-five mortality rankings, only three have a per capita GNP above US \$500. STATE OF THE WORLD'S CHILDREN, *supra* note 3, at 77-81.

²⁸ Where the ratio of share of income of the richest 20 percent to the share of the poorest 20 percent is large, there tends to be higher numbers of the population with less access to safe water, to health services and to sanitation. See United Nations Development Program, HUMAN DEVELOPMENT REPORT 2000, Table 4, *Human Poverty in Developing Countries*, 169 – 171 [hereinafter HUMAN DEVELOPMENT REPORT].

²⁹ See Figure 11, Section VII A, *infra* at 60.

³⁰ See Section VI A 1, Regional Disparities in Living Conditions, *infra* at 29.

Two important structural factors may be causing the difference between Mexico and the countries with similar developmental levels. Mexico has a very high income concentration among its richest people, making it one of the most unequal countries in the world.³¹ The Mexican government's spending policies also set Mexico apart from other countries, particularly because of reliance on foreign lenders and implementation of structural adjustment programs. Child mortality rates are affected greatly by distribution of resources and government spending policies. As will be discussed in detail throughout this report, there is a strong correlation between the priority the government places on social programs and child mortality rates.

B. Discrepancies in Vital Statistics

Before analyzing data on child mortality in Mexico, it is important to note that such statistics vary significantly depending on the source. Although available data indicate that Mexico has reduced its overall mortality rate for children under age five, significant discrepancies in data collection and reporting raise questions about the degree to which child mortality has declined. Because of a lack of accurate statistics, it is difficult to ascertain the magnitude of the problem of child mortality and to fully analyze the disparities in rates, particularly for the indigenous, rural and poor children. Despite imprecise data, disparities in mortality rates by state are evident and they show that there are also disparities in the enjoyment of economic and social rights in Mexico.

There is particular variation in data on child mortality between domestic and international sources as illustrated in Figure 3³² below. According to the Mexican Secretariat of Health, in 1998 the national child mortality rate was 16.8 deaths per 1,000 live births while for the same year UNICEF reported an under-five mortality rate of 34 per 1,000.³³

A second government institution, the National Commission for Action in Favor of Childhood, reported that the child mortality rate for 1998 was 4.6 per 1,000.³⁴ This rate

³¹ Mexico is among the 15 most unequal countries in the world. HUMAN DEVELOPMENT REPORT, *supra* note 28.

³² Data for Figure 3 were compiled from: SECRETARIAT OF HEALTH, MORTALIDAD 1998, at 11 (2000); COMISIÓN NACIONAL DE ACCIÓN EN FAVOR DE LA INFANCIA [NATIONAL COMMISSION FOR ACTION IN FAVOR OF CHILDHOOD] PROGRAMA NACIONAL DE ACCIÓN EN FAVOR DE LA INFANCIA, EVALUACIÓN 1990-2000, at 19- 21 [NATIONAL PROGRAM FOR ACTION IN FAVOR OF CHILDHOOD, EVALUATION 1990-2000] (hereinafter NATIONAL PROGRAM FOR ACTION, EVALUATION); UNICEF, THE STATE OF THE WORLD'S CHILDREN 2000, Table 1 Basic Indicators *available at* www.unicef.org/sowc00/stat3.htm; and Mexico Data Profile, World Bank, *available at* <http://devdata.worldbank.org/external/dgprofile.asp?rmdk=82525&w=0&L=E>.

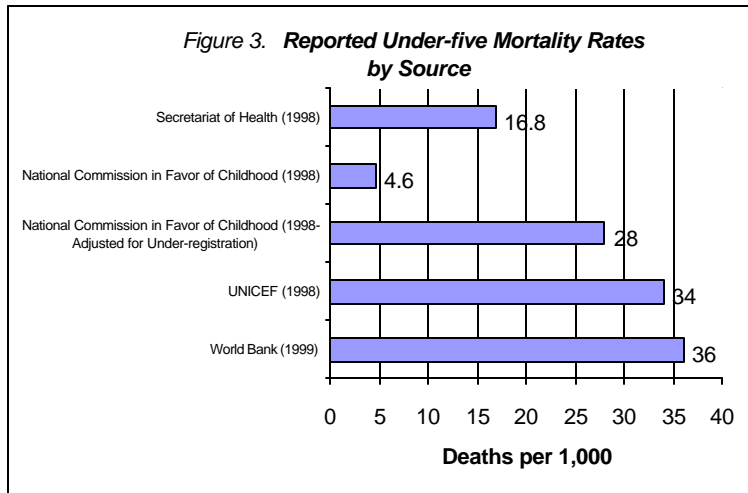
³³ UNICEF, THE STATE OF THE WORLD'S CHILDREN 2000, Table 1: Basic Indicators *available at* www.unicef.org/sowc00/stat3.htm. Representatives of UNICEF's Mexico office told Minnesota Advocates that UNICEF's statistics differ from those of the Mexican government due to "methodological variation." Interview, Sept. 4, 2000 (UNICEF, Mexico City).

³⁴ NATIONAL PROGRAM FOR ACTION, EVALUATION, *supra* note 32, at 15.

is comparable to countries with the lowest child mortality rates in the world, such as Sweden and Japan. Data collection among Mexico's government institutions is not standardized and is often not coordinated which adds to the likelihood of discrepancies between sources. Such inconsistencies necessitate cautious use and interpretation of the Mexican government's data regarding child mortality rates.

Underreporting is recognized as a significant problem in Mexico, and therefore institutions such as the National Commission in Favor of Childhood point out that a more precise calculation of mortality rates requires adjusting the data to account for under-

registration in each state.³⁵ Taking into account under-registration, the 1998 child mortality rate of 4.6 per 1,000 live births was adjusted upwards to 28 deaths per 1,000 live births, an increase of 500 percent.³⁶



The reason government data are usually low is because child deaths are typically underreported to the government. The reasons for underreporting are varied. On the one hand, many government offices lack resources, such as computers, and therefore rely on out-dated record-keeping methods. In this instance, a birth or death may be reported at a local registry office but may take years to arrive at the national office. On the other hand, the parents themselves may be prevented from registering their children's births or deaths. According to UNICEF, there are currently five to ten million children in Mexico with incomplete birth certificates,³⁷ including approximately one million children whose births have not been registered at all.³⁸ If a child's birth has not been recorded, then it is unlikely that the child's death would be recorded. The registry office may be located in a town that is far or difficult to reach, as is often the case in areas where the population lives in communities of fewer than 500 people. The cost of registration may be prohibitive for poor families. In addition, the parents and local authorities may not see the need or recognize that children have a right to be registered.³⁹ A study of child

³⁵ *Id.* at 20.

³⁶ *Id.* at 19-21.

³⁷ Bertha Fernandez, *Sin documentos oficiales, de 5 a 10 millones de niños*, [Without Official Records- 5 to 10 million children], EL UNIVERSAL, Oct. 11, 2000 at 16.

³⁸ Interview, Sept. 4, 2000 (UNICEF, Mexico City).

³⁹ *Id.*

mortality in the state of Guerrero, in Box 1, demonstrates the significant inaccuracies which occur when under-reporting is not factored into the calculation of child mortality statistics, as well as the barriers that prevent parents from registering the birth or death of a child.

Box 1. Under-reporting of Child Death in the State of Guerrero

Guerrero is one of the poorest states in Mexico and has geographical characteristics that greatly complicate access to health services. Guerrero is a mountainous state and has many small villages with populations of fewer than 500. Independent researchers have reported that in Guerrero nine of every ten children under the age of five are malnourished and up to 96 percent of infants suffer from parasites.⁴⁰ With these characteristics, one would expect the child mortality rate in Guerrero to be relatively high. Nevertheless, over the years, the official child mortality rates for Guerrero have been as much as three times lower than the national rates.⁴¹ The most recent under-five mortality rate in Guerrero was 8.41 deaths per 1,000 (1998), half the national rate.

Non-governmental researchers have concluded that the government statistics have created an inaccurate picture of child health in Guerrero, and in order to demonstrate how under-reporting distorts child mortality statistics, they conducted a study of child death there. Researchers studied 366 child deaths from 827 communities in Guerrero, all with populations under 2,500. Of these, 114 of the deaths had been registered and 252 had not been registered, resulting in an under-registration rate of 70 percent. In communities of fewer than 500 residents, the under-registration reached 73.2 percent, meaning that only slightly more than one quarter of all under-five child deaths were registered.⁴² The researchers found that under-registration was due to “the lack of birth and death certificates, the child was less than one month old, lack of information on the concept and purpose of a Public Registration Office, the distance to the Public Registration Office and to the doctor was more than 30 minutes and the community was smaller than 1,000 inhabitants.”⁴³ It is therefore vital that governmental registration campaign programs focus on communities with the characteristics identified above.

Another aspect of underreporting is the incorrect classification of the cause of death. The World Health Organization (WHO) has stated that there is “very little scientifically based information . . . on cause-specific mortality rates for many developing countries. What information does exist is often out-of-date, applicable only to major urban areas, and not sufficiently disaggregated to differentiate between important population sub-groups.”⁴⁴ This is also the case in Mexico where, for example, in 1998, eight percent of all under-five child deaths were classified as resulting from “other

⁴⁰ Ana Lilia Torres, *Guerrero, primer lugar nacional en desnutricion infantil*, [Guerrero - First Place Nationally in Child Malnutrition], EL SOL DE MÉXICO, Oct. 4, 2000 at 1B.

⁴¹ Patricia Tome et al., *Características asociadas al subregistro de muerte en niños del estado de Guerrero, México*, [Characteristics related to child mortality under-registration in the State of Guerrero, Mexico], SALÚD PUBLICA MEXICANA [MEXICAN PUBLIC HEALTH] 39 (1999) at 523-529.

⁴² *Id.*

⁴³ *Id.*

⁴⁴ Martha Anker, et al., *A Standard Verbal Autopsy Method for Investigating Causes of Death in Infants and Children*, World Health Organization, WHO/CDS/CSR/ISR/99.4 (1999), available at <http://www.who.org>.

unspecified causes.”⁴⁵ Moreover, child mortality statistics classified by racial or ethnic group do not exist in Mexico, in part, because there is a lack of consensus about who is considered “indigenous”.⁴⁶ The process of surveying the indigenous population is further complicated by the fact that a majority of the people in Mexico can be considered mestizo, meaning of combined indigenous and European ancestry.⁴⁷

Discrepancies in data and under-reporting of children’s births and deaths, particularly in marginalized areas, impede understanding of the problem of child mortality in Mexico. Without accurate data, it is virtually impossible to accurately monitor the number of children who are dying or to fully understand the causes of under-five child mortality. Obtaining accurate data on child mortality, for example classified by race, ethnicity and income levels, is a critical component for reducing child survival disparities in Mexico. Enhancing parents’ ability to register their children is an important way to improve the accuracy of the statistics, but the responsibility for registration is not the parents’ alone. Children have the fundamental right to be registered, to have a name and to acquire a nationality, and the government has the obligation to ensure that these rights are fulfilled.⁴⁸ The right to a name and a nationality is necessary so that the government can ensure that it is providing full and equal access to the services that promote child development. Furthermore, because a birth certificate is required to receive immunizations, to receive health care and to enroll in school in Mexico,⁴⁹ a child cannot realize his other rights without the proper registration.

The Mexican government has not widely introduced changes to the existing registry system that would address the serious problem of under-registration of births and deaths and misclassification of cause of death in the country. Although international organizations have developed campaigns to encourage registration in Mexico, they have not fully addressed the problem.⁵⁰ Some health experts have suggested improvements to birth registration⁵¹ while others have recommended simple methods that increase the

⁴⁵ Calculated from data from MORTALIDAD 1998, *supra* note 24, *Principales Causas de Mortalidad Infantil/Preescolar*, [Principle Causes of Infant/Preschool Mortality] at 83, 87.

⁴⁶ See Section VI A 2, Discrimination Against Indigenous Peoples, *infra*, for a discussion of the Mexican government’s lack of a clear methodology to identify people as “indigenous.”

⁴⁷ 60 percent of the Mexican population is mestizo. U.S. Central Intelligence Agency, THE WORLD FACT BOOK, <http://www.odci.gov/cia/publications/factbook/index.html>.

⁴⁸ See Article 7, Children’s Convention, Articles 18 and 20 of the American Convention on Human Rights and Article 30 of the Political Constitution of the United Mexican States on the right to a name and nationality.

⁴⁹ Unity Dow, *Birth registration: The ‘first’ right*, THE PROGRESS OF NATIONS 1998, UNICEF at 9.

⁵⁰ UNICEF currently has a project in the state of Veracruz to encourage registration through the use of a play at public events entitled *El Niño que No Existá* [The Child that Has No Name] followed by free registration of children. Interview, Sept. 4, 2000 (UNICEF, Mexico City).

⁵¹ In Tome *supra* note 41, the authors recommend the use of a birth certificate designed by the Secretariat of Health that clarifies the procedure for recording the date of birth.

accuracy of death reports, such as the expanded use of the “verbal autopsy,” particularly in areas “where civil registration and death certification systems are weak” and where children “die at home without having had contact with the health system.”⁵²

Because data available from the Mexican government are often incomplete, statistics from varied sources are provided throughout this report. Regardless of the accuracy of the under-five child mortality figures, however, the available data indicate that the Mexican government has not yet addressed the interrelated factors that contribute to preventable child deaths in different segments of the Mexican population.

C. Preventability of Child Deaths

Available data on the primary causes of child death reveal that many Mexican children die annually from preventable causes. According to Mexican government statistics, the leading causes of under-five child death are: perinatal illnesses; congenital anomalies; respiratory infections; intestinal infections; injuries and nutritional deficiencies, as illustrated in Figure 4. In 1998, these illnesses accounted for 84 percent of all deaths of children under age five in Mexico.

Figure 4. Leading Causes of Under-Five Child Death in Mexico 1998

Causes	Under-five mortality rate^a
1. Perinatal illnesses	745.0
2. Congenital anomalies	296.6
3. Respiratory infections ^b	185.8
4. Intestinal infections	95.6
5. Injuries (intentional and unintentional) ^c	79.0
6. Nutritional deficiencies	54.8

^a Represents rate per 100,000 registered live births for children aged zero up to five years.
^b Represents combined deaths from acute respiratory infections, influenza and pneumonia.
^c Represents combined deaths from accidental suffocation and drowning, traffic-related accidents, intentional violence, natural disasters and unspecified others.
Source: MORTALIDAD 1998, SECRETARIAT OF HEALTH 83, 87 (2000).

⁵² Anker *supra* note 44. The verbal autopsy consists of a detailed interview with the child’s caregivers and was the method used by researchers in a study in Guerrero to determine cause of death. See Box 1, *supra*. Results of research into child death from diarrhea and acute respiratory infections in Tlaxcala, Mexico indicate that 60 percent of child deaths occurred in the home. The verbal autopsy method is well-suited to determining cause of death when the death occurs at home. R. Bojalilet, et al., *A clinical training unit for diarrhoea and acute respiratory infections: an intervention for primary health care physicians in Mexico*, 77 BULLETIN OF THE WORLD HEALTH ORGANIZATION 936 (1999).

Most of the six leading causes of child death listed above can be prevented through the provision of basic health and sanitation services. These services include: (1) improved maternal and prenatal health care; (2) education and proper nutrition of both mother and child; (3) proper screening and early detection of specific illnesses and early treatment; (4) education on basic hygiene; and (5) the provision of clean water and sewage systems. Significantly, many other causes of child death in Mexico could be avoided completely through vaccinations, nutritional supplements or improved diagnosis, such as: typhoid fever, tuberculosis, shigellosis (a diarrheal disease), viral encephalitis, hepatitis B, neonatal tetanus and vitamin deficiencies.⁵³

Whether a child dies from these preventable causes depends greatly on his standard of living, including access to adequate health care, access to adequate food and access to sanitary living conditions. Inadequate health care, a lack of sanitation services and inability to obtain sufficiently nutritious food are closely associated with being poor, and therefore these ailments are sometimes referred to as “diseases of poverty.” While “diseases of poverty” disproportionately affect poor children, the fact of being economically poor is not the cause of illness. Such illnesses are the result of a lack of access to services that the wealthy are able to use freely. An NGO representative told Minnesota Advocates that the main causes of death for children are linked to discrimination and to “poverty of capacity, poverty of health and poverty of education.”⁵⁴ When the Mexican government focuses solely on economic poverty as a cause of child death, it is sidestepping its basic obligation to provide all people in Mexico, regardless of income, with a minimal level of health care, access to basic sanitation programs and adequate education. Currently, many children in Mexico are not able to realize their right to survive because the government is not providing them with a health care system or social programs that address preventable causes of death.

V. CAUSES OF UNDER-FIVE CHILD DEATH IN MEXICO

While the leading causes of under-five child death in Mexico are largely preventable, infants (from birth to age one) and children (aged one through four) suffer specific illnesses related to their ages. For example, infants die from perinatal illnesses and birth defects, while children aged one through four suffer higher mortality rates from injuries. Therefore, this report will discuss the preventability of infant causes of death separate from children’s causes of death. Finally, the report will describe the causes of

⁵³ Secretariat of Health, *Defunciones Generales según Causa de Muerte y Grupos de Edad, Estados Unidos Mexicanos 1998*, [Mortality Totals by Cause of Death and Age Group] in MORTALIDAD 1998, *supra* note 24 at 46-53. Official statistics for 1998 indicate a very low incidence of death from the vaccine-preventable diseases diphtheria, whooping cough and measles, most likely prevented through government-sponsored vaccination campaigns. See *Mortalidad por Enfermedades Preventibles por Vacunación (Excepto Tuberculosis) Según Entidad Federativa 1998*, [Death from Vaccine-preventable Diseases (Except Tuberculosis)], *id.* at 179.

⁵⁴ Interview, Sept. 9, 2000 (Women’s Rights NGO, Mexico City).

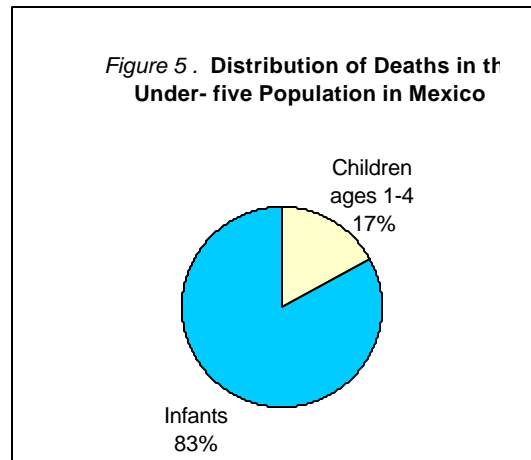
death that are common to infants and children: respiratory infections, intestinal infections and malnutrition.

A. Causes of Infant Death

Infants in Mexico suffer the greatest proportion of preventable child deaths. More than 83 percent of the estimated 50,724 deaths of children under age five in 1998 occurred within the first year of life (see Figure 5).

Approximately two-thirds of all infant deaths in 1998 resulted from perinatal illnesses and congenital anomalies.⁵⁵ (See Figure 6). Further, more than half of infant deaths occur during the neonatal period (from birth to 28 days). Thus, an infant's general state of health at birth, which includes birth weight, is an important predictor of infant mortality. Infant health, especially neonatal health, is closely associated with maternal health. As a result, some infant deaths can be prevented through improvements in the health of reproductive-age women, specifically improvements in maternal nutrition, elimination of adverse work environments and provision of emergency obstetric care.

Figure 5. Distribution of Deaths in the Under-five Population in Mexico



⁵⁵ Secretariat of Health, *Principales causas de mortalidad infantil, Estados Unidos Mexicanos 1998, [Main causes of Child Mortality, United Mexican States]* in MORTALIDAD 1998, *supra* note 24 at 83. Birth defects are often the result of a congenital condition caused by cell mutations or maternal malnutrition, and are therefore classified as “perinatal illnesses.” Because the Mexican Secretariat of Health separates causes of infant death into “perinatal illnesses” and “congenital anomalies,” this report will make this distinction as well.

Figure 6. Leading Causes of Infant Death in Mexico, 1998

Causes	Infant mortality rate^a
1. Perinatal illnesses	745.0
2. Congenital anomalies	285.3
3. Respiratory infections ^b	173.8
4. Intestinal infections	85.1
5. Injuries (intentional and unintentional) ^c	57.5
6. Nutritional deficiencies	47.9

^a Represents rate per 100,000 population under one year of age.
^b Represents combined deaths from acute respiratory infections, influenza and pneumonia.
^c Represents combined deaths from accidental suffocation and drowning, traffic-related accidents, intentional violence, natural disasters and unspecified others.
Source: SECRETARIAT OF HEALTH, MORTALIDAD 1998 at 83.

1. Perinatal Illnesses

Perinatal illnesses are conditions that occur during gestation or in the neonatal period of an infant's life. In Mexico, in 1998, approximately 46 percent of all infant deaths occurred during the first six days of life, and 60 percent of infant deaths occurred in the period from birth to 28 days.⁵⁶ Because perinatal illnesses are defined by the age at which they occur, various health problems that affect infants, may be included in this category. The leading causes of neonatal mortality in Mexico are disorders related to a short gestation, low birth weight, infections and respiratory problems.⁵⁷

Low birth weight and other gestational problems are associated primarily with maternal health, such as a woman's pre-pregnancy weight, nutritional health and obstetric care. Further, sociodemographic factors of the mother, such as a woman's age (either under age 16 or over age 35), multiparity (women who have had more than five previous pregnancies), low socioeconomic class and low education place a woman at risk for having infants with low birth weight.⁵⁸ Finally, environmental risk factors, such as

⁵⁶ SECRETARIAT OF HEALTH, *Niveles de la Mortalidad Infantil por Grupos de Edad Según entidad Federativa de Residencia Habitual 1998*, [Child Mortality Levels by Age Group and State of Residence, 1998] in MORTALIDAD 1998 *supra* note 24 at 21.

⁵⁷ SECRETARIAT OF HEALTH, *Defunciones Generales según Causa de Muerte y Grupos de Edad, Estados de México*, [Deaths by Cause of Death and Age Group, Mexican States] in MORTALIDAD 1998, *supra* note 24 at 51-52.

⁵⁸ See e.g., Geraldine Perry, et al., The Centers for Disease Control and Prevention Pregnancy Nutrition Surveillance System, *Nutritional Risk Factors Among Low-income Pregnant U.S. Women*, 19 SEMINARS IN

exposure to toxins, have also been correlated with low birth weight. Because perinatal illnesses are so closely tied to fetal development during gestation, maternal health plays a crucial role in whether an infant will develop such a disease.⁵⁹ State policies that aim to decrease preventable child deaths, therefore, must include programs that improve maternal and prenatal health care.

2. Congenital Anomalies

Congenital anomalies are defects that are present at birth. In Mexico, infants die primarily from anomalies such as malformations of the circulatory system, deformities that interfere with digestion, anencephaly and spina bifida.⁶⁰ Because little is known about the specific causes of congenital anomalies, it is unclear the extent to which they are preventable. There have been some attempts, however, to find links between maternal environment and the development of defects in the fetus. Although a clear correlation has not been established, various studies suggest a connection between a mother's exposure to toxins and abnormal fetal development.⁶¹ For example, in the early 1990s a number of children with anencephaly were born in Texas and in Matamoros, Tamaulipas, a Mexican border town. Subsequent studies revealed that of the women identified as having a pregnancy affected by a neural tube defect (spina bifida or anencephaly), 94.4 percent were Hispanic.⁶² Some researchers contend that the high incidence of such defects, particularly in Mexico, can be attributed to exposure to a chemical, Xylene, which is used in U.S.-owned factories located in Mexico.⁶³ Congenital anomalies, once thought to occur by chance, may be associated with such factors as

PERINATOLOGY, 211-221 (1995) and general information on Pregnancy Nutrition Surveillance System available at <http://www.cdc.gov/nccdphp/dnpa/PNSS.htm>.

⁵⁹ Maternal factors that can increase a child's vulnerability to death are discussed in Section VII A.

⁶⁰ SECRETARIAT OF HEALTH, *Defunciones Generales segun Causa de Muerte y Grupos de Edad, Estados de México*, [Deaths by Cause of Death and Age Group, Mexican States] in MORTALIDAD 1998, *supra* note 25 at 52.

⁶¹ See Section VII A 2, *infra*, for a further discussion on how a woman's environment and working conditions affect the health of her children.

⁶² *Neural Tube Defect Surveillance and Folic Acid Intervention -Texas-Mexico Border, 1993-1998*, 1 MORBIDITY AND MORTALITY WKLY. REP., Jan. 14, 2000 at 1.

⁶³ See e.g., *The Poison Next Door; Low Risk . . . High Yield; Bad Attitude; Update on "The Human Cost," Primetime Live* (ABC News transcript, June 11, 1992). Xylene is a synthetic chemical derived from petroleum and is produced in large quantities in the U.S. Xylene is used as a solvent in printing, in rubber and leather production and as a material in chemical, plastics and synthetic fiber industries. Because Xylene is a liquid, it can leak into soil, surface water or ground water, and may also evaporate then linger in the air for several days. Short-term exposure to Xylene causes skin and lung irritation, and the chemical has also been shown to cause harm to fetuses and may cause death. Eco-USA, available at <http://www.eco-usa.net/toxics/xylene.html> (excerpting information from the Agency for Toxic Substances and Disease Registry United States Public Health Service, *Toxicological Profile for Xylene August 1995 Update*).

maternal exposure to toxins, thus indicating that some deaths due to congenital defects may, in fact, be preventable.

B. Causes of Death in Children Aged One through Four

Although infants and children die from some of the same causes, children aged one through four are at a higher risk of dying from injuries than younger children. (See Figure 7 below). In 1998, approximately one quarter of all child deaths in Mexico resulted from injuries, both accidental and intentional.

Figure 7. Leading Causes of Death among Children Aged One through Four in Mexico, 1998

Causes	Child mortality rate ^a
1. Injuries (intentional and unintentional) ^b	21.5
2. Respiratory infections ^c	12.0
3. Congenital anomalies	11.3
4. Intestinal infections	10.5
5. Nutritional deficiencies	6.9

^a Represents rate per 100,000 population aged 1 to 4 years.
^b Represents combined deaths from accidental suffocation and drowning, traffic-related accidents, intentional violence, natural disasters and unspecified others.
^c Represents combined deaths from acute respiratory infections, influenza and pneumonia.
Source: MORTALIDAD 1998 at 87.

Intentional and Unintentional Injury

Among the 29 Organization for Economic Co-Operation and Development countries (OECD), Mexico has the second highest child mortality rate from injuries (both intentional and unintentional).⁶⁴ Furthermore, its injury death rate is twice as high as countries with similar wealth.⁶⁵ A majority of the injuries are what the Secretariat of Health terms “accidents,” including accidental suffocating and drowning as well as traffic accidents.

The unintended nature of many injury deaths in Mexico does not mean that the likelihood of a child being injured or the severity of that injury cannot be significantly

⁶⁴ UNICEF, INNOCENTI REPORT CARD, *A League Table of Child Deaths by Injury in Rich Nations*, Issue No. 2, at 4 (Feb. 2001). The study compared the 29 member-countries of the Organization for Economic Co-Operation and Development, which includes the countries that produce two-thirds of the world’s goods and services.

⁶⁵ *Id.* at 6.

reduced. Developed nations that have reduced the risk of child death from accidents have done so through government initiatives such as legislative changes (drunk-driving laws, child safety seat laws, legislation regarding safety measures in rental property), improved safety standards (flame resistant clothing, electrical safety standards, “child-safe” packaging for pharmaceuticals) and public awareness campaigns (swimming lessons for children, free smoke alarm programs).⁶⁶ Such risk-reducing interventions are crucial to reducing child mortality from accidents.

A small proportion of child deaths in Mexico are classified as homicides or as the result of intentional injury. In 1998, however, the Secretariat of Health, classified over half of accidental child deaths (52 percent) as “other accidents, including latent effects.”⁶⁷ A children’s rights activist in Mexico commented that the category “other accidents” not only includes domestic violence but that, in fact, most child deaths are caused by intentional violence.⁶⁸ The incidence of domestic violence (both abuse and neglect) can be reduced through such measures as domestic violence legislation, mandatory reporting laws, government services and aid for children and family members who experience violence, and public awareness campaigns. Domestic violence as a factor in child mortality is discussed in detail below.

C. Causes of Death Common to Infants and Children

While there are a number of age-specific causes of death, three leading causes of death are common to both infants and children. These particular causes of death are closely associated with marginalized communities: respiratory infections, intestinal infections and malnutrition. It is significant that each of these illnesses can be prevented or treated by currently available and inexpensive primary health care measures such as the provision of clean water and sanitation services, immunizations, oral rehydration therapy and food sufficiency.

1. Respiratory Infections

Of acute respiratory infections, pneumonia accounts for over three-quarters of all child deaths.⁶⁹ Because pneumonia is a disease of short duration, it is essential that treatment be given immediately. Bacterial respiratory infections can be treated with antibiotics. Most deaths, however, occur because of delay or failure to seek treatment.⁷⁰

⁶⁶ *Id.* at 12.

⁶⁷ MORTALIDAD 1998, *supra* note 24, *Principales causas de mortalidad preescolar, Estados Unidos Mexicanos 1998, [Main Causes of Death Among Preschoolers, United Mexican States, 1998]* at 87.

⁶⁸ Interview, Oct. 24, 2000 (Children’s Rights NGO, Mexico City).

⁶⁹ MORTALIDAD 1998, *supra* note 24, *Defunciones Generales Segun Causa de Muerte (Lista Mexicana) y Grupos de Edad*, at 43-53.

⁷⁰ World Health Organization, *Reducing Mortality from Major Childhood Killer Diseases*, Fact Sheet No. 178 at 3, available at <http://www.who.int/inf-fs/en/fact178.html> (revised Sept. 1998).

It is, therefore, imperative to maintain readily accessible treatment as well as to educate mothers and caretakers about the warning signs and the importance of seeking treatment from health care professionals. Risk factors for acute respiratory infections include malnutrition and low birth weight.⁷¹

2. Intestinal Infections

Diarrhea and gastroenteritis are the leading causes of death from intestinal infections in Mexican infants and children. Diarrheal diseases, and subsequent dehydration, are both preventable and treatable through a prompt increase in a child's fluid intake (oral rehydration therapy). Risk factors contributing to diarrheal diseases include lack of adequate clean water and adequate sanitation, both of which are often deficient in marginalized areas, both rural and urban.

3. Malnutrition

Recent studies estimate that between 19 percent⁷² and 24 percent of Mexican children under the age of five suffer from malnutrition, a figure that has changed little since 1990.⁷³ Some sources indicate that 7.5 percent of Mexican children under five suffer "severe" malnutrition.⁷⁴ Because malnutrition can be both a primary cause of death and a contributing factor, data on mortality rates are likely underestimated since deaths due to nutritional deficiencies may be improperly registered. Malnutrition, accompanied by dehydration, weakens a child's immune system, making him more vulnerable to infectious diseases. The diseases themselves may also contribute to malnutrition by suppressing the appetite, which leads to a reduction in a child's food intake. Thus, a child's death may be attributed to diarrheal disease when the true cause of death is the combined effect of protein energy malnutrition and dehydration from diarrhea.

To say that malnutrition is caused by food scarcity is to oversimplify the nature of the problem. While child nutrition depends greatly on the provision of food by parents, malnutrition persists in countries where food is plentiful but inequitably distributed and where governmental welfare policies are inadequate to enable families to purchase nutritionally adequate food. In spite of the Mexican government's food assistance and

⁷¹ Policy Statement, American Academy of Pediatrics, *Perinatal Care at the Threshold of Viability*, Vol. 96, No. 5, at 974-976 (Nov. 1995).

⁷² *Desnutridos, más de 2 millones de niños [Malnourished: More Than 2 Million Children]*, LA JOURNADA, Mar. 6, 2000 at 8 (citing a study by the Latin-American Council for Nutritional Information).

⁷³ Guillermina Guillen, *Sufren desnutrición 24% de menores de 5 años, afirman, [They State 24% of Children Under 5 Suffer Malnutrition]*, EL UNIVERSAL, Oct. 22, 2000 at A5.

⁷⁴ Juan Gerardo Reyes, *Sufren Desnutrición Aguda 7.5% de los Niños Menores de 5 Años; es un Importante Problema de Salud Publica: INSP e INEGI, [7.5% of Children Under 5 Suffer Severe Malnutrition – It's a Serious Public Health Problem]* EXCELSIOR, Sept. 7, 2000 at 29.

minimum wage policies,⁷⁵ malnutrition remains particularly widespread and severe among children in marginalized areas of Mexico.

VI. STRUCTURAL BARRIERS TO CHILD SURVIVAL IN MEXICO

A. The Right to an Adequate Standard of Living

All children in Mexico have the equal right to a standard of living adequate for their full development and survival.⁷⁶ The right to an adequate standard of living encompasses such factors as a clean environment, safe drinking water, basic sanitation, secure housing, nutritious food and warm clothing. While parents and other caretakers bear the primary responsibility for ensuring that the child's living conditions are satisfactory, the state is responsible for adopting measures that aid and support parents in the care of their children.⁷⁷

As discussed above, the decline in the national child mortality rate in the last decades indicates that Mexican government initiatives have improved the health and living conditions of many children. Despite an overall reduction in the under-five mortality rate, however, a significant number of children have not benefited equally from government programs. In Mexico, a disproportionate number of children live in conditions of marginalization where, due to structural inadequacies, they are isolated from state services. This isolation is caused, in part, by geographic location, low income, language differences and discrimination. The Mexican government has not fully addressed the structural barriers that increase a child's risk of death. Thus, the government has not ensured that marginalized children and their parents have the basic necessities for an adequate standard of living.

1. Regional Disparities in Living Conditions

Available child mortality rates indicate that children who live in regions that experience marginalization die at significantly higher rates than other children. The National Council on Population (CONAPO) measures levels of marginalization using the following factors: family income; literacy rates; access to electricity and running water; type of housing; number of family members per home; and degree of urbanization.⁷⁸ An

⁷⁵ See *infra* section VI C 4, Mexico's Minimum Wage Structure, at 56, and section VIII b 2, Food Subsidies, at 85.

⁷⁶ As discussed in Section II, International Obligations and Child Mortality, *supra*, the Economic Rights Covenant, the Children's Convention and the Women's Convention articulate the right to an adequate standard of living. Article 4 of the Mexican Constitution also provides "Every person has the right to live in an environment that is adequate for his or her development and well-being. . . . Every family has the right to a dignified and decent housing." See Appendix E, *infra*.

⁷⁷ See Article 24, Children's Convention, *supra* note 15.

⁷⁸ CONAPO, *Grado de marginación por entidad federativa*, 1995 [*Degree of Marginalization by State, 1995*], available at <http://www.conapo.gob.mx/indicaso/indices.htm#zip>.

NGO activist in Mexico City explained that poverty is only one aspect of marginalization. “All of the marginalized are poor, but the reverse is not true. The marginalized have no access to basic services, such as water, education, basic health and electricity . . . no[r] political participation.”⁷⁹ Some illnesses, malnutrition and intestinal infections for example, are exacerbated by the conditions associated with marginalization and can result in death. In fact, child mortality rates from these causes vary greatly between the northern and southern states of Mexico. Such regional disparities, however, are not related to geography but represent disparities in wealth, education and access to state-provided services.

According to official figures from the Secretariat for Social Development, of a total population of 97 million, approximately 44 million Mexicans currently live in poverty, and of these, 18 million live in extreme poverty.⁸⁰ Independent researchers dispute these figures, however. According to recent data from the Colegio de México, a public research institute, 75 million Mexicans are poor, and of these, 45 million live in extreme poverty.⁸¹ Both official and independent sources have verified an increase in the size of the population that lives in extreme poverty.⁸² According to the World Bank, “Mexico is among the 12 poorest countries in the world . . . Forty percent of the population lives on less than 17 pesos per day (less than two U.S. dollars), equivalent to 52 percent of the minimum wage for 1998.”⁸³ Children are also disproportionately poor in Mexico. A recent UNICEF study determined that in Mexico 26.2 percent of children are currently living below the national poverty line. Among the OECD member 29 countries, Mexico had the highest child poverty rate.⁸⁴ The poor in Mexico are concentrated in the southern states, such as Oaxaca, Chiapas, and Guerrero.⁸⁵ The North is characterized by a dynamic economy. Chihuahua, Coahuila and Nuevo León, for example, are among the states with the highest GDPs in Mexico.⁸⁶

⁷⁹ Interview, Oct. 24, 2000 (Human Rights NGO, Mexico City).

⁸⁰ Interview with Josefina Vázquez Mota, Secretary of Social Development (Mar. 14, 2001), available at http://sedesol.sedesol.gob.mx/ofsec/2001/entrevistas/e_1403_02.htm.

⁸¹ Posada García, *supra* note 11.

⁸² Casa y Ciudad, AC, et al., *The Situation of Economic, Social and Cultural Rights in Mexico: Alternative NGO Report to the Mexican Government's Third Periodic Report for Presentation to the United Nations Committee on Economic, Social and Culture Rights*, Oct. 1999 at 6, 23-24 [hereinafter *Alternative NGO Report*].

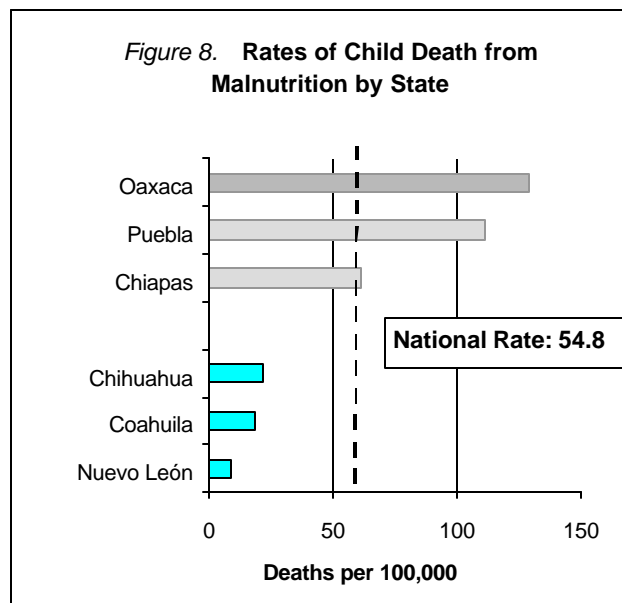
⁸³ *Id.* at 25.

⁸⁴ *A League Table of Child Poverty in Rich Nations*, *supra* note 25 at 4.

⁸⁵ Data compiled from INEGI, *Información por Entidad Federativa, Aspectos económicos, Producto Interno Bruto, 1993-99* [Information by Federal Entity, Economic aspects, Gross Domestic Product, 1993-1999], available at <http://www.inegi.gob.mx/entidades/espanol/fentidades.html>.

⁸⁶ *Id.*

States with the highest levels of poverty suffer the greatest food insufficiency, and scarcity of family resources often precedes conditions of malnutrition. In Mexico, the rates of child death from malnutrition are highest in the economically poorest regions of the country. The prevalence of malnutrition in the South is 29 percent, in the North it is slightly more than seven percent and in the central region, including Mexico City, the malnutrition rate fluctuates between 13 and 14 percent.⁸⁷ In rural areas, the prevalence is 32 percent, in contrast to urban areas where the malnutrition rate is 12 percent.⁸⁸ Figure 8 shows that the rates of child death from malnutrition are on average six times higher in three southern states, Chiapas, Oaxaca and Puebla, than in the northern states.⁸⁹ The rate of death from malnutrition in Oaxaca is 14 times higher than the mortality rate in Nuevo León. From the differences in child mortality rates from malnutrition by region, it can be inferred that there continue to be inequalities in food allocation. Although Mexico has reduced its national malnutrition rate in the last decade, the reduction was less than that achieved in other developing countries in the same period.⁹⁰ If the reduction in malnutrition continues at its present rate, by some estimates, it will take 15 years for the prevalence of malnutrition in Mexico to become comparable to countries considered to have a healthy state of nutrition.⁹¹



⁸⁷ Instituto Nacional de Salud Pública, *Niños menores de cinco años in ENCUESTA NACIONAL DE NUTRICIÓN 1999*, TOMO 1, at 7, 55 (2000) [National Institute of Public Health, *Children Under Age Five in NATIONAL NUTRITION SURVEY 1999*, VOLUME 1]. See Appendix A, *infra*, map of the United Mexican States.

⁸⁸ *Id.*

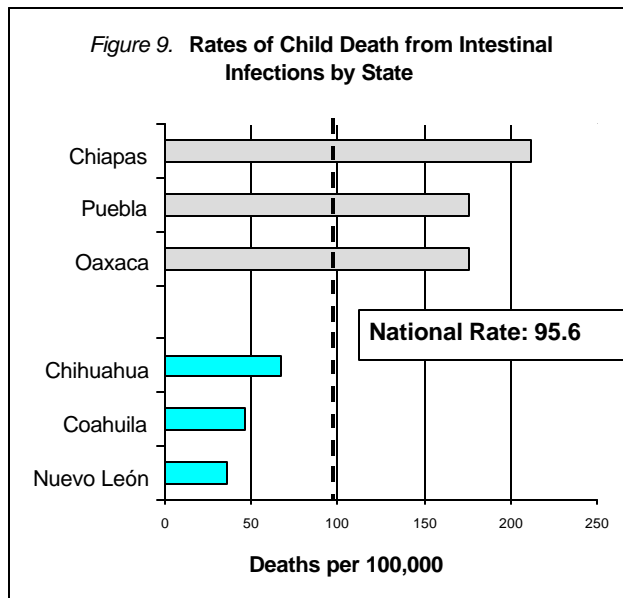
⁸⁹ Figure 8 was created from data from INEGI and the Secretariat of Health, LA SITUACIÓN DE LA SALUD [THE SITUATION OF HEALTH], *Principales causas de mortalidad infantil* [Principal causes of infant death] (1998) and *Principales causas de mortalidad preescolar* [Principal causes of pre-school age death] (1998).

⁹⁰ Instituto Nacional de Salud Pública, *Niños menores de cinco años in ENCUESTA NACIONAL DE NUTRICIÓN 1999*, TOMO 1, at 7, 55 (2000), *supra* note 37 at 52-53.

⁹¹ *Id.* at 53.

The lower child mortality rates in Mexico's northern states are not due to economic prosperity alone. Mexico's northern states are more urbanized than the southern states. Cities typically have resources that are not available in rural areas. According to the 2000 Census figures, approximately 25 million Mexicans (about a quarter of the total population) live in communities of under 2,500 residents.⁹² In the South, for example in Chiapas, Guerrero and Oaxaca, roughly half of the population lives in rural communities, as compared

to less than 20 percent of the populations of Coahuila, Chihuahua and Nuevo León. Consequently, from 20 to 30 percent of the population in Chiapas, Oaxaca and Puebla has no running water, and between 40 and 55 percent of the families in these states live in homes with no sewage systems. In contrast, only between five and seven percent of the population Chihuahua, Coahuila and Nuevo León lacks drinking water, and from 11 to 20 percent of families are without access to sanitation services.⁹³ Another example of disparities in resource allocation in Mexico is the fact that the northern states have on average almost twice



as many doctors per capita than the southern states.⁹⁴ Hence, people in the South not only have higher levels of poverty, but also have less access to services than other Mexicans.

Children who live in rural regions that lack basic services, such as clean water and sanitation, are particularly at risk for diarrheal diseases. In fact, as Figure 9 illustrates, children in Mexico's poor and rural states die from intestinal infections more than twice as often as children in urbanized states with higher per capita GDPs.⁹⁵ The states with the highest under-five mortality rates from intestinal infections are Chiapas, Guerrero,

⁹² Data compiled from INEGI, *Información por Entidad Federativa, Aspectos sociodemográficos*, [Information by Federal Entity, Socio-demographic Aspects,], available at http://www.inegi.gob.mx/estadistica/espanol/sociodem/asentamientos/ase_05.html.

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ Figure 9 was created from data from INEGI and the Secretariat of Health, LA SITUACIÓN DE LA SALUD [THE SITUATION OF HEALTH], *Principales causas de mortalidad infantil* [Principal causes of infant death] (1998) and *Principales causas de mortalidad preescolar* [Principal causes of pre-school age death] (1998).

Oaxaca and Puebla. Significantly, in Chiapas and Oaxaca, intestinal infections are the leading cause of death of children aged one through four.⁹⁶

The rural communities in Mexico are particularly underserved when compared to some other Latin American countries. For example, the rural populations of Chile, Mexico and Cuba are roughly between 15 and 25 percent of the total population.⁹⁷ Whereas only a third of the rural population in Mexico has access to adequate sanitation facilities, over 90 percent in of the rural population of Chile, and over 91 percent of the rural population of Cuba have such access.⁹⁸ In Cuba, 82 percent of the rural population has safe drinking water, whereas in Mexico only 63 percent of the rural population has access to clean water.⁹⁹ The under-five child mortality rates in both Chile and Cuba are less than half the rate for Mexico.¹⁰⁰ The lower child mortality rates in these countries suggests that the provision of comprehensive services to rural areas can reduce preventable child deaths.

Marginalized communities also exist in urban areas. In Mexico, the number of urban poor is increasing.¹⁰¹ Some researchers even contend that “the majority of those in extreme poverty . . . live in urban zones and not in rural areas.”¹⁰² For instance, the indigenous people who have migrated to Mexico City, despite living in the most urbanized region of the country, often live in substandard conditions. As one lawyer explained, “in the Federal District, two or three families, each with three members, live in one room. They live without basic services - no water, no bathroom, no electricity and no heat.”¹⁰³ Despite the fact that children in metropolitan areas are expected to be more likely to survive than children in remote rural areas, recent statistics do not entirely reflect this trend. The 1998 under-five child mortality rate for the Federal District was 21 deaths per 1,000 and for the state of Mexico it was 23.7, as compared to the national rate of 16.8 deaths per 1,000.¹⁰⁴

⁹⁶ INEGI, *Información por Entidad Federativa, Aspectos sociodemográficos*, [Information by Federal Entity, Socio-demographic Aspects], *supra* note 92.

⁹⁷ See Figure 2, National Child Mortality Rates in Relation to GNP Per Capita and Other Social Indicators, *supra* at 15.

⁹⁸ STATE OF THE WORLD'S CHILDREN *supra* note 3 at 86-87.

⁹⁹ *Id.*

¹⁰⁰ *Id.* at 77.

¹⁰¹ Emilio Pradilla Cobos, *Pobreza y política económica y social* [Poverty and economic and social politics], LA JORNADA, Oct. 4, 2000.

¹⁰² Posada García, *supra* note 11.

¹⁰³ Interview, Oct. 23, 2000 (Indigenous Rights NGO, Mexico City).

¹⁰⁴ The relatively high child mortality rates in Mexico City and the surrounding region may be due to the fact that births and deaths of children are often underreported in rural areas as compared to reporting in

It is likely that the increase in the population of Mexico's industrial centers has contributed to child deaths from injuries. Specifically, the number of young children living and working in the streets in Mexican cities has greatly increased in recent years. A joint study by UNICEF and the Mexican government in 100 cities (excluding Mexico City) determined that there are approximately 140,000 children living and working in the streets, roughly 12 percent under the age of five.¹⁰⁵ In Mexico City, it is estimated that there are 14,000 children in the streets, 1,500 of which are under the age of six.¹⁰⁶ Such young children generally do not live in the street but accompany their parents while they work. Infants and young children can be observed sleeping in boxes or on pieces of cardboard on the sidewalk. The fact of living and working in public places increases a child's exposure to dangerous situations that, in turn, leads to an increased risk of death from accidents and violence.¹⁰⁷ For example, the 1998 under-five mortality rates from unintentional injuries in two states along the U.S. border, Baja California and Chihuahua, were roughly double the national rate while the mortality rate in many rural states was below the national average.¹⁰⁸ The increased presence of young children on the streets in Mexico's urban centers is directly related to the current economic situation as well as a lack of services, such as affordable day-care for working parents.

The dramatic differences in child mortality rates by cause and by region indicate that governmental programs designed to aid marginalized communities are not alleviating disparities across children. The data also indicate that a particular segment of the population, consisting of marginalized people, is being denied their basic rights. When structural barriers, such as the failure to provide sanitation services to all communities, the failure of the state to create a health care system that can be accessed by all and the failure to improve the living conditions of the poor, contribute to child death, that child has been deprived of her right to the highest attainable standard of health and to the right to an adequate standard of living. Furthermore, when the government policies fail to address the structural barriers that play a part in preventable child mortality, the child has been deprived of his inherent right to survive and develop fully.

urban areas, and this artificially lowers recorded rural under-five mortality rates. See Section IV B, Discrepancies in Vital Statistics, *supra* at 17; for a fuller discussion of underreporting in Mexico.

¹⁰⁵ UNICEF and Desarrollo Integral de la Familia (DIF), *Yo tambien cuento! Estudio de Niñas, Niños y Adolescentes Trabajadores en 100 Ciudades [I count too! A Study of Girls, Boys and Adolescent Workers in 100 Cities]* (1999) (mimeographed reports on file with Minnesota Advocates for Human Rights).

¹⁰⁶ Flores Gonzalez, *DIF: mil 500 menores de 6 años laboran en las calles, [One thousand five hundred under the age of 6 working in the streets]*, UNO MÁS UNO, Jan. 21, 2000 at 13.

¹⁰⁷ Interview, Sept. 7, 2000 (Children's Rights NGO, Oaxaca City).

¹⁰⁸ INEGI, Dirección General de Estadística, [Director General of Statistics] (1998).

2. Discrimination Against Indigenous Peoples

According to a 1995 study by the National Institute on Indigenous Peoples (INI), the indigenous population in Mexico is over 10 million, approximately one tenth of the total population.¹⁰⁹ The Mexican government estimates that 96 percent of the indigenous community is concentrated in 13 areas, located in the central region, the south and the southeast of the country. The indigenous population in Mexico is also generally young, 40 percent are under 14 years old.¹¹⁰ It is important to note, however, that experts who work with indigenous communities in Mexico state that the government has been unable to determine the exact number of indigenous people living in the country.¹¹¹ The imprecision in official data on the indigenous population may result from the lack of a clear definition or methodology for identifying a person as “indigenous.” In Mexico, a locality is characterized as “indigenous” for the national census when 70 percent or more of the inhabitants speak their native language. The census also includes children under age four who live in homes in which the head of the household speaks an indigenous language.¹¹²

Using language as a criterion for defining a person as indigenous does not take into consideration many other cultural traits that identify people as members of indigenous groups. Such other traits include “[wearing] traditional clothing, belonging to a community located in a specific territory, integration with social-cooperative networks, knowledge of the natural habitat, production of household items for personal use and the idea of a common past which sometimes expresses itself in a shared plan for the future.”¹¹³ Furthermore, the Secretariat of Social Development suggested that the census does not categorize people as indigenous if they speak Spanish in addition to an indigenous language.¹¹⁴ Therefore populations that otherwise have many traits of an indigenous community are not identified as such.

Despite imprecise statistics about who is indigenous, it is well-documented that the indigenous peoples in Mexico are disproportionately marginalized. The National

¹⁰⁹ Instituto Nacional Indigenista, *supra* note 6.

¹¹⁰ Gerardo Rodríguez, *Niñ@s indígenas en México*, in *LOS HECHOS SE BURLAN DE LOS DERECHOS: IV INFORME SOBRE LOS DERECHOS Y LA SITUACIÓN DE LA INFANCIA EN MÉXICO 1994-1997*, at 164 (COMEXANI ed., 1998).

¹¹¹ Interviews, Sept. 6, 2000 (Secretariat of Social Development (SEDESOL), Mexico City); Oct. 23, 2000 (Indigenous Rights NGO, Mexico City).

¹¹² SECRETARIAT OF HEALTH, *LA SALUD DE LOS PUEBLOS INDÍGENAS, UNA CONQUISTA IMPOSTERGABLE [THE HEALTH OF INDIGENOUS PEOPLE, AN ACHIEVEMENT WE CAN'T POSTPONE]* CUADERNOS DE SALUD, 14 (1994).

¹¹³ PALOMA BONFIL SÁNCHEZ & RAÚL MARCÓ DEL PONT LALLI, *LAS MUJERES INDÍGENAS AL FINAL DEL MILENIO 11 [INDIGENOUS WOMEN AT THE END OF THE MILLENNIUM]* (1999).

¹¹⁴ Interview, Sept. 6, 2000 (Secretariat of Social Development, Mexico City).

Council on Population reports, “the large majority of the indigenous population of the country lives in a situation of extreme poverty and lives in very precarious conditions; they suffer from serious deficiencies in housing, basic infrastructure and health care; they experience elevated proportions of illiteracy . . . they suffer high rates of unemployment and underemployment.”¹¹⁵

Children in indigenous communities are particularly vulnerable to death before reaching age five. Mortality rates for both indigenous infants and children are almost double the rates for Mexico as a whole. For example, recent data about indigenous women between the ages of 25 and 29 revealed that 8.5 percent of their children had died at the time of the 1990 census, as compared to the national average of 4.7 percent.¹¹⁶ The infant mortality rate varies from 17.5 to 39.4 per 1,000 live births among indigenous populations.¹¹⁷ In a discussion of mortality rates of indigenous children, it is also important to note that the Mexican indigenous community is not uniform. There are 56 ethnic groups in Mexico that are considered indigenous, and they speak 62 distinct languages. While certain states with large indigenous populations, such as Oaxaca, Veracruz, Chiapas and Puebla, exhibit elevated rates of child mortality, research has also found variation between indigenous groups.¹¹⁸

The indigenous in Mexico experience marginalization in many forms. The indigenous population tends to be concentrated in poor, rural municipalities that lack basic services. The states with high rural populations also have large indigenous populations. Approximately 37 percent of the population of Oaxaca and 25 percent of the population of Chiapas speaks an indigenous language, compared to less than one percent of the populations of Coahuila and Nuevo León and three percent of the population of Chihuahua.¹¹⁹

¹¹⁵ CONAPO, *Ejecución del Programa de Acción de la Conferencia Internacional sobre la Población y el Desarrollo, México Informe*, [Implementation of the program for action of the international conference on population and Development – Report of Mexico] 112 (1999).

¹¹⁶ Bonfil Sánchez, *supra* note 113 at 138.

¹¹⁷ UNICEF Information on Mexico: Mexico. (CRC) (Report of UN Agencies/Organs) at www.unhchr.ch/tbs/doc.nsf (June 10, 1999).

¹¹⁸ For example, the mortality rate for infants whose mothers speak Chontal is 33 per 1,000 as compared to mothers who speak Zapoteco, 40 per 1,000, or Tojolabal, 87 per 1,000. Such differences have not been explained, but may be related to the fact that the number of children born per woman varies by indigenous group. *Mexico: Basic Country Health Profiles*, Epidemiological Bulletin, Vol. 21, No. 3, Pan American Health Organization (1999) at <http://www.paho.org/English/SHA/prflmex.htm>.

¹¹⁹ Information from the 2000 census regarding the over-five population that speaks an indigenous language and the number of households where the head of household speaks an indigenous language. XII General Census of Population and living Conditions, *supra* note 5 at <http://www.inegi.gob.mx/entidades/espanol/entidades.html>. See Appendix A, *infra*, map of the United Mexican States.

A 1996 survey by National Institute of Nutrition revealed that the malnutrition level among indigenous children reached 43 percent.¹²⁰ The 1999 National Nutrition Study concluded that the prevalence of malnutrition is the highest in areas where most of the indigenous populations live, in southern and rural areas, reflecting a “polarization in living conditions” between different regions of Mexico.¹²¹ Box 3, below, illustrates that rural indigenous people often live in such precarious conditions, in small and distant communities, that they are heavily affected by environmental changes and underserved by government welfare programs.

Box 2. Child Malnutrition among the Tarahumara

The Tarahumara (who refer to themselves as *arámuri*) are the largest indigenous group in Northern Mexico, representing 88 percent of the total indigenous population of the state of Chihuahua but only 3 percent of the entire state population.¹²² The Tarahumara are the “poorest and most marginalized in the state.”¹²³ They are subsistence farmers, growing corn, beans, potatoes and squash. They live in small communities in houses made of logs or stone, consisting of one room with a dirt floor. Running water, electricity and sewage services are “practically nonexistent.”¹²⁴ The Tarahumara have been experiencing a severe drought for several years, which has led to food scarcity and thus an increase in the number of child deaths from malnutrition. A recent evaluation of the under-five Tarahumara population revealed that 53 percent of the children suffer “slight malnutrition,” 24 percent suffer “moderate malnutrition” and 1.3 percent suffer “severe malnutrition.”¹²⁵ The study concludes that the high malnutrition rates in this indigenous group are not due to ethnic or racial differences but are due to outside factors; “the Tarahumara child is a victim of socioeconomic marginalization more than geographical.”¹²⁶

Although many indigenous people live in rural areas, the Federal District currently has the largest indigenous population in the country.¹²⁷ In fact, non-official sources suggest that there are half a million indigenous people living in Mexico City,

¹²⁰ INSTITUTO NACIONAL DE LA NUTRICIÓN, ENCUESTA NACIONAL DE ALIMENTACIÓN Y NUTRICIÓN EN EL MEDIO RURAL 1996 [NATIONAL NUTRITION INSTITUTE, NATIONAL DIET AND NUTRITION STUDY IN RURAL AREAS 1996] [hereinafter INN NUTRITION STUDY].

¹²¹ INSTITUTO NACIONAL DE SALUD PÚBLICA, *Niños menores de cinco años in ENCUESTA NACIONAL DE NUTRICIÓN 1999*, TOMO 1, [NATIONAL INSTITUTE OF PUBLIC HEALTH, *Children Under Age Five in NATIONAL NUTRITION SURVEY 1999*, VOLUME 1] at 55 (2000).

¹²² J. Monárrez, H. Martínez, *Prevalencia de desnutrición en niños tarahumaras menores de cinco años en el municipio de Guachochi, Chihuahua*, [Prevalence of malnutrition in under 5 Tarahumara children in Guachochi municipality of Chihuahua] 42 SALUD PUBLICA MEX No. 1, at 9 (Jan.-Feb. 2000).

¹²³ Carlos Coria Rivas, *Desnutridos, 1,042 niños*, [Malnourished: 1,042 Children], EL UNIVERSAL, Oct. 21, 2000 at 18B.

¹²⁴ Monárrez, *supra* note 122.

¹²⁵ *Id.* at 14.

¹²⁶ *Id.* at 13.

¹²⁷ Interviews, Sept. 4, 2000 (UNICEF, Mexico City); Oct. 23, 2000 (Indigenous Rights NGO, Mexico City).

representing a number of different groups.¹²⁸ The urban indigenous generally “live in conditions of poverty, frequently extreme poverty, and occupy positions in work and society which are the lowest, most vulnerable and precarious . . . and within [this group] women and children are the most disfavored.”¹²⁹ The UN Rapporteur on Indigenous Populations confirmed the view that the increase in indigenous populations in Mexico’s large cities has led to a greater awareness of their plight, but one which the government has not yet fully addressed. Migration of the indigenous has “created new challenges . . . for the government who bears major responsibility in finding solutions.”¹³⁰ While the marginalized indigenous populations “was for decades considerably out of sight [of] the more developed part of the country, [they are] now inhabiting urban centers.”¹³¹ This shift in the population has led to “intense contacts, contrasts and shocks between Mexicans living in different development and cultural dimensions.”¹³²

Because indigenous children suffer high rates of poverty and other forms of marginalization, they continue to die from preventable causes at rates significantly higher than other children. Such indigenous children have not benefited from the overall reduction in child mortality in Mexico to the same extent as non-indigenous children. The resulting higher mortality rate shows the discriminatory impact of the economic development and the poverty alleviation programs in Mexico. When indigenous children lack access to essential state-provided services, such as nutritional programs, health insurance programs and basic sanitation, in larger numbers than non-indigenous children, the state has failed to provide an adequate standard of living to all children, regardless of race or ethnicity. Furthermore, the Mexican government’s understanding of child mortality among indigenous populations is constrained by the lack of child mortality data disaggregated by ethnicity. This lack of data reflects a failure to systematically confront the issue of children’s health and survival with respect to these most vulnerable communities.

3. Discrimination Against Girls

Discrimination against women and girls also impacts infant mortality rates. In developed countries, mortality rates for both infants and children are generally higher for boys than for girls.¹³³ The reverse, however, is often the case in developing countries where “the advantage that girls have over boys in terms of survival is sometimes

¹²⁸ Interview, Oct. 23, 2000 (Indigenous Rights NGO, Mexico City).

¹²⁹ Bonfil Sánchez, *supra* note 113 at 275-276.

¹³⁰ Erica-Irene A. Daes, *Human Rights of Indigenous Peoples*, Report of the Chairperson-Rapporteur of the Working Group on Indigenous Populations UN Comm’n H. R., at 9, U.N. Doc. E/CN.4/Sub.2/2000/CPR.1 (2000) (regarding the situation of the indigenous peoples of Mexico).

¹³¹ *Id.*

¹³² *Id.*

¹³³ Ansley J. Coale, *Excess Female Mortality and the Balance of Sexes in Population: An Estimate of the Number of ‘Missing Females,’* 17 POPULATION & DEV. REV. NO. 3, at 518-19 (Sept. 1991).

outweighed by other factors, including discriminatory child-care practices favoring boys that lead to excess female mortality among children.”¹³⁴ In a report on development, the World Bank stated:

*Child mortality captures the effect of preferences for boys because adequate nutrition and medical intervention are particularly important for the age group one to five. Because of the natural female biological advantage, when child mortality is as high as or higher than male child mortality, there is good reason to believe that girls have been discriminated against.*¹³⁵

The World Bank has documented a higher rate of death for girls from age one to five in Mexico. The most recent statistics show that of children ages one through five, 17 girls per 1,000 children die, while 15 boys per 1,000 die.¹³⁶ Not all studies have found higher mortality rates for girl children but acknowledge, as one study explains, “more boys are born, but boys are at a higher risk of dying as well, because of biological reasons. Nonetheless, girls receive less attention and care than boys, with regard to nutritional needs and other necessities of care, which makes girls more vulnerable to certain diseases and malnutrition. Quality of life is also decreased, as girls lack opportunities for recreation, and are restricted to ‘women’s work’ in domestic areas.”¹³⁷

Data provided by the Mexican Secretariat of Health on under-five mortality rates are not categorized by sex of the child. Epidemiological and statistical data collected by the Institute of Public Health, however, are divided between males and females. While such data do not appear to support the finding that more girl children die in Mexico than boys, data on child mortality in Oaxaca for 1999 suggests that there are significant differences in how girls and boys are treated that affect mortality rates. For example, while the data indicate that more infant boys die than girls, by the age of one, the mortality rates for girls and boys aged one to five is about equal. The *causes* of death for girls and boys at this age, however, are different. For boys, malnutrition is the fourth leading cause of death, whereas it is the second leading cause of death for girls.¹³⁸

A pilot study carried out by the Secretariat of Health among the Otomi-Mazahua, in the state of Mexico showed that 57.6 percent of girls and 35.5 percent of boys under

¹³⁴ U.N. DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS, POPULATION DIVISION, UNITED NATIONS, HEALTH AND MORTALITY: A CONCISE REPORT, 12-13 (1998).

¹³⁵ THE WORLD BANK GROUP, WORLD DEVELOPMENT INDICATORS 2000, at 21 (2000).

¹³⁶ *Id.*, Table 2.18, *Mortality*, at 107.

¹³⁷ UNIFEM & COMISIÓN NACIONAL DE MUJER, MUJERES MEXICANAS AVANCES Y PERSPECTIVAS, 20 [MEXICAN WOMEN, ADVANCES AND PERSPECTIVES] (1999) [hereinafter MUJERES MEXICANAS AVANCES].

¹³⁸ Servicios de Salud de Oaxaca, Dirección de Planeación y Desarrollo [Oaxaca Health Services, Planning and Development Office], *Principales Causas de Mortalidad 1999 (Preescolar - Hombres/ Mujeres)* [Leading Causes of Mortality 1999] [Preschool –Males/Females] (2000).

the age of five suffer from malnutrition.¹³⁹ A similar disparities between the sexes was also observed in the northern states of Tamaulipas, Nuevo León and San Luis Potosí. In the central states, the study found that more girls than boys were underweight.¹⁴⁰ One Mexican NGO specifically addresses this type of disparity in survival rates between girls and boys, in part through a project based in Chiapas, which aims to teach girls about their equal rights to health care.¹⁴¹

In Mexico, discrimination against girls results in “the limited access of girls to education, food and health services”¹⁴² but may also take the form of physical abuse. According to a study of children seen by the National Institute of Pediatrics, girls made up 57 percent of the patients while 43 percent were boys.¹⁴³ The majority of the cases were classified as “trauma” while the rest included sexual abuse, burns, negligence, and all were considered harm of a severity that could lead to death.¹⁴⁴ Recently, the Commission on Human Rights of the Federal District reported that the homicide rate for the population of girl children in Mexico City is three times higher than for boys and that girls die eleven times more often from physical abuse than boys.¹⁴⁵ Likewise, the Center for Therapy and Support of Victims (CAVI), under the Prosecutor General of the Federal District, reported that of all the victims of violence under the age of 13 treated by the center, 70 percent were girls.¹⁴⁶ Such statistics indicate that girls are at a higher risk of dying from preventable causes than boys due to discrimination. Governmental programs, however, have not adequately focused on the discriminatory treatment of girls as a factor of child mortality.

¹³⁹ Miriam Ruiz, *Más niñas que niños menores de cinco años mueren por desnutrición* [More Girls than Boys Under the Age of Five are Dying From Malnutrition], Comunicación e Información de la Mujer (hereinafter CIMAC), Apr. 26, 1999.

¹⁴⁰ *Id.*

¹⁴¹ Interview, Sept. 6, 2000 (CIDEM, Mexico City).

¹⁴² MUJERES MEXICANAS AVANCES *supra* note 138 at 17.

¹⁴³ Programa Nacional contra la Violencia Intrafamiliar (PRONAVI) 1999-2000, March 1999 at 8.

¹⁴⁴ Verónica Hernández, *Apenas uno por ciento del total de casos que atiende el CAVI sigue proceso legal*, [Barely One Percent of All the Cases that CAVI Investigates are Prosecuted], CIMAC, Sept. 10, 1999.

¹⁴⁵ It is not clear whether girls of all ages, or young girls in particular, suffer such high rates of violence as the Human Rights Commission of the Federal District, in its findings, did not distinguish between girl infants, young children and adolescents (through age 17). Mónica Chavarría, *Las niñas, especialmente vulnerables a morir en casa CDHDF*, [Girls are Especially Vulnerable to Dying at Home According to the CDHDF], CIMAC, Mar. 11, 2001.

¹⁴⁶ The information reported by the Centro de Terapia y Apoyo para Víctimas (CAVI) corresponds to a nine-month period in 1997. UNICEF México, available at <http://www.unicef.org/mexico/programas/violencia.htm>.

B. The Right to an Adequate Level of Health Care

A child's right to enjoy the highest standard of health possible is not simply the right to live free from illness. It is the right of every person to enjoy the highest attainable standard of physical and mental health, as articulated by the International Convention on Economic, Social and Cultural Rights and the Convention on the Rights of the Child.¹⁴⁷ Implicit in this right is the obligation of the state to ensure that a functioning health care system is available to the entire population. Thus, a child's basic right to health includes the right to access an adequate level of health care services.

Mexico has a nationalized health care system, which is guided by the General Health Law (*Ley General de Salud*). The goals of the National Health System include supplying quality health services to all, contributing to family and community development, including the physical and mental growth of children, and collaboration with social assistance services to obtain equitable economic and social well-being.¹⁴⁸ Specific provisions of the General Health Law also address medical care particularly for the benefit of vulnerable groups, maternal-infant care, nutrition and basic sanitation.¹⁴⁹ The existing public health institutions, however, fail to provide adequate health care to large segments of the Mexican population, the poor, uninsured and often indigenous communities, and have not fully addressed the problem of child mortality. Therefore, the Mexican government is not in full compliance with its obligation to ensure that no child is deprived of the right to access an adequate level of health care necessary for full development.

¹⁴⁷ Article 4 of the Mexican Constitution also provides that "every person has the right to health protection." See Appendix E, *infra*.

¹⁴⁸ LEY GENERAL DE SALUD, GENERAL HEALTH LAW, title II, ch. 1, art. 6: [unofficial translation] The National Health System has the following objectives:

- (1) To supply health services to all the population and to improve the quality of such services, considering the priority of health problems and the factors that cause harm to health, with special interest in preventative actions;
- (2) To contribute to the harmonious demographic development of the country;
- (3) To collaborate for the social well-being of the population through social assistance services, particularly to (abandoned minors/orphans), helpless elderly, and disabled to promote their well being and to probe for the inclusion in an equitable life economically and socially;
- (4) To give impetus to the development of the family and the community, such as social integration and the physical and mental growth of children.

¹⁴⁹ GENERAL HEALTH LAW, tit. I, ch. 1, art. 3: [unofficial translation]

In the terms of the law, the matter of general health [includes] . . . :

- (1) Medical attention, particularly for the benefit of vulnerable groups;
- (4) Maternal-infant [care];
- (10) Information related to the health conditions, resources, and services in the country;
- (11) Health education;
- (12) Orientation and assistance in the matter of nutrition;
- (14) Occupational health and basic sanitation

1. Mexico's National Health System

The National Health System consists of three interrelated subsectors: (1) the Mexican Social Security Institutions; (2) public health services (provided primarily by the Secretariat of Health and the National Indigenous Institute); and (3) the private sector.¹⁵⁰ Each of these health care sectors works independently, developing its own financing and services, and operating independent networks of hospitals and clinics. The three main segments of the National Health System also correspond to specific populations. Workers employed in the formal economy, either employed by private enterprises or by the government, are covered by Mexican Social Security institutions. Public health services are available to the uninsured population, referred to as the “open population” in Mexico. Private health care is available to people who can afford it, because these health providers are outside of the government system. In Mexico, both people who have access to social security and people in the open population often choose to use private health care because they perceive the services as better.

a. Mexican Social Security Institutions

The Mexican Institute for Social Security (IMSS) is the largest public health care institution in Mexico. The Law on Social Security (Ley del Seguro Social) guarantees the right to health, medical assistance and social services,¹⁵¹ and the IMSS is the principal instrument through which social security is distributed in Mexico. The IMSS provides health care to workers, primarily those in the private sector, and their families. Independent private-sector workers, such as workers in family-owned businesses, artisans and domestic workers, may register with the IMSS voluntarily.¹⁵² The IMSS is financed through mandatory employer contributions, employee contributions and federal government allocations. The IMSS provides health services for city and rural populations through a three-tier system: family medical clinics at the first level, IMSS hospitals at the second level and tertiary care medical centers at the third level. The IMSS also administers social services for workers, including child day-care centers, health care education and recreation services. Significantly, in 1993, the IMSS undertook

¹⁵⁰ PAN AMERICAN HEALTH ORGANIZATION, MEXICO: PROFILE OF THE HEALTH SERVICES SYSTEM, I (Oct. 1998) [hereinafter MEXICO: PROFILE OF HEALTH SERVICES].

¹⁵¹ LEY DEL SEGURO SOCIAL, Capitulo Unico, Articulo 2: [unofficial translation]

The purpose of social security is to guarantee the right to health, medical assistance, the protection of means of support and those social services which are necessary for individual and collective well-being and also the granting of a pension which . . . will be guaranteed by the state.

¹⁵² Public sector workers, members of the military and police forces and workers in state-owned institutions, such as Petróleos Mexicanos (PEMEX) the state oil monopoly, have separate pension and health care systems. Of these, the Institute of Social Security and Services for Government Employees (ISSSTE) is the most extensive.

the Mother-Baby Friendly Hospital Initiative, discussed in detail below, in order “to integrate reproductive health concerns into its primary health care referral facilities.”¹⁵³

The fact that coverage by the IMSS is dependent on a person’s employment status significantly limits access to its benefits. Currently, the economically active population (PEA in Spanish) is 43 million persons, but of these only 37 percent (14.8 million) are employed in the formal sector and participate in the IMSS.¹⁵⁴ Thus, members of the informal economy¹⁵⁵ and workers who move in and out of the private sector do not have access to social services through the IMSS. In Mexico, less than one third of the PEA is employed in the formal sector, and the informal economy consists predominantly of women, children and indigenous workers. By some estimates, 50 percent of the female workforce is employed in the informal economy.¹⁵⁶

Even those people who are eligible for benefits through Mexican social security institutions often do not receive them. According to Maria Sauri Riancho, coordinator of the National Women’s Program (Programa Nacional de la Mujer), even though women make up 37 percent of Mexico’s labor force (12 million women) only half of them are covered by the Mexican health systems (including the IMSS, ISSSTE and other health institutions).¹⁵⁷ Moreover, despite efforts to extend coverage by the IMSS, a large proportion of the rural and indigenous population is still excluded. For instance, in 1998 former President Zedillo instituted a program to extend IMSS coverage to agricultural day laborers¹⁵⁸ (temporary and permanent farm workers who work for wages) but in 1999 only 327,000 day laborers, out of a total of 5.2 million such workers, were enrolled in the IMSS.¹⁵⁹

¹⁵³ *Report presented on Women-friendly Health Services: Experiences in Maternal Care in Mexico City*, WHO/ UNICEF/UNFPA 39 (Jan. 1999) [hereinafter *Women-friendly Health Services*].

¹⁵⁴ *Social Statistics*, MEXICAN LABOR NEWS & ANALYSIS Vol. 5 No. 2, (Feb. 2000), available at www.igc.org/unitedelect/vol5no2.html.

¹⁵⁵ The informal economy refers to businesses that have no legal existence: they do not pay taxes, do not pay social security (health, retirement and other benefits), and do not have organized labor unions.

¹⁵⁶ *Women in Mexican Society and the Mexican Labor Movement*, MEXICAN LABOR NEWS & ANALYSIS, Vol.4, No. 9 (May 16, 1999), available at <http://www.igc.org/unitedelect/vol4no9.html>.

¹⁵⁷ *Women and Children – Labor Base of Mexican, North American Economy*, MEXICAN LABOR NEWS & ANALYSIS, Vol. IV, No. 4 (Mar. 2, 1999), available at www.igc.org/unitedelect/vol4no4.html.

¹⁵⁸ *Peasants' Situation Deteriorating: Abuses Continue as Government Programs Dwindle*, MEXICAN LABOR NEWS & ANALYSIS, Vol. 3, No. 19 (Nov. 2, 1998), available at <http://www.igc.org/unitedelect/vol3no19.html>.

¹⁵⁹ *Peasant Organizations in Conflicts in Various Mexican States*, MEXICAN LABOR NEWS & ANALYSIS, Vol. IV, No. 14 (Sept. 16, 1999), available at <http://www.igc.org/unitedelect/vol4no14.html>.

Although large segments of the population do not benefit from the IMSS, it has historically executed more than half of the public health budget.¹⁶⁰ According to recent figures, “the IMSS has a per capita expenditure for its users [that is] three times higher than is allocated to the public assistance sector for the [uninsured] population.”¹⁶¹ At the same time, however, the IMSS budget has itself decreased in recent years. In 1999, the IMSS “served 40 million people on a budget of just [US] \$5.5 billion, down 30 percent from the year before. The budget crunch left it short of doctors and equipment. The lines for basic services such as flu shots and gynecological exams have swelled.”¹⁶²

b. The Secretariat of Health

The Secretariat of Health is the federal executive agency that regulates Mexico’s health system and directs and implements its health policy. The Secretariat of Health administers most of the health care services provided by the public health sector, the largest direct provider of health services in Mexico. The Secretariat of Health has the authority to: (1) regulate health services; (2) create sanitation standards for products, facilities and services; (3) exercise control over the certification of health professionals and accreditation of facilities; and (4) generate statistics.¹⁶³ The Secretariat of Health also conducts periodic surveys of the population on a variety of health topics and carries out epidemiological surveillance. There is little coordination between the Secretariat of Health and the Social Security institutions, with the exception of consolidating public health data at the state and national level. The Secretariat of Health and the social security institutions, however, do carry out joint public health campaigns, known as *Semanas Nacionales de Salud* (National Health Weeks) three times a year. During these campaigns, volunteer medical professionals travel to areas without permanent health care and administer services such as vaccinations and vitamin A supplements.¹⁶⁴

¹⁶⁰ MEXICO: PROFILE OF HEALTH SERVICES, *supra* note 150 at 7.

¹⁶¹ Rodolfo Aguirre Reveles, *La condición de la niñez mexicana en los años del ajuste* in AJUSTE Y EMPOBRECIMIENTO: VEINTE AÑOS DE CRISIS EN MÉXICO. EJERCICIO DE EVALUACIÓN CIUDADANA DEL AJUSTE ESTRUCTURAL [*The Situation of Mexico’s Children During the Adjustment Years* in ADJUSTMENT AND IMPOVERISHMENT: 20 YEARS OF CRISIS IN MEXICO: CITIZEN EXERCISE OF EVALUATION OF THE STRUCTURAL ADJUSTMENT] (CASA-SAPRIN, México, forthcoming 2001).

¹⁶² Esther Schrader, *Managed Health Care Latest U.S. Export to Mexico; Medicine: Employers Compete for Workers by Offering HMOs to a Growing Middle Class Disenchanted with Socialized Clinics*, L.A. TIMES, Nov. 7, 1999 at A1.

¹⁶³ MEXICO: PROFILE OF HEALTH SERVICES, *supra* note 150 at 6.

¹⁶⁴ See e.g., *Se aplicarán más de 14 millones de vacunas durante la Segunda Semana Nacional de Salud* [*More than 14 million Applied for Vaccinations During the Second National Health Week*], Secretariat of Health Press Release No. 065, May 17, 2001, at <http://www.ssa.gob.mx/>.

c. Private Health Care

Private health services operate independently of government health services and independently from each other. Private medical services are generally concentrated in wealthy states and large cities. According to 1999 statistics, just under half of all private medical units (clinics for short-term stay and hospitals) were concentrated in five areas: the Federal District, the state of Mexico, Guanajuato, Michoacán and Jalisco.¹⁶⁵ It is estimated that only four percent of the IMSS subscribers are forwarded to private health care facilities.¹⁶⁶ The private health care sector is not supervised by the governmental health institutions.

Private medical services represent a large portion of the total health expenditures in Mexico. Currently, out of pocket payment for private health care accounts for over half of all health care expenditures in Mexico.¹⁶⁷ At a recent symposium on health care reform, Secretary of Health Julio Frenk Mora explained that because of funding shortages in the public sector, Mexican families are dissatisfied with public health care, and therefore prefer private services even though they have to pay out of pocket for the treatment.¹⁶⁸ Even poor families who do not have health insurance use private services because of the perceived or actual inferior quality of public health care. According to Dr. Frenk, “every year close to two million Mexican families are ruined financially by the cost of medical treatment [and] furthermore a number that is impossible to determine do without health care because they cannot pay for it.”¹⁶⁹ The costs of private care are “as high as the market will bear” and private health insurance is limited.¹⁷⁰ Approximately a third of total private health care expenditures are for provider’s fees, 27 percent for medicines and 20 percent for hospitalization.¹⁷¹

d. The Uninsured “Open” Population

The uninsured population, referred to as the “open population” in Mexico, is estimated at approximately 48 percent of the total population.¹⁷² The open population,

¹⁶⁵ Secretariat of Health, <http://www.ssa.gob.mx/unidades/dgied/index111.htm>.

¹⁶⁶ MEXICO: PROFILE OF HEALTH SERVICES, *supra* note 150 at 6.

¹⁶⁷ Ricardo Rodriguez Olivo, “Privatización Silenciosa” de los Servicios de Salud: Frenk, [“Silent Privatization” of Health Services – Frenk], EXCELSIOR, Apr. 12, 2001.

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ Pan American Health Organization, *Mexico: Basic Country Health Profiles*, EPIDEMIOLOGICAL BULLETIN, Vol. 21, No. 3, (1999) at <http://www.paho.org/English/SHA/prflmex.htm>.

¹⁷¹ *Id.*

¹⁷² MEXICO: PROFILE OF HEALTH SERVICES, *supra* note 150 at 2.

however, represents a disproportionate number of vulnerable people. According to the 2000 Census, 60 percent of children age 14 and under are uninsured in Mexico.¹⁷³ Furthermore, more than 80 percent of the uninsured people in the country live in rural localities of fewer than 2,500 inhabitants.¹⁷⁴

The open population can receive health services through various sources, mainly the Secretariat of Health, the IMSS Solidarity Program (hereinafter IMSS-Solidaridad) and the National Institute of the Indigenous. The Secretariat of Health serves approximately 80 percent of the open population.¹⁷⁵ Under the administration of IMSS, IMSS-Solidaridad receives federal funding to offer basic health services to the open population, particularly the rural marginalized population. Through this program, IMSS offers medical services in 17 states.¹⁷⁶ The IMSS-Solidaridad program operates hospitals that provide a significant percentage of maternal health care to rural populations and also implements services geared toward reproductive health and family planning services. IMSS-Solidaridad also addresses nutrition in conjunction with the government PROGRESA program. As discussed above, the economically poor also use private health care facilities, but for these they must pay out of pocket. Finally, the open population may receive health care through charitable organizations, such as the Mexican Red Cross, and through university hospitals.

e. Other Health and Social Assistance Institutions

In addition to the National Health System, other public institutions in Mexico provide health and social assistance programs for the population. For example, the Secretariat of Social Development (SEDESOL) determines social policy and oversees the government's extensive poverty alleviation scheme, discussed in detail below. SEDESOL also works in close collaboration with the Secretariat of Education, the Secretariat of Health and the National Program for Integral Development of the Family (DIF). DIF regulates the health provisions of the General Health Law regarding social assistance and development matters. DIF is charged with monitoring and evaluating health, education, and other social development matters in conjunction with other institutions in the National Health System and international organizations such as UNICEF. DIF services exist at the national, state and municipal level and are organized into five basic programs: (1) Nutrition and community development; (2) Rehabilitation and social assistance; (3) Protection of childhood; (4) Service delivery methods; and (5) Legal aid.¹⁷⁷ DIF also administers its own social welfare programs, for instance free

¹⁷³ Aguirre Reveles, *supra* note 161.

¹⁷⁴ *Id.*

¹⁷⁵ MEXICO: PROFILE OF HEALTH SERVICES, *supra* note 150 at 8.

¹⁷⁶ See website of the Mexican Institute for Social Security, <http://www.imss.gob.mx/solidaridad/Salud%20Rep/SALUDMAPA.htm>.

¹⁷⁷ See website of the National Program for Integral Family Development, <http://www.dif.gob.mx/web/>.

breakfast programs and temporary shelters for minors, many of which directly address issues of child health.¹⁷⁸

2. Lack of Access to Quality Health Care

Access to primary health care services is fundamental to ensuring protection of health and life. A large part of the population of Mexico currently lacks sufficient access to quality health care. The open population has no health insurance, resulting in reduced access to quality services for the poor or unemployed. Lack of access to health care, however, is not merely the result of a lack of insurance, but may also be due to any of the following: (1) lack of health resources; (2) geographic barriers that impede members of rural communities from using health services; (3) prohibitively high costs for health services; and (4) poor quality of health care, especially in the rural areas.

As part of a general program of health care reform, the quantity of clinics and hospitals, human resources (physicians, nurses and other medical staff) and material resources (equipment) have steadily increased in Mexico.¹⁷⁹ Distribution of these resources, however, remains unequal. For example, while there are 136 and 126 doctors per 100,000 inhabitants in Coahuila and Nuevo León, respectively, there are only 89 and 86 doctors for the same size population in Chiapas and Oaxaca.¹⁸⁰ The distance from the communities to health facilities as well as the lack of paved roads, transportation costs, and other infrastructure weaknesses prevent many individuals from poor, isolated communities from obtaining health care.

Even where public health services are available, there is still a shortage of service providers.¹⁸¹ This shortage has resulted in declining quality of care, increased waiting time for appointments and little equipment or materials. The different levels of quality correspond with the population served, with urban populations having more access to specialized services, while marginalized communities continue to die of curable diseases.¹⁸² For pregnant women and for children, the lack of medical staff can mean the difference between life and death.

Access to health services in the rural areas is also compromised when existing health facilities are non-functional. Residents of a small rural community in Oaxaca, with a population of about 200, reported that their only local health resource is the *casa*

¹⁷⁸ *Id.*

¹⁷⁹ See generally, MEXICO: PROFILE OF HEALTH SERVICES, *supra* note 150.

¹⁸⁰ Data compiled from INEGI, *Información por Entidad Federativa, Aspectos sociodemográficos*, [Information by Federal Entity, Socio-demographic aspects,], available at http://www.inegi.gob.mx/estadistica/espanol/sociodem/ asentamientos/ase_05.html. See Appendix A, *infra*, map of the United Mexican States.

¹⁸¹ Alternative NGO Report, *supra* note 82 at 95.

¹⁸² *Id.*

de salud, a simple wooden building that contains a bed, a scale and medicine such as antibiotics, analgesics and ointments. Because medical personnel do not work at the *casa de salud*, it cannot be considered a clinic. According to a teacher in the area, “There is nothing here . . . [the nearest health clinic] is three hours away on foot, and [the closest hospital] is two and a half hours by car. . . . [T]here are no services at the *casa de salud*. The mothers take turns to clean it. They just dust off the medicines in there.”¹⁸³

Where health services are available, the high cost and low quality can create serious barriers for disadvantaged people to exercise their right to health prevention and treatment. For example, in 1998, health care users in the region with the highest poverty index received the fewest drugs free of charge.¹⁸⁴ The average charge was 40 pesos for those who purchased drugs. At the time, this cost represented more than twice the daily minimum salary.¹⁸⁵ People who earn the minimum wage cannot afford the provider’s fees or medicines. As a result, many rural, poor, and indigenous families rely on alternative forms of health care, particularly traditional medicine.¹⁸⁶ The degree to which traditional health care practices are used, however, has not been widely documented in Mexico.

Members of rural communities frequently report dissatisfaction with the quality of health care they receive in government clinics as well as inhumane or culturally insensitive treatment.¹⁸⁷ For example, an NGO activist described examinations of indigenous women and children that she observed in Guerrero. “The population only speaks Mixteco, but the nurse knew no local language, so she only weighed and measured the children. The [parents] could not express themselves or explain that the child had a parasite.”¹⁸⁸ Finally, the case of Baby H, Box 2 below, illustrates how the confluence of such factors as a family’s lack of economic resources, the distance from health care facilities and the quality of care can contribute to the unnecessary death of a child.

¹⁸³ Interviews, Feb. 20, 2001 (community members, Oaxaca).

¹⁸⁴ René Leyva-Flores, et al., *Prescripción, acceso y gasto en medicamentos entre usuarios de servicios de salud en México*, [Medical prescription, drug access and drug expenditure among health service users in Mexico], SALUD PUBLICA MEX. No. 24, at 31 (1998).

¹⁸⁵ *Id.*

¹⁸⁶ *Acuerdo de INI e Imifap para atender mujeres indígenas* [Agreement by INI and Imifap (the Mexican Institute for Research on Family and Population) To Consider Indigenous Women], CIMAC, Feb. 14, 2000.

¹⁸⁷ In a study conducted by Physicians for Human Rights, residents of a village in Chiapas reported that they “distrusted the quality of Government health care and treatment [because] . . . health care providers treated residents in a patronizing and discriminatory manner, for instance, by talking down to them, asking them seemingly politically-motivated questions . . . or failing to provide personnel or translators.” *Health Care Held Hostage*, PHYSICIANS FOR HUMAN RIGHTS, Jan. 1999 at 28. Interviews, Aug. 7, 1998 (NGOs and community members, Chiapas).

¹⁸⁸ Interview, Oct. 27, 2000 (Indigenous Rights NGO, Guerrero).

Box 3. The Case of Baby H.

The Facts:

Baby H was born near Zacatepec, Morelos in June 1997. His family lived in a brick house with an unfinished floor and without a sewage system. The family was of a low socioeconomic status. Baby H's mother was an indigenous woman, who had primary education. She did not completely understand Spanish, preferring her native language, Mixteco. Baby H was born without complications and began to nurse soon after birth. His mother sometimes supplemented his feeding with milk formula. When Baby H was seven days old, his mother took him to an IMSS Family Clinic for his well-baby check-up. She took Baby H to the same clinic for medical check-ups every month from July to December, and each time, the doctors found that he was a healthy baby.

On January 10, 1998, at about 1:00 in the morning, Baby H began to cry, had diarrhea, was vomiting and felt hot to the touch. The next morning at 6:00, his mother took him in her arms and walked to the highway where she caught a local bus to the IMSS hospital in Zacatepec. Baby H was examined at 8:00 that morning. According to his mother, the examination of Baby H was quick and careless; the doctor never undressed him to conduct a physical examination. The doctor did not give the mother instruction on how to feed Baby H nor did he counsel her on breastfeeding. Baby H was diagnosed with a viral infection of the nose and throat, a viral intestinal infection and formula intolerance. His mother was given some instruction, in Spanish, about how to prepare a saline solution for her baby. She was told to return in two days.

Baby H and his mother returned home, where she tried to give him the saline solution, but he could not digest it. His diarrhea persisted and he would not eat. Baby H's father was working away from home. In her words, Baby H's mother did not take her son back to the IMSS clinic because she was told not to return for two days. The next day, when the father returned home, he took his son to the Secretariat of Health General Hospital in Jojutla. While he was waiting outside the hospital, a doctor came out and told him that Baby H had died. Baby H was seven months old. An autopsy revealed that Baby H died from "probable hydroelectrolyte imbalance caused by severe dehydration as a consequence of gastroenteritis, probably infectious." The family filed an official complaint with the state Human Rights Commission in Morelos, stating that their son died due to negligence, specifically lack of care, on the part of the staff at the IMSS clinic. The case was eventually transferred to the National Human Rights Commission.

The Findings:

After reviewing the case, the National Human Rights Commission concluded that the examination of Baby H by the doctors of the IMSS clinic was inadequate. Specifically, they did not take his temperature, did not order tests or laboratory work to determine the severity of his dehydration and did not check his heartbeat or respiration. The clinic staff did not ask the mother about her baby's history or his diet and did not check his current weight against clinic records. Finally, the clinic staff was negligent in not considering the socioeconomic conditions of the mother, including the family's living conditions and the fact that Spanish was not her first language.

Violations of Baby H's rights:

The National Human Rights Commission determined that the urgent care physician who examined Baby H on January 10 was negligent in giving insufficient care. The Commission further concluded that the doctor violated the rights of Baby H under Article 4 of the Constitution, the right to health protection, and under the Convention of the Rights of the Child. Finally, the Commission issued its recommendation that the IMSS Family Clinic carry out an investigation to determine the physician's responsibility for the inadequate attention provided to Baby H. The Commission also noted that the family was entitled to receive monetary compensation.

Source: National Commission on Human Rights, Recommendation 70/99.

C. Mexico's Macroeconomic Policies and Social Sector Spending

Poverty and inequality are tremendous problems in Mexico.¹⁸⁹ Mexico has been trying to remedy poverty through provision of government benefits to the poor and by instituting reforms for the economic development of their country.¹⁹⁰ Various forces have pushed Mexico to embrace a “neo-liberal model” which consists of minimal government intervention, unrestricted manufacturing, and increased trade as the keys to economic growth.¹⁹¹

One of the forces behind Mexico's economic policies since the 1980s is the World Bank Group. This international lending group states that their goal is to achieve “a world free of poverty.”¹⁹² Underlying the World Bank Group's decisions about making loans is the philosophy that a developing country must open its markets to world trade in order to end poverty.¹⁹³ To that end, the World Bank requires borrowing countries to make changes to their trade policies and government budgets. Since the World Bank's inception, Mexico has received the second largest share of the disbursed portfolio, totaling US \$31.5 billion.¹⁹⁴

Rather than improve economic conditions for all people, Mexico's public policies have resulted in an increasing disparity between the incomes of the richest Mexicans and the poorest Mexicans (“the income gap”).¹⁹⁵ It is becoming less evident in the 21st century that the World Bank's neo-liberal perspective is in the best interest of the poor. The policies often call for reducing social sector spending as a way to reduce government budgets. In addition, research has shown that in Mexico, free trade has resulted in fewer economic opportunities that elevate people out of poverty.

¹⁸⁹ Mexico recognized the magnitude of the country's economic, social and cultural shortcomings in its Third periodic report to the Committee on Economic, Social and Cultural Rights, ¶ 9, U.N. Doc. E/1994/104/Add.18. (1998).

¹⁹⁰ See, JORGE G. CASTANEDA, *THE MEXICAN SHOCK ITS MEANING FOR THE U.S.* 47–61 (1995) (providing a brief synopsis of recent Mexican economic history).

¹⁹¹ Gerardo Otero, *Neoliberal Reform and Politics in Mexico: An Overview in NEO-LIBERALISM REVISITED, ECONOMIC RESTRUCTURING AND MEXICO'S POLITICAL FUTURE* 1, 7 (Gerardo Otero ed., 1996).

¹⁹² www.worldbank.org.

¹⁹³ See e.g., The World Bank Group, *Global Economic Prospects and the Developing Countries*, 2001, available at www.worldbank.org/prospects/gep2001/sumeng.htm

¹⁹⁴ The World Bank Group, *World Bank Group Country Brief, Mexico*, www.worldbank.org, (indicating the amount borrowed between 1949 and 2000).

¹⁹⁵ The poorest 20 percent of Mexicans hold 3.6 percent of the country's wealth, while the richest 20 percent hold 58.2 percent of the wealth. HUMAN DEVELOPMENT REPORT, *supra* note 28.

1. Mexico's Social Sector Spending

In order to judge whether Mexico is meeting its obligation under the Economic Rights Covenant to progressively implement health rights, its budget and policy decisions must be examined. In recent years there have been more legislative efforts to alleviate poverty through government programs.¹⁹⁶ For example, in the late 1990s, the Mexican government increased its social budget significantly and has reportedly been increasing since then.¹⁹⁷ In 2000, SEDESOL reported that 61.5 percent of the programmable budget went for the social development of the country.¹⁹⁸ However, the programmable budget is relatively small compared to Mexico's "non-programmable" budget. To illustrate the relative position of poverty alleviation programs in the Mexican budget, in 1998, 38.1 billion pesos (about US \$4.7 billion) were designated for poverty alleviation programs. This amount was "equivalent to 1 percent of the GDP, 4.3 percent of total net spending [and] equivalent to 5.8 percent of the resources destined to [the bank rescue scheme, FOBAPROA]."¹⁹⁹ The most recent figures demonstrate that public funds for health spending is 2.8 percent of the entire budget, resulting in a public expenditure of about US \$100 per capita.

While the proportion of the budget that Mexico allocates for health care has grown, it may not be effectively targeting child mortality caused by "diseases of poverty." Children die of easily preventable diseases because of a lack of resources in their communities that is particularly evident in rural and indigenous communities. The distribution of government resources is an important method to analyze whether Mexico is meeting its obligations of non-discrimination under the Economic Rights Covenant and the International Convention on the Elimination of All Forms of Racial Discrimination. One method to analyze whether a government is distributing health benefits equally is to look at who benefits from the spending. Research has been able to quantify how much of the public health funds benefit each quintile of the population.²⁰⁰ Dividing the population into quintiles according to their income, one researcher found that the poorest Mexicans receive less of the public health dollars than the next three richest quintiles. The research showed that the poorest 20 percent receives only 17.6 percent of the public health spending, whereas the three middle quintiles, received 23.9 percent, 24.4 percent and 21.8 percent respectively (from least wealthy to most wealthy).²⁰¹ Thus resource

¹⁹⁶ Mexico is a signatory to the 1995 World Summit on Development, which promises *inter alia*, universal access to primary health care.

¹⁹⁷ www.sedesol.gob.mx/html2/over/supob.htm

¹⁹⁸ *Id.*

¹⁹⁹ Alternative NGO Report, *supra* note 82 at 134.

²⁰⁰ Research of John Scott of CIDE, "Desarrollo económico y humano. El fracaso social de la revolución", en *Enfoque*, Núm. 350, 15 de Octubre de 2000, PERIÓDICO REFORMA, México. p. 6, cited in Rodolfo Aguirre Reveles, *supra* note 161.

²⁰¹ *Id.*

allocation is a matter that must be addressed when examining Mexico's progressive implementation of health rights.

Outside of poverty alleviation programs, Mexico targets most economic and development resources at urban centers, resulting in widening levels of inequities in health and socioeconomic well-being between urban and rural populations. The continuing cycle of poverty, malnutrition, and preventable diseases remains an imposing barrier to reduction of mortality among disadvantaged children. To a considerable extent, Mexico's child survival disparities are attributable to government policies of resource allocation, which inevitably impact children and families. Non-governmental organizations have expressed dissatisfaction with the lack of access to the budgeting process and budget information. In order for human rights to be observed and protected, economic and social rights must be considered in policy decisions.

2. Mexico's Structural Adjustments and Reductions in Social Sector Spending

For the past 18 years, Mexico has been receiving loans from the international monetary institutions. The World Bank and other institutions require borrowing countries to make certain changes in the country's economy. For instance, privatization of state enterprises or reducing public spending may be required by a lender. Countries implement these changes through structural adjustment policies (SAPs). SAPs are economic policies believed to create wealth and bring more people into the national and global economies.²⁰² Typical SAP policies may include:

- reductions in public expenditures, including social services;
- elimination or targeting of government subsidies;
- tax reform;
- restriction of credit;
- privatization of many state enterprises;
- trade liberalization;
- monetary devaluation;
- removal of barriers to foreign investment; and
- the maintenance of "competitive wages."²⁰³

SAP policies resulted in an economic loss for many citizens, especially people on the margins of the cash economy. Low-income people suffered most from the inflation,

²⁰² Aguirre Reveles, *supra* note 161, at 4 – 7, has a comprehensive description of the changes experienced in Mexico, including: elimination of social programs, restructuring of public administration, decentralizing federal government functions, selective reduction of subsidies for production and consumption, increase in funds for the government, reduction in price controls for consumer goods, "apertura commercial," and "competitive wages."

²⁰³ Latin America Working Group (LAWG), Mexico's Economic Crisis (Mar. 1997) (background information article on file with Minnesota Advocates for Human Rights). These structural adjustment programs are intended to maintain economic stability, but are geared toward the industrialized global economy, not the pervasive poverty in marginalized areas. Economic growth is encouraged through state-society and state-led market relations, a closer integration into the world economy, and the active promotion of exports.

public sector cutbacks, reduction of subsidies and government austerity measures such as wage and price controls.²⁰⁴ In the 1990s, the reductions in the public welfare budgets came at the same time that families were experiencing cash shortages.²⁰⁵ These changes were a devastating blow for poor children's health, as fewer government services were available and families had less money to spend on private health care. While government services were expanded in some areas, overall, living conditions for poor people did not improve.²⁰⁶

Because of the reduction in social spending, Mexico has not been able to implement basic programs to benefit its working poor. Mexico's lack of social services rose to a critical situation during the economic crisis of 1994-1995. In late 1994, the value of the peso dropped dramatically while the cost of living rose sharply. This drop was followed by a severe recession in 1995, which had a devastating economic impact on workers and their families, particularly in poor, rural, and indigenous communities. Millions of workers lost jobs, over one-third of small businesses failed, and poverty increased. This economic crisis resulted in the increased vulnerability of poor communities to disparities and partisan social programs.²⁰⁷

State-provided services normally serve to shield people from macroeconomic shocks, such as the 1995 recession or increasing unemployment. For instance, when a head of household loses his or her job, unemployment insurance provides money, buffering an individual family from the economic changes, and transferring the economic burden to society as a whole. Mexico does not have this more equitable system, and instead poor families have shouldered the burden of the economic changes. The combination of unequal socioeconomic development, negative impacts of structural adjustments, and persistent and pervasive poverty have left marginalized communities in Mexico with neither the economic opportunities to attain an adequate standard of living, nor the social conditions to maintain the health and survival of their children.

²⁰⁴ NEOLIBERALISM REVISITED, *supra* note 191, at 45.

²⁰⁵ For instance, the World Bank Project, "Mexico-Estado de Mexico Structural Adjustment Loan of October, 2000," was granted with the objective of fiscal reform. The project placed constraints on the health care budget and called for the end of state subsidies for the state water supply. *World Bank Proposal Mexico-Estado de Mexico Structural Adjustment Loan of October, 2000*, MXPE7400, www.worldbank.org/pics/pid/mx7400.txt.

²⁰⁶ "The collapse in the peso in 1994 generated very high inflation. As a result levels of basic food consumption dropped by nearly 30 percent, suggesting that hunger is growing." Extract from Sonia Murphy, "Trade and Food Security" in John Madeley *Trade & Hunger – An Overview of Case Studies on the Impact of Trade Liberalisation*, 4 GLOBALA STUDIER 23 (ed. Johanna Sandahl, Oct. 2000), http://online.forumsyd.se/web/FS_Globala%20studier/%23431388.0/T&Hunger.pdf.

²⁰⁷ In order to receive social welfare payments, some people were forced or scared into voting for a certain political party. Interview, Apr. 16, 2001 (Attorney, Mexico City).

3. Free Trade Policies and Reduced Economic Opportunities

On a macroeconomic level, the structural adjustment and trade liberalization policy changes have resulted in a more stable Mexican peso, a reasonable rate of inflation and significant economic growth. Mexico's rapid economic transformation has led to impressive growth in the 1990s.²⁰⁸ Economic growth provides an opportunity to improve the living conditions of poor people. As the Committee on Economic, Social and Cultural Rights noted in its concluding observations, Mexico's "improved macroeconomic performance, particularly the reduction of foreign debt, the decrease in inflation and the growth of export capacity, . . . create an environment conducive to a more effective implementation of the rights under the Covenant."²⁰⁹ However, the economic benefits of this growth have not been distributed equitably across Mexico. For instance, the beneficiaries of increased trade are primarily multi-national or foreign corporations, not Mexican companies. Mexican businesses, particularly in farming, have suffered as a result of the trade liberalization policies. Mexico's spending policies have also increased the economic problems of the poor.

Free trade policies are designed to promote investment by foreign companies and open new markets to trade. The main policies reduce tariffs and relax foreign investment laws. Under the U.S. version of free trade, the government does not play the role of a social actor. The government simply allows the market forces to control all socioeconomic conditions.²¹⁰ However, on the other hand the U.S. also seeks to implement policies that provide opportunities for U.S. products to be sold in other markets.²¹¹

Tariffs are often the subject of international trade agreements because they are seen as barriers for foreign companies selling their products in international markets. When the World Trade Organization (WTO) and the North American Free Trade Agreement (NAFTA) came into full effect in 1994, they reduced "barriers" to foreign investment and prohibited state involvement with production subsidies. Tariffs were reduced or had upper limits imposed, and direct subsidies for farmers were prohibited. This policy allowed exporting countries access to new markets in the global economy.

Normally, a country's government charges a tariff on goods coming from foreign countries. The tariff has a dual purpose of raising revenues for the importing country and increasing the price of imported products, making lower-priced, locally made products

²⁰⁸ World Bank Group, *Country Brief: Mexico*, <http://wbln0018.worldbank.org/external/lac/lac.nsf> (Sept. 2000).

²⁰⁹ Concluding Observations of the Committee on Economic, Social and Cultural Rights: Mexico, ¶ 3, U.N. Doc. E/C.12/1/Add.41 (1999).

²¹⁰ NEOLIBERALISM REVISITED, *supra* note 191 at 33.

²¹¹ Casteñada, *supra* note 190, at 177-207 (Explaining that the United States' pressure on Mexico to open its borders for increased imports and other trade liberalization policies cannot be overlooked).

more attractive to consumers. The tariff can be seen as a surcharge for the benefit of having access to a new market. Without tariffs, the income flowing to the government is reduced, and more foreign goods are available in the market. In conjunction with the reduction of government subsidies for farm production, these trade liberalization policies have been devastating for the small-scale Mexican farmers. The foreign grains have created additional supply that has caused downward pressure on prices. Small Mexican farms have had reduced income, which has resulted in reduced access to food for marginalized children, as explained in Box 4.

Box 4. Example of Food Scarcity and Allocation Policies

Marginalized people in Mexico have been seriously affected by international policies including most economic restructuring and international trade agreements. Food scarcity and allocation policies provide an example of the combination effect of international and national policies. Research has shown that “liberalized trade, including WTO trade agreements, benefits only the rich while the majority of the poor do not benefit but are instead made more vulnerable to food insecurity.”²¹²

SAPs and the World Trade Organization’s Agreement on Agriculture (AoA) have forced countries to change their food and agricultural policies. “[Countries] are obliged to open up their economies to cheap food imports and to reduce and severely limit support for their farmers. . . . [The AoA calls on] member countries of the WTO to reduce tariffs on food imports by 24 percent over a ten year period.”²¹³

Mexico implemented the agricultural policies required by international trade organizations. However, no provisions were made for food security or economic security of small-scale farmers. Mexico’s commitments under the AoA and many other agreements included dismantling the protective tariff structure for staple food crops and substantially cutting support for producers and for stabilization of consumer prices. The result has been devastating for smallholder farmers.²¹⁴

As the cost of exporting goods to Mexico dropped in the 1990s, there was an increase in imports that created a glut of cereal on the market. This was profitable for U.S. companies that sold grain in Mexico, as well as those that owned processing mills in Mexico.²¹⁵ However, the Mexican producers of maize (corn), the country’s staple food, were not so lucky. During the mid-1990s, subsidies for farmers were eliminated as part of the international trade agreements and structural adjustment. Without the subsidies but facing rising costs, many farmers lost their land and their livelihood.

The result of this situation has been an increase in unemployment with more people seeking work outside of farming. However, some researchers assert that people will not be able to compensate for the income losses through off-farm employment.²¹⁶ “As a result, households will be forced into increasingly

²¹² Herzon O. Nyangito, excerpt reprinted in John Madeley, *supra* note 206, at 45.

²¹³ The 48 least developed countries are excluded from this and from other reduction commitments. *Id.* at 7.

²¹⁴ Kevin Watkins, *Globalisation and liberalisation: Implications for poverty, distribution and inequality*, HUMAN DEVELOPMENT REPORT OFFICE OCCASIONAL PAPER 32, 1997 (no page numbers), www.undp.org/hdro/oc32a.htm “Most [Mexican] smallholders are net-deficit households, selling maize in the post-harvest period and carrying out wage work to buy it after household supplies have run out.” *Id.*

²¹⁵ Murphy, *supra* note 206.

²¹⁶ Watkins, *supra* note 214.

desperate survival strategies, including labour migration to commercial farm areas, to urban centers and to the U.S.”²¹⁷

Change in agricultural policies have also had a direct impact on children’s caloric intake. With the price of grain so low, the small farmers found their income severely reduced. Thus, the levels of basic food consumption dropped.²¹⁸ Malnutrition persists in Mexico although there is a surplus of grain in Mexico. This country is not suffering from a lack of food, or food scarcity, but has inequitably distributed food. Again, it is the marginalized areas which lack food.²¹⁹ Malnutrition is linked with structural factors, such as governmental allocation of resources, that cause certain groups to have less access to food. Reducing malnutrition depends on whether a country makes nutritional well-being a priority and, in particular, “[targets] women and children for special attention.”²²⁰ The agricultural policies resulted in increased nutritional deficiencies which continue to pose a grave danger to the survival of Mexico’s vulnerable children.

4. Mexico’s Minimum Wage Structure

Mexico’s minimum wage is another economic policy that ultimately affects children. In Mexico, there are three minimum wage levels for the country, which correspond to geographical divisions of zones A, B and C. Mexico City is in zone A where the minimum monthly wage was 887 pesos in the year 2001²²¹ (approximately US \$97).²²² In 2001, the monthly minimum wages for zones B and C were 834 pesos (US \$91) and 788 pesos (US \$86) respectively.²²³ Although the minimum wage zones are not divided according to state lines, it appears that states with the highest levels of poverty, such as Chiapas, Michoacán, Oaxaca and Puebla, are entirely in zone C, the area with the lowest minimum wage.²²⁴ This system of regional minimum wages reinforces the regional disparities in poverty and child mortality.

²¹⁷ *Id.*

²¹⁸ Murphy, *supra* note 206.

²¹⁹ Gary Gardner & Brian Halweil, *The World Pays Heavy Price for Malnutrition*, INTL. HERALD TRIBUNE, Mar. 9, 2000 at 9.

²²⁰ *Id.*

²²¹ Secretaría del Trabajo y Previsión Social (Secretariat of Labor), Salarios minimos vigentes del 1o. de enero de 2001 [Secretariat of Work and Social Provision, Minimum Salaries as of January 1, 2001], available at <http://www.stps.gob.mx>.

²²² In this report, all approximate equivalents in U.S. dollars are based on the official exchange rate in May 2001 of 9.18 Mexican pesos per US \$1, unless otherwise specified.

²²³ Secretaría del Trabajo y Previsión Social, Salarios minimos vigentes del 1o. de enero de 2001, *supra* at note 221.

²²⁴ *Id.* See Appendix A, *infra*, map of the United Mexican States.

The minimum wage is established by legislation and regulated by the National Commission for Minimum Wage Rates (CONASAMI). Article 123 of the Mexican Constitution states “the minimum salary must be sufficient to satisfy the basic needs of the head of the household, including material, social and cultural needs and the mandatory education of the children.” The basic goods, mentioned in the Constitution, are known as the *canasta basica* and are based on the daily needs of a family of five, including food, housing, transportation, education, health, clothing, goods for the home, recreation and culture.²²⁵ Because the cost of the *canasta basica* is subject to change due to inflation, its value fluctuates. Thus, it is possible for a family to earn more than the minimum wage, yet still be unable to afford basic necessities. Currently, the National Council on Population considers a family to be living in poverty if their total income is less than three times the minimum wage. The UN Committee on Economic, Social and Cultural rights, however, recently concluded, “at present about five minimum wages are needed to obtain the officially set basic food basket . . . in violation of [the Economic Rights Covenant and the Constitution].”²²⁶

Not only is the minimum wage insufficient to meet family needs but it has been declining at a rapid pace. Both governmental and independent sources have documented a decline in the purchasing power of the minimum salary since 1993.²²⁷ While the purchasing power of the minimum wage has been declining for the last 20 years, the sharpest decline (more than half of the total decline) occurred between 1994 and 1999.²²⁸ In the year 2000, the Secretary of Labor reported that a family needed over 5,000 pesos per month to afford the *canasta basica*.²²⁹ Thus, a family would require between five and a half and seven minimum monthly salaries to meet basic needs. Table 6 below illustrates the decrease in purchasing power from 1994 to 2000.

²²⁵ Alternative NGO Report, *supra* note 82 at 47.

²²⁶ Concluding Observations of the Committee on Economic, Social and Cultural Rights: Mexico. 08/12/99. E/C.12/1/Add/41/ (Concluding Observations/ Comments).

²²⁷ According to Mexico’s Fifth Government Report (Quinto Informe de Gobierno), between 1994 and 1999, workers’ wages fell 25 percent in terms of real purchasing power. During this period, the inflation rate was 187.3 percent but the minimum wage only increased by 128 percent. Sergio Miranda G., *Salarios Reales, Deprimidos* [Real Salaries, Decreasing], EXCELSIOR, Sept. 6, 1999. See also Alternative NGO Report, *supra* note 82 at 48.

²²⁸ *Id.*

²²⁹ *Social Statistics*, MEXICAN LABOR NEWS & ANALYSIS, Vol. V, No. 2, (Feb. 2000), available at <http://www.igc.org/unitedelect/Vol5no2.html>.

Figure 10. Minimum Wage Buying Power

In December 1994, the monthly minimum wage bought:	In May 2000, the monthly minimum wage bought:
Flour: 9 kilos	Flour: 4.4 kilos
Tortillas: 20.3 kilos	Tortillas: 10 kilos
Bread: 101.8 loaves	Bread: 56.5 loaves
Eggs: 4.8 kilos	Eggs: 3.1 kilos
Salt: 17.7 kilos	Salt: 11.5 kilos
Biscuits: 3 kilos	Biscuits: 2 kilos
Milk: 8.4 liters	Milk: 5.9 liters

Source: Research of the University of Obrera, Mexico.²³⁰

By current estimates, between 59.7 and 66.3 percent of the workforce in Mexico only earns from one to two minimum salaries and 15 percent of families report that they receive no income whatsoever.²³¹ Due to the inability of many adults to support their families on the adults' wages alone, children are increasingly required to work in Mexico. UNICEF estimates that there are five million children working in Mexico, some as young as six years old. The children who live in the city often work as street vendors or grocery packers.²³² Large numbers of young Mexican children also work in rural regions, sometimes migrating with their families for agricultural work. A Mexican NGO reported that children as young as four years old work in fields in Baja California.²³³ Child labor poses a risk of work-related accidents and contributes to other health problems. Child labor also contravenes the Economic Rights Covenant and the Children's Convention, both of which expressly prohibit economic exploitation of children.

Rather than focus on macroeconomic policies from the perspective of the impact on children, Mexico continues to expand its free trade agreements worldwide. Mexico wants to be a market for foreign goods and attract foreign companies to produce their products in Mexico. Mexico negotiated a trade agreement with the European Union that took effect in the summer of 2000. In the spring of 2001, negotiations are taking place for a western hemispheric free trade agreement.

²³⁰ Carolina Gómez Mena, "Enfermedad de la pobreza" matan cada año a 20 mil niños, [Diseases of Poverty kill 20 thousand children a year], LA JOURNADA, Sept. 4, 2000.

²³¹ *Unions Call for Abolition of National Minimum Wage Commission*, MEXICAN LABOR NEWS & ANALYSIS, Vol. V, No. 6, (Sept. 2000), available at <http://www.igc.org/unitedelect/Vol5no6.html>.

²³² Interview, Sept. 4, 2000 (UNICEF, Mexico City).

²³³ Blanca Roca and Rodolfo Zamora, *Migración en las Comunidades de Origen, Migración: México Entre sus Dos Fronteras 14* (Migration in the Communities of Origin, Migration: Mexico between Its Two Borders) (1999).

Meanwhile the interest on Mexico's current foreign debt (US \$159 billion) continues to accrue and Mexico must make loan payments.²³⁴ Research has shown that countries with high debt service simply cannot allocate the necessary resources to child welfare.²³⁵ While the funds provided an opportunity to invest in Mexico, they now represent a loss of financial resources that could otherwise be spent on basic services. The problem with debt repayment has been demonstrated by the numerous developing countries that have not been able to repay their loans, and the resulting debt relief programs created by the international lending institutions.

VII. OTHER CONDITIONS THAT PLACE CHILDREN AT RISK

A. Maternal Factors

The ability of a child to realize his or her right to survive and develop depends greatly on whether his or her mother's rights are also respected. When women experience poverty, illness and discrimination, their children's well-being is compromised. A woman's health during pregnancy greatly affects the health of her child, particularly during the prenatal period, but also during the child's infancy. Maternal health is not limited to adequate maternal nutrition and safe delivery practices. It also includes a woman's right to be free from violence. A woman's level of education also plays an important role in her child's ability to survive. Thus, government programs that aim to reduce the incidence of preventable child deaths must also consider whether the state is ensuring that women are able to realize their rights, such as the right to health care, education and freedom from violence.

Based on comparisons of Mexico and other Latin American countries with similar GNP per capita, Chile, Costa Rica and Cuba, it appears that inadequacies in women's health care and education have contributed to an elevated child mortality rate in Mexico. (See Figure 11, below). Fewer women in Mexico are attended by health personnel when during delivery, as compared to the selected Latin American countries. The female literacy rate is also lower in Mexico. The maternal mortality rate in Mexico, 55 deaths per 100,000 live births, is approximately double the maternal mortality rates in Chile, Cuba and Costa Rica. While Mexico's maternal mortality rate has improved since 1985, it has not improved to the same extent as the child mortality rate, nor is it comparable to the levels achieved by other developed nations.²³⁶ For example, the maternal mortality rate from 1980 to 1999 in three industrialized countries, the United States, Norway and Japan, was between six and eight maternal deaths per 100,000 births.

²³⁴ HUMAN DEVELOPMENT REPORT, *supra* note 28 at 219.

²³⁵ Shridath Ramphal, *Debt has a child's face*, in THE PROGRESS OF NATIONS, 26 (UNICEF, 1999).

²³⁶ CONAPO, *supra* note 115, at 155. Maternal mortality has declined from 64 per 100,000 live births in 1985 to 55 per 100,000 in 2000.

Figure 11. National Child Mortality Rates in Relation to Selected Indicators of Maternal Health

	Latin American Countries	Under-5 mortality rate 1999 ^b	Fertility rate 1999 ^c	Adult female literacy rate 1995-1999 ^d	% of births attended by trained health personnel 1995-2000	Maternal mortality 1980-1999 ^e
Lower-Middle Income ^a	Cuba	8	1.6	96	100	27
	Costa Rica	14	2.8	95	98	29
Upper-Middle Income ^a	Chile	12	2.4	96	100	20
	Venezuela	23	2.9	90	95	60
	Panama	27	2.5	92	90	70
	Mexico	33	2.6	87	86	55

^a Countries are classified as Lower-Middle Income (US \$761- \$3,030) or Upper-Middle Income (US \$3,031- \$9,360) according to World Bank estimates of GNP per capita, 1998.

^b The under-five mortality rate is the probability that a child will die between birth and exactly five years of age, expressed per 1,000 live births.

^c The fertility rate is an estimation of the number of children born per woman throughout her child-bearing years.

^d The adult female literacy rate is the percentage of persons aged 15 and over who can read and write.

^e The maternal mortality rate is the annual number of deaths of women from pregnancy-related causes per 100,000 live births.

Source: The State of the World's Children 2001, UNICEF Report.

In descending order, the regions with the highest maternal mortality rates in Mexico are Guerrero, Morelos, the state of Mexico, Chiapas, Oaxaca and the Federal District.²³⁷ The leading causes of maternal death are toxemia during pregnancy, hemorrhage, puerperal complications (complications before, during and after labor and delivery, such as infection, lacerations or seizure) and unspecified other causes.²³⁸ In its 1999 Concluding Observations, the Committee on Economic, Social and Cultural Rights also expressed concern that “the fourth highest cause of death among women in Mexico is illegal abortion” and called upon the Mexican government to reduce the incidence of

²³⁷ MORTALIDAD 1998, *supra* note 24, at 157.

²³⁸ Comisión Nacional de la Mujer (CONMUJER), *México. Informe de Ejecución. Plataforma de Acción de la Cuarta Conferencia Mundial sobre la Mujer. Pekín + 5*, [Mexico. Report on the Platform for Action of the Fourth World Conference on Women. Beijing + 5] 13 (2000) [hereinafter *Report on Platform for Action*].

death due to abortion.²³⁹ It is significant that maternal mortality rates from hemorrhage and toxemia during pregnancy have increased since 1980.²⁴⁰ These conditions can be controlled through regular prenatal care and, if necessary, emergency obstetric care. The causes of maternal mortality suggest that both rural and urban women in Mexico experience inadequate and improper medical attention and that women often cannot access specialized health services. Mexico's relatively high maternal mortality rate indicates that the government does not provide adequate health care to the entire female population.

1. Maternal and Infant Health Care

Within the public health care system, the Reproductive Health General Directorate of the Secretariat of Health and the Inter-Institutional Group for Safe Motherhood promote safe motherhood practices and develop guidelines for a national reproductive health program. Through committees, the Inter-Institutional Group for Safe Motherhood addresses such specific aspects of maternal and infant care as promotion of exclusive breastfeeding, maternal medical care, prevention of birth defects and investigation of maternal and neonatal deaths. In 1992, the Inter-Institutional Group for Safe Motherhood started the Mother and Baby-Friendly Hospital Initiative, (Hospital Amigo del Niño y de la Madre) to certify hospitals with good practices as "baby-friendly." To date, all of the institutions that make up Mexico's National Health System are participating in the initiative and "over 90 percent of the Secretariat of Health hospitals have been accredited."²⁴¹ At the same time, approximately 1,500 Family-Friendly Health facilities representing nearly 85 percent of care provided by the IMSS were certified.²⁴²

Despite such initiatives to improve maternal and infant health, marginalized communities, particularly in rural areas, are still experiencing deficits in obstetric care. Only 86 percent of births in Mexico are attended by health personnel,²⁴³ and half of all women who have given birth receive no medical examinations after delivery.²⁴⁴ Furthermore, twice as many women in rural areas than in urban areas receive no prenatal

²³⁹ *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Mexico*, at paras. 28, 43, E/C.12/1/Add.41 (08/12/99).

²⁴⁰ *Report on Platform for Action*, *supra* note 238 at 13. The high death rate from hemorrhage is most likely related to the fact that because abortion is illegal in Mexico, it is typically not provided by trained medical professionals as a general health service.

²⁴¹ *Women-friendly Health Services*, *supra* note 153 at 38.

²⁴² *Id.* at 39.

²⁴³ STATE OF THE WORLD'S CHILDREN, *supra* note 3 at 103.

²⁴⁴ *Report on Platform for Action*, *supra* note 238 at 80.

care (14 percent of rural women) and the majority of rural women (63 percent) receive no post-delivery care either.²⁴⁵

Moreover, specific health concerns that contribute to high-risk pregnancies have not yet been fully addressed by the initiatives of the Inter-Institutional Group for Safe Motherhood. Closely spaced births and pregnancy early or late in a woman's life can cause problems for both the mother and the fetus. Family planning can reduce the incidence of high-risk pregnancies and reduce maternal and neonatal morbidity and mortality. Spacing births at least two years apart can reduce infant mortality by 25 percent and also reduce the risks of childhood malnutrition and disease.²⁴⁶ In 1995, the Mexican government adopted a five-year plan to address family planning. This program, the Program of Reproductive Health and Family Planning, includes universal access to contraception. In 1998, CONAPO estimated that 69 percent of women of childbearing age used contraception. Similarly, UNICEF reported that between 1995 and 2000, 69 percent of married women (aged 15- 49) used contraception.²⁴⁷ Differences remain, however, in the use of contraception by age and by region. For example 31 percent of women of child-bearing age living in rural areas have never used contraception.²⁴⁸

Young women have a particularly low rate of contraceptive use. The National Program for Integral Development of the Family (DIF) estimates that only 36 percent of women between the ages of 15 and 19 use some type of contraception.²⁴⁹ Each year in Mexico, roughly 450,000 babies are born to women under the age of 20, representing 16 percent of all births.²⁵⁰ Currently, in Mexico City, there are approximately 15,000 mothers between the ages of 12 and 19 with at least one child.²⁵¹ According to some estimates, in Mexico, 6.2 percent of first-born infants of teenage mothers will die in their first year of life in contrast to 2.9 percent of first-born infants born to mothers over the age of 20.²⁵² Girls who become pregnant before they reach 15 are at a high risk for

²⁴⁵ *Id.*

²⁴⁶ *Family Planning Saves Lives*, Population Health and Nutrition, United States Agency for International Development (USAID), available at http://www.usaid.gov/pop_health/cs/csfamplan.htm.

²⁴⁷ STATE OF THE WORLD'S CHILDREN, *supra* note 3 at 103.

²⁴⁸ *Report on Platform of Action*, *supra* note 238 at 73-75.

²⁴⁹ See website of the National Program for Integral Development, *Prevencion y Atencion de Madres Adolescentes [Prevention and Attention to Adolescent Mothers]*, available at <http://www.dif.gob.mx/attmadadol.htm>.

²⁵⁰ Gobierno del Distrito Federal (Mexico City Government), et al. *La Prevención del embarazo entre las y los jóvenes de la Ciudad de México por el ejercicio de los derechos sexuales y reproductivos [Contraception Among Young People in Mexico City Through the Exercise of Sexual and Reproductive Rights]*, 39 (1999) [hereinafter *Contraception Among Young People*].

²⁵¹ Martin Rivera, *Madres solteras, resultado de la pobreza y la marginación en el DF [Single Mothers: Consequences of Poverty and Marginalization in Mexico City]*, EL DÍA, Jan. 22, 2000 at 17.

²⁵² *Contraception Among Young People*, *supra* note 250 at 41.

miscarriage, premature delivery (which can lead to either maternal or infant death), delivery complications during prolonged labor, toxemia and eclampsia (convulsions which can seriously affect infant health). Children born to young mothers are also at higher risk of having low weight at birth.²⁵³ Finally, pregnancy not only affects the health of a young woman's child at birth, but also may interrupt her education. Because maternal education is correlated with child survival, pregnancy during adolescence presents a significant risk for the child. DIF addresses the issue of adolescent pregnancy through a program that educates young women about their rights and how to assert them, aims to improve their self-esteem and provides information on sexual and reproductive health as well as domestic violence and caring for children.

With the initiation of the Universal Vaccination Program in 1990, under-five child mortality from vaccine-preventable diseases has been greatly reduced. The vaccination program includes both permanent initiatives and targeted vaccination activities during national health campaigns. Recent UNICEF data confirm that vaccination rates are now high in Mexico, with a reported 100 percent of basic immunizations financed by the government.²⁵⁴ UNICEF reports the following immunization rates for children aged one: 100 percent vaccinated against tuberculosis, 87 percent vaccinated against DPT (Diphtheria, Pertussis, Tetanus), 97 percent against polio and 98 percent receiving measles vaccinations. Data from UNICEF also reveal, however, that only 67 percent of pregnant women are fully immunized against tetanus.²⁵⁵ The Secretariat of Health subsumes neonatal tetanus as a cause of death within the category of perinatal illnesses, the leading cause of death for infants. Thus, although Mexico has declared that neonatal tetanus has been eliminated, both the high number of non-vaccinated women and significant numbers of women who give birth without medical personnel suggest that the existing vaccination program should be expanded to ensure that all women are immunized against tetanus in an effort to reduce child mortality and protect maternal health.

2. Working Conditions

According to the United Nations Development Program (UNDP), in 1998, 38 percent of all Mexican women over the age of 15 were economically active.²⁵⁶ Because pregnancy outcomes are impacted by a woman's environment, which include her work environment, safe working conditions are essential to healthy birth outcomes. Two types of unsafe working conditions appear to contribute to health problems in infants and children in Mexico: exposure to toxic substances and strenuous working conditions. As discussed above, women who are exposed to toxins, sometimes through pesticides, report

²⁵³ *Id.* at 39.

²⁵⁴ STATE OF THE WORLD'S CHILDREN, *supra* note 3, at 87.

²⁵⁵ *Id.*

²⁵⁶ HUMAN DEVELOPMENT REPORT, *supra* note 28, Table 29: Gender and Economic Activity, at 260.

high rates of children born with congenital deformities. For example, a study by the Pan-American Health Organization found that tobacco workers are routinely exposed to toxic substances through pesticide spraying. According to a Mexican activist, women who work in tobacco fields in Nayarit often give birth to children with congenital anomalies who die a few days after birth.²⁵⁷

Difficult working conditions may also cause complications in pregnancies. Research into the working conditions in multi-national assembly plants located along the U.S.-Mexico border, known as maquiladoras or maquilas, have found that many women workers experience health problems. In particular women suffer from complications during pregnancy that affect their children, such as miscarriage, pre-term delivery (low birth weight) and congenital malformations.²⁵⁸ Such health problems are attributed to long workdays and heavy manual labor. Furthermore, a study of female street vendors in Mexico City indicated that such women are at a high risk for delivering infants with low birth weight due to stressful working conditions and labor fatigue.²⁵⁹ This type of informal employment is associated with prolonged workdays, exposure to city pollutants, a lack of attention to hygiene and no vacation, maternity leave or minimum salary.²⁶⁰ The Mexico City study found specifically that, among the women interviewed, 56 percent worked more than 48 hours per week and 87 percent had no social security and thus no health care plan. Many of the women also reported that they spent long periods of the day sitting, that they frequently carried packages that weighed more than 10 kilograms (approximately 22 pounds) and that they experienced abuse from the police or other vendors.

Finally, research by the WHO has documented a decline in exclusive breastfeeding of infants in urban areas, despite an increase in the country as a whole and a high prevalence in rural areas.²⁶¹ One reason for the regional differences may be related to the nature of women's work in urban areas. The Federal Labor Law allows

²⁵⁷ Marwaan Macan-Markar, *En riesgo de tener hijos con malformaciones congénitas, plantadoras de tabaco en Nayarit* [*The Risk of Having Children with Birth Defects: Tobacco-field Workers in Nayarit*], CIMAC, Aug. 29, 2000, available at www.cimac.org.mx.

²⁵⁸ M. Jasis & S. Guendelman, *Maquiladoras y mujeres fronterizas: beneficio o daño a la salud obrera?* [*Maquiladoras and Women at the Borders: Benefit or Harm to Worker's Health?*], 35 SALUD PUBLICA DE MÉXICO 6, Nov.-Dec. 1993; Silvia Magally, *En complicidad con autoridades mexicanas, la explotación laboral en maquiladoras* [*Worker Exploitation in Maquiladoras with the Complicity of the Mexican Government*], CIMAC, June 28, 1999; Silvia Magally, *En ambulante, un oficio nocivo para la salud reproductiva* [*Street Sales: A Trade Harmful to Reproductive Health*], CIMAC, July 26, 1999, available at www.cimac.org.mx.

²⁵⁹ P. Hernandez-Peña, et. al., *Condiciones de trabajo, fatiga laboral y bajo peso al nacer en vendedoras ambulantes* [*Work Conditions, Work Fatigue and Low Birth Weight in the Children of Street Saleswomen*], 41 SALUD PUBLICA DE MÉXICO No. 2 at 102 (Mar.-Apr. 1999).

²⁶⁰ *Id.*

²⁶¹ M.L. Guerrero et al., *Rapid ethnographic assessment of breastfeeding practices in periurban Mexico City*, 77 BULLETIN OF THE WORLD HEALTH ORGANIZATION No. 4 at 326 (1999).

women two half-hour periods during the workday in which to feed their babies, for up to six months. In reality, however, urban working conditions make it impossible to return home to feed a child or to bring a child to the workplace.²⁶² Workers who participate in the IMSS are entitled to receive infant formula which may promote the early discontinuation of breastfeeding among working women. Other researchers, however, have linked the decline in breastfeeding not to work conditions, but to the fact that that “existing postpartum care policies and practices” related to breastfeeding in Mexican hospitals do not reflect the needs of mothers and infants.²⁶³ Specifically, 42 percent of women surveyed stated that they had ceased breastfeeding after a doctor had advised them to do so.²⁶⁴ Thus, education programs directed to medical professionals as well as increased governmental supervision of workplace standards could be instrumental in promoting child health and reducing child mortality.

Discrimination against women in the workplace also has a negative impact on women’s families and their children. Human Rights Watch has documented wide-spread pregnancy-based sex discrimination in the maquiladora sector in Mexico.²⁶⁵ According to their research, the maquiladoras that practice sex discrimination are motivated by “a desire to avoid having to absorb the costs of potential disruptions in production schedules due to maternity leave . . . or women workers’ reduced capacity to meet . . . production quotas” and also “to avoid . . . additional costs in the form of maternity payments.”²⁶⁶ Thus, both female job-seekers and female workers are routinely asked personal questions about their pregnancy status, required to undergo physical examinations and are terminated if they become pregnant. Not only is sex-based discrimination a violation of women’s right to equal treatment, it also excludes women from the workforce and places them at an economic disadvantage. According to government statistics, approximately 20 percent of families in Mexico have a female head of household.²⁶⁷ At the same time, most women earn less than five minimum salaries, which is considered insufficient to afford basic goods.²⁶⁸ When discriminatory labor practices prohibit women from working, their ability to support their families is significantly restricted. Such a limitation leads to impoverishment of women and children.

²⁶² Míriam Ruiz, *Por falta de recursos económicos las madres mantienen el lema “amamantar es amar”* [Due to Lack of Financial Resources, Mothers Use the Slogan “To Breast-feed is to Love”], CIMAC, May 2000, available at www.cimac.org.mx.

²⁶³ Guerrero, *supra* note 261 at 326.

²⁶⁴ *Id.*

²⁶⁵ *A Job or Your Rights: Continued Sex Discrimination in Mexico’s Maquiladora Sector*, 10 HUMAN RIGHTS WATCH 1, Dec. 1998.

²⁶⁶ *Id.*

²⁶⁷ INEGI, *Indicadores Relevantes para Estudios de Genero 2000* [Indicators Relevant to Gender Studies 2000], available at <http://www.inegi.gob.mx/estadistica/espanol/sociodem/fsociodemografia.html>.

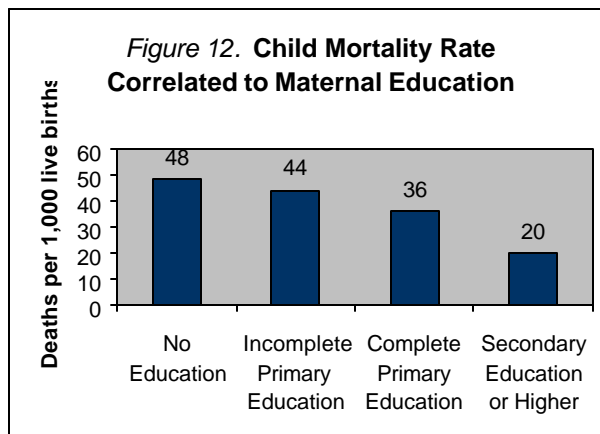
²⁶⁸ *Id.*

3. Education

There is a strong correlation between maternal education and child mortality, generally because an educated mother has children later in life, provides better care and nutrition for herself and her children, is more able to detect health risks and seeks medical attention for herself and her children.²⁶⁹ According to figures from CONAPO, mothers with no education had the highest levels of child mortality (48 deaths per 1,000 live births from 1991 to 1995). The infant mortality rate for mothers with incomplete primary education was 44. Mothers who completed primary education exhibited an infant mortality rate of 36 per 1,000 live births, and mothers with secondary education or higher had the lowest infant mortality rates (20 per 1,000).²⁷⁰ See Figure 12.

In Mexico City, recent reports place the current child mortality rate for illiterate mothers at 42 deaths for every 1,000 live births. In contrast, the rate for mothers with elementary education is ten deaths for every 1,000 live births.²⁷¹ Higher maternal education is not only associated with a lower risk of child death, but is also correlated to the level of a child's general health. For example, a study of breastfeeding and diarrheal diseases in Guadalajara revealed "each increment in the mother's level of education is associated with a two-fold increase in ending an asymptomatic infection and a 90 percent decrease [in the risk of the child getting a diarrheal infection]."²⁷²

Mexican women are disproportionately under-educated compared to Mexican men. While eight percent of the male population over the age of 15 is illiterate, the figure for the female population of the same age is 13 percent.²⁷³ For the country as a whole, 29



Source: CONAPO, 1998

²⁶⁹ See Santosh Mehrotra, et al., *Basic Services for All?*, UNICEF INNOCENTI PUBLICATIONS 8 (2000).

²⁷⁰ CONAPO, *III Informe de Avances del Programa Nacional de Población, 1995- 1998, [Third Report on the Advances of the National Program on Population]* at 18.

²⁷¹ Humberto Rios Navarrete, *Desnutrición y muerte, secuelas de la pobreza [Malnutrition and Death: Consequences of Poverty]* EL UNIVERSAL, Feb. 22, 2000 at 10.

²⁷² K. Long, et al., *The Impact of Infant Feeding Patterns on Infection and Diarrheal Disease Due to Enterotoxigenic Escherichia Coli*, 41 SALUD PÚBLICA DE MÉXICO No. 4., 268 (Jul.-Aug., 1999).

²⁷³ INEGI, *Indicadores Comparados por Genero Segun Entidad Federativa, 1995, Población analfabeta de 15 años y mas; Población sin instrucción o primaria incompleta de 15 años y mas*, <http://www.inegi.gob.mx/estadistica/espanol/sociodem/fsociodemografia.html>.

percent of men over the age of 15 either have no education or have not completed primary school. The comparative figure for women is 35 percent without education. Women's illiteracy rates are considerably higher in poor states with large indigenous populations. For example, 33 percent and 29 percent of women in Chiapas and Oaxaca are illiterate (meaning they cannot read or write). In Chiapas, Guerrero and Oaxaca, half to almost 60 percent of the female population has no education or has not finished primary school.²⁷⁴ Other studies have confirmed that 27 percent of the women in communities of fewer than 2,500 residents cannot read or write, compared to only six percent of women in cities. Finally, 49 percent of indigenous women and 29 percent of indigenous men are considered illiterate. Even within Mexico City, more than 60 percent of the children excluded from postsecondary education are female.²⁷⁵ The serious inequities in education for women and girls, in particular indigenous women, point to discrimination that has not been adequately addressed by the government. The level of a woman's education not only impacts her ability to realize her rights, but also affects the likelihood that her children will die from preventable causes. Therefore, improving access to education for women and girls is necessary for long-term improvements in the situation for children.

B. Domestic Violence

Domestic violence has a profound effect on the health of women and children as well as on the stability of the family as a whole. International studies suggest that domestic violence "may undermine child survival" both because the abuse affects a child's development directly and because it impedes a woman's ability to maintain her child's good health.²⁷⁶ Violence against women has been linked to high-risk pregnancies, and is specifically correlated with an increased risk of pre-term delivery and low birth weight,²⁷⁷ both of which are leading causes of infant mortality in Mexico. Conflicts between adults also adversely affect the health of young children and often lead to child abuse.²⁷⁸ Available government data indicate that in Mexico one of the principal causes of death for children aged one through four is "injury," and children's rights experts suggest that intentional family violence is a significant cause of child injury.

Not only does domestic violence inhibit child survival, it is also a violation of international human rights standards. The UN Committee of the Elimination of All Forms of Discrimination Against Women (CEDAW) has interpreted the Women's Convention to condemn violence against women as gender discrimination. CEDAW's

²⁷⁴ *Id.*

²⁷⁵ LOS HECHOS SE BURLAN DE LOS DERECHOS, *supra* note 110 at 169.

²⁷⁶ Lori Heise, et al., *Ending Violence Against Women*. POPULATION REPORTS, SERIES L, NO. 11. at 20, 25 (Johns Hopkins University School of Public Health, Dec. 1999).

²⁷⁷ *Id.* at 17.

²⁷⁸ *Id.* at 20.

General Recommendation 19 characterizes family violence as “one of the most insidious forms of violence against women.”²⁷⁹ The Convention on the Rights of the Child also condemns violence and abuse. Mexico has ratified the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (Convention of Belem Do Para).²⁸⁰ The Convention of Belem Do Para sets forth specific duties of state parties, including the adoption of appropriate measures to prevent, investigate and penalize violence against women as well as establishing effective remedies to provide women with restitution. Thus, the Mexican government has an obligation to ensure that women and children enjoy their basic human rights, security of person and bodily integrity in the home. When such rights are violated, the government is also obligated to respond.

The Mexican government has addressed the issue of domestic violence but not as it impacts preventable child death. Furthermore, the government has not implemented many of the recommendations of CEDAW that are intended to assist women, and their children, to leave violent situations.

1. Violence Against Women

Domestic violence is a pervasive problem in Mexico. By government estimates, “some form of domestic abuse occurs in one of every three homes” in Mexico.²⁸¹ Non-governmental organizations have found that “over one million women each year seek emergency medical treatment for injuries sustained due to domestic violence, which is the fourth highest cause of death for women.”²⁸² The Mexican Association for Combating Violence Against Women (COVAC), however, has found that “more than 65 percent of all women suffer some form of abuse, . . . but only 30 percent lodge formal complaints.”²⁸³ Pilot studies, carried out in various cities and states in Mexico, such as the Federal District, Guadalajara, Durango, Monterrey and Chiapas, indicate that domestic violence against women includes physical violence, sexual violence and emotional violence.²⁸⁴

²⁷⁹ Committee on the Elimination of Discrimination against Women, General Recommendation No. 19, *Violence Against Women*, 11th Sess. (1992), para. 23, Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI\GEN\1\Rev.1 at 84 (1994).

²⁸⁰ A-61, Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women, Adopted on June 9, 1994 by the Organization of American States at its twenty-fourth session, *entered into force* March 5, 1995. Ratified by Mexico June 19, 1998.

²⁸¹ U.S. Department of State, 2000 Country Reports on Human Rights Practices, Mexico (2001), *available at* <http://www.state.gov/g/drl/rls/hrrpt/2000/wha/index.cfm?docid=810> (citing a 1999 survey carried out by INEGI, the National Institute of Statistics, Geography and Informatics).

²⁸² *Id.*

²⁸³ *Id.*

²⁸⁴ J.C. Radriguez Ramirez and M.C. Patino Guerra, *Some aspects of the magnitude and consequences of domestic violence against women: a pilot study*, 20 SALUD MENTAL No. 2 at 5-16 (1997); G. Alvarado-Zaldivar et al. *Prevalence of Domestic Violence in the city of Durango, Mexico*, 40 SALUD PUBLICA DE

Medical studies have shown that not only does domestic violence increase in severity over time, it also tends to worsen during pregnancy. Abuse during pregnancy presents serious health risks to both the mother and developing child. A study of pregnant women in Morelos found that women who suffered violence during the pregnancy had three times more complications during delivery and also had a four times greater risk of having babies with low birth weight.²⁸⁵ Violence has also been linked to an increase risk of miscarriage or abortion, premature labor and fetal distress.²⁸⁶ Adverse pregnancy outcomes may can be due to a variety of factors associated with violence, for example, physical injury such as abdominal trauma, elevated stress levels, isolation and inadequate access to prenatal care or nutrition.²⁸⁷ According to a study of 342 randomly selected women in Mexico, 20 percent had received blows to the stomach during a pregnancy.²⁸⁸ An NGO, however, reported that there are few services and little information specifically available to pregnant women on either how to prevent violence or how they can leave abusive situations.²⁸⁹

Domestic violence against women seldom takes place in isolation. A study conducted in Mexico City revealed that of women from the age of 14 to 57 who were beaten by their partners, most had children and that in 90 percent of the cases, the women were beaten in front of the children.²⁹⁰ Children who live in violent families are at risk for various health problems. Battered mothers may be unable to provide children with adequate care due to feelings of depression and anxiety and male control over family decisions.²⁹¹ In 86 percent of domestic violence cases where women are the victims, the perpetrator of the abuse is the father or husband.²⁹² Data from the government office for the Integral Family Development (DIF) and pediatric hospitals, however, indicate that of the child abuse cases that enter the medical or legal systems, approximately 40 percent of

MEXICO No. 6 at 481-486 (1998); Mayra Buvinic, et al., *Violence in the Americas: A Framework for Action*, in TOO CLOSE TO HOME: DOMESTIC VIOLENCE IN THE AMERICAS 5(1999); L. Miranda, et al., *Characteristics of domestic violence and women's replies in a rural community of Las Margaritas, Chiapas*, 21 SALUD MENTAL No. 6 at 19-26 (1998).

²⁸⁵ R. Valdez-Santiago and L H. Sanín-Aguirre, *La Violencia Doméstica Durante el Embarazo y Su Relación con el Peso al Nacer*, [Domestic violence during pregnancy and its relation to birth weight], SALUD PUBLICA MEXICANA No. 38[Mexican Public Health] at 352-362 (1996).

²⁸⁶ Heise, *supra* note 276 at 17.

²⁸⁷ See generally, Heise, *supra* note 276 at 17, 20, 25.

²⁸⁸ María Huerta, *Mujeres en edad reproductiva, las más afectadas por la violencia de género* [Women of reproductive age- the most affected by gender-based violence], CIMAC, June 1, 2001.

²⁸⁹ Interview, Sept. 7, 2000 (Women's Rights NGO, Mexico City).

²⁹⁰ Center for Reproductive Law and Policy, *Women of the World: Laws and Policies Affecting their Reproductive Lives: Latin American and the Caribbean*, 156 (1997).

²⁹¹ Heise, *supra* note 276 at 25.

²⁹² U.S. Department of State, *supra* note 281.

the abusers are mothers, 20 percent are fathers and the rest are other relatives.²⁹³ Several NGOs reported that people in Mexico generally understand that mothers may abuse their children as a result of their own experiences of violence, but this phenomenon has not been researched or addressed by government programs.²⁹⁴

2. Violence Against Children

Available data suggests that violence against children occurs frequently in Mexico. A public opinion poll conducted in 1998 by COVAC suggested that infants and children constitute 82 percent of all victims of physical or emotional violence.²⁹⁵ According to UNICEF, half of all children report being spanked or beaten at home.²⁹⁶ At the same time, the DIF office registers relatively few cases of child abuse.²⁹⁷ Experts on children's rights in Mexico explained that child abuse cases are generally under-registered.²⁹⁸ The director of a government development office estimated that 70 percent of infant deaths are caused by violent family members, but that as many as 20 percent of child abuse cases are not reported or prosecuted.²⁹⁹ Cases of violence against children may be underreported because low-level abuse is often viewed as appropriate discipline. According to a children's rights advocate, "the majority of cases of child abuse [concern] physical violence when it becomes extreme. Cases are not reported when they are mild; when the mother or father just slaps the child it is not considered abuse. When it is almost torture, then it is reported to the system. Children are seen as objects and not as subjects. This is the perception in Mexico."³⁰⁰ In fact, in several states the "right of correction," allowing parents and teachers to discipline children physically, is still part of state law despite the fact that it contradicts the federal law on children's rights, discussed below.³⁰¹

²⁹³ Other abusers include stepparents, grandparents and other family members. Coordinación General de la Comisión Nacional de la Mujer [General Coordination of the National Commission on Women], *Programa Nacional contra la Violencia Intrafamiliar 1999-2000* [National Program against Intra-family Violence 1999- 2000] (Mar. 1999) at 9 (hereinafter *National Program against Intra-family Violence*).

²⁹⁴ Interviews, Sept. 4, 2000 (Women's Rights NGO, Mexico City); Sept. 7, 2000 (Children's Rights NGO, Oaxaca); Oct. 29, 2000 (Women's Rights NGO, Mexico City).

²⁹⁵ *National Program against Intra-family Violence*, *supra* note 293 at 8.

²⁹⁶ UNICEF Information on Mexico, *supra* note 117.

²⁹⁷ For example, DIF reported only 25,259 cases of child abuse for the entire country in 1997. *National Program against Intra-family Violence*, *supra* note 293 at 9.

²⁹⁸ Interview, Oct. 24, 2000 (Children's Rights NGO, Mexico City).

²⁹⁹ Interview, Sept. 6, 2000 (Women's Rights NGO, Mexico City).

³⁰⁰ Interview, Oct. 24, 2000 (Children's Rights NGO, Mexico City).

³⁰¹ *Concluding Observations of the Committee on the Rights of the Child: Mexico*, at 11, CRC/C/15/Add.112 (10/11/99).

Apart from physical injuries, children who experience abuse are more likely to suffer poor health generally. The Mexican National Institute of Pediatrics, in a study of child abuse victims, found that of the patients, 43 percent also suffered from infectious and parasitic illnesses and 38 percent had nutritional illnesses, such as malnutrition.³⁰² Such data suggest that domestic violence contributes to elevated child mortality rates, both directly and indirectly.

3. Government Response to Family Violence

The Mexican government has recognized that domestic violence is an issue of serious concern and has taken a number of major steps to address the problem. The Mexican government has addressed intra-family violence at both the international and national level, through legislation and other changes within the criminal justice system to allow women and children better access to prosecution. At the federal district level, the Assembly of Representatives adopted the Law for the Assistance and Prevention of Intra-Family Violence (*Ley de Asistencia y Prevención de Violencia Intrafamiliar*) in 1996. The law proscribes both abuse and neglect of children. While the creation of such a law is a significant and positive step, many NGOs report that the Federal District law is weak because it is limited to prevention and does not create new sanctions for abuse. Instead, existing penal code provisions continue to apply. The intra-family violence law further focuses on conciliation and arbitration over prosecution. According to a woman's rights lawyer the intra-family violence law does not create any "real . . . process [or] institution to deal with such cases."³⁰³ As of 1999, six states had also adopted laws for the prevention and punishment of family violence and four others had initiated such reforms. Virtually every state has initiated either legal reform or normative projects that address family violence in the areas of health, education and social assistance.³⁰⁴ State domestic violence laws, however, are modeled after the federal law and thus have similar weaknesses. A representative of an NGO in Oaxaca explained that despite a law that prohibits family violence, women who attempt to prosecute abusers do not receive justice because judges often try to convince the woman not to leave her husband.³⁰⁵ Furthermore, existing anti-violence initiatives do not include educational programs so that abusers can "learn that violence is not normal."

In March 2000, the Secretariat of Health issued a normative act that requires medical professionals to register cases of abuse and neglect with the Secretariat of Health.³⁰⁶ The act applies to all providers of health services in the public, social and

³⁰² *National Program against Intra-family Violence*, *supra* note 293 at 11.

³⁰³ Interview, Oct. 29, 2000 (Women's Rights NGO, Mexico City).

³⁰⁴ *National Program against Intra-family Violence*, *supra* note 293 at 21.

³⁰⁵ Interview, Sept. 7, 2000 (Women's Rights NGO, Oaxaca City).

³⁰⁶ Secretaria de Salud Norma, *Prestación de servicios de salud. Criterios para la atención médica de la violencia familiar* [*Provision of health services. Criteria for medical attention of domestic violence*], Oficial Mexicana NOM-190-SSA1-1999.

private sectors, which make up the National Health System in Mexico. Further, the act categorizes violence as abandonment, physical abuse, psychological abuse or sexual abuse. Although the effect of the act on alleviating family violence is not yet clear, an expert on domestic violence pointed out that the mandatory reporting law will likely lead to the collection of more accurate statistics about the rates of domestic violence against women and children in Mexico.³⁰⁷

Finally, the state-provided services that do exist to protect women and children from violence are disproportionately located in Mexico City and other urban areas. In 1997, the first government-initiated Temporary Shelter for Women Victims of Domestic Violence was opened in the Federal District. There are currently only two other state-supported shelters in the country, in Monterrey, Nuevo León and Morelia, Michoacán, which offer a place to live to women and children who are fleeing violence.³⁰⁸ The office of the Attorney General of the Federal District has also made efforts to help victims of domestic violence through the creation of agencies specialized in sex crimes and psychological and legal support and intervention centers, such as the Family Violence Assistance Center (CAVI). The Mexico City government also operates a free 24-hour telephone advice and information line, only available to residents of the capital. The telephone line includes medical, legal and psychological support directed to women (Línea Mujer) and a line for children to speak with “specialists who provide free psychological help to children victims of mistreatment and also their families” (Niñotel).³⁰⁹ According to the city government, Niñotel staff direct complaints to DIF and other appropriate authorities.³¹⁰

Services outside of the capital are markedly more limited. For instance, the director of a women’s rights organization in Oaxaca stated that there is no state-supported shelter for battered women in the state. “The DIF office is the only thing like [a shelter], but they won’t accept women there. Instead they send them to our organization. A woman came recently from DIF with bruises all over her, but we have no place for her to stay.”³¹¹ The lack of state-sponsored services for victims of domestic violence is evident from the efforts of NGOs in various states, which are attempting to provide specialized help. While the Mexican government’s initiatives in the area of family violence are beneficial and important, another crucial aspect of protecting the rights of women and

³⁰⁷ Interview, Oct. 29, 2000 (Women’s Rights NGO, Mexico City).

³⁰⁸ Miriam Ruiz, *Albergue en el DF, una esperanza para mujeres que viven violencia intrafamiliar* [A Shelter in the DF: A hope for women that experience domestic violence], CIMAC, Mar. 2000.

³⁰⁹ Website of the Mexico City government, <http://www.df.gob.mx/servicios/locatel/>.

³¹⁰ Hernández, *supra* note 145. María Angélica Luna Parra, the president of the Commission on Special Attention for Vulnerable Groups of the Legislative Assembly in the Federal District, reported that in 1999 the Línea Mujer received 5,540 calls related to intra-family violence and the Niñotel line received 2,532 calls.

³¹¹ Interview, Sept. 8, 2000 (Women’s Rights NGO, Oaxaca City).

children is the support and strengthening of NGOs which have knowledge of the specific needs of victims. The government itself is also obligated to provide women and children victims of violence with services that make it easier for them to leave violent situations, in all parts of the country. Finally, the government should include information about injuries caused by violence in mortality statistics.

C. Militarization and Armed Conflict

Armed conflicts have taken place in Mexico for centuries, mainly over land, political interests and between religious sects. Disputes over land, in particular, both between and within indigenous communities, large and small land owners, political parties and campesino organizations have frequently erupted into violence. The armed movement led by the Zapatista Army of National Liberation in Chiapas is perhaps the best-known illustration of the response by national security forces to local territorial and political disputes. Many other states,³¹² such as Oaxaca and Guerrero, have also been the sites of indigenous movements that have denounced the political and economic situation in which they live as well as the systematic violation of their rights. The Mexican military occupies many southern regions and, since the introduction of NAFTA, militarization of the northern border has also increased, mainly for drug interdiction purposes. In fact, the government justifies maintaining a military presence in the South in order to combat narcotics trafficking and the smuggling of immigrants from Guatemala. However, “since antinarcotics counterinsurgency equipment and training are fungible and spill over easily and with regularity against political insurgents and their alleged sympathizers,”³¹³ militarization also has profound effects on the population as a whole.

The most dramatic violations of the rights of local community members occur when they clash directly with armed forces. For example, in December 1997, a paramilitary group loyal to the government massacred 45 people, mainly indigenous women and children, at Actéal, Chiapas. The presence of military and paramilitary troops also creates an atmosphere of repression, intimidation and fear for community members and limits their access to basic necessities, such as health services, food and water. For example, after the Actéal massacre, “the quality and quantity of the food deteriorated to [the point] of not harvesting the corn or vegetables that were grown on the land; [people did] not even take care of their fruit trees or their chickens . . . they depended solely on food given out by the Red Cross.”³¹⁴ When demonstrating against the installation of a military encampment in their community of X’oyep, a group of women argued that they “don’t want to see any more weapons and want even less to see

³¹² Centro de Investigaciones Económicas y Políticas de Acción Comunitaria (CIEPAC), *Los Grupos Guerrilleros en México [Guerrilla Groups in Mexico]*, available at <http://www.ciepac.org> (documenting the existence of guerrilla groups in a majority of the Mexican states).

³¹³ Jerry W. Sanders, *Two Mexicos and Fox’s Quandary*, THE NATION, Feb. 26, 2001 at 20.

³¹⁴ COMEXANI, AVANCES Y RETROCESOS: BALANCE DE UNA DÉCADA, V INFORME SOBRE DERECHOS Y LA SITUACIÓN DE LA NINEZ EN MÉXICO 1998-2000, 285 (2000).

the [military] exercises because they are afraid; and besides [the soldiers] are surrounding the well where we get our water.”³¹⁵

Militarization is particularly harmful since the communities with the strongest military presence are generally those which suffered elevated levels of marginalization even before armed conflict began. For example, by some estimates, in 1997 there was one medical doctor for every 1,178 inhabitants in Chiapas, which was below the national average. In contrast, in the conflict zone, there was less than one doctor per every 18,900 inhabitants. In the same year, NGOs estimated that one of every three military officers in Mexico was stationed in Chiapas.³¹⁶ A representative of an indigenous rights organization in Guerrero stated that clinics are only located in the capital, but the military has created checkpoints along various routes from the communities to the capital. This has further decreased access to health care for those in rural areas, who now will only seek medical service when they are seriously ill.³¹⁷

Militarization also causes large-scale displacement of the population who often suffer a severe decline in their standard of living. For example, health promoters in Chiapas documented such problems among displaced people as a lack of adequate sanitation services, latrines that were built too close to community wells³¹⁸ and poorly-constructed and overcrowded housing which offered little protection against the elements.³¹⁹ The story of the women and children of Loxicha, Oaxaca, Box 4 below, also illustrates how residents who are displaced from their homes by armed conflict experience further hardships which compromise a child’s ability to survive and develop.

³¹⁵ Centro de Información de la Mujer A.C. (CIMAC) et al., *El cauteloso encanto de la discreción, Las mujeres indígenas en el contexto de la militarización en México* [The Cautious Charm of Discretion: Indigenous Women in the Context of Militarization in Mexico] (July 1998) (NGO report submitted to the United Nations).

³¹⁶ Alternative NGO Report *supra* note 82 at 9.

³¹⁷ Interview, Oct. 27, 2000 (Indigenous Rights NGO, Guerrero).

³¹⁸ In X’oyep, for example, it was found that there was only one latrine per ten families (50 - 60 persons). The available latrines were far below the standard set by the UN High Commissioner for Refugees of one latrine per 20 people. Centro de Investigaciones Economicas y Politicas de Accion Comunitaria (CIEPAC) *La Salud en Los Tiempos de Guerra, [Health in times of war]* (1998) available at www.ciepac.org/analysis/saludenguerra.htm.

³¹⁹ *Id.* In X’oyep and Actéal, 10 to 15 families (60- 90 people) were sharing a shelter consisting of a nylon roof over a dirt floor. For sleeping, parents were given one blanket for themselves and another for their children.

Box 5. The Women and Children of Loxicha, Oaxaca³²⁰

In 1996, when counterinsurgency forces of the Mexican Army arrived in the mountainous Loxichas region of southern Oaxaca, the human rights abuses that the indigenous communities already suffered took on the form of a low intensity war. After an armed rebel attack on a resort town was attributed to the Popular Revolutionary Army (EPR), police, army troops and paramilitary troops were dispatched to Loxicha, which the government identified as the stronghold of a guerrilla movement.

Los Loxichas is a region in the state of Oaxaca, in the south of Mexico. Loxicha is an impoverished area populated by the indigenous Zapotecs. Between 1996 and 1999, more than 130 residents, mostly men, were imprisoned; others were assassinated or simply disappeared. The Loxicha community maintains that it is not associated with the EPR, and according to the women of Loxicha, they have suffered these abuses simply “for having demanded that the government improve the conditions of our people, such as highways, electricity, schools, clinics.” The detention of a large part of the male population and the continued military occupation, led to human rights violations against the women of Loxicha in the form of rape, sexual abuse, harassment and political persecution. Furthermore, left as the sole wage earners for their families, many women of Loxicha were unable to support their children and were forced to leave the region. By some estimates, more than 500 residents have been displaced by the conflict.

Faced with repression and a new level of economic hardship, a group of women who felt they could no longer endure the situation traveled to the state capital in 1997 to stage a protest in front of the Governor’s office. They are asking for justice for their families as well as amelioration of the conditions in their community, including an end to the militarization. Since that time, the women and children of Loxicha have lived on the pavement across from the town plaza. They continue to sleep on pieces of cardboard and cook over charcoal stoves. A recent survey carried out by a local human rights organization revealed the following about the women who are protesting the situation in Loxicha:

- 73.6 percent of the women are between the ages of 20 and 31.
- 63 percent of the women speak the indigenous language, Zapoteco; of these, only ten percent also speak Spanish.
- More than half of the women are unable to read or write, and very few have finished primary school.
- On average, the women have three or four children each; three percent of the children are under the age of five and 76 percent are under the age of 11.

Some of the Loxicha children are sponsored by local individuals to attend school, but many simply spend their days as king passersby for money to help their cause. As a result of multiple stresses in their lives, both the women and children suffer chronic illnesses, such as colds, flu, gastrointestinal illnesses as well as loss of appetite, insomnia and depression.

Since the protests began, there have been some improvements in the situation in Loxicha. Through the assistance of Mexican human rights attorneys, a number of political prisoners have been freed. In 1999, the governor of Oaxaca ordered a review of the cases of those who are still imprisoned. Yet the other demands of the women of Loxicha- for the government to aid the poor in their community- have remained largely unanswered.

³²⁰ Information compiled from the following sources: José Antonio Román, *En Loxicha, represión desde antes de 96 [In Loxicha, Repression Since before 1996]*, LA JORNADA, Apr. 5, 2000; Miguel Concha, *Mujeres contra el olvido [Women Against Indifference]*, LA JORNADA, Mar. 25, 2000; Soledad Jarquín Edgar, *El rostro de mujeres loxichas, tres años de historia [The Face of the Women of Loxicha: Three Years of History]*, CIMAC, June 20- 26, 2000; Interview, Sept. 8, 2000 (Human Rights NGO, Oaxaca City); flyer from the Union de Pueblos contra la Represión y Militarización de la Región Loxicha (People’s Union Against the Repression and Militarization of the Loxicha Region) on file with Minnesota Advocates.

In areas of militarization, the government is under more scrutiny, both national and international, for its actions. This scrutiny appears to have both positive and negative effects. The Mexican Army carries out social work for civilian populations, mainly in conflict zones, such as medical and dental examinations, vaccinations, food distribution, improvement of sanitation services and repair of schools. Many NGOs, however, have expressed concern because the provision of such services by the Army requires military personnel to be stationed in small communities, it “thereby [impedes] their normal functioning . . . [and] deepens the social cleavages and serves as a pretext for military presence within communities, with counterinsurgency and control objectives.”³²¹ A human rights activist described a situation in which a charity group created a dental clinic in Chiapas, but when this effort created a negative image of the government’s services, the clinic was burned down and the group was forced to leave.³²² A human rights activist who works with indigenous populations reported that pre-existing government social programs are often discontinued in conflict areas, in particular Guerrero and Chiapas.³²³

D. Natural Disasters

Although not a major cause of child death, an NGO representative identified periodic natural disasters in Mexico as contributing to an increase in child mortality, particularly in rural areas.³²⁴ Disasters, such as flooding, hurricanes and earthquakes, have a greater impact on rural and impoverished communities than on other areas that are able to recover more quickly. A study by Mexico’s National Center for disaster Prevention (CENAPRED) concluded that 68 percent of the people who are affected by natural disasters in Mexico are “poor” or “extremely poor” and that property losses from natural disasters in the last 20 years have totaled over US \$11 billion.³²⁵

While natural disasters are directly responsible for some deaths, their most significant effects are indirect. For example, the destruction of houses and crops leads to food scarcity and economic losses for local families. Because many indigenous communities depend on farming for income or practice subsistence (non-commercial) farming, they are disproportionately affected by such climactic changes. For example, heavy flooding in 1999 resulted in malnutrition and a dramatic reduction of family income in Oaxaca, Chiapas, Tabasco, Veracruz, Hidalgo and Puebla.³²⁶ An NGO

³²¹ Alternative NGO Report, *supra* note 82 at 125.

³²² Interview, Oct. 25, 2000 (Human Rights NGO, Mexico City).

³²³ Interview, Sept. 7, 2000 (Indigenous Rights NGO, Mexico City).

³²⁴ Interview, Oct. 24, 2000 (Human Rights NGO, Mexico City).

³²⁵ *World Bank Approves \$404 Million to Support Management of Natural Disasters in Mexico*, World Bank News Release No. 2001/150/LAC, available at <http://wbln0018.worldbank.org/news/>.

³²⁶ Juan G. Reyes, *Causan las Lluvias 95 Muertos y 102 Desaparecidos, en 8 Estados* [95 Dead and 102 Disappeared Because of the Rain in 8 States], EL EXCELSIOR, Oct. 7, 1999. See Appendix A, *infra*, map of the United Mexican States.

representative who works in some of the areas most affected by the floods reported, “mainly rural areas were affected. There are about one million people with health effects in infant mortality and in nutrition Some families lost all their crops. Some products, like coffee, were damaged by the floods and [because it takes three to four years for coffee plants to produce fruit] they won’t have production for the next three years.”³²⁷ In Chihuahua, the Tarahumara, an indigenous group living mainly in southeastern part of the state, is suffering from an elevated rate of malnutrition as a result of a prolonged drought. (See Box 2, *supra*).

In December 2000, the World Bank approved a loan to the Mexican government to finance emergency reconstruction projects and to improve “the efficiency and effectiveness with which Mexico responds to such natural disasters, including environmental, social and cultural issues arising from them.” Under the terms of the loan, the government is required to develop strategies to reduce human and economic losses resulting from natural disasters.³²⁸

E. Migration and Displacement

In the recent years, internal migration in Mexico has increased dramatically.³²⁹ The indigenous population, in particular, has experienced both massive migration and significant displacement as a result of such factors as natural disasters, militarization, developments in infrastructure (e.g. highway development or tourism) and land conflicts. Internal migration in Mexico, however, is generally based on economic factors in the community of origin. In Mexico, the states with the highest levels of out-migration (both internal and international) are also those with the highest levels of poverty, such as Chiapas, Oaxaca, Guerrero, Hidalgo, Veracruz, Puebla, Michoacán, Guanajuato and Yucatán.³³⁰

Migration patterns in Mexico are increasingly to urban areas, reflecting the impoverished conditions of many rural communities. According to CONAPO, which documents migration patterns, internal migration was once mostly to Mexico City but is now increasing to other large metropolitan areas. Experts who work with migrant groups in Mexico City reported to Minnesota Advocates that there has been an increase in the number of migrant women by about 15 to 20 percent each year and that these women are often single parents with no income.³³¹ Further, the women often travel while pregnant

³²⁷ Interview, Oct. 24, 2000 (Human Rights NGO, Mexico City).

³²⁸ *World Bank Approves \$404 Million*, *supra* note 325.

³²⁹ There is significant migration across the Mexican national borders as well, but this type of external migration is beyond the scope of this report.

³³⁰ Blanca Roca & Rodolfo Zamora, *Migración en las Comunidades de Origen, Migración: México Entre sus Dos Fronteras* [Migration Within Communities of Origin, Migration: Mexico Between Its Two Borders] 19 (1999).

³³¹ Interview, Sept. 4, 2000 (Refugee and Migrant Rights NGO, Mexico City).

and have specific health concerns such as tuberculosis, gastrointestinal diseases and malnutrition.³³² The majority of those who migrate from rural areas to cities are searching for economic opportunities not available in their communities. As discussed earlier in this report, however, the indigenous who settle in urban zones often experience further marginalization, in the form of inadequate housing, lack of basic services and lack of employment opportunities.

Migrant children, in particular, are subjected to conditions that leave them vulnerable to preventable causes of death. For instance, children who cross the northern border are likely to be returned or deported back to Mexico.³³³ In the process of crossing the border and being returned, the children may be separated from their families. The children then find themselves in a high-risk situation. At present there are insufficient aid programs to assist migrant populations. Furthermore, the Mexican government has not responded adequately to the conditions that lead to displacement and migration of specific populations within the country.

VIII. MEXICAN GOVERNMENT PROGRAMS THAT ADDRESS CHILD WELFARE

The Mexican government has taken measures to respond to the serious inequality and deprivation of human rights in their country. Mexico is aware of its obligations under the Children's Convention and has taken the first steps toward complying with it. Through the adoption of new legislation and the development of new programs, Mexico seeks to address children's rights.

A. Legislation to Protect Children's Rights

Mexico is a federation with a civil law system. Under this system, the Congress passes federal laws that apply to the country as a whole, and each state passes legislation on a state level. The Federal District is also an entity with its own local laws.

Since 1998, there have been significant changes to Mexican legislation pertaining to children, at both the national and state levels. These changes have been a direct outgrowth of Mexico's ratification of the Children's Convention.³³⁴ On the national level there have been changes to the Mexican Constitution as well as enactment of a

³³² *Id.*

³³³ *Supplementary report to the Second periodic report submitted by Mexico to the Committee on the Rights of the Child*, ¶ 165, U.N. Doc. CRC/C/65/Add. 16 (1999) [Hereinafter *Supplementary Report of Mexico to the Committee on the Rights of the Child*].

³³⁴ *Id.*

comprehensive Children's Law.³³⁵ Some states have enacted corresponding children's legislation to enforce and bolster the efforts to protect children's rights.³³⁶

On December 13, 1999, Mexico amended its Constitution to provide a guarantee for the protection of children's rights. Article 4 of the Constitution now reads:

Children have the right to the satisfaction of their needs with respect to nutrition, health care, education and healthy leisure, to allow for their integral development.

Parents, grandparents,³³⁷ guardians, and individuals legally responsible for children and adolescents have the duty to preserve these rights. The Government will provide whatever is necessary to bring about respect for the dignity of children and the exercise of their rights.

The Government will provide the means for private individuals to help uphold the rights of children.³³⁸

Soon after this important step towards recognizing children's rights, Mexico adopted a Federal Children's Law, codifying the rights contained in the Children's Convention.³³⁹ The national law provides protections for children's basic needs, including those things needed to improve children's survival, such as clean water, adequate nutrition and access to health services. The Children's Law sets forth both the government's obligations and the parents' obligations with respect to children's rights.³⁴⁰ The government is responsible for guaranteeing that children's rights are protected and taking the necessary measures to ensure children's well-being. To this end, the law

³³⁵ "LEY DE PROTECCIÓN DE LOS DERECHOS DE NIÑAS, NIÑOS Y ADOLESCENTES," D.O. 29 de mayo de 2000. [LAW FOR THE PROTECTION OF THE RIGHTS OF CHILDREN AND ADOLESCENTS] [hereinafter CHILDREN'S LAW]. See Appendix F, *infra*.

³³⁶ *Supplementary Report of Mexico to the Committee on the Rights of the Child*, *supra* note 333 (listing changes in state legislation to protect children's rights).

³³⁷ Grandparents, great-grandparents, etc. have specific responsibilities and obligations to the children under Mexican law.

³³⁸ CONSTITUCIÓN POLÍTICA DE LOS ESTADOS UNIDOS MEXICANOS, art. 4 (Mx.) (unofficial translation).

³³⁹ One major difference between the international convention and the Mexican law is the definition of a child. The international standard defines a child as a person younger than 18 years old. However, the Mexican legislation makes a distinction between children and adolescents. Children are people under 12 years old, and adolescents are people aged 12 to 18 years old. For the purposes of this discussion, the word "children" will be used to mean people under age 18 (the definition from the Children's Convention).

³⁴⁰ Article 1 of the Children's Law provides that "The Federation, the Federal District, states and municipalities, in their respective legal jurisdiction, will be able to create legal norms and take the necessary administrative measures to uphold this Law." Chapter II sets forth the obligations of parents, grandparents, legal guardians, or any individuals legally responsible for children or adolescents.

requires the Federal Government to establish a National Program for the Attention to the Rights of Children and Adolescents. This program will promote policies that improve the social condition of children and adolescents.³⁴¹ Parents and guardians, however, retain ultimate responsibility to provide their children with a dignified life and to guarantee all of the child's needs.³⁴² The government commits itself only to a role of supporting the parent's abilities.³⁴³

The Children's Law addresses many issues relevant to a child's right to survival. The law states that children have a right to be healthy and free from violence. In Article 18, the government obligates itself to work with other government authorities to reduce child mortality and to guarantee children's access to health. The law also provides, in Article 21, that children will be protected against armed conflict, natural disasters and situations involving refuge or migration.³⁴⁴

Enforcement of the law is achieved by the establishment of an office for the defense and protection of children's rights.³⁴⁵ This office is given the mandate to monitor and ensure that the constitutional guarantees are observed as well as the government's obligations under international treaties. In terms of sanctions,³⁴⁶ nothing is contemplated for systematic or policy-created violations of children's rights. Existing sanctions focus on individual perpetrators, and thus rarely apply to the enforcement of economic rights.

Mexican experts see the national children's law as a significant step forward, but are concerned about its ultimate usefulness.³⁴⁷ The Children's Law is still very new and its implementation is in progress. While Mexico has adopted sophisticated legislation and has ratified all of the major international treaties, the country still has difficulties implementing many of these laws. Bringing the rights into force on a state level may be difficult, for instance, because the state laws are often declarative in nature. In order to ensure the complete enforcement of children's rights, there must be effective state legislation regarding children's issues that fall under the state's jurisdiction. Sufficient resources also have to be allocated to the enforcement of children's rights. Another frustration for child advocates is that the children's laws are difficult to enforce because

³⁴¹ CHILDREN'S LAW, Article 7.

³⁴² *Id.*, Article 11.

³⁴³ *Id.*

³⁴⁴ *Id.*, Article 21.

³⁴⁵ *Id.*, Article 48.

³⁴⁶ *Id.*, Articles 52, 53, 54 and 55.

³⁴⁷ "LEY DE LOS DERECHOS DE LAS NIÑAS Y NIÑOS EN EL DISTRITO FEDERAL," Gaceta Oficial del Distrito Federal, 31 de enero de 2000. EDNICA, a children's rights non-governmental organization, has published several papers regarding the strengths and weaknesses of the new legislation, at www.ednica.org/manifiesto.htm.

they do not create a cause of action for violating children's rights. In addition, many NGOs were disappointed that despite their extensive participation in drafting the national proposal, a number of their agenda items were later amended or deleted during the legislative process.³⁴⁸

B. Social Welfare Programs

The government has taken steps to improve the welfare of the poor in Mexico and to alleviate conditions of severe poverty in the rural areas. The PROGRESA program is currently the main poverty alleviation program in Mexico. Several relatively small food subsidy programs also exist.

1. Poverty Alleviation and PROGRESA

The poverty alleviation program, Coordinación Nacional del Programa de Educación, Salud y Alimentación (National Coordination Program for Education, Health and Food, hereinafter PROGRESA) began in 1997.³⁴⁹ PROGRESA has three components: education, health and nutrition. The objectives in the three areas, respectively, are to increase child participation in school, to improve the level of health in rural communities, and to raise the nutritional intake of the rural poor.³⁵⁰

To achieve these objectives, families that participate in PROGRESA receive financial assistance in the three areas. For education, families with children receive money for each child attending school between grades three through nine.³⁵¹ The assistance increases each year as the child continues with school, in order to promote and reward continuation with studies through the ninth grade. To encourage girls' education, families receive slightly higher monetary assistance for sending a daughter to school than they do for sending a son.³⁵² Health benefits are services, rather than cash assistance, such as free primary health care for pregnant and nursing mothers. These mothers, as well as young children, can obtain medicine and vitamins free of charge. Money is

³⁴⁸ A comparison of the proposed law created by an NGO network and the legislation passed by Congress shows that the law was significantly changed. The NGO proposal had 344 articles relating to the rights of children whereas the final legislation contains only 56 articles. *Propuesta de Ley de los niños, niñas y adolescentes*, Oct. 1998 (on file with Minnesota Advocates for Human Rights).

³⁴⁹ The program is administered by the Secretariat of Social Development (SEDESOL).

³⁵⁰ Report of SEDESOL, Secretaria de Desarrollo Social, Delegación Estatal Oaxaca, May 18, 1999 (Original in Spanish).

³⁵¹ The education assistance begins at 80 pesos per month (US \$8.71) for a child in the 3rd grade and increases each year to a maximum of 265 pesos per month (US \$28.87) for a child in the 9th grade. *PROGRESA - Programa de educación, salud y alimentación, evaluación de resultados del programa de educación, salud y alimentación, resumen de los primeros avances* [PROGRESA – Program for education, health and nutrition, Evaluation of results of the education, health and nutrition program, Summary of the first advances/accomplishments] 7 (1999) [hereinafter *PROGRESA Self-evaluation*].

³⁵² *Id.*

provided to families to purchase nutritious foods, such as meat and vegetables. The maximum amount of cash assistance for food is 125 pesos per family per month, which is less than US \$14. The monthly maximum for all PROGRESA benefits is 750 pesos (US \$82).³⁵³

When they register with PROGRESA, families commit to a list of program requirements. Families must ensure the children's regular school attendance and take the children for regular medical visits. Pregnant and nursing mothers must take vitamins and give vitamins to their children. The family also promises to spend the subsidy on adequate food, clothing and improvements to their home, such as toilets, cement floors, roofs, and windows. If the family does not meet these obligations, sanctions may be imposed, such as temporary suspension of benefits or indefinite suspension from the program.

In 1999, the government issued a self-evaluation of PROGRESA. According to official statistics, participation in PROGRESA has grown dramatically in recent years, from benefiting an estimated 404,241 families in 1997 to benefiting 2,298,586 families in 1999.³⁵⁴ The states with the highest number of beneficiary families in 1999 were Veracruz, Chiapas, Puebla, Guerrero and Oaxaca.³⁵⁵ Some of the positive results of PROGRESA included an increase in doctor visits from an average of five visits per family per year to 8.6 visits per year.³⁵⁶ In addition, the number of women seeking prenatal care within the first trimester of pregnancy has increased by 16 percent since the inception of PROGRESA.³⁵⁷

PROGRESA has also drawn much criticism. Many NGOs feel that the administration of the program has been unfair and the structure of the benefits is not fulfilling families' needs. For instance, the program is targeted at certain populations to the exclusion of many needy families. The requirement that participants live in rural areas has excluded a significant number of poor people living in urban zones. One NGO activist explained "the government allocated resources to [alleviate] very extreme poverty, but only in rural areas and not in urban areas The current [PRI] government has no policy or program on urban poverty."³⁵⁸ Another problem with the distribution of PROGRESA assistance is that the income guidelines are far below the income level of poor people who need this assistance.³⁵⁹

³⁵³ *Id.* at 11 (1999 figures).

³⁵⁴ *Id.* at 3- 4.

³⁵⁵ *Id.* at 4. See Appendix A, *infra*, map of the United Mexican States.

³⁵⁶ *PROGRESA Self-evaluation, supra* note 351 at 22.

³⁵⁷ *Id.* at 23.

³⁵⁸ Interview, Oct. 24, 2000 (Economic and Social Rights NGO, Mexico City).

³⁵⁹ While the government reports that 14 million receive assistance from PROGRESA, many scholars estimate that between 40 and 70 million Mexicans live in poverty, *supra* Section VI A 1, Regional

Another complaint about PROGRESA is that the aid provided is insufficient to elevate a family out of poverty. The food assistance provided to a family is actually quite low, only 125 pesos per month (US \$13.60). This amount translates into just enough money to buy one kilo of tortillas per day and nothing more.³⁶⁰ “This financial support will only cover basic needs for two weeks or a little longer. If the payments are made every eight weeks, they will not make the expected impact on the nutrition of the people who receive this benefit.”³⁶¹

Other NGO activists stated that the PROGRESA program does not teach mothers about health and nutrition,³⁶² and, in fact, PROGRESA may even interfere with traditional good practices. As an NGO representative in Oaxaca explained, “groups that worked together have now stopped because they are just given money. . . . They lost the survival methods they once had. For example, they give people money to buy water, so they stop boiling it. When the money ends, they go back to drinking water without boiling it.”³⁶³ A government health official explained that indigenous and rural peoples have not incorporated the nutritional supplements into their diets because the taste and the texture is not appealing. Instead, the families feed it to their animals.³⁶⁴ The health prevention and treatment provided by PROGRESA is not geared towards indigenous groups, as clinic staff frequently speak only Spanish and no indigenous languages.

In response to the deficiencies with PROGRESA, one NGO has developed a program in areas of Oaxaca, Chiapas and Hidalgo, in which women are taught to weigh their children, to chart their growth and to monitor their nutrition. Furthermore, the participants learn which of the naturally growing foods are nutritious. Unlike PROGRESA, in this initiative, participants only receive “payment” in return for work they do in the community, such as helping to repair roads or schools.³⁶⁵

The fact that a large proportion of the population continues to live in extreme poverty³⁶⁶ suggests that PROGRESA has not achieved much success in alleviating poverty.

Disparities in Living Conditions, at 29.

³⁶⁰ Julio Boltvinik, *Evaluando el PROGRESA [Evaluation of PROGRESA]* May 26, 2000, www.journada.unam.mx/2000/may00/000526/boltvinik.html.

³⁶¹ Agustín Escobar, *PROGRESA y cambio social en el campo en México; IV Seminario de Política Social Teorías vigentes para combatir la pobreza [PROGRESA and Social Change in Rural Mexico; IV Seminar of Social Politics; Current Theories on Fighting Poverty]*, Jalisco, Mexico, 1999.

³⁶² Interview, Oct. 24, 2000 (Human Rights NGO, Mexico City).

³⁶³ Interview, Sept. 7, 2000 (Children’s Rights NGO, Oaxaca City).

³⁶⁴ Interview, Sept. 8, 2000 (Oaxaca public health official, Oaxaca City).

³⁶⁵ Interviews, Sept. 6, 2000; Oct. 24, 2000 (Human Rights NGO, Mexico City).

³⁶⁶ See Section 6 A 1, *supra*.

Furthermore, many scholars and Mexican NGOs discussed PROGRESA's ineffectiveness because it does not improve the economic infrastructure of the rural areas. Instead, monetary assistance is given to people contingent upon fulfilling certain obligations. This type of assistance does not provide people with skills or resources to effectively alleviate poverty. Critics, such as researcher Augustin Escobar, have said: "The program does not try to create conditions for development, to create jobs, or to improve the infrastructure, but to change people's behavior. In other words, since poverty is understood as a consequence of the lack of certain skills in people, the program seeks to modify behaviors, so that people will acquire these skills."³⁶⁷ The program does not work to eliminate poverty now, but rather seeks to "break the cycle" of poverty for the next generation.³⁶⁸ If the infrastructure and economic opportunities for people in the rural areas are not improved, poverty will not decrease. In response, NGOs are working to expose the government's view of poor people.³⁶⁹ As one interviewee said, "we are not working to eradicate poverty but to improve the quality of life [for the poor]. This is a way to change [people's] perspective because the government is just working to get rid of poverty. However, one can be poor, but still have a minimum of rights. This is especially true for children."³⁷⁰

Politics and corruption have negatively affected the fairness of how PROGRESA benefits are distributed. Reports of the Institutional Revolutionary Party (PRI) using PROGRESA to bolster their votes at the polls were numerous during the presidential election campaign of 2000.³⁷¹ One NGO representative who works with indigenous communities in Guerrero stated that, in her opinion, the only people who received PROGRESA aid were those who acquiesced to government demands in other areas, such as "giving ballots to a specific political party, not denouncing military violations [and] not criticizing those giving the benefits."³⁷² Recipients of PROGRESA reported that they were told to sign a list with their name and voter identification numbers. The sign-up sheet was a pledge to vote for Francisco Labastida Ochoa, the PRI presidential candidate.³⁷³ The women were told that if they did not sign the sheet, they would lose

³⁶⁷ Escobar, *supra* note 361.

³⁶⁸ Boltvinik, *supra* note 360.

³⁶⁹ *Id.*

³⁷⁰ Interview, Sept. 7, 2000 (Children's Rights NGO, Oaxaca City).

³⁷¹ Sam Dillon, *In Mexican Campaign, Money Still Buys Votes*, NYT, June 19, 2000, at 1; Henry Tricks, *Fingers Crossed for a Fair Fight on Mexico's Election Day: Henry Tricks Assesses the Chances of a Clean Presidential Poll on July 2*, FINANCIAL TIMES (LONDON), June 7, 2000, at 6.; Henry Tricks, *Mexican Candidates Battling for the Female Vote: Political Parties are Realising that there are 2m More Women Votes than Men*, FINANCIAL TIMES (LONDON), June 3, 2000 at 10.

³⁷² Interview, Oct. 27, 2000 (Indigenous Rights NGO, Guerrero).

³⁷³ Dillon, *supra* note 371.

their PROGRESA benefits.³⁷⁴ Given that PROGRESA has been a tool of the PRI party to garner votes, it is not surprising that a Mexican poll found that 65 percent of PROGRESA recipients supported the PRI party.³⁷⁵

Use of PROGRESA to buy or coerce votes is illegal in Mexico. According to a complaint about voting irregularities filed by Alianza Civica, a meeting took place between a representative of PROGRESA and a number of PROGRESA recipients in May of 2000, in the state of Chiapas.³⁷⁶ During the meeting people were told they were obligated to vote for the PRI candidates for President and State Governor. The PROGRESA recipients were then required to sign a document indicating their intention to vote for the PRI candidates, their names and addresses. Penal Code Articles 407 and 403 specifically prohibits people in public office from using public benefits to obtain votes or denying public benefits based on a person's vote. Such actions also violate Article 38 of the Federal Code of Electoral Institutions and Procedures (Codigo Federal de Instituciones y Procedimientos Electorales), which require the political parties to conduct their campaigns in a democratic manner, respecting the free participation of the other political parties and the rights of the voters. While a number of complaints have been registered, the Federal Election Bureau (Instituto Federal Electoral) has been slow to issue any findings.³⁷⁷

2. Food Subsidies

Twenty-eight percent of families in Mexico with children under the age of five receive food subsidies.³⁷⁸ Most beneficiary families live in the central part of the country, and the fewest are in the North. Rural families receive benefits primarily through PROGRESA and the National Program for Integral Development of the Family (DIF). DIF's nutrition programs focus on the provision of food subsidies to marginalized populations. Breakfast and school lunches are provided by DIF for preschool and school-age children in indigenous communities as well as other marginalized areas. Through DIF's Social Food Aid to Families Program, vulnerable families, including pregnant women and families with children younger than five, are provided with a monthly food allotment containing basic food products.³⁷⁹ Urban families not covered by PROGRESA, may be assisted through two alternate food subsidies programs: Liconsa, a subsidized

³⁷⁴ *Id.*

³⁷⁵ Tricks, *Mexican Candidates Battling for the Female Vote: Political Parties are Realising that there are 2m More Women Votes than Men*, *supra* note 371 (citing a poll by Mund).

³⁷⁶ *Boletín de prensa*, Junio 22, 2000, [Press release, June 22, 2000] www.laneta.apc.org/alianza.

³⁷⁷ Interview, Apr. 16, 2001 (Attorney, Mexico City).

³⁷⁸ SECRETARÍA DE SALUD, ENCUESTA NACIONAL DE NUTRICIÓN, 1999, [1999 NATIONAL NUTRITION SURVEY] 48.

³⁷⁹ *Supplementary Report of Mexico to the Committee on the Rights of the Child*, *supra* note 333 at ¶ 116.

milk program and Fidelist, a program providing subsidized tortillas.³⁸⁰ Currently, 46 percent of urban children under the age of five receive aid through the Liconsa program, as compared to 14 percent of rural children.³⁸¹ The enrollment in the specialized food subsidy programs is low in the rural areas because families receiving PROGRESA are not allowed to participate in other food programs. Other more targeted food programs are administered by the National Indigenous Institute and various NGOs.

C. Health Reform Efforts

The Mexican government has recognized that the National Health System has not been able to address the health care needs of many people in Mexico. For this reason, health reform policies are oriented toward expanding existing coverage so that the whole population will have access to efficient and high quality services. While the primary health reform efforts are aimed at remedying the lack of health resources in marginalized areas, providing small rural communities with effective health services remains a challenge. Programs to expand health coverage tend to be focused on one-time infrastructure improvements, such as building small clinics, rather than improving the quality of and availability of the care. Additionally, initiatives to provide rural communities with better health coverage often focus on specific epidemiological problems, such as malaria in Oaxaca,³⁸² but not on routine preventative care by qualified medical personnel.

Such a situation could prove to be detrimental to children. Because children grow and develop more rapidly than adults, their health care needs are unique. Children are “extremely vulnerable to factors in their physical and social environment, which affect their immediate and long-term health and development. Consequently, preventative health care is particularly important for children.”³⁸³ The majority of children under age five who die annually in Mexico, die from preventable causes, many of which can be remedied from preventive care. The reform of Mexico’s health care system is an important way in which the government can address the inter-related causes of child mortality.

1. Health Sector Reform Program 1995- 2000

The Health Sector Reform, drafted by the Federal Government in 1995, affects both the Secretariat of Health and the Social Security institutions. The Health Sector Reform Program established four basic objectives in reforming the health care system: (1) to promote the quality and efficiency in service delivery; (2) to expand coverage of

³⁸⁰ 1999 NATIONAL NUTRITION SURVEY, SUMMARY OF FINDINGS, *supra* note 378 at 49.

³⁸¹ *Id.* at 17.

³⁸² Interview, Feb. 21, 2001 (community members, Oaxaca).

³⁸³ *Children and Managed Health Care: Analysis and Recommendations*, in 8 THE FUTURE OF CHILDREN No. 2 at 8 (1998).

the care provided by Social Security institutions, facilitating voluntary affiliation; (3) to complete decentralization of services for the uninsured population within the Secretariat of Health; and (4) to expand coverage of health services to marginalized populations in rural and urban areas who currently have little or no access.³⁸⁴ Within the project, health reform efforts are guided by six principles: (1) to allow users the freedom to choose their physicians at the primary care level of the Social Security institutions; (2) to create voluntary family insurance in the IMSS for families that have the ability to pay; (3) to decentralize health services for the uninsured population to the states; (4) to achieve greater municipal participation through the “Healthy Municipios” movement; (5) to expand health coverage through the provision of a basic package of services for people without regular access to health services; and (6) to strengthen the steering and regulatory role of the Secretariat of Health in order to separate social security functions in order to achieve more comprehensive and coordinated health care.³⁸⁵

a. Decentralization of Health Services

Decentralization of the health care system by the Secretariat of Health is viewed as a long-term effort, proceeding in several stages. Under the decentralization scheme, services for the uninsured population, which are currently provided primarily by the Secretariat of Health, will become the responsibility of the Mexican states. At the same time, it is expected that the Social Security institutions, such as the IMSS, and private insurers will enlarge their coverage to insure segments of the population that are currently uninsured. The voluntary family insurance program, through the IMSS, is one of the ways that the obligation of providing health care will be shared between the state and other insurers.

While decentralization will have the effect of placing each state in a better position to evaluate the health care needs of the population, it is not clear how resources will be allocated under the new scheme. For example, GDP per capita varies widely by state in Mexico, as discussed above, and the states that currently have the highest uninsured populations also have the lowest GDPs per capita in the country. States such as Oaxaca, Chiapas, Guerrero and Hidalgo may be overly burdened if they are given sole responsibility for provision of health services.

b. Program for Expansion of Coverage (PAC)

In 1996, the Secretariat of Health implemented the Program for Expansion of Coverage (PAC), under the general health care reform efforts. PAC was designed specifically to address a population of ten million Mexicans who do not have regular access to health services, with a priority on the indigenous population. This population is predominantly rural and lives in areas of high marginalization. In 1996, the World Bank

³⁸⁴ MEXICO: PROFILE OF THE HEALTH SERVICES SYSTEM, *supra* note 150 at 11.

³⁸⁵ *Id.*

provided Mexico with US \$330 million for PAC over a five-year period.³⁸⁶ The aim of PAC is to provide a “basic package” of health services to target populations in the states with the greatest deficits in basic services. Eleven states, Campeche, Chiapas, Guerrero, Hidalgo, Michoacán, Oaxaca, Puebla, San Luis Potosí, Veracruz, Yucatán, and Zacatecas were the initial recipients of PAC, but the program has since been expanded to include 19 states, 850 municipalities and over 36,000 rural localities.³⁸⁷

The basic health package, under PAC, consists of the following 12 “controlled interventions”:

- (1) Basic sanitation at the family level;
- (2) Standard and effective case management of diarrhea in the home;
- (3) Anti-parasitic treatment to families;
- (4) Identification of acute respiratory infection warning signs and referral to medical attention;
- (5) Prevention and control of pulmonary tuberculosis;
- (6) Prevention and control of arterial hypertension and diabetes;
- (7) Immunization;
- (8) Monitoring of nutrition and growth of children;
- (9) Family planning;
- (10) Prenatal care, post-natal care and care in childbirth;
- (11) Accident prevention and initial management of injuries; and
- (12) Community participation and training for self-care of health.
- (13) Screening for cervical cancer.³⁸⁸

Consistent with the general goals of the Health Sector Reform program, an important element of PAC is the inclusion of local community structures (*asamblea comunitaria*) in the planning, execution and evaluation of the program, as part of the decentralization process and also in order to increase community self-care in health. Thus PAC has an extensive organizational structure, from the national level to the community level. In brief, the Secretariat of Health oversees PAC at the national and state levels. At the regional level, areas benefiting from PAC are divided into “health jurisdictions” (*jurisdicciones sanitarias*). Mobile health units and traveling health teams operate within these jurisdictions to provide health education, specialized medical attention, diagnosis of illness and sanitation projects. The mobile health units are designed to meet the needs to the community, so in geographically remote areas, they could use trucks, helicopters, boats or mules.³⁸⁹ PAC is further divided into a microregional level, an inspection level and a community level. Community Health

³⁸⁶ The parallel to PAC in the Mexican social security system is the IMSS program of Attention to the Rural Population, IMSS-Solidaridad, which aims to increase health coverage to the marginalized population. In 1998, the World Bank granted a loan of US \$700 million to improve IMSS programs.

³⁸⁷ Alejandra Viveros, World Bank Group, *Mexico Gets Closer to Basic Health Coverage for All: Bank-supported program targets rural denizens*, available at <http://www.worldbank.org>.

³⁸⁸ The cancer screening program was added in 1998.

³⁸⁹ Viveros, *supra* note 387.

Auxiliaries are responsible for overseeing PAC at the local or community level. They are members of the local assembly and represent the community in such activities as prioritizing problems, planning projects and managing resources. Finally, the supervisors of the Community Health Auxiliaries are instructed to oversee eight to ten localities by traveling around them on foot and providing the same kind of service as the mobile units.

Although a comprehensive survey of PAC has not yet been carried out by the government, NGOs have conducted their own assessments of PAC in specific communities. For example, a Oaxaca-based NGO analyzed the PAC initiatives in 25 indigenous communities (Mixe and Mazateca) in the state.³⁹⁰ The study determined that community participation in PAC was insignificant and inadequate. The local communities were not receiving health care education in a meaningful manner and therefore the community members were not given the capacity to manage their own health care. Other scholars have pointed out that the PAC model is “not seeking to attack poverty and marginalization, but [attacks] the primary causes of morbidity and mortality, only offering a *minimum* of simple attention in order not to worsen health conditions.”³⁹¹

2. Systems to Register Complaints About Health Care Services

The Mexican Constitution protects the right to health, but the legal system does not provide enforcement mechanisms for claims concerning the accessibility or adequacy of the health care system. Instead, Article 60 of the General Health Law, which allows individual to file complaints about acts and omissions in the health care system, functions as a negligence lawsuit against personnel in medical malpractice cases which are reviewed by the National Medical Arbitration Commission (CONAMED) and the National Commission on Human Rights (CNDH).

In 1996, CONAMED was created by presidential decree in order to address increased medical complaints and conflicts between health care recipients and health care providers. CONAMED acts as a mediator and investigates complaints of negligence and malpractice by both public and private medical services. CONAMED can only review complaints for negligence but has no mechanisms to enforce the health protection rights of the citizens.

The mandate of the National Commission on Human Rights is to ensure compliance of national policies and protection of human rights and to implement preventative, remedial and coordinating measures to safeguard the rights of Mexicans. The CNDH is also authorized to conduct investigations, issue findings and resolve disputes over “presumed irregularities in the delivery of [health] services.”³⁹² Although it

³⁹⁰ Martha Aida Castañeda Pérez, Centro de Estudios de la Mujer y la Familia [Center for Women’s and Family Studies], *El Programa de Ampliación de Cobertura en Comunidades Indígenas de Oaxaca: participación comunitaria y perspectiva de género*, [Program for Expansion of Coverage in Indigenous Communities in Oaxaca: Community Participation and Gender Perspectives] Nov. 1999.

³⁹¹ Aguirre Reveles, *supra* note 161 [Emphasis in original].

³⁹² MEXICO: PROFILE OF THE HEALTH SERVICES SYSTEM, *supra* note 150 at 10-11.

does have the authority to carry out investigations, in the protection of the right to health, the CNDH largely functions as an appellate court which reviews CONAMED's decisions. Like CONAMED, the CNDH can only issue non-binding recommendations to agencies when the rights of a citizen have been violated. The Baby H Case, Box 3, above, is an example of a negligence case that was appealed from CONAMED to the National Commission on Human Rights.

D. President Fox and the Future of Child Welfare Programs

Vincente Fox Quesada was elected President of Mexico in July 2000. As a member of the National Action Party (PAN), Fox's victory ended 71 years of one-party rule by the Institutional Revolutionary Party (PRI). Since welfare programs in Mexico are closely tied to the presidency under which they are created, it is likely that Fox's presidency will have an impact on the welfare of Mexico's children. In his first 100 days in office, for instance, President Fox launched several projects that are intended to improve conditions for marginalized populations in Mexico, such as poverty alleviation, improvements in education and recognition of indigenous rights.

The *Plan Puebla-Panama*, implemented in March 2001, is a US \$25 billion series of projects designed to spread the benefits northern Mexico has received from U.S. trade and NAFTA to southern Mexico.³⁹³ With the stated intention to bring increased revenue to the South through infrastructure improvements, the plan's projects include the construction of three main highways (one to the U.S. border), renovating four coastal ports, modernizing airports and railroads in Chiapas and Oaxaca and constructing two hydroelectric plants in these states.³⁹⁴ Critics note that this plan is an extension southward of NAFTA and will not necessarily provide economic infrastructure that will improve the impoverished conditions of the indigenous communities.³⁹⁵

In April of 2001, President Fox delivered a fiscal reform package (Nueva Hacienda Publica) to Congress. In an effort to reduce the country's outstanding debt and increase government revenues, the fiscal reform is aimed at increasing Mexico's tax base. Most significantly, Fox's proposed reforms would standardize current value added tax (VAT) rates. Food and medicine, which were formerly "zero-rated" for VAT, would now be taxed at 15 percent for the majority of the country and 10 percent in border states. Fox has promoted the imposition of the VAT as a sales tax that will primarily affect wealthy consumers, thereby raising funds for programs that serve the poor, such as highway construction, increased employment and improvements to education and health

³⁹³ Andrew Bounds & Andrea Mandel-Campbell, *Fox Addresses Development*, FINANCIAL TIMES, Mar. 26, 2001, www.ft.com

³⁹⁴ *Id.*

³⁹⁵ Edgar Cortes Morales, Press Release, *PRODH denounces the Puebla Panamá Plan and Fox's visit to El Salvador*, June 15, 2001, www.globalexchange.org/campaigns/mexico/news/prodh061501.html.

programs.³⁹⁶ The reform package has raised controversy, namely that the tax increase will prove harmful to vulnerable populations. A report released by the Mexican Consumer Protection Agency warned that “imposing the tax hike could spur severe inflation and would disproportionately affect the nation’s poor who spend anywhere from 40 to 70 percent of their earnings on food and medicine.”³⁹⁷ NGOs argue that the addition of the VAT will have a particularly detrimental effect on women who look after the nutritional and health needs of their children.³⁹⁸

Supporters of the reform program, however, contend that the Nueva Hacienda Publica contains specific protections for low-income families. For instance, the President has suggested that 100 generic medicines that will be exempt from taxation. Opposition party members have argued that the number of exempt medicines should be increased to 800, which would reduce the risk that poor people would be unable to afford certain drugs. The medicines included in the proposed basket of 800 are those that are bought most frequently by the public health system, so the tax exemption would not result in lost revenue for the government.³⁹⁹ Fox has also proposed a direct cash subsidy of 110 pesos a month (approximately US \$12) under the *Contigo* program to offset the cost of the VAT on medicine and food.⁴⁰⁰ The subsidy would be given to the poorest 20 percent in the country, about 27 million people.⁴⁰¹ Critics have stated that the *Contigo* program will not address the needs of 13 million low-wage earners⁴⁰² and that it is unclear how the very poor, for example workers in the informal economy or subsistence farmers, will be compensated for increased VAT.⁴⁰³ Alternatively, some members of Congress are lobbying to allow some foods, such as tortillas and milk, to remain zero-rated.

³⁹⁶ Traci Carl, ‘Trust Me’ on Financial Package, Fox Pleads With Nation, THE NEWS, Apr. 3, 2001 at 2.

³⁹⁷ Stevenson Jacobs, Mayor Attacks ‘Tax Hike’ As Blow To Poor, THE NEWS, Apr. 3, 2001 at 2.

³⁹⁸ Silvia Magally, Red de Mujeres anuncia campaña nacional “No al IVA”, [The Women’s Network Announces a National Campaign: “No to the VAT”], CIMAC, Apr. 4, 2001.

³⁹⁹ Harmonising VAT; Opposition to VAT on food and drugs, LATIN AMERICA REGIONAL REPORTS: Mexico & NAFTA, Apr. 10, 2001 at 7 [hereinafter *Harmonising VAT*].

⁴⁰⁰ Funcionarios de la SHCP explican la Nueva Hacienda Pública Distributiva, [Officials of the Secretariat of Finance and Public Credit Explain the New Fiscal Reform Programs], Press Conference, Apr. 5, 2001, www.presidencia.gob.mx.

⁴⁰¹ Olivo, *supra* note 167.

⁴⁰² Henry Tricks, Fox Takes Biggest Gamble with Revenue Package: Mexican Fiscal Reform Bill Aimed at Weaning Country off Dependency on Oil Revenues, FINANCIAL TIMES, Apr. 5, 2001 at 9.

⁴⁰³ Harmonising VAT, *supra* note 399.

IX. ASSESSMENT OF MEXICO'S COMPLIANCE WITH INTERNATIONAL LEGAL OBLIGATIONS

In Mexico, international instruments ratified by the legislature and President become binding law.⁴⁰⁴ Box 6, below, illustrates the international instruments that define Mexico's legal obligations and provide a framework for Mexico's compliance with obligations relevant to child health and survival.

Box 6. International Instruments that Protect Children's Rights, Applicable to Mexico	
United Nations:	
Convention on the Elimination of All Forms of Racial Discrimination	ratified February 20, 1975
International Covenant on Civil and Political Rights	ratified March 23, 1981
International Covenant on Economic, Social, and Cultural Rights	ratified March 23, 1981
Convention on the Elimination of All Forms of Discrimination Against Women	ratified March 23, 1981
[ILO] Convention 169: Indigenous and Tribal Peoples Convention	ratified May 9, 1990
Convention on the Rights of the Child	ratified September 21, 1990
Organization of American States:	
American Convention on Human Rights	ratified March 2, 1981
Convention on the Prevention, Punishment and Eradication of Violence Against Women	ratified June 19, 1998

When a child dies from preventable causes, a number of human rights are violated. For example, the child's right to adequate food and clean water, the parents' right to earn enough money to support a family, the right to an adequate public health care system and the right to freedom to make life decisions without the constraints of poverty are critical for child survival. Despite a decline in child mortality over the last decades in Mexico, the reduction has not been experienced to the same degree by all children. This fact indicates that the Mexican government is not in full compliance with its international obligations, in particular its obligation to guarantee children the full enjoyment of economic and social rights.

⁴⁰⁴ CONSTIT. ART. 133.

A. Economic, Social and Cultural Rights

1. The Right to an Adequate Standard of Living

The right to an adequate standard of living is a fundamental right that guarantees all people a basic level of well-being and is described in the International Covenant on Economic Social and Cultural Rights (Economic Rights Covenant) and the Convention on the Rights of the Child (Children's Convention). The Mexican government is not in full compliance with its obligation to guarantee the right to an adequate standard of living to the maximum extent possible and without regard to race or social origin.

By official estimates, close to half of the population lives in poverty. Over one quarter of the children in Mexico are impoverished. Poverty, in turn, is closely connected to marginalization and a lack of basic services, such as drinking water, electricity, sanitation services and means of communication. In Mexico, the rural and indigenous communities experience high levels of marginalization. As set forth in detail throughout this case study, the Mexican government has not allocated resources to the maximum extent possible to address the vast economic disparities in the country.

Poverty alleviation programs in Mexico have not been allocated the maximum of available financial resources, but only a small percent of the budget. The principle poverty alleviation program in Mexico, PROGRESA, is not available to everyone, as it excludes the urban poor. The assistance provided through PROGRESA has been criticized as insufficient for long-term improvement of a family's standard of living and, more significantly, such financial assistance may itself hinder self-sufficiency. Finally, NGOs have alleged that PROGRESA benefits have been used as a political tool in order to secure votes.

Under the Economic Rights Covenant, the Mexican government is obligated to use all appropriate means, particularly legislation, to continuously improve living conditions for the population. The Mexican government, however, has not protected the right to fair wages and remuneration, which provide all workers with a decent living for themselves and their families. The current minimum wage structure is inadequate to meet the needs of workers or their families. The purchasing power of the minimum wage has been declining over the last decades, but has not been adjusted sufficiently to account for the increased cost of the basic package of goods (*canasta basica*). Mexican human rights experts believe that it is due to the combination of minimum wage policies, food assistance programs and other reasons that malnutrition and poverty remain widespread across Mexico.

The Mexican government has not fully protected the right of pregnant women and their children to adequate nutrition. Although the Mexican government indicates that malnutrition rates are slowly declining, NGOs contend that malnutrition rates have not

improved over 22 years of government spending programs.⁴⁰⁵ The ending of various government subsidies has made it more difficult for families to feed themselves, and changes in the government programs have not improved the situation.⁴⁰⁶ Recent studies have also revealed that indigenous children suffer from malnutrition at a significantly higher rate than non-indigenous children.

2. The Right to the Highest Attainable Standard of Health

The right to health is an essential human right without which children cannot exercise their other rights. The right to health for children is outlined in the Children's Convention. The Economic Rights Covenant, the Convention on the Elimination of all Forms of Discrimination Against Women and the Convention on Indigenous and Tribal Peoples (Indigenous Rights Convention) also proscribe the right to a high standard of health. Marginalized people, who suffer deprivations of economic and social rights generally, are also most frequently denied the right to health care.

The Mexican government has not complied with its obligation to provide the population with equal access to health services. A large population of people has no access to employment-based health services, which are provided by the government social security system. It is estimated that 48 percent of the total population is without health insurance, a large number of whom are children. The lack of government-provided health insurance results in reduced access to health care for the poor and unemployed. The lack of access is compounded by the increasing demand for health services, such as family planning and contraceptives, especially in the rural and marginalized communities.

The Mexican government provides public health services to the uninsured, through the Secretariat of Health. Inadequacies in these services, however, have caused many poor Mexicans to turn to private health services. The cost of private health care impedes poor families' ability to pay for other necessary goods, or is so high that families are eventually forced to go without health care. Although there are state-structures in Mexico which offer health services to all, such services do not respond to the actual needs of the population. Thus, the government is not fulfilling its obligation under the Economic Rights Covenant to guarantee the full realization of the right to health to all people.

The Mexican government has undertaken reform of the National Health System in an attempt to provide increased access to the rural populations. Such structural reform, however, cannot be designed without an accurate assessment of the situation of marginalized children. The Mexican government has failed to gather and keep accurate

⁴⁰⁵ Alternative NGO report, *supra* note 82 at 82. In addition, there is underreporting of cases, and an unwillingness to disclose on the part of the Mexican government.

⁴⁰⁶ For instance, in 1999, tortillas were removed from the basic food package (*canasta basica*). *Id.* at 83.

statistics regarding existing health services, causes of death, and other health data which are necessary to measure Mexico's compliance with international standards.

Furthermore, programs such as PAC, which aim to increase access to health services, have not responded to the specific needs of the communities. The PAC program has emphasized education efforts over primary treatment and has not adequately given indigenous community members the capacity to manage their health care, an obligation set forth in the Indigenous Rights Convention. Health care facilities, *casas de salud*, in small towns generally offer few medical services and are not operated by medical personnel. Many rural populations lack access to adequate health care because the nearest clinic or hospital is far away and difficult to reach. In this respect, the Mexican government has not taken the necessary steps to create conditions that assure access to medical services and medical attention to all.

3. Non-governmental Efforts to Protect Economic, Social and Cultural Rights

Non-governmental organizations have begun to take action to ensure the recognition of economic, social and cultural rights by the Mexican government. NGOs in Mexico, however, tend to focus on one specific economic or social right, for instance, labor rights or the right to food. This specialization has prevented NGOs from obtaining a more general vision of the content of the Economic Rights Covenant. It was in response to this division that in 1998, a group of human rights NGOs and development NGOs came together to create a forum to coordinate efforts to promote and defend economic, social and cultural rights (hereinafter, the Collective Group).⁴⁰⁷

The objective of the Collective Group was to create a mechanism for monitoring governmental practices that affect economic, social and cultural rights and to pressure the government to fulfill their obligations with the idea of improving living conditions in Mexico. In November of 1999, the Collective Group submitted an alternative report to the Mexican government's official report to the United Nation's Committee on Economic, Social and Cultural Rights. The alternative report specifically addressed the impact of government economic policies on employment, social security, working conditions, salaries and loss of purchasing power. The report also examined the situation of housing and nutrition, placing special emphasis on the dire effects these deficiencies have on women and children.⁴⁰⁸

⁴⁰⁷ The organizations that form part of the Economic, Social and Cultural Rights Collective are: *Centro de Derechos Humanos Miguel Agustín Pro*, *Centro de Reflexión y Acción Laboral*, *Comisión Mexicana de Defensa y Promoción de los Derechos Humanos*, *Colectivo Mexicano de Apoyo a la Niñez*, *Convergencia de Organismos Civiles por la Democracia*, *DECA Equipo Pueblo*, *Defensoría del Derecho a la Salud*, *FIAN Mexico*, *Frente por el Derecho a la Alimentación*, *Liga Mexicana por la Defensa de los Derechos Humanos*, *Red de Jóvenes por los Derechos Sexuales y Reproductivos*, *Centro de Derechos Humanos Económicos, Sociales y Culturales*.

⁴⁰⁸ Equipo Pueblo, *The Mexican Experience from the Alternative Report as a Lobbying Instrument for ESC Rights Enforcement*, 3 (Jan. 27, 2000).

More recently, the Collective Group convened to discuss potential actions for the enforcement of such rights. Presently, no sanctions exist for governments that fail to guarantee the fulfillment of such rights, either through their acts or omissions. In the era of economic globalization and neo-liberal agendas, however, it is not only governments who violate economic rights but also multinational corporations and international financial institutions. Due to the free reign and lack of accountability of all of these actors, protections of economic rights have been practically non-existent. More importantly, failure to promote the advancement of economic, social and cultural rights is due in large part to a lack in enforcement mechanisms.

The Collective Group is seeking out mechanisms to enforce economic rights under international law, particularly within the United Nations and the Organization of American States structures. Specifically, the Collective Group is working to develop a potential framework to document violations of economic and social rights in Mexico in order to present claims before the Inter-American Commission on Human Rights.⁴⁰⁹ In addition, the Collective Group has continued lobbying efforts before the UN Committee on Economic, Social and Cultural Rights. As it works to develop a methodology to report on government violations of economic rights, the Collective Group seeks to ensure that the appropriate socio-economic conditions are met for improving the standard of living for Mexican citizens. Through their proposed actions, the Collective Group in Mexico is conscious of the vital and important work of creating social and political responses designed to counter the inequalities that prevent true democracy and development in their country.

B. The Convention on the Rights of the Child

The Convention on the Rights of the Child (Children's Convention) defines children's right to survival and development, children's economic, social and cultural rights and Mexico's obligations to uphold these rights. The Children's Convention also requires the government to ensure non-discrimination in all aspects of children's lives.

As discussed above, much more needs to be done to guarantee that children's economic, social and cultural rights are respected. Furthermore, the government has not allocated sufficient economic resources or enacted legislation to address the problem of family violence, a serious rights violation children experience. The UN Committee on the Children's Convention stated concern about the serious problem of child abuse in Mexico, as well as the lack of domestic legislation prohibiting corporal punishment in the schools.⁴¹⁰ The Mexican government has not developed a comprehensive program to address family violence as a factor in child mortality.

The current government commitment of resources for the monitoring and enforcement of children's rights is inadequate. With regard to its obligation of self-

⁴⁰⁹ Economic Social and Cultural Rights Workshop with ESC Collective, Mexico City, Mar. 29, 2001.

⁴¹⁰ Concluding Observations of the Committee on the Rights of the Child: Mexico, *supra* note 301 at 11.

monitoring, many critics have pointed out that Mexico does not spend sufficient resources to determine accurately the situation for children. For instance, the government created a National System for the Follow-up and Monitoring of the Implementation of the Children's Convention, but it is currently only operating in less than a quarter of the states.⁴¹¹

Following the Children's Convention, Mexico has also enacted a Law for the Protection of the Rights of Children and Adolescents. For this law to have national application, however, each Mexican state must adopt corresponding state legislation. Without the corresponding state legislation, children's rights will not be enforceable in areas under state control. The federal children's law establishes a new office of "the attorney for the defense of the rights of the child and the family" in each state. The UN Committee on the Children's Convention also commented that at the state level, the child and family attorneys lack power and resources to effectively protect children's rights.⁴¹²

C. The Indigenous and Tribal Peoples Convention

Under international law, discrimination based on race and national origin is prohibited. The Indigenous and Tribal People's Convention (Indigenous Rights Convention) not only condemns discrimination but also requires signatory countries to take a pro-active stance on improving the living conditions of indigenous peoples. In this convention, Mexico recognizes the marginalized position of indigenous people throughout the world.

The Mexican government has not adhered to the general policy set forth in the Indigenous Rights Convention on defining indigenous peoples. The Indigenous Rights Convention states that "self-identification as indigenous shall be regarded as a fundamental criterion for determining the groups to which the provisions of this Convention apply."⁴¹³ Mexico, however, uses language as the basis for identifying indigenous groups in carrying out the census and collecting data. By not recognizing indigenous groups based on self-identification, the Mexican government is not following the spirit of the treaty.

Indigenous peoples have not enjoyed the improvements in child survival and health to the same extent as the majority of children in Mexico. The UN Committee on the Rights of the Child raised a concern about the persistence of regional disparities in access to health care, the high rates of malnutrition among children, especially in rural and remote areas, and children in indigenous groups.⁴¹⁴ The Mexican government agrees

⁴¹¹ *Id.* at 9.

⁴¹² *Id.*

⁴¹³ Convention No. 169, *supra* note 19, Article 1(b)(2).

⁴¹⁴ *Concluding Observations of the Committee on the Rights of the Child: Mexico, supra* note 301 at 12.

that the improvements in living conditions have been uneven between the country's different regions and social groups.⁴¹⁵

Mexico's efforts to eliminate the socio-economic gaps between urban dwellers and the rural indigenous have not met the requirements of the Indigenous Rights Convention. According to Article 2 of the Indigenous Rights Convention, governments have the responsibility to promote "full realization of the social, economic and cultural rights of [indigenous] peoples" which includes "assisting the members of the peoples concerned to eliminate socio-economic gaps that may exist between indigenous and other members of the national community." The convention also requires the improvement of conditions of life, work, health and education shall be a priority in a nation's overall economic development plans. As discussed in detail in this report, Mexico's macroeconomic policies do not address the needs of indigenous peoples generally or of indigenous children specifically.

Most significantly, the Indigenous Rights Convention states "governments shall ensure that adequate health services are made available to the peoples concerned, or shall provide them with resources to allow them to design and deliver such services under their own responsibility and control . . ." ⁴¹⁶ The fact that indigenous children have a much higher risk of dying from a preventable cause, such as malnutrition, intestinal infections or respiratory infections, than non-indigenous children indicates that they also suffer from lack of access to basic health care. Efforts to extend coverage of health care services to indigenous populations remain inadequate and have not been "planned and administered in cooperation with the peoples concerned [to] take into account their economic, geographic, social and cultural conditions" as required by Article 25 of the Indigenous Rights Convention.

The proof that Mexico is not fulfilling its obligations under the Indigenous Rights Convention can be seen in many areas. However, child mortality and child health provide clear examples that Mexico is not doing all it can to promote full realization of economic, social and cultural rights of indigenous peoples.

X. CONCLUSION

Throughout the world the phenomenon is the same: poor children die of easily preventable diseases and rich children do not. The conditions of life that have made some children poor, sick and unable to access health care are numerous and complicated. The conditions are often caused by violations of fundamental human rights, such as discriminatory treatment, violations of the right to self-determination and violations of the right to work and to fair wages. These rights violations are further compounded by

⁴¹⁵ *Periodic reports of States parties due in 1997: Mexico*. Committee on the Rights of the Child, Addendum to State Party Report Considered 17/08/98, at 30, U.N. Doc. CRC/C/65/Add.6.

⁴¹⁶ Convention No. 169, *supra* note 18, Article 25.

conditions of poverty, in which children are often unable to realize their rights to basic necessities.

The Mexican government is obligated to monitor the situation of children and to improve children's lives, not merely because it is necessary for the survival of the country, but because children themselves are entitled to the fundamental right to survive. The Mexican government is, therefore, obligated to defend and promote all the interconnected rights of children in order to ensure that they can develop fully. Yet, tens of thousands of children still die of preventable diseases every year in Mexico. Viewing these deaths as human rights violations demonstrates that preventable child mortality in Mexico merits concern and, more significantly, it illustrates where the government has failed in its obligations to protect the rights of those who need the most protection.

APPENDIX A - Map of the United Mexican States



Source: Instituto Nacional de Estadística, Geografía e Informática (INEGI) [National Institute of Statistics, Geography and Informatics].

APPENDIX B

Excerpts from the INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, *entered into force* January 3, 1976.

Preamble

The States Parties to the present Covenant,
Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,
Recognizing that these rights derive from the inherent dignity of the human person,
Recognizing that, in accordance with the Universal Declaration of Human Rights, the ideal of free human beings enjoying freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his economic, social and cultural rights, as well as his civil and political rights,
Considering the obligation of States under the Charter of the United Nations to promote universal respect for, and observance of, human rights and freedoms,
Realizing that the individual, having duties to other individuals and to the community to which he belongs, is under a responsibility to strive for the promotion and observance of the rights recognized in the present Covenant,
Agree upon the following articles:

PART I

Article 1

1. All peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.
2. All peoples may, for their own ends, freely dispose of their natural wealth and resources without prejudice to any obligations arising out of international economic co-operation, based upon the principle of mutual benefit, and international law. In no case may a people be deprived of its own means of subsistence.

....

PART III

....

Article 7

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of just and favourable conditions of work which ensure, in particular:

- (a) Remuneration which provides all workers, as a minimum, with:
 - (i) Fair wages and equal remuneration for work of equal value without distinction of any kind, in particular women being guaranteed conditions of work not inferior to those enjoyed by men, with equal pay for equal work;
 - (ii) A decent living for themselves and their families in accordance with the provisions of the present Covenant;
- (b) Safe and healthy working conditions;

- (c) Equal opportunity for everyone to be promoted in his employment to an appropriate higher level, subject to no considerations other than those of seniority and competence;
- (d) Rest, leisure and reasonable limitation of working hours and periodic holidays with pay, as well as remuneration for public holidays

.....

Article 9

The States Parties to the present Covenant recognize the right of everyone to social security, including social insurance.

Article 10

The States Parties to the present Covenant recognize that:

1. The widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of dependent children. Marriage must be entered into with the free consent of the intending spouses.
2. Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits.
3. Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions. Children and young persons should be protected from economic and social exploitation. Their employment in work harmful to their morals or health or dangerous to life or likely to hamper their normal development should be punishable by law. States should also set age limits below which the paid employment of child labour should be prohibited and punishable by law.

Article 11

1. The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realization of this right, recognizing to this effect the essential importance of international co-operation based on free consent. General comment on its implementation
2. The States Parties to the present Covenant, recognizing the fundamental right of everyone to be free from hunger, shall take, individually and through international co-operation, the measures, including specific programmes, which are needed:
 - (a) To improve methods of production, conservation and distribution of food by making full use of technical and scientific knowledge, by disseminating knowledge of the principles of nutrition and by developing or reforming agrarian systems in such a way as to achieve the most efficient development and utilization of natural resources;
 - (b) Taking into account the problems of both food-importing and food-exporting countries, to ensure an equitable distribution of world food supplies in relation to need.

Article 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - (b) The improvement of all aspects of environmental and industrial hygiene;
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Article 13

1. The States Parties to the present Covenant recognize the right of everyone to education. They agree that education shall be directed to the full development of the human personality and the sense of its dignity, and shall strengthen the respect for human rights and fundamental freedoms. They further agree that education shall enable all persons to participate effectively in a free society, promote understanding, tolerance and friendship among all nations and all racial, ethnic or religious groups, and further the activities of the United Nations for the maintenance of peace.
2. The States Parties to the present Covenant recognize that, with a view to achieving the full realization of this right:
 -
 - (d) Fundamental education shall be encouraged or intensified as far as possible for those persons who have not received or completed the whole period of their primary education;
 -

APPENDIX C

*Excerpts from the CONVENTION ON THE RIGHTS OF THE CHILD,
G.A. res.44/25, annex, 44 U.N GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989),
entered into force September, 2 1990:*

Preamble

The States Parties to the present Convention,

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Bearing in mind that the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom,

Recognizing that the United Nations has, in the Universal Declaration of Human Rights and in the International Covenants on Human Rights, proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,

Recalling that, in the Universal Declaration of Human Rights, the United Nations has proclaimed that childhood is entitled to special care and assistance,

Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community,

Recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding,

Considering that the child should be fully prepared to live an individual life in society, and brought up in the spirit of the ideals proclaimed in the Charter of the United Nations, and in particular in the spirit of peace, dignity, tolerance, freedom, equality and solidarity,

Bearing in mind that the need to extend particular care to the child has been stated in the Geneva Declaration of the Rights of the Child of 1924 and in the Declaration of the Rights of the Child adopted by the General Assembly on 20 November 1959 and recognized in the Universal Declaration of Human Rights, in the International Covenant on Civil and Political Rights (in particular in articles 23 and 24), in the International Covenant on Economic, Social and Cultural Rights (in particular in article 10) and in the statutes and relevant instruments of specialized agencies and international organizations concerned with the welfare of children,

Bearing in mind that, as indicated in the Declaration of the Rights of the Child, "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth,"

Recalling the provisions of the Declaration on Social and Legal Principles relating to the Protection and Welfare of Children, with Special Reference to Foster Placement and Adoption Nationally and Internationally; the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules); and the Declaration on the Protection of Women and Children in Emergency and Armed Conflict,

Recognizing that, in all countries in the world, there are children living in exceptionally difficult conditions, and that such children need special consideration,

Taking due account of the importance of the traditions and cultural values of each people for the protection and harmonious development of the child,

Recognizing the importance of international co-operation for improving the living conditions of children in every country, in particular in the developing countries,
Have agreed as follows:

PART I

Article 1

For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

Article 2

1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability birth or other status.

....

Article 3

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

....

Article 6

1. States Parties recognize that every child has the inherent right to life.
2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

Article 7

1. The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents.
2. States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless.

....

Article 18

1. States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.

2. For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.
3. States Parties shall take all appropriate measures to ensure that children of working parents have the right to benefit from child-care services and facilities for which they are eligible.

Article 19

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

....

Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
 - (a) To diminish infant and child mortality;
 - (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
 - (c) To combat disease and malnutrition, including within the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
 - (d) To ensure appropriate pre-natal and post-natal health care for mothers;
 - (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
 - (f) To develop preventive health care, guidance for parents and family planning education and services.
3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

....

Article 26

1. States Parties shall recognize for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realization of this right in accordance with their national law.
2. The benefits should, where appropriate, be granted, taking into account the resources and the circumstances of the child and persons having responsibility for the maintenance of the child, as well as any other consideration relevant to an application for benefits made by or on behalf of the child.

Article 27

1. States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.
2. The parent(s) or others responsible for the child have the primary responsibility to secure, within their abilities and financial capacities, the conditions of living necessary for the child's development.
3. States Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.
4. States Parties shall take all appropriate measures to secure the recovery of maintenance for the child from the parents or other persons having financial responsibility for the child, both within the State Party and from abroad. In particular, where the person having financial responsibility for the child lives in a State different from that of the child, States Parties shall promote the accession to international agreements or the conclusion of such agreements, as well as the making of other appropriate arrangements.

Article 28

1. States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:
 - (a) Make primary education compulsory and available free to all;
 - (b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need;
 - (c) Make higher education accessible to all on the basis of capacity by every appropriate means;
 - (d) Make educational and vocational information and guidance available and accessible to all children;
 - (e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates.
2. States Parties shall take all appropriate measures to ensure that school discipline is administered in a manner consistent with the child's human dignity and in conformity with the present Convention.

....

Article 32

1. States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.
2. States Parties shall take legislative, administrative, social and educational measures to ensure the implementation of the present article. To this end, and having regard to the relevant provisions of other international instruments, States Parties shall in particular:
 - (a) Provide for a minimum age or minimum ages for admission to employment;
 - (b) Provide for appropriate regulation of the hours and conditions of employment;
 - (c) Provide for appropriate penalties or other sanctions to ensure the effective enforcement of the present article.

....

APPENDIX D

Excerpts from the **INDIGENOUS AND TRIBAL PEOPLES CONVENTION**
(ILO No. 169), 72 ILO Official Bull. 59, *entered into force* September 5, 1991.

The General Conference of the International Labour Organisation,
Having been convened at Geneva by the Governing Body of the International Labour Office, and having met in its 76th Session on 7 June 1989, and

Noting the international standards contained in the Indigenous and Tribal Populations Convention and Recommendation, 1957, and

Recalling the terms of the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and the many international instruments on the prevention of discrimination, and

Considering that the developments which have taken place in international law since 1957, as well as developments in the situation of indigenous and tribal peoples in all regions of the world, have made it appropriate to adopt new international standards on the subject with a view to removing the assimilationist orientation of the earlier standards, and

Recognising the aspirations of these peoples to exercise control over their own institutions, ways of life and economic development and to maintain and develop their identities, languages and religions, within the framework of the States in which they live, and

Noting that in many parts of the world these peoples are unable to enjoy their fundamental human rights to the same degree as the rest of the population of the States within which they live, and that their laws, values, customs and perspectives have often been eroded, and

Calling attention to the distinctive contributions of indigenous and tribal peoples to the cultural diversity and social and ecological harmony of humankind and to international co-operation and understanding, and

Noting that the following provisions have been framed with the co-operation of the United Nations, the Food and Agriculture Organisation of the United Nations, the United Nations Educational, Scientific and Cultural Organisation and the World Health Organisation, as well as of the Inter-American Indian Institute, at appropriate levels and in their respective fields, and that it is proposed to continue this co-operation in promoting and securing the application of these provisions, and

Having decided upon the adoption of certain proposals with regard to the partial revision of the Indigenous and Tribal Populations Convention, 1957 (No. 107), which is the fourth item on the agenda of the session, and

Having determined that these proposals shall take the form of an international Convention revising the Indigenous and Tribal Populations Convention, 1957;

Adopts the twenty-seventh day of June of the year one thousand nine hundred and eighty-nine, the following Convention, which may be cited as the Indigenous and Tribal Peoples Convention, 1989;

Part I. General Policy

Article 1

1. This Convention applies to:
 - (a) tribal peoples in independent countries whose social, cultural and economic conditions distinguish them from other sections of the national community, and whose status is regulated wholly or partially by their own customs or traditions or by special laws or regulations;
 - (b) peoples in independent countries who are regarded as indigenous on account of their descent from the populations which inhabited the country, or a geographical region to which the country belongs, at the time of conquest or colonisation or the establishment of

- present state boundaries and who, irrespective of their legal status, retain some or all of their own social, economic, cultural and political institutions.
2. Self-identification as indigenous or tribal shall be regarded as a fundamental criterion for determining the groups to which the provisions of this Convention apply.
 3. The use of the term peoples in this Convention shall not be construed as having any implications as regards the rights which may attach to the term under international law.

Article 2

1. Governments shall have the responsibility for developing, with the participation of the peoples concerned, co-ordinated and systematic action to protect the rights of these peoples and to guarantee respect for their integrity.
2. Such action shall include measures for:
 - (a) ensuring that members of these peoples benefit on an equal footing from the rights and opportunities which national laws and regulations grant to other members of the population;
 - (b) promoting the full realisation of the social, economic and cultural rights of these peoples with respect for their social and cultural identity, their customs and traditions and their institutions;
 - (c) assisting the members of the peoples concerned to eliminate socio-economic gaps that may exist between indigenous and other members of the national community, in a manner compatible with their aspirations and ways of life.

Article 3

1. Indigenous and tribal peoples shall enjoy the full measure of human rights and fundamental freedoms without hindrance or discrimination. The provisions of the Convention shall be applied without discrimination to male and female members of these peoples.
2. No form of force or coercion shall be used in violation of the human rights and fundamental freedoms of the peoples concerned, including the rights contained in this Convention.

Article 4

1. Special measures shall be adopted as appropriate for safeguarding the persons, institutions, property, labour, cultures and environment of the peoples concerned.
2. Such special measures shall not be contrary to the freely-expressed wishes of the peoples concerned.
3. Enjoyment of the general rights of citizenship, without discrimination, shall not be prejudiced in any way by such special measures.

Article 5

In applying the provisions of this Convention:

- (a) the social, cultural, religious and spiritual values and practices of these peoples shall be recognised and protected, and due account shall be taken of the nature of the problems which face them both as groups and as individuals;
- (b) the integrity of the values, practices and institutions of these peoples shall be respected;
- (c) policies aimed at mitigating the difficulties experienced by these peoples in facing new conditions of life and work shall be adopted, with the participation and co-operation of the peoples affected.

Article 6

1. In applying the provisions of this Convention, governments shall:
 - (a) consult the peoples concerned, through appropriate procedures and in particular through their representative institutions, whenever consideration is being given to legislative or administrative measures which may affect them directly;
 - (b) establish means by which these peoples can freely participate, to at least the same extent as other sectors of the population, at all levels of decision-making in elective institutions and administrative and other bodies responsible for policies and programmes which concern them;
 - (c) establish means for the full development of these peoples' own institutions and initiatives, and in appropriate cases provide the resources necessary for this purpose.
2. The consultations carried out in application of this Convention shall be undertaken, in good faith and in a form appropriate to the circumstances, with the objective of achieving agreement or consent to the proposed measures.

Article 7

1. The peoples concerned shall have the right to decide their own priorities for the process of development as it affects their lives, beliefs, institutions and spiritual well-being and the lands they occupy or otherwise use, and to exercise control, to the extent possible, over their own economic, social and cultural development. In addition, they shall participate in the formulation, implementation and evaluation of plans and programmes for national and regional development which may affect them directly.
2. The improvement of the conditions of life and work and levels of health and education of the peoples concerned, with their participation and co-operation, shall be a matter of priority in plans for the overall economic development of areas they inhabit. Special projects for development of the areas in question shall also be so designed as to promote such improvement.
3. Governments shall ensure that, whenever appropriate, studies are carried out, in co-operation with the peoples concerned, to assess the social, spiritual, cultural and environmental impact on them of planned development activities. The results of these studies shall be considered as fundamental criteria for the implementation of these activities.
4. Governments shall take measures, in co-operation with the peoples concerned, to protect and preserve the environment of the territories they inhabit.

Article 8

1. In applying national laws and regulations to the peoples concerned, due regard shall be had to their customs or customary laws.
2. These peoples shall have the right to retain their own customs and institutions, where these are not incompatible with fundamental rights defined by the national legal system and with internationally recognised human rights. Procedures shall be established, whenever necessary, to resolve conflicts which may arise in the application of this principle.
3. The application of paragraphs 1 and 2 of this Article shall not prevent members of these peoples from exercising the rights granted to all citizens and from assuming the corresponding duties.

Article 9

1. To the extent compatible with the national legal system and internationally recognised human rights, the methods customarily practised by the peoples concerned for dealing with offences committed by their members shall be respected.
2. The customs of these peoples in regard to penal matters shall be taken into consideration by the authorities and courts dealing with such cases.

Article 10

1. In imposing penalties laid down by general law on members of these peoples account shall be taken of their economic, social and cultural characteristics.
2. Preference shall be given to methods of punishment other than confinement in prison.

Article 11

The exaction from members of the peoples concerned of compulsory personal services in any form, whether paid or unpaid, shall be prohibited and punishable by law, except in cases prescribed by law for all citizens.

Article 12

The peoples concerned shall be safeguarded against the abuse of their rights and shall be able to take legal proceedings, either individually or through their representative bodies, for the effective protection of these rights. Measures shall be taken to ensure that members of these peoples can understand and be understood in legal proceedings, where necessary through the provision of interpretation or by other effective means.

....

Part V. Social Security and Health

Article 24

Social security schemes shall be extended progressively to cover the peoples concerned, and applied without discrimination against them.

Article 25

1. Governments shall ensure that adequate health services are made available to the peoples concerned, or shall provide them with resources to allow them to design and deliver such services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health.
2. Health services shall, to the extent possible, be community-based. These services shall be planned and administered in co-operation with the peoples concerned and take into account their economic, geographic, social and cultural conditions as well as their traditional preventive care, healing practices and medicines.
3. The health care system shall give preference to the training and employment of local community health workers, and focus on primary health care while maintaining strong links with other levels of health care services.
4. The provision of such health services shall be co-ordinated with other social, economic and cultural measures in the country.

Part VI. Education and Means of Communication

Article 26

Measures shall be taken to ensure that members of the peoples concerned have the opportunity to acquire education at all levels on at least an equal footing with the rest of the national community.

Article 27

1. Education programmes and services for the peoples concerned shall be developed and implemented in co-operation with them to address their special needs, and shall incorporate their histories, their knowledge and technologies, their value systems and their further social, economic and cultural aspirations.
2. The competent authority shall ensure the training of members of these peoples and their involvement in the formulation and implementation of education programmes, with a view to the progressive transfer of responsibility for the conduct of these programmes to these peoples as appropriate.
3. In addition, governments shall recognise the right of these peoples to establish their own educational institutions and facilities, provided that such institutions meet minimum standards established by the competent authority in consultation with these peoples. Appropriate resources shall be provided for this purpose.

Article 28

1. Children belonging to the peoples concerned shall, wherever practicable, be taught to read and write in their own indigenous language or in the language most commonly used by the group to which they belong. When this is not practicable, the competent authorities shall undertake consultations with these peoples with a view to the adoption of measures to achieve this objective.
2. Adequate measures shall be taken to ensure that these peoples have the opportunity to attain fluency in the national language or in one of the official languages of the country.
3. Measures shall be taken to preserve and promote the development and practice of the indigenous languages of the peoples concerned.

Article 29

The imparting of general knowledge and skills that will help children belonging to the peoples concerned to participate fully and on an equal footing in their own community and in the national community shall be an aim of education for these peoples.

Article 30

1. Governments shall adopt measures appropriate to the traditions and cultures of the peoples concerned, to make known to them their rights and duties, especially in regard to labour, economic opportunities, education and health matters, social welfare and their rights deriving from this Convention.
2. If necessary, this shall be done by means of written translations and through the use of mass communications in the languages of these peoples.

Article 31

Educational measures shall be taken among all sections of the national community, and particularly among those that are in most direct contact with the peoples concerned, with the object of eliminating prejudices that they may harbour in respect of these peoples. To this end, efforts shall be made to ensure that history textbooks and other educational materials provide a fair, accurate and informative portrayal of the societies and cultures of these peoples.

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APPENDIX E

Excerpts from the **POLITICAL CONSTITUTION OF MEXICO**

Article 4 – The Mexican Nation has a multicultural composition, originally based on its indigenous peoples. The law will protect and promote the development of their languages, cultures, means, customs, resources, and specific forms of social organization, and will guarantee to them effective access to the jurisdiction of the State. In judicial and agrarian proceedings in which they are part, their practices and judicial customs shall be taken into account in the terms that the law establishes.

Men and women are equal before the law. The organization and the development of the family will be protected by law.

Every person has the right to decide, in a free, responsible, and informed manner, the number and spacing of his or her children.

Every person has the right to health protection. The law will define the ways and means for access to health services and will establish the concurrence of the Federation and the federated entities in matters of public health, in conformance to that which is specified by section XVI of Article 73 of this Constitution.

Every person has the right to live in an environment that is adequate for his or her development and well-being.

Every family has the right to a dignified and decent housing. The law will establish the instruments and supports necessary to accomplish this objective.

Children have the right to the satisfaction of their needs with respect to nutrition, health care, education and healthy leisure, to allow for their integral development.

Elders, guardians, and custodians have a duty to preserve these rights. The Government will provide whatever is necessary to bring about respect for the dignity of children and the exercise of their rights.

The Government will make it possible for private individuals to help uphold the rights of children.

....

Article 133 - This Constitution, the laws of the Congress of the Union that come from it, and all the treaties that are in accord with it, that have been concluded and that are to be concluded by the President of the Republic with the approval of the Senate will be the Supreme Law of all the Union. The judges of every State will follow this Constitution and these laws and treaties in considering dispositions to the contrary that are contained in the constitutions or the laws of the States.

APPENDIX F

LAW FOR THE PROTECTION OF THE RIGHTS OF CHILDREN AND ADOLESCENTS
[Ley de Protección de los Derechos de Niñas, Niños y Adolescentes, D.O. 29 de mayo de 2000]

.....

LAW FOR THE PROTECTION OF THE RIGHTS OF CHILDREN AND ADOLESCENTS

Published and Proclaimed in the Official Newspaper of the Federation on May 29th, 2000.

FIRST TITLE

General Provisions

Article 1- This Law is based upon the sixth paragraph of Article 4 of the Political Constitution of the United States of Mexico. Its provisions pertain to public order and are of social interest and general observance throughout the Mexican Republic. Its purpose is to guarantee children and adolescents the protection and respect of their fundamental rights recognized in the Constitution.

The Federation, the Federal District, states and municipalities, in their respective legal jurisdiction, will be able to create legal norms and take the necessary administrative measures to uphold this Law.

Article 2- For the purposes of this Law, “children” means people strictly under 12 years of age and “adolescents” means people 12 or over but strictly under 18 years of age.

Article 3- The protection of these rights is meant to ensure the full and integral development of children and adolescents, giving them the opportunity to grow physically, mentally, emotionally, socially, and morally in conditions of equality.

Guiding principles for the protection of the rights of children and adolescents are:

A- The principle of the best interests of the child

B- Non-discrimination, for any reason or in any circumstance

C- Equality regardless of race; age; gender; religion; language or dialect; political or other opinion; ethnic, national, or social origin; financial situation; disability; circumstances of their birth or any other status pertaining to the children, their parents, direct lineal ascendants, legal guardians, or legal representatives.

D-To live in a family, as basic environment for development

E-To live free of violence

F- Shared responsibility among family members, the government, and society at large

G- Full and equal protection of human rights and constitutional guarantees.

Article 4- In accordance with the principle of the best interests of the child, it will be understood that all norms that apply to children and adolescents are basically intended to providing them with all the care and assistance they need for their full development and growth in an environment of well-being for their families and societies.

Abiding by this principle, the rights of adults will not, at any time or under any circumstances, override or restrict the rights of children and adolescents.

The application of this Law will observe respect for this principle, as well as for all guarantees and fundamental rights recognized in the Political Constitution of the United States of Mexico.

Article 5- The Federation, the Federal District, states and municipalities will do their best to implement the necessary mechanisms to promote a culture of protection of the rights of children and adolescents, based on the content of the UN Convention on the Rights of the Child and any related treaties approved by the Senate.

Article 6- When explicit provisions are not found in the Constitution, this Law, or any international treaties as defined in Article 133 of the Constitution, the references used will be the general principles derived from those codes, and if those are lacking, general legal principles.

Article 7- Federal, Federal District, state and municipal authorities must, in their respective legal jurisdiction, guarantee children and adolescents the protection and exercise of their rights, and they must take the necessary measures to ensure the children's and adolescents' well-being, taking into account the rights and obligations of parents, other direct lineal ascendants, legal guardians, or any other individuals legally responsible for them. In the same manner and without prejudice attached to the previous statement, children and adolescents must be offered respect and assistance with the exercise of their rights by the community to which they belong and by society in general.

The Federal Government will promote the adoption of a National Program for the Care of the Rights of Children and Adolescents. This program will involve the participation of the Federal District, states and municipalities in their respective legal jurisdiction, as well as of the social and private sectors, for the implementation of policies and strategies that contribute to the observance of this Law and guarantee an improvement in the social situation of children and adolescents.

Article 8- When applying this Law, and to ensure that all children and adolescents can exercise their rights equally, special attention will be paid to the situation of those whose rights are being restricted.

The Federal Government, the Federal District, states and municipalities, in matters under their respective legal jurisdiction, will provide special protection to those children and adolescents whose rights are being violated or restricted, and will adopt whatever measures are necessary to put an end to that situation. Once the situation has been corrected, the children and adolescents that were affected will be referred to the regular services and programs available to all children and adolescents.

Those governmental institutions responsible for carrying out the obligation mentioned above will implement programs and guarantee they remain in place until their goals have been met.

Article 9- Children and adolescents have the responsibility to respect all persons; to take proper care of their own property, family and community properties; and to take advantage of any resources available for their development.

Failure by children or adolescents to fulfill their obligations will not be an excuse or justification to abuse or violate their rights.

CHAPTER II

Obligations of Parents, Direct Lineal ascendants, Legal Guardians, and Any Individuals Legally Responsible for Children or Adolescents

Article 10- To guarantee and promote the rights recognized in this Law, federal, Federal District, state and municipal authorities, in their respective legal jurisdiction, will promote actions conducive to offering proper assistance to parents, legal guardians, or any individuals legally responsible for children and adolescents, so that they are able to fulfill their duties.

Article 11-The obligations of parents and other people responsible for the care of children and adolescents are as follows:

A-To provide a dignified life, guaranteeing children and adolescents proper nutrition and a full and harmonious development of their personality within their family, school, community, and institutions in accordance with the provisions of this Article.

For the purposes of this precept, “nutrition” includes food, housing, education, clothing, health care, and recreation.

B-To protect children and adolescents against any form of mistreatment, prejudice, harm, aggression, abuse, sale or traffic, and exploitation. The previous statement implies that those who have patria potestadⁱⁱ or custody of children and adolescents cannot, while fulfilling their roles, do anything detrimental to the children's and adolescents' development or their physical or mental integrity.

The norms will establish whatever is necessary to guarantee the fulfillment of the duties mentioned above. In any case, procedures and legal assistance will be provided as needed to ensure that parents, direct lineal ascendants, legal guardians, or any individuals legally responsible for children and adolescents fulfill their duty to provide nutrition. The law will establish the corresponding penal responsibility of those who abandon children without justification.

Federal, Federal District, state and municipal authorities, within their respective legal jurisdiction, will promote the availability of day-care facilities as well as assistance and support for those who work and must take care of children.

Article 12- According to the obligations of parents mentioned before, and because of them, the father and mother will have equal authority and receive equal consideration within the family and with respect to their children.

When parents do not live with their children, this fact will not release them from the obligations imposed on them by this Law.

Article 13- With the purpose of guaranteeing the rights established in this chapter, federal, state, and Federal District laws will make any necessary provisions to ensure throughout the country:

A-That parents, direct lineal ascendants, legal guardians, or any individuals legally responsible for children or adolescents fulfill their obligation to protect them against any form of abuse; to treat them with respect for their rights and dignity; and to offer care, assistance and guidance so that they know their rights, learn to defend them, and learn to respect the rights of others.

B-That the federal, state, and municipal governments have the capacity to intervene, using all available legal means, to prevent general or particular violations of the laws that protect children and adolescents. In particular, any necessary measures will be taken to prevent children or adolescents from leaving the country without proper authorization from their parents, legal guardians, or a judge with legal jurisdiction over the matter.

C-That family members, neighbors, medical doctors, teachers, social workers, public servants, or any persons who know of cases of children or adolescents who are experiencing violations of the rights included in this Law, in any form, fulfill their obligation to make that fact immediately known to the proper authorities, so that the corresponding investigation of the matter can be carried out.

In schools or similar institutions, teachers and educators will be responsible for preventing all forms of mistreatment, prejudice, harm, aggression, abuse, or exploitation of children or adolescents.

SECOND TITLE

About the Rights of Children and Adolescents

CHAPTER I

About the Right to Priority

Article 14- Children and adolescents have the right to guaranteed priority in the exercise of all their rights. In particular, they have the right:

A-To be offered protection and help in any circumstance and in a timely manner.

B-To be offered assistance prior to adults in any public service setting, when under the same circumstances.

C-That the design and implementation of any public policies necessary for the protection of their rights be given due consideration.

D-That institutions in charge of protecting their rights be given more resources.

CHAPTER II

About the Right to Life

Article 15- Children and adolescents have the right to live. Their survival and development will be guaranteed to the maximum extent possible.

CHAPTER III

About the Right Not to Be Discriminated Against

Article 16- The rights of children and adolescents are recognized, and there must not be any discrimination against them based on their race; color; gender; language or dialect; religion; political opinion; ethnic, national or social origin; financial situation; physical disability; circumstances of their birth; or any other status not anticipated in this Article.

It is the obligation of the authorities to adopt appropriate measures to guarantee that children and adolescents enjoy the right to equality in all manners.

Article 17- Any measures adopted or norms created to protect the rights of children and adolescents who are in a particularly difficult situation because of restrictions or violations of their rights, and which are intended to guarantee these children and adolescents the equal exercise of their rights, must not imply discrimination against any other children or adolescents, nor restrict their equal access to the same rights. Any special measures taken in favor of the former but showing respect for the latter will not be understood as discrimination.

Article 18- It is the duty of the authorities, parents, direct lineal ascendants, legal guardians and members of society to promote and impel equality in the development of girls, boys and adolescents, and to fight and eradicate from a very early age any custom, habit or prejudice that supports the notion of superiority of one gender over another.

CHAPTER IV

About the Right to Live in a Situation of Well-being and the Right to a Healthy Psychological and Physical Development

Article 19- Children and adolescents have the right to live in conditions that allow for their healthy and harmonious growth, not only from a physical but also from a mental, material, spiritual, moral, and social point of view.

Article 20- While pregnant or breast-feeding, mothers have the right to the necessary medical and nutritional care, in accordance with women's right to integral health care.

CHAPTER V

About the Right to Protection of Integrity and Freedom and from Mistreatment or Sexual Abuse

Article 21- Children and adolescents have the right to be protected against acts or omissions that might affect their physical or mental health, their normal development, or their right to an education, in accordance with Article 3 of the Constitution. The norms will establish the manner in which this type of behavior will be anticipated and avoided. Specifically, children and adolescents will be protected against:

A-Lack of care; negligence; abandonment; and emotional, physical, or sexual abuse.

B-Exploitation; the use of drugs and stimulants; kidnapping; and sale or traffic.

C-Armed conflict; natural disasters; situations involving refuge or migration; and being recruited to participate in armed conflicts.

CHAPTER VI

About the Right to an Identity

Article 22-The right to an identity includes:

A-Having a given name and the parents' last names from birth, and to have the birth entered in national records.

B-Having a nationality, according to what is established by the Constitution.

C-Knowing their affiliation and origin, except when it is prohibited by law.

D-Belonging to a cultural group and sharing traditions, religion, and language or dialect with other members of this group, which cannot be used as a reason to interfere with any of the children's and adolescents' other rights.

In order that children and adolescents are able to fully exercise their right to an identity, the norms corresponding to each state and the Federal District may stipulate whatever is necessary so that the mother and father are able to register their children without any distinction made regarding the circumstances of their birth.

CHAPTER VII

About the Right to Live in a Family Environment

Article 23- Children and adolescents have the right to live in a family environment. A lack of resources will not be considered sufficient cause to separate them from their parents or the relatives with whom they live, nor a reason for the parents to lose *patria potestad*.⁴¹⁷

The Government will see that children and adolescents are only separated from their parents when there is a sentence or preventive judicial order that establishes the separation legally and in accordance with causes previously stipulated by the law, and also with proceedings in which the right to a fair hearing is guaranteed to all the parties involved, including the children or adolescents themselves. The law will stipulate whatever is necessary to ensure that the cases of those parents who have difficulties taking care of their children themselves on a regular basis, due to extreme poverty or to having to find work away from their homes, are not considered cases of

⁴¹⁷ This concept, similar to "legal custody" in the U.S. system, describes the rights and obligations of parents (e.g. making decisions regarding education and discipline, providing for the children's needs, providing legal representation and administering an estate). It can only be lost by court order when there has been serious transgressions (e.g. mistreatment, domestic violence, or abandonment). In case of divorce, both parents keep their *patria potestad* even though only one of them might have physical custody. If both parents die, it is transferred to grandparents in a specific order determined by a judge.

*exposición*⁴¹⁸ or abandonment as long as the parents entrust their children to the care of other persons, do not use violence against them, and provide for their means of support.

Programs will be established to offer support to families, so that a lack of resources is not a cause for separation.

Article 24- The authorities will establish the necessary norms and mechanisms to attempt to reunite children and adolescents with their families of origin when they have been separated from them. Furthermore, it will be a priority to provide children of divorced or separated parents with the right to live with them or to maintain personal relationships and direct interactions with both of them. The only exceptions will be made when the authorities, in accordance with the law, determine that these relationships or interactions are contrary to the best interests of the children or adolescents in question.

Article 25- When children and adolescents are deprived of their family they will have the right to be protected by the Government, which will attempt to provide a foster family. Furthermore, during Government custody, they will receive any special care they need as a consequence of the separation from their family.

The norms will stipulate whatever is necessary so that children and adolescents who need it can fully exercise the right recognized in this Article by means of:

A-Adoption, preferably *full adoption*⁴¹⁹

B-The participation of foster families

C-If the two previous options are not available, public or private assistance institutions will be used, or assistance centers will be created for this purpose.

Article 26- Federal, Federal District, state and municipal authorities, in their respective legal jurisdiction, will see that adoptions are carried out with respect for the norms that regulate them. These norms will be designed so that children and adolescents are adopted with full respect for their rights, and will include dispositions that will tend to ensure that:

A-Children and adolescents are listened to and their opinions are taken into account as far as the law permits.

B-Those who place children or adolescents as well as those who adopt them have appropriate legal counsel, so that all persons involved in the adoption are aware of the consequences it will have.

⁴¹⁸ *Exposición* is a particular type of child abandonment, where the parent hides his or her identity and whereabouts, with no intention to reclaim the child.

⁴¹⁹ Under Mexican law, *full adoption (adopción plena)* gives the adopted child the same status as a birth child, and carries obligations and responsibilities for the extended adoptive family with respect to education, nutrition, housing, inheritance, etc. (For example, grandparents must provide for the children in case of death or disability of the parents.)

In the case of simple adoption (*adopción simple*), only the parents take on responsibilities and the extended family would not be obligated to the child.

C-The adoption does not provide improper financial gain to any of the parties involved.

Article 27-In the case of international adoption, national regulations will stipulate whatever is necessary to ensure that children and adolescents are adopted by nationals of countries where judicial norms pertaining to adoption and protection of the rights of children and adolescents are at least equivalent to Mexican norms.

CHAPTER VIII

About the Right to Good Health

Article 28- Children and adolescents have a right to good health. Federal, Federal District, state and municipal authorities, in their respective legal jurisdiction, will cooperate to:

A-Reduce child mortality.

B-Guarantee children and adolescents access to medical and sanitary care, for prevention, treatment, and restitution of their health.

C-Promote breast-feeding.

D-Fight malnutrition by promoting an appropriate diet.

E-Promote vaccination programs.

F-Offer prenatal and postnatal care to mothers, according to what it is established in this Law.

G-Pay special attention to HIV/AIDS and endemic, epidemic, and sexually transmitted diseases by promoting programs for prevention and education.

H-Implement measures oriented to prevent early pregnancies.

I-Provide whatever is necessary so that children and adolescents with disabilities receive care appropriate to their condition to be rehabilitated; to improve their quality of life; to be reincorporated into society; and to be placed on equal footing with the rest of society with respect to their rights.

J-Implement measures so that health services detect cases of domestic violence and provide special care to the children and adolescents involved.

CHAPTER IX

The Rights of Children and Adolescents with Disabilities

Article 29-For the purposes of this Law, people with disabilities are all those affected by an alteration of their physical, intellectual, or sensory functions that prevents them from carrying out activities that are appropriate for their age and social situation, and that implies disadvantages for integration into society and family or access to education and work.

Article 30-Discrimination for any reason against children and adolescents with a physical, intellectual, or sensory disability will not be permitted. Independently of other rights recognized and given to them by this Law, they have the right to the full development of their skills, to enjoy a dignified life that allows them to be an integral part of society, and to participate in society, to the extent of their possibilities, in education, work, culture, finances and recreation.

Article 31- The Federation, the Federal District, states and municipalities, in their respective legal jurisdiction, will establish norms that tend to:

A-Recognize and accept the existence of disability.

B-Offer support through education and training to parents and relatives of children and adolescents with disabilities, so that they have the necessary means to promote the children's development and a dignified life for them.

C-Promote interdisciplinary activities for early diagnostic, treatment, and rehabilitation of children and adolescents with disabilities and any related research, according to the needs of each case and making sure their families can afford them.

D-Support specialized educational centers and special-education projects that allow children and adolescents with disabilities, to the extent of their possibilities, to be reincorporated into the regular school system. These children and adolescents will be provided with free basic care, access to early-stimulation programs, health services, rehabilitation, leisure and occupational activities, as well as work training. If these services are not available, they will need to be created.

E-Adapt the environment in which children and adolescents with disabilities live to their specific needs.

CHAPTER X

About the Right to Receive an Education

Article 32- Children and adolescents have the right to receive an education that shows respect for their dignity and prepares them for life in an atmosphere of understanding, peace, and tolerance, in accordance with Article 3 of the Constitution. The laws will promote the necessary measures so that:

A-They are provided the educational care required for their full development, according to their age, maturity, and special circumstances.

B-Girls and female adolescents are not discriminated against in matters of educational opportunities. The necessary mechanisms will be implemented to counteract cultural, economic, or any other factors that promote gender discrimination.

C-Gifted children and adolescents receive an education appropriate to their ability, and that the right conditions are created for their incorporation into society.

D-There is education on human rights and respect for them, in particular with respect to non-discrimination and coexistence without violence.

E-Mechanisms for democratic participation are incorporated into all school activities, to educate and train children for their role as citizens.

F-Educational institutions are prevented from imposing disciplinary measures that are not within established norms and are contrary to the dignity of children and adolescents, or that threaten their lives or their physical or mental integrity.

G-Educational institutions favor mechanisms for conflict resolution that clearly state what constitutes a violation of discipline and how disciplinary rules and procedures are to be applied.

CHAPTER XI

About the Right to Rest and Play

Article 33-Children and adolescents have a right to rest and play, which will be considered essential factors for their development and growth. They also have a right to enjoy any cultural or artistic events or activities in their communities.

Article 34-No lifestyle, school or work schedule, or disciplinary measure will be imposed on children or adolescents that impair these rights or have a detrimental effect on them.

Article 35-To ensure the protection of the rights recognized in this Law, the constitutional prohibition to hire people under 14 years of age, under any circumstances, is ratified here.

Those who infringe this prohibition, and put at risk the integrity and development of children and adolescents, will be subject to the sanctions dictated by the Penal Code.

Furthermore, federal authorities, authorities of the Federal District, state and municipal authorities will provide whatever is necessary so that children and adolescents do not find themselves in a situation of abandonment or lack of protection because of the application of this regulation.

CHAPTER XII

About Freedom of Thought and the Right to One's Own Culture

Article 36-Children and adolescents will have freedom of thought and conscience.

Article 37-Children and adolescents who are members of an indigenous group have the right to freely enjoy their language, culture, customs, traditions, religion, resources, and specific forms of social organization.

The above paragraph will not be understood as a limitation to the right to receive an education in accordance with Article 3 of the Constitution, or any other right protected by this Law.

Furthermore, the appropriate authorities will ensure that the education provided is not contrary to the first paragraph of Article 4 of this Law.

CHAPTER XIII

About the Right of Participation

Article 38- Children and adolescents have the right to enjoy freedom of expression. This includes having access to information and expressing their opinions. No restrictions may be placed on the exercise of this right other than those imposed by the Constitution.

Article 39- Children and adolescents have the right to express opinions, analyze, criticize, and introduce proposals within their schools, families, communities, or any other environment, without any restrictions other than those imposed by the Constitution and the obligation to respect the rights of others.

Article 40- Children and adolescents have the right to access information. In compliance with this right, norms will be established and policies will be designed so that they are guided in the exercise of the right recognized in Article 39. Furthermore, particular emphasis will be placed on those measures that protect them from any danger that may affect their lives, health, or development.

Article 41- The right of children and adolescents to express their opinions implies that:

A- Their opinions must be taken into account when considering matters that affect them or the content of resolutions that concern them.

B- They must be listened to and their opinions and proposals must be taken into account in any issue pertaining to their family or their community.

Article 42- Children and adolescents have the right to freedom of association and assembly. The laws must stipulate whatever is necessary so that they can exercise this right without any restrictions other than those imposed by the Constitution.

THIRD TITLE

CHAPTER I

About the Mass Media

Article 43- Without prejudice the regulations that apply to the mass media, the federal authorities will do their best to verify that they:

A- Disseminate information and materials of social and cultural interest to children and adolescents, in accordance with the educational objectives stipulated in Article 3 of the Constitution and the Convention on the Rights of the Child.

B- Avoid disseminating information contrary to those objectives and injurious to the well-being of children and adolescents, or contrary to the principles of peace, non-discrimination, and respect for all persons.

C- Disseminate information and materials that contribute to guiding children and adolescents in the exercise of their rights, help their harmonious development, and help them to protect themselves from any harm to their lives or health.

D-Avoid the broadcasting and publication of information, during times of family programming, with content prejudicial to the children's and adolescents' education and upbringing, that promotes violence or a lack of values, or condones or incites the commission of a crime.

E-Furthermore, the authorities will oversee the application of a rating system for public performances, motion pictures, radio and television programs, videotapes, printed matter, and any other type of communication or information, transmitted by any medium, which might be prejudicial to the well-being of children or adolescents or might threaten their dignity.

FOURTH TITLE

ONLY CHAPTER

About the Right to Due Process When Having Infringed the Penal Law

Article 44-The norms will protect children and adolescents from any intervention that is arbitrary or contrary to their constitutional guarantees, or their rights as recognized in this Law and any treaties underwritten by our country in accordance with Article 133 of the Constitution.

Article 45-To this end, the norms will stipulate the bases to ensure that:

A-Children and adolescents are not subject to torture or any treatment or sentence that is cruel, inhumane, or degrading.

B-They are not arbitrarily or illegally deprived of their freedom. The detention and deprivation of freedom of adolescents will be carried out in accordance with the law and with respect for the guarantees to a fair hearing, defense, and due process as recognized in the Constitution.

C-Children and adolescents are deprived of their freedom only when it has been proved that a serious infringement of the penal law has occurred, and then only as a last resort, for a period as brief as possible, and having regard for the principle of the best interests of the child.

D-The treatment and detention of adolescents who infringe the penal law are different from those of adults, and therefore that they are sent to separate facilities. Special facilities will be created for this purpose.

E-In accordance with part D of this Article, there are codes or laws promoted that establish procedures and create specialized authorities and institutions for dealing with adolescents alleged as having infringed the penal law. These actions will include creating public ministries and appointing specialized judges.

F-When dealing with adolescents as mentioned in part E of this Article, the importance is taken into account of promoting their reintegration and social adaptation, and their assuming a constructive role in society.

G-The following are included among the measures for dealing with those who have infringed the penal law: care, orientation and guidance, supervision, counseling, probation, foster homes, educational and professional training programs, as well as other alternatives to institutional care. The purpose of these alternatives is to ensure adolescents are dealt with in a manner appropriate

for their integration and social adaptation, tending towards their well-being, and that the sanctions applied are proportionate to the circumstances of their offense.

In case of infringement of the penal law, a distinction will be made between rehabilitation and confinement measures. In the case of serious crimes, or crimes organized by the adolescents themselves, rehabilitation can be prolonged or expanded, and as a last resort, confinement can be deemed preferable.

H-Any adolescents alleged as having infringed the penal law have the right to prompt access to legal or any other appropriate assistance, so that their rights are protected. Specialized Public Defenders will be appointed to this end.

I-In the case of alleged infringement of the penal law, there is respect for the right of adolescents to have the presence of their parents, legal guardians, or those who have custody of them or are responsible for their care.

J-Those who are legally deprived of their freedom are treated with respect for their human rights and the dignity inherent to any person.

K-Those who are deprived of their freedom have the right to continuous and permanent contact with their families, and that they are able to share their lives together except when this is contrary to the principle of the best interests of the child.

L-Children are not deprived of their freedom under any circumstances. Because of their particularly difficult situation, adolescents living under extraordinary circumstances, who have suffered abandonment or live in the streets, will not be deprived of their freedom either.

Article 46-The proceedings pertaining to adolescents alleged as having infringed the penal law must show respect for all constitutional guarantees relative to due process, and to the following guarantees in particular:

A-Presumption of innocence: to be presumed innocent until proven guilty.

B-Speedy Proceedings: oral summary proceedings for those deprived of their freedom.

C-Defense: to keep adolescents informed, at every moment, of the charges against them and of any developments pertaining to their cases; to secure the assistance of a public defender when adolescents or their legal representatives have not designated one; to ensure that they are not forced to testify against themselves or their families or subject to judicial *careo*,⁴²⁰ and to allow them to be present in all proceedings, to be heard, to provide evidence, and to file motions, appeals, or petitions.

D-Not to be subject to judicial or ministerial *careo*

⁴²⁰ *Careo* is the act of setting opposite parties face to face to extract the truth, or a witness face to face with the defendant, in order that the latter may make any objection he or she has to the witness. Judicial *careo* is carried out by a judge during a trial, and ministerial *careo* by the authority in charge (e.g. minister or prosecutor) during an investigation.

E-Confrontation: to inform adolescents timely of all actions, developments, and measures pertaining their cases, so that they are able to intervene on behalf of their rights and to file motions, appeals, or petitions.

F-Oral Proceedings: the adolescents implicated have the right to be heard directly.

Article 47- Adolescents who infringe administrative norms will be subject to the legal jurisdiction of specialized institutions, or of equivalent institutions in the Federal District or the state where they are located. These institutions will assist them without depriving them of their freedom or severing their ties with their families.

FIFTH TITLE

CHAPTER I

About Providing Defense and Protecting the Rights of Children and Adolescents

Article 48-For a better defense and protection of the rights of children and adolescents at the national level, the institutions established by the Federation, the Federal District, states and municipalities in their respective legal jurisdiction will rely on qualified personnel and will become specialized offices, with authority to effectively investigate and prosecute in defense of these rights.

Article 49-The institutions indicated in Article 48 will have the following faculties:

A-To oversee the observance of all constitutional guarantees that protect the rights of children and adolescents; all provisions corresponding to the Government's obligation under any relevant international treaties underwritten by our country as defined in Article 133 of the Constitution, and all provisions included in any applicable legislation.

B-To provide legal representation in the interest of children and adolescents before judicial or administrative authorities, without infringing any applicable legal provisions.

C-To provide mediation in case of family conflict when there is a violation of the rights of or the guarantees to children and adolescents.

D-To report to the Public Ministry all those events that suggest the commission of a crime, and to contribute to the investigation.

E-To promote the participation of the public, social, and private sectors in planning and carrying out actions in favor of the care, defense, and protection of the rights of children and adolescents.

F-To advise the appropriate authorities and the social and private sectors in what relates to the protection of these rights.

G-To conduct, promote, and distribute studies and research that strengthen actions in favor of the care, defense, and protection of these rights, and to make them available to the appropriate authorities and to the social and private sectors for their use in any corresponding programs.

H-To define, implement, and carry out policies and mechanisms that guarantee the protection of the rights of children and adolescents.

I-To apply sanctions according to this Law.

J-Any other faculties expressly given to them by any applicable legal provisions.

Article 50-The Federal Government will promote coordination agreements with the governments of the Federal District, the states and the municipalities, so that they can cooperate to procure, protect, and defend the rights of children and adolescents.

Article 51-Institutions will be able to rely on consultative bodies or commissions for support, evaluation, and coordination in the exercise of their functions. The corresponding authorities will participate in these bodies, and so will representatives of the social and private sectors that have been recognized for their activities in favor of the rights of children and adolescents.

CHAPTER II

About Sanctions

Article 52-Violations of this Law will be sanctioned by the specialized procurator offices established as indicated in Article 48, with fines going from 1 to 500 times the current minimum salary in the Federal District.

Article 53-In cases of serious or repeated offenses, the fines mentioned in Article 52 can be doubled, and up to 36 hrs. of administrative arrest can be applied. Repeated offenses are understood to be those in which the same person violates the same legal provision two or more times during a period of one year.

Article 54-Sanctions for violations of this Law, and any provisions derived from it, can have bases in any of the following:

I-Records or official documents drawn up by the authorities.

II-Investigations carried out by staff of the specialized procurator offices or persons appointed by them.

III-Corroborated evidence provided by the children or adolescents or their legal representatives.

IV-Any other element or circumstance that provides persuasive arguments to apply the corresponding sanction.

Article 55-For the determination of sanctions, the specialized procurator offices will follow this Law and any provisions derived from it, taking into account the following factors in the order indicated:

I-The seriousness of the offense

II-If the offence was intentional or not

III-If it is a case of a repeated offense

IV-The financial situation of the offender

CHAPTER III

About Administrative Procedures

Article 56-Any resolutions approved by the specialized procurator offices, based on this Law or any provisions derived from it, will be applied in accordance with the Federal Law for Administrative Procedures.

PROVISIONAL ARTICLES

First-This Law will go into effect the day after it is published in the *Official Newspaper* of the Federation.

Second-The proper authorities will be able to approve laws, regulations, and provisions to implement throughout the country what is established by this Law, in a period no longer than a year after this Law is published, as indicated in the previous Article.

Third- All provisions contrary to what is established by this Law are hereby revoked.