THESIS

# ZAPATISTA HEALTHCARE IN A CIVILIAN TARGETED WARFARE ZONE: CHIAPAS, MEXICO

Submitted by

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WE HEREBY RECOMMEND THAT THE THESIS PREPARED UNDER OUR SUPERVISION BY JULIE ANN MARIE SULLIVAN ENTITLED ZAPATISTA HEALTHCARE IN A CIVILIAN TARGETED WARFARE ZONE: CHIAPAS, MEXICO BE ACCEPTED AS FULFILLING IN PART REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS.

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ABSTRACT OF THESIS

ZAPATISTA HEALTHCARE IN A CIVILIAN TARGETED WARFARE ZONE:

CHIAPAS, MEXICO

Indigenous people in Chiapas, Mexico have endured hundreds of years of attacks on their cultures and life ways. They have been marginalized, excluded, and oppressed. They have experienced the loss of ancestral lands and the destruction of their natural resources and environment. They have been denied fundamental human rights including access to land, education, and healthcare. They have suffered disproportionately high infant and maternal mortality rates and deaths from curable, preventable disease. They have survived without access to clean water, sanitation facilities, or electricity. Finally in 1994 with the implementation of the North American Free Trade Agreement and other Neoliberal economic projects on the horizon, over three thousand Indigenous people came together, called themselves Zapatistas, and declared war on the Mexican government. The world watched as the Zapatistas demanded basic human rights and the Mexican government promised reform. When the government failed to honor their promises, the Zapatistas responded by creating autonomous communities with their own form of government, education, and health care.

The purpose of this study is to assess the autonomous Zapatista healthcare system in the Oventic caracole following the Zapatista rebellion using a political ecology theoretical approach. Specifically, does the Zapatista healthcare system operate successfully and how has this model changed healthcare access and well being of the people living in this civilian targeted warfare zone? What effect has the militarization had on health care?

This research has the potential to provide valuable contributions to the Zapatista struggle as they continue to develop and improve the healthcare system in autonomous communities living in resistance. Additionally, this work may serve as a resource and guide for local and international non-governmental organizations, non-profit organizations, medical professionals, and Zapatista support groups who wish to contribute to the growth, sustainability, success, and autonomy of the Zapatista healthcare system.

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This work is dedicated to

my father, Lyle Edwin Tams...who would have loved this adventure,
the loves of my life, Christopher, Scott, Alex, Katie, Ayden, Lilly Ann, and Grady,
and the Zapatistas.

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The Zapatistas waited...for promises to be honored, for their lands to be restored, for vaccinations for their children, for a voice in politics, for clean water, for education, for healthcare, for fundamental human rights and dignity. They cried out, but their pleas went unanswered. They organized and armed themselves and when they had nothing more to lose...they declared war on the Mexican government. This time the world heard their cry and demanded a response. The armed Zapatista rebellion lasted only 12 days, and when the Mexican government offered the Zapatistas an official pardon, this was the Zapatista response:

> What do we have to ask forgiveness for? What are they going to "pardon" us for? For not dying of hunger? For not accepting our misery in silence? For not humbly accepting the huge historic burden of disdain and abandonment?...For being Mexicans, every one of us? For mostly being Indigenous?...For fighting for freedom, democracy, and justice?...Who should ask forgiveness and who can grant it?...(Higgins 2004). Or should we ask pardon from the dead, our dead, those who die natural deaths of "natural causes" like measles, whooping cough, dengue fever, cholera, typhoid, mononucleosis, tetanus, pneumonia, malaria, and other lovely gastrointestinal and pulmonary disease? Our dead, the majority dead, the democratically dead, dying of sorrow went just like that, without anyone even counting them without anyone saying, "Enough!" which would have at least given some meaning to their deaths, a meaning which no one ever sought for them, the forever dead, who are now dying again, but this time in order to live (Farmer 2005).

The Zapatistas captured the attention of the world and they were undaunted when the Mexican government broke their promises, again and again. The Zapatistas continued to organize. They built communities and schools, coffee cooperatives and communication systems, and they built their own hospitals and clinics. Brick by brick they built remote clinics in the jungle and in the mountains. Then they recruited community volunteers to train and staff the new healthcare system. By 2009 the Zapatistas had established a central hospital and clinic along with eleven regional microclinics. Today Indigenous children are receiving childhood vaccinations for the first time in their lives and thousands of people have access to healthcare in or near their own communities. Women have health care and the right to exercise control over their own bodies. Health promoters are learning new westernized medical practices while recovering traditional ancient healing methods. This study will explore the Zapatista healthcare system in the Oventic caracole region of Chiapas, Mexico. Employing a political ecology theoretical approach I seek to answer the following questions: How have 15 years of militarization affected Indigenous healthcare in Chiapas and how are the Zapatistas responding to the healthcare needs of thousands of Indigenous people living in a civilian targeted warfare zone?

## CHAPTER 1

## A HISTORY OF THE ZAPATISTAS

This chapter provides a history of Indigenous people in Chiapas, Mexico and examines the effects of globalization, the emergence of neoliberal politics and economics, and the subsequent response of the Zapatistas. Additionally, the historical oppression and marginalization of Indigenous people related to access to land, resources, and healthcare will be discussed. When the Zapatista National Army of Liberation (EZLN) declared war on the Mexican government in 1994 one of their 34 demands addressed the right for all Indigenous people to have access to healthcare. How did this history influence the rebellion and what did this mean for the future of Zapatista healthcare in Chiapas?

### Chiapas Demographics

Today, over one third of Mexico's 105 million people are Indigenous, representing 62 cultures and over 100 languages (World Health Organization 2008). The Indigenous population is concentrated in the state of Chiapas, home to the richest natural resources in Mexico. Although Chiapas possesses the most productive amber mines in the world, ancient rain forests, vast coffee plantations, rich oil and natural gas reserves, and expansive hydroelectric power plants, Indigenous people receive little benefit from these resources (Eber 2003).

On average, a Chiapas [1]campesino earns $1.78 per day and over 25% of the people in Chiapas have no income at all (Gall 1998). Over one half of the population in Chiapas is illiterate and less than one third of the children complete first grade. Government schools provide classes through third grade but over half of the schools have only one teacher for all grade levels. Young girls are less likely to attend school than boys. Indigenous children are often humiliated and physically punished by Mestizo teachers for speaking their native languages or for wearing traditional clothing. The few Indigenous teachers who live in Chiapas travel for days to reach distant community schools and are often subjected to checkpoints, interrogation, and harassment from the Mexican military (Eber and Kovic 2003). Indigenous men, women, and children die of curable diseases and suffer from malnutrition, dysentery, measles, cholera, typhus, parasites, and other "deaths of poverty" (Holloway 1998). The Mexican national average life expectancy plunges from 70 to 44 in Chiapas and infant and maternal mortality rates are the highest in all of Mexico (MADRE 2001).

**History of Healthcare in Chiapas**

According to Paul Farmer, "...it is true that members of any subjugated group do not expect to be received warmly even when they are sick or tired or wounded. They wouldn't expect...a long disquistion about their pain. They wouldn't expect the sort of courtesy extended to the privileged," (Farmer 2005:25-26). Prior to the 1994 Zapatista rebellion Indigenous people had little or no access to healthcare in rural Chiapas. Without ambulances or money to pay for transportation patients

[1] Subsistence farmer, peasant farmer; usually Indigenous, generally associated with economic, social, and political marginalization

risked military checkpoints and harassment as they were forced to walk for days to government clinics and hospitals in distant cities. [2]One woman told me, "I was a girl when we carried my grandmother for three days by walking to the government clinic and she died trying to get to that place, so we learned to teach ourselves and recover our traditional methods of healing...and we did not give up...we organized" (interview with a Zapatista woman, July 20, 2007). Patients who did make their way to government clinics found them so profoundly understaffed and underequipped that in many cases they still died (Eber and Kovic 2003). Doctors and nurses subjected Indigenous patients to discrimination and humiliation, often denying them treatment or sending them to the back of the line. A young mother whose baby died after arriving at a government clinic told me, "Even when we were screaming they did not help my baby...they would not look at her...they did nothing for us. My husband screamed too and they looked away" (interview with an anonymous informant, August 6, 2005). Government clinics failed to provide Indigenous language interpreters so patients were unable to describe their medical conditions or receive accurate diagnoses. Some patients were told they were receiving antibiotics but instead they were given sedatives to "dull their minds and make them go away," (interview with a health promoter, July 18, 2006). Other patients were refused antibiotics and urgently needed pharmaceuticals unless they agreed to "special vaccines" that were believed to be contraceptive injections. Many government hospitals reportedly sterilized Indigenous women without their

[2] All interviews were confidential; the names of the interviewees are withheld or changed by mutual agreement.

consent during cesarean sections and implanted nonconsensual IUDs (intrauterine devices) during vaginal births (MADRE 2001).

Indigenous women had essentially no access to birth control and no right to deny their husband sex. In Chiapas the average woman gives birth to two or three babies while still a child herself, and she may bear eight to ten children in her lifetime (Eber and Kovic 2003). Three or four of her children will die of curable diseases before the age of five. The deaths of children are so common that women often state how many children they had and how many of their children died in the same sentence (Eber and Kovic 2003). Overall, women's mortality rates during childbirth exceed 14% in Chiapas. In the most remote highland areas, maternal mortality is six times the national average and pregnancy related complications are the leading cause of death in women (Eber and Kovic 2003). It is likely that the maternal and infant mortality rates are actually higher than reported and as many as 45% of maternal deaths go unreported. The long trip to major cities often prohibits Indigenous families from registering births and deaths (Eber and Kovic 2003, Gonzalez 1998) and they see little point in registering deaths with a government who does not appear to care.

I had the opportunity to interview a Zapatista health promoter who had previously worked in a government hospital. Juan said he came to work in the Zapatista microclinics after witnessing, "many bad things happen to Indigenous patients" at the government hospital. He described how Indigenous patients were "brushed to the side and forgotten. They did not care about people who wore traditional clothing or who spoke Tzotzil." Juan said the doctors refused to treat

campesinos because "they sweat and can't take showers and the doctor called them dirty and left them to die." The government hospital was slow to attend to Indigenous patients and the doctors would never walk or leave the building to help people in their homes or community much less in remote villages. Juan emphasized that the doctors had "pure bad ideas" and women were pressured to get operations that were unnecessary. Women were also pressured to be sterilized and were told, "If you want this medication you must get the operation to be sterilized." If the woman refused she was told her husband must have a vasectomy in order to receive treatment or medication. Women who could not read Spanish were given birth control pills without knowing what they were. Juan said many of the medications caused patents to become more ill but he was uncertain what the medications were (interview with Juan, July 18, 2005). This process of coerced sterilization appears to be aligned with a covert government strategy to reduce the number of Indigenous people living on resource rich land that the Mexican government wants to acquire for development. According to Andrea Smith, similar policies have been applied to Native American women in the United States. "With the majority of the energy resources in the U.S. on Indian lands, the continued existence of Indian people is a threat to American capitalism" (Smith 2005:107). Another example is the philosophy of the late Garrett Hardin who was a member of Population Environment Balance and president of the American Eugenics Society. Hardin favored China's one-child policy and along with other environmentalists argued "population control takes precedence over women's reproductive freedom" (Smith 2005:73). Mexican government clinics appear to have subscribed to the same

philosophy. Juan said women's healthcare in the government clinics was merely an "opportunity for taking away the women's chances to have children" (interview with Juan, July 18, 2005).

**Neo-liberalism and the Zapatista Rebellion**

Healthcare was only a symptom of the greater issues surrounding Indigenous rights in Mexico. Following the 1917 Mexican Revolution, Article 27 of the Mexican Constitution provided for agrarian reform, which included programs to redistribute land to the landless. Indigenous communities were among the benefactors of Article 27 and ejidos (communal lands) were established so campasinos had the ability to work, grow crops, and support their families and communities (Ross 1994). Article 27 provided essential protections over Indigenous rights including access to and ownership of communal lands. However, by 1991 Article 27 presented an obstacle to the Mexican government's plans for the North American Free Trade Agreement (NAFTA) and other massive development projects. Under pressure from neoliberal politicians, Mexico's President Carlos Salinas reformed Article 27, reversing most Indigenous rights, specifically the right to petition for land (Harvey 1998). The reforms provided for state ownership of all land and water resources, mineral rights, and forests. Indigenous communities immediately argued that the loss of communal land holdings would mean the final "death of our culture" (Evans 2003). Pleas to halt the reform of Article 27 were ignored and millions of acres of land became available for purchase and development by agribusiness and multinational corporations (Ross 1995).

Neoliberalism spread swiftly throughout Mexico and South America. Unfortunately Chiapas, with her rich natural resources was a primary target. The introduction of neoliberal economics and politics meant pro-market, pro-business strategies that would benefit big business and the national interests while increasingly excluding, exploiting, and marginalizing the poorest of the poor. Economic development intended to modernize and bring progress to Mexico included plans such as the North American Free Trade Agreement, Plan Puebla Panama, huge hydroelectric power plants, and dams. The poor reap few benefits from these mega projects and instead face expulsion from their lands and the loss and destruction of their natural resources. Neoliberalist governments view Indigenous communities and the poor as barriers to progress, often removing protections such as Article 27 from groups who are perceived as backward or as obstacles to progress. Little concern is shown for the displacement and destruction of Indigenous communities and traditional cultures. This was evidenced immediately after the reform of Article 27 when the Mexican government began evicting Indigenous families from their lands, threatening community leaders, outlawing Indigenous use of natural resources, and arresting, beating, and torturing hundreds of Indigenous people. Expansive development projects forced thousands of people from their ancestral lands to make room for new ranches, highways, stockyards, dams, golf courses, and tourist sites.

On January 1, 1994 the United States, Canada, and Mexico signed the North American Free Trade Agreement and the repercussions were felt throughout Mexico. NAFTA provided for the elimination of tariffs on most

products imported and exported between Mexico, the U.S. and Canada. Because Mexico has less stringent environmental and labor laws than the United States, foreign corporations erected hundreds of maquiladoras (factories) along the U.S./Mexico border and began reaping the benefits of low production costs. This has resulted in unparalleled environmental degradation on both sides of the border due to toxic waste dumping, untreated sewage being released into streams and rivers, air pollution, and heavy metal contamination of soils and aquifers (Smith 2003). Meanwhile, the poor and Indigenous people in Mexico plummeted even deeper into poverty. Consumer prices in Mexico have risen over 200% since NAFTA was signed and the cost of living in Mexico increased by 257% (Center for Economic and Political Investigations of Community Action, CIEPAC 2004). The U.S. Department of Agriculture estimates that eliminating import tariffs increased the number of poor in Mexico to 8 million people. Campasinos were among the highest casualties of NAFTA. When the U.S. flooded the Mexican market with agricultural products, corn lost 64% of its value and beans lost 46% of their value, yet these products did not become cheaper for Mexican consumers (CIEPAC 2004). Of the 8.2 million campesinos in Mexico, 65% became homeless and an average of six hundred men abandoned their land every day (CIEPAC 2004). Some men migrated to work in maquiladoras, leaving their families to tend to the land and farming responsibilities. This has changed the social structure of families and has had an especially negative impact on women (Smith 2003).

Imported, genetically modified strains of corn began contaminating native corn in Indigenous communities and hundreds of varieties of ancient maize disappeared. Eggs, beef, chicken, and coffee prices plummeted (CIEPAC 2004). NAFTA also paved the way for logging, bioprospecting, and oil and gas exploration (Evans 1998). Thousands of people lost their homes, land, and livelihoods and in turn they were left with even less access to basic human services such as education and healthcare.

Another threat of the neoliberal structural reforms to Indigenous land and resources is the implementation of a transnational development project called Plan Puebla Panama (PPP). The plan will cost an estimated 20 billion dollars and span a period of 25 years (O'Neill 2004). PPP calls for the massive development of electrification, telecommunication, agricultural "modernization" programs, and transportation systems that will advance corporate globalization. Although the intellectual architects of PPP claim the projects will increase the quality of life for the 64 million inhabitants of the region, they have shown no concern for the dislocation of people whose ancestors have lived on the land for thousands of years (Warpehoski Undated). To facilitate increasing demands for hydroelectric power, two dam projects are scheduled for construction. Both projects would dam the 600-mile long and ecologically pristine Usumacinta River. The dams will create reservoirs over 20 miles long and flood several Classic Maya archeological sites and Indigenous communities (O'Neil 2004). New railways and super-highways will link industrial and free trade zones from the Mexican state of Puebla to the Panama Canal. One highway called the "Ruta Maya" will take tourists to ancient Mayan

archaeological sites and open vast areas of land for the construction of luxury hotels, golf courses, and resort zones. The corridor will cut through the heart of ancient forests and Indigenous communities in seven countries and expose the most important biodiversity regions in Southern Mexico and Central America to development (Marcos 2001a). Plans are also in place to duplicate the maquiladora zones on the U.S./Mexico border and increase the global manufacture, import, and export of foreign goods. The result will be gigantic sweatshop-dominated, export-processing zones (O'Neill 2004). A cheap work force will be assured when campasinos are evicted from their lands and forced to work wage labor jobs. Women and children will likely fill factory or service jobs as well. Oil exploration, genetic engineering projects, and bio-prospecting ventures are expected to be key lucrative aspects of the plan. PPP will result in forced evictions of thousands of Indigenous communities, destruction of natural resources, erosion of Indigenous culture, loss of traditional medicinal plants and healing methods, increased poverty, hunger, and health problems. When completed, millions of mostly Indigenous and poor people will be affected. According to Brendan O'Neill, "This megaproject represents one of the greatest threats to the social, economic, and ecological integrity Mesoamerica" (O'Neil 2004:4).

**The Zapatista Rebellion**

Long before the coming of NAFTA Indigenous appeals for justice and reform went unanswered. Hundreds of Indigenous people had already begun organizing and preparing for a rebellion. Men and women worked side-by-side training and establishing secret military bases in the mountains and jungles of Chiapas. They

built an army, prepared for war, and called themselves "Zapatistas." The name honors Emiliano Zapata, the beloved agrarian reformer and assassinated hero of the Mexican Revolution. Although Mexican, European, and American historians wrote the history of Chiapas, the Zapatistas rejected the ethnocentric concept of a "people without a history," placed upon them as if they were somehow invisible now and in the past (Thomas 2000). They rejected the image of backward nobodies who impeded progress with no place in, or contribution to society or the "modern world" (Thomas 2000). The Zapatista rebellion would make history, and in preparation for war, the soldiers learned to read and write while mastering the use of firearms. They studied Mexican history, politics, and the struggles of former liberation movements. Finally, they learned Spanish, the language of their oppressor. The rebellion gave rise to a resurgence of the history, traditions, and culture of the Zapatista ancestors and ways of life (Thomas 2000).

By the mid 1990s the Zapatista plans for an armed military action had been underway for over a decade. After more than 500 years of oppression and marginalization a cry was heard deep in the highlands of Chiapas, a cry that would change Chiapas forever. "Ya Basta!" Enough! The Zapatista rebellion would offer a new path, a new world alternative for thousands of Indigenous people living in Chiapas and throughout Mexico. The Zapatista Army of National Liberation (EZLN) declared war on the Mexican government on January 1, 1994.

Over 3,000 Zapatista soldiers emerged from the highlands and seized control of the Chiapas state capitol of San Cristóbal de Las Casas, and the communities of Ocosingo, Las Margaritas, Altamirano, Chanal, Oxchuc, and Huixtán. The Zapatistas

presented the Declaración de la Selva Lacandona (Declaration of the Lacandon Jungle) to the Mexican government and spokesperson Subcomandante Marcos announced, "We have nothing to lose, absolutely nothing, no decent roof over our heads, no land, no work, poor health, no education, no right to freely and democratically choose our leaders, no independence for foreign interests, and no justice for ourselves or our children" (Evans 1998). The declaration demanded that the Mexican government grant Indigenous people full participation in determining the future of their culture, including securing a voice in politics, recognition of Indigenous land rights, autonomy, environmental protection, and access to all of the services afforded to other citizens of Mexico (Holloway 1998). The right to healthcare was clearly addressed in the ninth demand which stated: "We want hospitals to be built in all of the municipal seats, and that they have specialized doctors and sufficient medicine to attend to all patients, and rural clinics in the ejidos (communal lands) and communities, with training and fair salaries for health representatives. Already-existing hospitals in the area should be rehabilitated as soon as possible and have complete surgical services. Clinics should be built in large communities, which have sufficient doctors and medicine to more closely attend to the needs of the people" (Collier 1999). [3]Zapatista women announced their own demands and created the Revolutionary Laws of Women" which outlined specific rights for women and children (Klein 2001). Among the women's demands for equality, they specifically addressed healthcare stating: "Women and their children

[3] The complete text of "The Women's Revolutionary Law is on page 125 of the Appendix.

have the right to primary attention in the matters of health and nutrition" (EZLN 1994).

It was no coincidence that the rebellion began on the same day that NAFTA went into effect. In one of his first interviews on January 1, 1994 Subcomandante Marcos commented, "Today the North American Free Trade Agreement begins, which is nothing more than a death sentence to the Indigenous ethnicities of Mexico, who are perfectly dispensable in the modernization program of Salinas de Gortari. Then the compañeros decided to rise up on that same day to respond to the decree of death that the Free Trade Agreement gives them, with the decree of life that is given by rising up in arms to demand liberty and democracy, which will take them to the solution to their problems. This is the reason that we have risen up today" (flag.blackened.net/revolt/mexico/ezln/marcos_interview_jan994.html). Marcos left no doubt that the rebellion was a war against neoliberalism, a war to save the lives, culture, and traditions of thousands of Indigenous and poor.

The Mexican government initially responded by sending over 12,000 troops to Chiapas and indiscriminately bombing Indigenous communities, executing Zapatistas, and flippantly reporting the deaths of innocents as collateral damage. Before long one-third of the entire Mexican army was stationed in Chiapas (CIEPAC 1998). By the twelfth day of the conflict intensive international criticism and the demands of civil society compelled Mexico President Ernesto Zedillo to declare a ceasefire. The armed conflict came to an end and both sides gathered in the community of San Andres to negotiate a peace agreement. A peace agreement,

called the "San Andrés Accords," was finally reached between Mexican President Ernesto Zedillo and the Zapatistas in 1996.

**Zapatista Communities Living in Resistance**

Fifteen years after the signing of the San Andrés Accords essentially none of the government's promises have been honored. Instead the Mexican army established 56 permanent military bases in Chiapas and deployed an estimated 70,000 soldiers to surround Zapatista communities and settlements (CIEPAC 2001). Today at least 40,000 soldiers still remain in Chiapas. The Zapatistas have responded by increasing their efforts to organize and declaring over half of the state of Chiapas as Zapatista autonomous zones. Communities situated in these areas identify themselves as "communities living in resistance" and have implemented ancient Mayan practices of governing and community. Indigenous people within the autonomous zones participate in a political atmosphere free of Mexican government authority. There are five Zapatista geographical regions called caracoles; each with its own democratically elected Juntas de Buen Gobierno (Juntas of Good Government). My research was conducted in the Oventic caracole where the seat of government is called Corazo'n Ce'ntrico de los Zapatistas Delante del Mundo (the Central Heart of the Zapatistas in Front of the World). The caracole refers to a spiral likened to a conch shell; a place where all things come together. A Mayan story tells of gods who did not have enough time to finish the sky after the world was created. So four gods decided to stay on Earth and stand in four different corners of the world in order to hold the sky in place. They took turns sleeping so one god was always awake to ensure that the sky did not fall. The god that was awake alerted the

other gods within the caracole if evil was near or if the sky was falling. Eventually the gods taught humans how to use the caracole to awaken the other humans if evil fell on the earth or if the sky started to fall. The Zapatistas also use the symbol of the snail to represent expanding and evolving in an endless spiral like the conch shell. The snail represents a philosophy that I heard many times during my research, "Un poco, un poco," meaning little by little. Like the snail, the Zapatistas are taking small steps, moving forward little by little.

The Junta de Buen Gobierno have recovered the traditional Indigenous philosophies and practices of governing and justice. They resolve disputes, provide counseling, and listen to the suggestions, concerns, and ideas from the people they serve. Focus is placed on Indigenous autonomy and three essential components of the resistance: education, economic development, and health care. Individual communities are empowered to make local decisions including the selection of local authorities, teachers, and health promoters. Within the autonomous zones the Zapatistas established new communities, schools, housing, cultural recovery projects, cooperatives, water and sewage systems, community based agriculture, small businesses, and a regional healthcare system. It is here that the Zapatistas have found power in reviving ancient traditional practices, such as the caracole, the Junta de Buen Gobierno, oral traditions, education, and traditional healing. Zapatista schools teach Mayan history and culture as well as traditional ways of family and women's rights. Men, women and children are learning Spanish but also preserving their traditional Mayan languages of Tzelal and Tzotzil. The Zapatistas embrace traditional teaching methods and communication by incorporating songs,

stories, music, and poetry in the classroom and in the resistance movement. Perhaps one of the most remarkable ways in which the Zapatistas are recovering ancient knowledge is in the restoration of traditional healing methods and cooperative efforts to establish a healthcare system. Working together, Zapatista communities have established community-based healthcare in the Oventic caracole that combines traditional Mayan practices of health and wellness with contemporary methods. Coupled with saving the lives of Indigenous people, the Zapatistas are saving Indigenous culture as well.

Two years prior to the 1994 rebellion, the Zapatistas had already begun construction on the first autonomous health clinic. The Oventic Clinic was the beginning of a system that would provide access to quality healthcare for thousands of Indigenous people throughout Chiapas. Over the next fifteen years the Zapatistas established a complex system of microclinics, pharmacies, vaccination centers, health promoter training programs, women's healthcare programs, traditional healing methods, and community wellness programs. The system is growing and for the first time the medical needs of Indigenous people in Chiapas are being recognized and addressed.

Indigenous people in Chiapas have endured hundreds of years of oppression; oppression that may change forms, but results in the same outcome. Today's oppressor is neoliberalism. With no regard for the poor, the North American Free Trade Agreement, Plan Puebla Panama, and other massive development projects will result in the evictions of millions of people from their ancestral lands and homes. At the hands of the Mexican army and government sponsored paramilitary

groups, Indigenous families and communities have become the targets of harassment, assault, rape, murder, and a myriad of civilian targeted warfare tactics. In spite of these hardships and attacks, the Zapatistas continue to resist the neoliberal model. They have created a new society in the Zapatista autonomous zones...and they continue to resist.

## CHAPTER 2

## RESEARCH METHODS

Healthcare in Chiapas has undergone dramatic changes since the Zapatista rebellion. I was afforded the unique opportunity and privilege of having access to the Zapatista Oventic caracole healthcare system for this work. One of the primary goals of this study was to provide ethical, applied research that would be of value to the Zapatistas as they continue to develop and improve healthcare in the Oventic caracole. I also hoped to provide information that might assist Zapatista supporters, medical professionals, humanitarian groups, and non-governmental organizations in their work with the Zapatistas. I employed a number of research methods in order to gain a clear understanding of the Zapatista healthcare system and the work of the health promoters. This chapter provides insight into how this research was inspired, collected, and what the future might hold for this work.

### Choosing The Research Topic

I became interested in the Zapatista struggle in 2003 as an undergraduate student when I enrolled in a Latin American Peasantries course at Colorado State University. The history of the Zapatista struggle so moved me that I decided to attend the First Hemispheric Forum on Militarization in South America in San Cristóbal de Las Casas in Chiapas, Mexico. I traveled as a member of the Mexico Solidarity Network delegation and we visited the Zapatista communities of Oventic,

Polhó, and Nicholas Ruiz. I will never forget my first introduction to the Zapatistas. The following is an excerpt from my personal journal: I did not speak any Spanish that first day...as I sat on a rough-sawn wooden bench, in a tiny building in a Zapatista community called Polhó...looking into the eyes of three bandana clad Zapatista faces...the first Zapatistas I had ever seen. One of the men began to speak, and someone in the room translated. I started writing...

> The government wants to kill the Zapatistas, but it is not easy and many people support us so it is not going to be easy. You being here supports us and supports our struggle. Thank you for making the decision to go to this place and see for your self, and get information for yourself about how the autonomous communities are working, about our schools, and our healthcare, and our struggle. Spread the truth, please tell the truth, please tell the world that we are not bad or aggressive, we are good and organized. Our children are starving. Our women are dying in childbirth and we are suffering only because we are Indians and the government does not care about us. We thank you for your visit. You are our compañeros and compañeras. Please tell the people in the world the truth about what is happening here. That is what we ask, (Anonymous Zapatista, May 2003).

Thirty minutes later we were told the Mexican army was at the Polhó entrance gate. I felt weak and scared. The Zapatistas told us to stay inside. The women were going to the gate, to block the entrance with their own bodies...they would stand arm in arm and face off the soldiers. It was a strategy that worked only because human rights observers and journalists were there to document the confrontation. The soldiers demanded that the women clear the road, but they stood united and the soldiers went away. The women would later tell me they had nothing to lose; they fight for the lives of their children. In just one visit to Polhó I saw the reality of the day-to-day struggle of the Zapatistas. I left Chiapas with a promise to fulfill the Zapatistas' request to carry the story of their struggle to the world.

In January of 2004, I returned to Chiapas to attend the 10-year Anniversary Celebration of the Zapatista Resistance in Oventic. The evening of my arrival I witnessed a medical emergency at a bus station in Tuxtla Gutierrez. I had worked in emergency medicine for over 25 years, so when I saw a family with a baby running through the station screaming for help I quickly responded. No one knew what to do...the baby was limp in her mother's arms and she had stopped breathing. I intervened with a very simple life-saving maneuver and began mouth-to mouth resuscitation. After a few minutes the baby responded, started to breath, and regained consciousness. The parents hugged the baby and cried. The grandmother reached up, took my face in her hands and kissed my eyes. I had to run to catch my bus but I could not stop thinking about the baby. She almost died from choking...this scenario would not happen in the U.S. I felt sick at heart. By the time I arrived in San Cristóbal de Las Casas the following morning I had made a life-changing decision. I would offer my healthcare knowledge and experience to the Zapatistas and inquire if they needed any help.

I continued on to Oventic where I lived for the next two weeks. While there I attended the anniversary celebration and enrolled in the Zapatista Spanish Language School. I spent time observing at the central Oventic clinic and visiting with the health promoters. I also had two meetings with the Oventic Junta de Buen Gobierno. We discussed the potential of a research project that could fulfill my Master's thesis requirements while providing significant benefit to the Zapatista healthcare system. I explained that I had extensive experience in both teaching and the practice of emergency medicine. The Junta suggested the possibility of conducting a

comprehensive study of the Oventic Caracole healthcare system and I offered to do so. They instructed me to write a proposal, which they would evaluate and then make a final decision.

In April of 2005 I submitted a formal request to the Junta de Buen Gobierno asking for permission to write my Master's thesis on the healthcare system in the Oventic Caracole. My research would provide a comprehensive description of each microclinic and assess the strengths and weaknesses of the system. My request included letters of support from my Graduate committee at Colorado State University and the Mexico Solidarity Network. The Junta required that I obtain additional endorsements from Rebeldía, the Zapatista Army of National Liberation (EZLN), and the Zapatista National Liberation Front (FZLN). I received those endorsements and entered into an agreement with the Zapatistas that promised I would provide an unedited copy of my final research to them. The Junta granted me permission to visit the Oventic clinic and all of the microclinics in the caracole. I was also given permission to photograph the microclinics and to take notes during interviews. Photographs of people were allowed only with their permission and only while wearing masks. I agreed to destroy all of my research notes at the conclusion of my research. I received endorsement to conduct my research from the Colorado State University Human Research Committee and appropriately renewed my application throughout the duration of this research.

**Research Methods**

This work was drawn from primary research conducted in the autonomous Zapatista zone of the Oventic Caracole in the highlands of Chiapas, Mexico. I worked

in the central clinic in Oventic and in eleven autonomous Zapatista microclinics located throughout a very large geographical region. Research data was also obtained from Zapatista Army of National Liberation (EZLN) communiqués and documents, Oventic Caracole demographic reports, records from the Oventic Clinic and eleven Zapatista autonomous microclinics, five non-governmental medical and humanitarian organizations, and conversations and interviews with the Zapatista Junta de Buen Gobierno, community authorities, clinic coordinators, microclinic health promoters, families, insurgents, and coffee, honey and textile cooperative members. Because my research was conducted in a civilian targeted warfare zone, as stated earlier all of the interviews were confidential. The names of the interviewees are changed or withheld by mutual agreement. The locations of many interviews are also confidential to ensure the safety and confidentiality of the informants.

My research reflects fieldwork acquired over a span of more than six years. I conducted all of the research myself in English. My son Alex accompanied me on every research trip and served as my photographer and Spanish translator. My primary research was conducted on site in Chiapas, Mexico during the following time periods: eight weeks in July and August of 2005, three weeks in July and August of 2006, three weeks in December of 2007 and January of 2008, three weeks in December of 2008 and January of 2009.

I incorporated participant observation, and qualitative and quantitative research methods through the use of informal, unstructured, and semistructured interviews, and the direct observation of health promoters and microclinic

activities. I also reviewed microclinic records containing medical and patient data at three microclinics. Participant observation at the microclinics was limited to health promoter activities. No direct patient observation was conducted and patient data remained anonymous.

I did not select specific microclinics for this research; rather the Junta de Buen Gobierno directed me to visit all of the eleven microclinics and they also chose the timetable for the visits. I conducted interviews with Zapatista leaders including 24 members of the Oventic Junta de Buen Gobierno and approximately 16 community authorities. I interviewed over 75 health promoters and clinic coordinators and observed approximately 32 health promoters at eleven rural microclinics and the Oventic Clinic. All of the health promoters, clinic coordinators, Junta de Bueno Gobierno, and community authorities were selected based on who happened to be on duty at the time of my visit. Seventy-one health promoter and clinic coordinator interviews took place at the Oventic Clinic and on site at the 11 microclinics. Three health promoters were interviewed in San Cristóbal de Las Casas during the Red Alert in 2007.

According to H. Russell Bernard, informal interviews are conducted without structure or control. They take place anywhere and anytime over the course of the research and require the researcher to remember conversations and write notes after the interview. Informal interviews build rapport and lead to topics that may not be addressed in other forums (Bernard 2002). Unstructured interviews include a basic interview plan but are exercised with minimal control and lead to open conversations and a sort of "chit-chat." They are useful in situations where the

researcher will have additional opportunities to interview the individuals. Unstructured interviews provide people with the chance to "open up and let them express themselves" (Bernard 2002:205). Semi-structured interviews are used in situations when the researcher may have only one opportunity to interview the person. An interview guide is employed with specific questions and goals in mind (Bernard 2002). Qualitative and quantitative data is collected in semi-structured interviews.

Because I spent a long period of time working in the Oventic caracole I had opportunities to include informal, unstructured, and semi-structured interviews with most of the health promoters and clinic coordinators. I employed an interview guide and wrote field notes when conducting semi-formal interviews. My semi-formal interview guide included questions regarding the following topics: history of healthcare in the area, history of the microclinic, current microclinic facilities, pharmacies, medical supplies and pharmaceutical inventories, vaccination programs, health services provided, illnesses and injuries treated, infant and maternal mortality rates, women's healthcare, universal precautions and biohazards, traditional medicine, health promoter routines and training, militarization, strengths and weaknesses of the microclinics and of the healthcare system in general, and microclinic needs. I also asked the health promoters what they hoped for and what their vision was for the future.

The number of health promoters I interviewed at each microclinic varied by occasion. In some cases I met with one health promoter or clinic coordinator and at other times as many as twenty-two. Interested community members and Zapatista

authorities often joined us and contributed to the conversations. The length of the interviews varied depending on the level of activity and the number of patients at the microclinic. In some cases we spent a few days at a microclinic and in others we had only a few hours. For example, on my second visit to Polhó the health promoters were conducing a vaccination clinic and we only had one hour with one health promoter.

Generally the atmosphere was relaxed so informal and unstructured interviews were mixed with participant observation during meals and late into the evening while sitting around a fire. Often these interviews elicited more information than the semi-formal interviews; perhaps because we were getting to know one another and everyone was more at ease. I believe that combining participant observation, qualitative, and quantitative research methods afforded me the most advantageous means of acquiring quality research data. Employing all of these methods enabled me to observe as well as experience the day-to-day routines of the health promoters and microclinics while collecting specific information through multiple types of interviews.

Interviews with the Junta de Buen Gobierno were conducted in the Junta office at Oventic. Because the Junta also asked many questions of me our conversations were structured most closely to the informal interview format. Often our conversations centered on my research reports to the Junta de Buen Gobierno and future planning. They tended to refer me to the clinic coordinators for specific data on the healthcare system.

Bernard describes participant observation as both a humanistic and a scientific method (Bernard 2002). This was clearly my experience during this research project. On one level I was seeking empirical data, and on another level I was very engaged in the daily lives of the people involved in my research. Witnessing their struggles instilled in me a very deep and sustaining level of commitment to this work. I collected a substantial amount of information with the goal of providing a direct and applied research contribution to the Zapatista struggle.

As a participant observer I found that keeping my word and returning over and over to Chiapas won the trust and respect of the Junta de Buen Gobierno as well as the health promoters. Our first visits to the Junta were friendly but formal and we were required to return to Oventic before every microclinic visit to receive official admission documents. This involved hours of extra travel to and from Oventic. However, after a few weeks the Junta began to chat with us more casually and sometimes we spent an hour or more just hanging out and talking. They began giving us entrance documents for several microclinics at a time. We had become familiar and accepted; they trusted us. There were however, times when a new group of Junta would arrive in Oventic for their work rotation. This meant starting over from the very beginning and presenting my initial research permission documents, letters, long explanations of my work, and establishing trust with the new Junta.

I had the same experience with the health promoters. As Alex and I spent more time at each location we became less of a novelty and people relaxed and

opened up. The health promoters were more likely to talk about the challenges and problems they were facing after we had established a trust relationship. As Bernard describes, "Presence builds trust. Trust lowers reactivity. Lower reactivity means higher validity of data" (Bernard 2002:334). I should note that the trust was mutual. My son and I literally placed our lives in the hands of the Zapatistas. They led us safely in and out of the communities deep in the militarized highlands of Chiapas. They fed us and housed us...they took care of us. We trusted them.

In San Cristóbal I conducted unstructured interviews with three non-governmental, non-profit organizations every time I traveled to Chiapas. We compared notes and shared information on the progress of the Zapatista healthcare system and also worked together to acquire supplies for the microclinics.

Based on the availability of electricity I always typed my field notes as soon as I had an opportunity. I did not use my computer during interviews as I felt it was too impersonal. In addition to my field notes I kept a diary and daily logs of my research as well as my personal thoughts and feelings about the experience.

Due to the extreme sensitivity of the data I was collecting I took extensive precautions to protect my research. After typing my field notes I emailed them to myself and then deleted the files from my computer. This provided a safeguard in case my computer was stolen or confiscated by paramilitaries or the Mexican army. I also backed up my data with a jump drive, which I secured in a safe place in San Cristóbal de Las Casas. I concealed my handwritten field notes deep inside my backpack or clothing when traveling.

**Field Setting**

The majority of my field research was conducted over the course of eight weeks during the summer of 2005. The focus of this trip was to obtain an overview of the Zapatista healthcare system including detailed descriptions of all of the microclinics in the Caracole. We visited the central Oventic Clinic and seven microclinics including Santa Catarina, Polhó, Zinacantán, Estación, Magdalena, Tenejapa, and Candelaria. We were scheduled to visit the Agua de León microclinic but a landslide closed the road and we were unable to get through. I also met with two non-governmental medical organizations and one non-profit human rights organization.

In July and August of 2006 we retuned to Chiapas for three weeks. The focus of this trip was to share my preliminary research with the Junta and to discuss the future of the project. I presented portfolios of my research to the Junta and also provided copies for each of the microclinics. We discussed the strengths and weaknesses of the Zapatista healthcare system to date and begin addressing specific issues regarding the need for medical supplies, lap top computers, and pharmaceuticals. We also discussed my research project and the Junta endorsed me to continue. I spent five days at the Oventic Clinic observing the health promoters during their on-duty and off duty time. I also made short visits to Polhó and Magdalena to speak with health promoters and get updates on the microclinic statistics.

With the permission of the Zapatistas I met with two non-governmental organizations regarding the acquisition of pharmaceuticals for the microclinics and

also consulted with two physicians from an international medical organization. I had not anticipated including physicians in my research; however they became a valuable resource and contributed significantly to this project. They provided information regarding the operation of the microclinics, health promoter training, vaccination programs, and the use of traditional medicines. I continued to exchange information with these physicians on successive visits to Chiapas.

In December of 2007 we made the difficult decision to keep our travel plans to Chiapas even though the Zapatista Clandestine Indigenous Revolutionary Committee (CCRI) had declared a Red Alert. Red Alerts are called in times of escalating military threats or when Zapatista leaders gather together to strategize or address important issues confronting the struggle. During a Red Alert all five of the Zapatista caracoles close down and the Juntas and other Zapatista authorities are moved to secure locations. They continue to work but do so in a nomadic and clandestine manner. The Zapatistas urge all non-governmental organizations to leave Zapatista territory during Red Alerts. If they stay they do so at their own risk (Marcos 2001; CCRI 2007). This meant I did not have access to any of the Zapatista communities for my research; they were deserted. I stayed in San Cristóbal de Las Casas and spent my time meeting with physicians, international non-governmental medical organizations, and human rights organizations. However, I was surprised one day to find that two health promoters had traveled to the city for medical training and I was able to spend an afternoon talking with them. Three women from a Zapatista cooperative also came to San Cristóbal de Las Casas for a day and I had an opportunity to visit with them. Although this trip

did not go as I had expected my time in Chiapas was productive after all.

In December of 2008 I traveled to Chiapas to meet with the Junta to discuss my final research. When I arrived I was surprised to learn that three new microclinics had been built since last year and the Junta asked that I include them in my research. I agreed and my son and I visited the 16th de Febrero, San Juan Cancuc, and Chankolom microclinics. The new microclinics are located in very rural areas and due to reports of increased military and paramilitary activity the Junta de Buen Gobierno insisted that we have Zapatista escorts. Establishing three new microclinics in such a short period of time once again demonstrated the effectiveness of grass roots organizing and the remarkable level of cooperation between communities. I was pleased to learn that the road to the Agua de León microclinic had been repaired so we traveled there as well. At Agua de León we met a married couple that worked as health promoters at the microclinic. They introduced us to their toddler daughter and spoke of how she would someday benefit from the struggle her parents had endured. It was a very special way to conclude my final interview for this project.

By January of 2009 I had visited every Zapatista clinic and microclinic in the Oventic caracole. Looking back on this project, I believe the ability to freely move between informal, unstructured, semi-structured interview formats was a very effective method in this setting. Using specific interview criteria yielded quantitative data while the more relaxed and open-ended conversations often led to additional topics and questions I had not anticipated. These various interview styles combined with participant observation enabled me to live and work

alongside the Zapatistas and gain a firsthand understanding of their daily lives and the inner workings of the microclinics.

**Research Challenges**

It was very difficult to find statistical data on the microclinics and the Zapatista communities. Demographic surveys of each microclinic would have significantly contributed to this work. Merely having access to the number of municipalities and communities did not provide the detailed statistical data required to clearly understand the magnitude of the healthcare challenges in the Zapatista autonomous zones. Acquiring this data would be difficult and time consuming given the large geographical area and language barriers; however, it would be essential to any future research. It would also be beneficial to sample patient records for statistical data regarding trends of disease and illness patterns by region and to examine the success of traditional versus allopathic medical treatment modalities. The microclinics are gradually acquiring computers for patient data collection so eventually many of these statistics could be readily available for future research.

This research was conducted in the unique and challenging environment of a civilian targeted warfare zone. In addition to ensuring my own safety I realize that the nature of my research and the politically charged atmosphere of Chiapas could place my informants in danger. I took extensive precautions to protect the confidentiality of my sources as well as the physical research contained on my computer and in my field notes. It was daunting to see so many soldiers. military vehicles, and check points on the roads every day. The extreme level of

militarization was also demonstrated by the numerous military bases we passed on our way to every microclinc. I had a frightening moment one time when an armed soldier demanded that I turn over my camera but I stood my ground and he backed off. I learned quickly not to take my camera out near a military base or a roadblock, and we never talked about my research in public. When traveling Alex and I assumed the roles of tourists in order to blend in. We were stopped occasionally when traveling with Zapatistas but it seemed as though the soldiers were reluctant to hassle Americans, so we were usually waved on by.

I do not speak Spanish so initially I hired two translators from San Cristóbal de Las Casas. Unfortunately I realized that without any research experience they tended to paraphrase and generalize rather than translate word for word. Fortunately I had recorded the first few days of interviews and was able to recover valuable information lost in translation. Being unable to communicate for myself was difficult and frustrating. My 15-year-old son Alex offered a solution to the problem. Alex had accompanied me on two research trips to Pine Ridge Indian Reservation during my undergraduate studies and he had an affinity for research. His Spanish was excellent so we gave it a try and he became my official translator. Alex was conscientious, detailed, and devoted to the research...so much that he even learned to speak a little Tzotzil.

Most of the health promoters spoke Spanish as their second language but occasionally one or two members of the group spoke only Tzotzil or Tzeltal. I included their voices by asking other health promoters to translate for them. In one case several members of the community authorities spoke Tzeltal, so a health

promoter translated to Spanish and then my son translated to English. Actually this worked pretty well; we took our time and I think the mutual desire to truly understand one another was really quite amazing. All of the microclinic records, Zapatista demographics, and non-governmental organization reports were in Spanish, so I spent a significant amount of time learning to read Spanish, especially medical Spanish. I also hired a translator to assist in the translation of some of the more complex documents.

Traveling to the microclinics was time consuming, expensive, and difficult. We always carried heavy backpacks filled with medical supplies so this presented a physical challenge. Frequently several hours of road travel was followed by short walks or up to six hours of additional hiking. We hitch hiked, walked, and climbed. We traveled on treacherous mountain roads stuffed into collectivos, taxis, the back of farm trucks, and in pickups. Sometimes transportation was unavailable or roads were washed out and we were left with no option other than to hike. A few times we traveled on foot at night in total darkness.

Frankly, most of the time we had almost no idea where we were geographically. The Zapatistas renamed the autonomous communities after the rebellion and the Mexican government has refused to recognize the changes, so we found all of the maps of Chiapas to be useless. Alex and I usually traveled to the microclinics unescorted. However, it seemed that every time we were lost we ran into Zapatistas walking down the road who showed us the way, or a pickup full of Zapatistas would happen by and give us a lift.

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Due to the sensitive nature of this topic and given that the research was conducted in a militarized zone, I was faced with the formidable task of assuring what I publish does not pose a threat to the Zapatistas while still meeting the academic requirements for completion of my Master's thesis. I believe I was able to achieve this balance. However, several hundred pages of research was edited from this thesis and reserved solely for the use of the Zapatistas due to safety and confidentiality issues. It is my understanding that this work may provide the most comprehensive evaluation of the Oventic caracole healthcare system that has been completed to date. It is my hope that this knowledge will serve as a baseline for future work in the region and contribute to a better understanding of the Zapatista struggle. This research may be of value to medical professionals, humanitarian groups, aid organizations, and non-governmental organizations that are working in solidarity with the Zapatistas on healthcare, training, education, cooperatives, and supply issues. Most importantly, this research will fulfill the request of the Zapatistas in providing them with an objective and comprehensive evaluation and study of the existing healthcare system in the Oventic caracole.

Communication with the microclinics was very limited. A few years ago the only communication was by short wave radio so on my first three trips to Chiapas the health promoters rarely knew we were arriving. They seemed unconcerned about getting visitors but I felt awkward imposing when they did not have any notice. By 2008 several of our Zapatista escorts and microclinics had cell phones. This improved mode of communication helped us time our visits a little better and was a courtesy to the health promoters who were expecting us.

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# CHAPTER 3

# THEORETICAL APPROACH

Using a political ecology model, I examine the historical and current political, social, cultural, environmental, economic, and power processes of globalization and militarization in Chiapas, Mexico. The political ecology theoretical approach addresses ways in which political power and violence are used to ensure that governments acquire and maintain control of valuable environmental resources while the people who rely on these resources are excluded. This work examines the effects of these forces on Indigenous people and the emergence of the Zapatista resistance. Specifically focusing on the establishment of healthcare in Zapatista autonomous zones, I examine how the Zapatistas have responded and adapted to these challenges and the impact of globalization, neoliberal politics, and civilian targeted warfare on health and healthcare in Chiapas.

## The Emergence of Political Ecology Theory

In the 1960s biological anthropology united evolution with ecology and addressed adaptation as a mechanism of human change. Soon anthropological studies expanded to examine biocultural responses to harsh climates and physical environments as well as biological factors such as nutrition and disease. The results of this research revealed that while humans showed significant evidence of biological plasticity, they developed only minimal genetic

adaptations. While continuing to examine physical factors, researchers turned their attention to social and economic issues – addressing nutrition, land tenure, living conditions, psychosocial stress, poverty, and disease. Humans continued to be viewed as passive actors and relatively little consideration was given to how humans impacted their environments. Research began to concentrate on "modernization" and how traditional groups of people remained essentially unchanged while other groups embraced more modern life ways.

Throughout the 1960s and 1970s Andre Gunder-Frank's dependency theory and Immanuel Wallerstein's world systems theory became dominant paradigms. Dependency theory attempted to explain the persistent poverty of poor countries as an historical condition in which rich countries export the resources of poor countries, manufacture products, and then sell them back at substantial profits. Similar to dependency theory, Wallerstein described how the historical rise of modern capitalism influenced nation-state relationships. Wallerstein posited that industrialized core countries dominate the world system politically and economically by exploiting resources, including raw materials and labor, from undeveloped periphery and semi-periphery countries thus increasing expansion of the core. In both theories poor nation-states shape their economic structures to meet the demands of rich capitalist nations. The success of rich nation-states essentially requires the failure of poor nation-states (Greenberg and Park 1994; Milton 1996; Schultz and Lavenda 2001). World systems theory was criticized for focusing on politics and economics while omitting culture and social systems. By the 1980s research began to address the

effects of non-technical forces such economic and political impacts on the environment. Finally political ecology emerged from these and other theories and in response to concerns that previous environmental studies neglected to include social, economic and political issues. Drawing from the fields of geography, human ecology and political economy, political ecology addressed issues of history, ecology, culture, politics, power, natural resources, disease, land tenure, development, economics, and law (Greenberg and Park 1994).

While this study primarily employs a political ecology theoretical approach to address issues of the environment, culture and politics, I also draw upon some aspects of Wallerstein's world systems theory as a contribution to a broader understanding of the dynamics of globalization, capitalism, and social oppression experienced by Indigenous populations.

**Political Ecology**

Political ecology can be defined as a theory that "examines how people negotiate, cooperate, or fight over the access, control, use and character of the Earth's environmental resources with a strong eye to the historical regional and ecological context" (Kull 2004:22). Contemporary political ecology is expanding to encompass a deeper understanding of humans in ecosystems. The paradigm is increasingly focusing on locally based studies of people and how they interact with their immediate environment as well as internationally and globally. Special emphasis is being placed on the loss livelihoods due to the loss of land and other resources. Bryant and Sinéad (1997) posit that the costs and benefits of environmental capitol are unequally distributed and have an effect on societies,

cultures, economics, and politics. Ultimately this unequal distribution either increases or decreases existing power structures. The group that receives the high-end distribution of resources is likely to benefit politically and economically while the other group is likely to experience economics loses, poverty, and their political voice (Bryant and Sinéad 1997).

Similarly according to Carol Crumley political ecology examines the positive and negative political influences of capitalism, local politics, and nation-states on landscapes and environments and acknowledges that responses to environmental issues can include social activism, resistance, and even rebellion as transformers of the environment. Furthermore, what is viewed as positive to one group frequently clashes with the objectives of other groups; so environmental change and adjustments often create social and political conflicts (Crumley 2001).

Militarization and violence are important components of contemporary global political ecology. In "Ecological Politics, Violence and the Theme of Empire," Simon Dolby (2004) explains that violence frequently erupts when states attempt to control resources. He cites conflicts in South America and the Mid-East as having a direct relationship to petroleum resources. Violence may take the shape of guerilla warfare, outright war, or grass roots resistance from people affected by the destruction or domination of their ecosystems and livelihoods. Dolby also charges that U.S. imperialism and the war in Iraq are directly linked to the acquisition of oil and other resources in the Middle East (Dolby 2004).

Thomas Leatherman (2005) argues that political ecology is essential in understanding global social and economic inequalities that are resulting in

increased social conflict, violence, environmental degradation, food insecurities, and population displacement in poor countries. Leatherman also notes the escalating rates of people suffering from inadequate nutrition, illness, disease, and generally poor health are primarily due to "unequal and unjust" access to resources (Leatherman 2005). Political ecology theory serves to explain the interconnection between globalization, poverty, health, and the environment (Leatherman 2005).

Political ecology has also expanded to encompass medical concerns such as pharmaceuticals, medical technology, traditional medicine, disease, and reproduction. Issues and diseases such as malnutrition, infant and maternal mortality, malaria, tuberculosis, and HIV/AIDS are of special concern. Overpopulation is becoming increasingly politicized as policies are being created regarding contraception, sterilization and family size (Goldman and Schurman 2000).

**Feminist Political Ecology**

Feminist political ecology addresses the unique inequalities faced by women. As an extension of political ecology, feminist political ecology examines the connections between the oppression of women and the oppression of nature, addressing ways in which "gender interacts with class, race, culture and national identity to shape the experience of and interest in the environment" (Scott 2003:45). While political ecology includes class and ethnicity in regard to the unequal distribution, access and control of resources, feminist political ecology includes gender as a critical element. The relationship between political ecology

and gender exposes the unique inequities faced by women and contributes a critical and often overlooked perspective to environmental issues.

Ecofeminists argue that gender dictates the control and access to resources and that Western culture, capitalism, and patriarchal institutions have long subordinated women. Traditionally women, especially poor and rural women, depend on men for access and entitlement to resources, leaving them with essentially no political voice. Increasing privatization and changes in land tenure are also significantly decreasing women's access to communally held resources, affecting women's ability to forge sustainable livelihoods for herself and her children (Rocheleau et al. 1996). Feminist political ecology assures that gender is taken into consideration in environmental issues.

Current economic conditions in third world countries are having dramatic affects on traditional family structures and women. For example, as communal and family lands are lost to privatization, development and globalization, families lose their ability to maintain sustainable livelihoods. Small subsistence farmers are forced to produce cash crops, which are exported to industrialized countries. In turn, the farmers resort to wage labor to pay for food and other necessities, migrating out of their communities and leaving women behind to care for the land and their families. Since women have essentially no entitlement or recognized access to land, they are politically voiceless and thus powerless to control land resources.

**Political Ecology Critics**

Certainly political ecology has critics. Andrew Vayda and Bradley Walters offer a

critical analysis of political ecology in "Against Political Ecology." Vayda and Walters (1999) argue that political ecology simply does not address ecology and that political issues are always of primary concern. Furthermore, they assert that the effects of politics on ecology are never truly addressed (Vayda and Walters 1999). I argue that ecology and politics are equally represented in political ecology theory. For example, the traditional healing methods employed by the Zapatistas are wholly dependent upon the preservation and sustainability of hundreds of plants in the Chiapas highlands and jungles. The Zapatista's interaction with the environment is focused on sustainable access to life saving, medicinal resources. The politically motivated Mexican military seeks to destroy the environment in Zapatista zones for the sole purpose of forcing Indigenous communities out of the region and acquiring the resources for development and profit. The Zapatistas, through their own need for survival depend upon the environment for life and thus protect it. The struggle between the politics of development and control of resources verses the human need for a sustainable environment exemplifies political ecology theory.

Feminist political ecology is also subject to criticism. Janet Biehl in "Finding Our Way, Rethinking Eco-Feminist Politics," argues that ecofeminist politics are irrational and that the discipline biologizes and essentializes women's nurturing and care-giving qualities while discounting scientific and cultural issues just because men advocate them. According to Biehl ecofeminist politics exclude men from having any ethical or caring relationship with the environment (Roussopoulos 1993). I assert that political ecology can indeed

address the interactions and roles of men and women and the environment equitably. Feminist political ecology was essential to this study in recognizing that Zapatista men and women participate equally in the preservation of the environment and the exploitation of resources in Chiapas as well as holding positions as health promoters and leaders in the rebellion. Feminist political ecology is essential in providing a forum in which women's contributions and roles can be given value commensurate to those of men.

**The Lacandon Jungle / Montes Azules Bio Reserve**

The interaction of neoliberal politics, globalization, and the poor is exemplified in the struggle for the Lacandon Jungle and the Motes Azules Bio Reserve that is occurring as I write this research. Indigenous descendents of the ancient Mayans have lived in the Lacandon jungle, the third most biologically diverse rain forest in the world, for thousands of years. Once a vast rain forest covering over 200,000 square miles, only 10 percent of the forest remains. The 61,874-hectare Montes Azules Bio Reserve and Classic Maya archeological sites of Yazchilan and Bonampak lie within the Lacandon jungle (Weinberg 2000). When the Mexican government created the reserve in 1978 over half of the Lacandon forest was preserved (MacLean 2003). Montes Azules shelters over 30% of all of Mexico's bird species, 25% of Mexico's animal species, 50 types of orchids, 1,500 tree species, and over 300 species of diurnal butterflies (Weinberg 2000). The U.N. Program on the Environment calls the area one of the most important "global ecological landmarks on the planet" (MacLean 2003).

The Lacandon jungle is also home to at least 142 Indigenous communities. In 1972 the Mexican government granted the legal ownership of 80% of the forest to 66 Mayan families. Settlers in the community of Nuevo San Gregorio were among those encouraged to move to the region to relieve land pressure in the highlands, but eight years later when the government sponsored Montes Azules reserve was developed they were called squatters. Additionally, thousands of displaced Zapatistas fleeing the Mexican military have migrated to the jungle since the 1994 resistance (MacLean 2003).

Conservation International, a U.S. based environmental conservation group, identifies the Lacandon jungle as a "global diversity hot spot" (MacLean 2003). Recently, the group began lobbying to create an ecological reserve in the jungle. They cite the environmental impact of slash and burn farming and deforestation from Indigenous wood gathering as a reason to intervene and save the forest. Conservation International has forged agreements with the Mexican government to preserve the area while generating income through ecotourism in the Lacandon and surrounding areas. Plans are in place to construct elite, exclusive resorts, golf courses, and a water park. The World Wildlife Fund has joined Conservation International in pressuring the Mexican government to evict the settlers. Additionally, the U.S. Agency for International Development funded a conservation campaign for Montes Azules that hinges on the eviction of the settlers. Logistical and financial supporters and contributors to these groups include Starbucks, Pulsar Group, Chiquita, and Exxon who all have investments in the region (MacLean 2003).

The Mexican government views the Mayans as "squatters" and embraces the preserve and ecotourism as a solution to a long-standing problem. They have responded to pressure from the World Wildlife Fund and Conservation International with increased militarization and intensification of civilian targeted warfare toward Indigenous communities. In several incidents, paramilitaries have threatened villagers with violence while government officials passively stood by and watched. In one case, paramilitaries armed with pistols and machetes approached the community of Nuevo San Rafael and demanded the villagers leave. They were accompanied by a Mexican Navy patrol boat and two representatives from the Federal Agency for the Protection of the Environment (PROFEPA). Later government officials stated that the presence of PROFEPA and the Navy boat were merely a coincidence (Weinberg 2000). Mexican soldiers are stationed in key locations throughout the region and make regular patrols and surveillance flights over the communities. The primary military base for the Lacandon region is called San Quentin. The U.S. reportedly provided satellite images of the forests to the Mexican government (MacLean 2003).

While some Indigenous families and small communities have been forcefully removed, the Mexican government has made deals with other settlers to relocate on new land outside of the reserve. Unfortunately, the government has not kept its promises. Six families who agreed to move were relocated to a temporary camp outside the reserve, and then waited almost a year for their land. Finally, the group gave up and returned to Montes Azules (MacLean 2003).

Critics argue that Conservation International is nothing more than a Trojan horse whose real objective is to gain access to the forest to exploit its natural resources. Exxon, Pulsar Group, Starbucks, and Chiquita are backing the campaign financially and fueling skepticism that the settlers are merely an obstruction to plans to exploit the forest for its pharmaceuticals, coffee, fruit, timber, genetic resources, oil, and natural gas reserves (MacLean 2003). Others argue that it is simply a military project to suppress the Zapatista movement and leave the campesinos permanently landless (Weinberg 2000).

Communities living in the region argue that the government and environmental groups are making false claims about the sources of environmental degradation in the forest. Indigenous representatives charge that the government-sanctioned exploitation of resources is to blame. They argue the years of logging, road building, oil exploration, bioprospecting, cattle ranching, military bases, and commercial land use are responsible for the deforestation, pollution, and the loss of traditional Indigenous medicinal plants. Community leader Nicolas Morales Pale' argues Indigenous people have not used slash and burn agriculture for 10 years. Instead, they have developed a sustainable crop rotation method that preserves the forest. Furthermore, the communities have made agreements not to clear the forest and to grow only traditional, native corn varieties. Pale' pledges to fight and says, "We will shed our blood on this land...we won't leave alive" (Weinberg 2000). Sophisticated politically, the communities are demanding constitutional recognition of Indigenous rights under Convention 169 of the International Labor Organization

and the San Andres Accords. They have also filed a formal protest with the Inter-American Commission on Human Rights.

Most of the communities in the Lacandon forest are Zapatista support bases while others are unarmed and not formally part of the resistance. On December 29, 2003, Subcomandante Marco pledged to defend the Indigenous land rights in the Lacandon forest and stated that rebels are prepared to resist all government plans for the expulsion of Indigenous communities. Marcos further stated, "There will not be a peaceful expulsion" (Weinberg 2000).

The situation in the Lacandon jungle is a harrowing example of the neoliberal ideology. While international corporations and supposed environmental organizations invade the ancestral homelands of thousands of Indigenous people, children are dying of preventable and curable diseases. Intensive militarization prevents families from accessing health care, going to school, or carrying on their daily routines. Men are murdered, assassinated in extrajudicial executions, or simply disappear. Entire communities are displaced, and crops go unharvested while women and children suffer from malnutrition. The elegant new resorts, golf courses, water parks, and eco-reserves will surely have water, electricity, and toilets while Indigenous communities will continue to go hungry and wait for electricity, clean water, and sanitation facilities.

The political ecology theoretical approach coincides well with the neoliberal political and economic model. All of the components of neoliberal economics and politics are clearly at work in Chiapas. Neoliberal economics promote the development and expansion of the global market while cutting back on government

programs that do not favor business (Holloway1998). Neoliberalism seeks to increase free trade by removing trade quotas and tariffs; thus the North American Free Trade Agreement. Privatization is also a key element of neoliberalism, calling for the sale of public assets to the private sector as in the case of the maquiladoras and Plan Puebla Panama. Indigenous communities located in these areas of development become casualties of neoliberalism in concert with the environment as traditional lands, communities, social programs, natural resources, and human rights are cast aside in favor of projects that will benefit the state and the rich...leaving thousands and perhaps millions of people living in poverty, landless, and hungry.

## CHAPTER 4

## THE ZAPATISTA OVENTIC CARACOLE HEALTHCARE SYSTEM

Healthcare in Chiapas has been transformed by the Zapatistas. Thousands of Indigenous people finally have access to safe, quality medical care, many for the first time in their lives. This chapter provides an overview of the extensive Oventic caracole Healthcare system including the Oventic Clinic and microclinics. While health promoters and patients have endured living in communities that experience sustained civilian target warfare, the microclinic system continues to expand to meet the needs of the Zapatistas. The growing success of community education, women's health clinics, traditional and allopathic healing, vaccination programs, and health promoter training are significantly contributing to the autonomy of the Zapatista healthcare system.

Five Zapatista caracoles are located in the mountains, the north, the lowlands, and the jungles of Chiapas. Each caracole operates its own healthcare system free of Mexican government involvement, control, aid, or funding. My research was conducted exlusively in the Oventic caracole which is located in the mountain region and encompasses seven Zapatista autonomous municipalities including: San Andrés Sakamchen de los Pobres, San Juan de la Libertad, Magdalena de las Paz, San Pedro Polhó, 16th de Febrero, Santa Catarina, and San Juan Cancuc.

Three hundred and seven communities and 28 political regions are located in this caracole. In 2004 the population of the Oventic caracole was approximately 31,000 people (OSIMECH 2004); however, by 2009 the Oventic Junta de Buen Gobierno indicated the population had increased by thousands, but no current statistics were available at the time of this study. Tzotzil, Tzeltal, and Spanish are the primary languages spoken in the region (OSIMECH 2004).

The Zapatista health care system master plan is centered around one large, central, medical center in Oventic and 11 smaller microclinics strategically located in remote areas throughout the caracole. The Oventic Clinic serves as the base for all major medical operations in the caracole and provides the most sophisticated patient care and medical resources in the system. Additionally, the Oventic Clinic coordinates the activities of the rural microclinics, as well as overseeing system wide vaccination programs, acquisition and distribution of medical supplies and pharmaceuticals, health promoter education, finances, and all other aspects of healthcare operations in the caracole.

**The Oventic Clinic - La Guadalupana de Oventic**

The central Oventic Clinic (La Guadalupana de Oventic) serves the Zapatista autonomous municipalities of San Andrés Sakamchen de los Pobres as well as the territories and municipalities of San Andrés Larrainzar and San Juan Chamula. In addition to the Oventic Clinic three casas de salud serve the communities of Chamula, Nicholas Ruiz, and Zitala. The clinic is situated within five political regions including Emiliano Zapata, Francisco Villa, San Juan Bautista, San Pedro, and Monterrey. Each microclinic in turn serves a specific geographical territory.

Twenty-four of the communities served by this clinic are accessible by vehicle and 19 are only accessible by walking (OSIMECH 2004).

Like all visitors to Oventic, Alex and I are always greeted at the entrance by one or two unarmed, masked Zapatista gatekeepers. After showing our passports and documents from the Junta de Buen Gobierno we pass through a small white garden gate, which is essentially, the only barrier to entering the community. Oventic is surrounded by lush forests and towering mountains where low lying clouds hover over the valley creating dense fog and a misty, thick feeling in the air. Down the hill from the entrance children shoot hoops on a huge basketball court day and night; I am always struck by the fact that I never see children at play in Chiapas except in Zapatista communities. All the annual Zapatista celebrations, school graduations, and political gatherings are held at the basketball court and surrounding open-air auditorium. Here I have witnessed the EZLN emerge from the trees and ride in on horseback at midnight, listened to revolutionary speeches from Zapatista leaders, and watched families and soldiers dance and sing.

My son and I have visited Oventic more than 50 times over the past several years and we are always warmly welcomed and enjoy returning to familiar faces and friends. Situated in the center of an insurgent base, the Oventic Clinic is surrounded by a cluster of small buildings including three or four women's cooperatives, a couple of small stores, a coffee and honey cooperative, a tiny lunch counter, and the official Oventic store and cafe. The clinic is cheerful and welcoming with gigantic murals of Zapatistas, snails, and maize adorning the outside of the building. Two sets of double doors mark the clinic entrance and are opened wide as

patients pass freely in and out of the clinic. Roaring revolutionary Zapatista music competes with the sounds of hammers and saws as clinic construction and renovation seem to be perpetually underway. A couple of artists add final touches to a new mural on the side of the building while children play nearby. Patients and families sit in the shade on long, colorful benches while waiting their turn to check in with a health promoter. Last year a pair of Weimeranian puppies showed up in Oventic and they relentlessly chase the kids around the clinic yard and try to steal their toys. Three bandana-clad Zapatistas drop off a pile of 2x4s for the guys with the hammers. Parked in front of the clinic, a shiny new ambulance draws the attention of passersby and one of the health promoters gives tours of the patient compartment. It seems that no one walks past the clinic without stopping for a chat or getting a cup of coffee from the health promoter kitchen.

Construction of the Oventic Clinic began in 1991 and was completed in 1992, a full two years before the Zapatista rebellion. Over 400 volunteers from all of the surrounding communities worked every day to build the clinic, which was funded in part by foreign donations. During construction the area was under constant military threat with helicopters, low flying airplanes, military personnel carriers, tanks, and soldiers swarming the region. Some days the women blocked the road to Oventic with their bodies in order to keep the army out. The Oventic clinic coordinators recall that it was a very difficult struggle to establish this clinic but the people used "everything they had in their hearts," to make the clinic a place where everyone would be welcome to come for medical treatment (interview with three health promoters, August 4, 2005, interview with a clinic coordinator, January 5, 2007).

This type of grass roots cooperation and organizing is taking place throughout the Zapatista autonomous zones. Entire communities come together to build schools, clinics, roads, water and sewage systems, and to plant community gardens. It is the way of the Zapatistas, to build everything together...men and women side-by-side struggling together to create a new society of peace, respect, and dignity...they call it "Zapatismo."

The Oventic Clinic is a two story concrete block building that houses a community clinic and hospital on the ground floor with health promoter living quarters and training rooms on the second floor. Every time I visit the clinic some type of construction, expansion, or other improvements are underway on the building. Most recently a new surgical unit with two or three operating suites was scheduled for completion by the summer of 2009. The Oventic Clinic is especially significant because it houses an actual hospital with three adult in-patient hospitalization rooms and six patient beds, and one in-patient pediatric hospital room with two patient beds. Additionally, the clinic has two examination and treatment rooms, consultation rooms, an emergency room, traditional and allopathic pharmacies, an herbal laboratory, a women's health examination and treatment area, a dentistry suite, three latrines, showers, medical equipment sterilization facilities, refrigeration for vaccines, storage areas for medical equipment, non-reusable supplies and pharmaceuticals, and an office with computer technology. The clinic also houses a clinical laboratory where health promoters analyze blood, urine, and other patient chemistry profiles and test for conditions such as asthma, malaria, diabetes, and pregnancy. Oventic has the only

ophthalmology and optometry clinic in the region. They have a small inventory of eyeglasses and the capability of grinding their own lenses.

The health promoters at the Oventic Clinic provide the most sophisticated healthcare services in the region including general consultations, emergency care, gynecology, obstetrics, general women's health consultations and treatment, optometry, dentistry, minor surgery, vaccinations, trauma care, and in-patient hospitalization. The clinic is staffed by a minimum of six health promoters 24 hours a day. The Oventic clinic treated 8,214 patients in 2004, almost 23 patients per day. General consultations accounted for 5,084 patient visits, 216 people were hospitalized, and 625 pregnant women received prenatal services (Mexico Solidarity Network 2004). In January of 2009 the clinic coordinators estimated the clinic was treating more than 90 patients every day (interview with two clinic coordinators, January 2, 2009).

**The Microclinic System**

The microclinics are pivotal to the success of the Zapatista healthcare system. The central Oventic Clinic and hospital is surrounded by eleven smaller microclinics located throughout the Zapatista autonomous zones. In turn, each microclinic is situated at the center of small clusters of communities. This strategy allows people to pass relatively freely to and from the microclinic and decreases the risk associated with traveling long distances through civilian targeted warfare zones. One health promoter described the microclinic system as a snail; the ancient Mayan way of viewing everything and everyone as interconnected and every microclinic is vital to the survival of the others. The microclinic system is designed to ensure that

every person living in rural Chiapas has unhindered and affordable access to good quality healthcare in or near their own communities. It is working and patients are no longer refused care by Mestizo doctors and nurses nor left to die simply because they are Indigenous or poor. Instead they are welcomed and treated with dignity and respect by Zapatista health promoters. The eleven microclinics are located in the communities of Agua de León, Candelaria, Chankolom, 16th de Febrero, Estación, Magdalena, Polhó, San Juan Cancuc, Santa Catarina, Tenejapa, and Zinacantán.

The Zapatista healthcare system provides medical care to everyone regardless of race, ethnicity, gender, or political affiliation. A member of the Junta de Buen Gobierno told me, "Every person deserves to have good health, even if they are against our organization they are still our brothers and our sisters," (interview with the Junta de Buen Gobierno, December 31, 2007). Healthcare services are free for Zapatistas and Zapatista supporters. Journalists, visitors, and members of opposition political parties such as the National Action Party (PAN), the Party of the Democratic Revolution (PRD), and the Institutional Revolutionary Party (PRI) are charged a nominal fee to cover the cost of pharmaceuticals and medical supplies. Small paper identification cards called fiches are issued to all Zapatistas by the community authorities. The fiches bear the name of the microclinic community, a special symbol, and the signatures of the authorities. Presentation of the fiche identifies the bearer as a Zapatista and guarantees free health care at any microclinic. I had never seen or heard of the fiches until 2008 when I observed several health promoters printing little tickets at the microclinic in Estación. When I inquired what they were doing they told me about the system and then honored me

by presenting me with my own fiche (interview with three health promoters, July 21, 2008).

Community members are essentially the benefactors as well as the beneficiaries of the microclinics and the health promoters. They build the microclinics with their own hands, contribute money for pharmaceuticals and medical supplies, and provide basic necessities for the health promoters. Even people who are completely opposed to the Zapatista struggle seek healthcare at the Zapatista microclinics rather than the government clinics. The health promoters told me it is a very good sign that people can overcome prejudices...because once they enter the microclinic and they are treated with dignity, they may in turn treat the Zapatistas with respect (interview with a health promoter, December 2008). I witnessed this several times at a microclinic located in a highly paramilitarized zone. In one incident a man identified as a PRI member came to the microclinic with a machete wound, he was angry and impatient when a female health promoter came to escort him to the consultation room. When he left with a bandaged arm and a supply of antibiotics, he took the health promoter's hand and thanked her. Perhaps the microclinics will serve a purpose beyond health care; perhaps this may in some small way transcend hundreds of years of racism, prejudice, and aggression.

Many of the microclinics are secluded deep in the Chiapas highlands while others are situated in the heart of Indigenous communities. In contrast to the dungy government clinics, the microclinic buildings are cheerful and brightly painted with murals of Zapatistas, flowers, snails, and other symbols of the resistance. Like the Oventic Clinic, the microclinics are the centers of community, spaces where patients

are nurtured and cared for. The atmosphere is inviting and people who might otherwise be reluctant to come to the microclinic are beginning to view it as a place they can trust; not like the former days when they were humiliated at the government clinics. Patients arrive at all times of the day or night and rarely have to wait to be seen. They are warmly greeted by Indigenous health promoters who speak Indigenous languages and dress in traditional clothing.

When a new patient arrives at the microclinic a health promoter escorts them to a consultation room where they sit together at a small desk and discuss the reason for the visit. The patient's family is welcome to join them. The health promoter takes notes and follows a checklist of diagnostic questions. The interview is quite comprehensive and normally includes dialogue regarding family health history, stress, nutrition, and lifestyle. Height and weight are recorded and the health promoter inquires about the patient's living conditions such as access to clean water, sanitation facilities, and whether or not cooking fires are used inside the family home. The health promoter takes the patient's vital signs and does a physical assessment, usually on an examination table in the same room. In larger microclinics the patient may be escorted to the women's health room or other specialty examination room. Since many patients have never been to a clinic before, or have had bad experiences at government clinics, every step of the examination and treatment procedure is carefully explained. Patients are given a voice in their own treatment and consulted about what course of action they wish to take. When available they are offered the option of using traditional medicine or allopathic pharmaceuticals; often the health promoters use a combination of the two. After the

patient has been treated, they return to the consultation room and the health promoter writes take-home instructions, which might include medication dosages, or perhaps wellness reminders such as hand washing, water purification or other sanitation practices. Grass roots community healthcare education is a hallmark of the Zapatista healthcare system. Health promoters try to make a point of discussing wellness and healthy lifestyles with all of the patients and families who visit the microclinic. This is usually accomplished with the aid of hand painted murals or posters that don the walls of the microclinics. A holistic approach to patient care is encouraged and seems to have a ripple effect on the patient's family and on the community. Counseling even one patient on the necessity of boiling drinking water can change the habits and health of an entire family. That in turn could prevent the spread of disease or parasites to other community members.

According to a 2004 OSIMECH report, the most common medical conditions treated in the Oventic caracole in order of frequency are respiratory infections, gastrointestinal infections and gastritis, malnutrition, skins infections and genitourinary infections. Twenty-five percent of the communities in this caracole have cases of tuberculosis and 30 percent of the communities have cases of malaria. The most common causes of death in the Oventic caracole in order of frequency are respiratory infections, gastrointestinal infections, malnutrition, complications of pregnancy, cancer, and accidents. In 2004 the maternal mortality rate in the Oventic caracole was141 per 100,000 and the infant mortality rate were 66.3 per thousand (OSIMECH 2004). In industrialized countries, the average maternal mortality rate is 10 deaths per 100,000 births. In Mexico the maternal mortality rate is 51 deaths

per 100,000 births and in the state of Chiapas the rate is 117 deaths per 100,000 births. Between 1999 and 2002 the highest number of maternal deaths in Chiapas occurred in Indigenous highland and jungle communities (CIEPAC 2001). Clearly there is an urgent need for comprehensive women's healthcare reform throughout Mexico and especially in Chiapas, but these issues continue to be ignored by the government.

**Zapatista Health Promoters and Clinic Coordinators**

Zapatista clinic coordinators and health promoters are the heart of the healthcare system. Clinic coordinators oversee the day-to-day operations of the microclinics and many coordinators also double as health promoters. Community members select the health promoters and everyone must be in agreement on the choice. Although the positions are voluntary and health promoters do not receive any financial compensation, it is considered an honor to serve the Zapatista struggle in this way. In 2004 over 400 health promoters were working in the Oventic caracole system amounting to approximately one health promoter for every 85 people in the region (OSIMECH 2004). In 2009 the Junta de Buen Gobierno reported the number had at least doubled; however, no exact statistics were available at the time of this study. About two thirds of the health promoters are men; however, the number of women health promoters is increasing. In 2009 the age of the health promoters ranged from 12 to 56 years old. A health promoter named Fernando explained that the health promoters have many different personalities, skill levels, and age differences, but they all get along because they are committed to learning and helping one another. He also discussed the importance of women's

participation in the struggle and how Zapatista women work beside men as equals (interview with Fernando and other health promoters, January 7, 2009). This was evidenced over and over during my visits to Chiapas. Health promoters treated one another with respect and dignity. They work together, struggle together, and succeed together, says Fernando (interview with Fernando, January 7, 2009).

Health promoters live in communities spread throughout the caracole so some promoters travel long distances to work while others live in or near the microclinic community. Work rotations range from three to eight days on duty and the health promoters live at the microclinic during their shifts. In one case a group of health promoters changed from working three-day rotations to seven-day rotations in order to decrease the number of times they had to travel through an intensely occupied paramilitary region. Additionally, some health promoters work longer rotations to reduce the cost of travel to and from the microclinc. On average, most health promoters work a schedule of three to four day rotations (interview with five health promoters, July 2005).

Health promoters are provided with a dormitory and kitchen during their rotation and typically all of the promoters share one or two rooms with single beds constructed of concrete blocks and a piece of plywood. They prepare meals over traditional stone or cement fireplaces inside the dormitory kitchen. Some of the new microclinics do not have dormitories yet so health promoters sleep in the microclinic. All of the kitchens I visited were in need of very basic supplies such as pots, kettles, soup bowls, spoons, and coffee cups; the food shelves were consistently almost bare.

The personal needs of health promoters are met in various ways. Usually community members provide food, clothing, and funds for the cost of travel to and from the microclinics. This represents a return to the traditional communal ways of the Maya. However, support varies greatly based on the resources of each community and in many cases the health promoters simply do without. This may mean having no shoes to wear, no warm blanket, no change of clothes, and often going hungry. Some health promoters try to farm or find other work between microclinic rotations in order to support their families but it is very difficult to balance two jobs. All of the health promoters appear to share the philosophy of solidarity and one health promoter summed it up in this way: "Our lives are very difficult but as Zapatistas we believe we can overcome the challenges. We often go hungry because there is not enough food in the community, but the words of encouragement from the patients and the community fulfill us" (interview with a health promoter, August 3, 2005). In spite of the many hardships, every health promoter expressed dedication to the Zapatista struggle and believed their "small sacrifices" were insignificant compared to the suffering people had endured when there was no health care. They express pride in their work and feel honored to have the chance to contribute to the health and well being of their communities. Several health promoters said that members of the community also suffered because they support the health promoters by sharing their food, clothing, and other necessities. Although the health promoters suffer many hardships, they are surely the most important aspect of the microclinic system. Every minute of their daily routine is spent in service to the Zapatista struggle and the reputations of the health

promoters closely correlate to the reputations of the microclinics. Because they are chosen by their communities the health promoters are well known, respected, and trusted by their patients and their communities. Almost all of the health promoters are bilingual and some are trilingual.

Sometimes health promoters have, however, chosen to leave the microclinics. I did not have an opportunity to speak with any past health promoters but I was told they occasionally leave because they can no longer support their families and are forced to find wage labor jobs. At least two promoters left to find work across the border in the United States. One promoter who lived in a highly militarized zone was afraid to leave his wife and family alone after hearing that soldiers were threatening to rape the wives of Zapatistas. Several years ago health promoters left because the government spread rumors about the microclinics and the health promoters. One microclinic lost 18 health promoters during that time. However, today the rumors no longer work because the microclinics have proven themselves. One health promoter from Zinacantan told me when people leave it is because being a health promoter is hard and they suffer too much and their families suffer. She said sometimes people simply "lose heart," and must return to their communities to care for their families. No one appears to judge the health promoters who leave. Said one health promoter, "we are all brothers and sisters struggling together" (interviews with two health promoters, August 1, 2005).

**Women's Health Program**

The Zapatista movement, according to Subcomandante Marcos, is for all human beings; all Indigenous peoples, the poor, women, children, and any person

who is excluded, marginalized, or oppressed (Marcos 2001b). A few months before the January 1994 occupation of Chiapas, the Zapatista Clandestine Revolutionary Indigenous Committee called together the men, women, and children of the struggle. A woman named Susana came forward to read a document called "The Women's Revolutionary Law." The law demanded rights for Indigenous women within the Zapatista struggle, including the right for women to take part in the revolution and to hold positions of authority and military rank, the right to receive fair pay for their work, the right to have an active voice in community politics and to hold office, the right for themselves and their children to have access to health care and nutrition, the right to receive an education, the right to choose marriage partners and not to be forced into marriage, the right to decide the number of children they will have, the right to be free of physical violence and rape, and that such actions will be punished, and the right to benefit equally from all the laws established within the revolution. Susana's message was translated throughout the crowd in Spanish, Tzotzil, and Tzeltal. When Susan finished, women were singing, men were mumbling, and the room fell silent as the law was unanimously passed. Later Subcomandante Marcos wrote, "The first EZLN uprising was in March 1993, and it was headed up by the Zapatista women. There were no casualties and they were victorious!" (Holloway and Pelaez 1998:76).

Women's healthcare has been at the forefront of the Zapatista agenda since the beginning, and the first official women's health program was established in Oventic in 1998. Today Oventic has a rapidly expanding women's healthcare practice which offers annual gynecological exams, pap tests, prenatal care,

childbirth, sexual health, family planning, nutrition, and treatment for common genitourinary infections and sexually transmitted diseases. All of the microclinics have varying degrees of women's health services and most have at least one health promoter who specializes in women's health. In addition to medical care, women learn about wellness, healthy life styles, and the importance of regular checkups. Health promoters refer women to a trusted women's clinic in San Cristóbal de Las Casas when they are unable to diagnose or provide certain treatments in Oventic. They also send pap and other test samples to the same clinic for reading (interviews with 3 health promoters, July 30, 2006).

I met with a health promoter named Katiana from the Oventic Clinic several times during the course of this research. Katiana is one of many health promoters who has received special training in women's health. She lives at the clinic full time with her husband, who is also a health promter, and their little boy. Katiana speaks candidly about women't rights and healthcare including issues of sexually transmitted diseases and sexual relations. Katiana explained that occasionally women come to the Oventic Clinic for chilbirth; however, 94% of births occur at home with the assistance of one of the 31 parteras who work in the regon. About 5% of women give birth at home without medical assistance (OSIMECH 2004). The microclinic statistics are simliar to those of Oventic, demonstrating that most births in this caracole occur in the mother's home in the care of parteras. If a partera encounters difficulties during a delivery the mother is taken to the Oventic Clinic for treatment or transported directly to the nearest hosptial. Katiana explained that because Oventic does not have the facilities to perform caesarean sections yet,

women who require more advanced care are transported via the Zapatista ambulance to a hospital in San Cristòbal de Las Casas. In the past women often died before they could reach a hospital with surgical facilities and government ambulances refused to respond to Oventic (interviews with Katiana, August 2005, July 2006, January 2009).

The Oventic Clinic and most microclinics offer birth control counseling and provide oral contraceptives, condoms, intrauterine devices (IUDs), Depo Provera injections, and natural contraceptive techniques such as abstinence and the rhythm method. Patients are told the rhythm method is not reliable. Women who wish to use traditional Indigenous methods of birth control are referred to community iloletiks and curanderos[4] who have knowledge of plants and herbs specifically for that purpose. Health promoters spend time with women and teach them how to use birth control, for example specifically how to properly use condoms or how to insert IUD's. Katiana says many women want to use birth control but the husbands of non-Zapatista women often forbid it. In my interview with Katiana she reminds me of the Zapatista "Women's Revolutionary Law," which declares that women have the right to decide how many children they will have and so Zapatista women are free to use contraceptives. Katiana also notes that contraceptives are an option and are never forced upon women as they are in the government clinics (interview with Katiana, August 2005, July 2006, January 2009).

Regarding the sensitve issue of abortion, Katiana says that Zapatistas do not officially endorse nor condemn abortion. She was very clear that abortions are not

[4] Iloletiks and Curanderos are traditional Indigenous healers.

performed at the Oventic Clinic or microclinics and said the Zapatistas believe such circumstances are best avoided by education and preventative measures. However, Katiana says that sometimes after a woman has had nine or ten children she may seek an abortion anyway and "sometimes women must to it to themselves." Women who come to the clinic requesting abortions are told of the dangers of abortion and that it is illegal, but Katiana says there are probably some doctors in San Cristóbal de Las Casas who still perform abortions (interview with Katiana, August 4, 2005, December 30, 2008).

Katiana and other health promoters pass their knowledge on to new health promoters who wish to specialize in women's health issues. The Oventic Clinic provides trainees with opportunities to observe examinations and aquire practical experience in women's healhcare. Eventually several women's healthcare specialists will staff every microclinic (interview with Katina, July 2006). Although the women's health program is in desperate need of medical equipment, supplies, contraceptives, and additional training, the program is successfully serving a very important purpose in the system. For the first time women have power over their own bodies and a voice in their own healthcare.

**Allopathic Pharmaceuticals and Traditional Medicine**

The Oventic Clinic and every microclinic in the caracole has an allopathic pharmacy. All of the health promoters receive training in the use of allopathic pharmaceuticals including indications, contraindications, dosages, and side effects. The pharmacies are equipped with wall-to-wall shelves, neatly labeled with dozens of tiny identification tags, treatment indications, and dosages. However, only a

modest inventory of pharmaceuticals is on the shelves. The critical shortage was evidenced during this study when every microclinic in the caracole listed allopathic pharmaceuticals as their top priority need. Acquiring a sufficient inventory to meet the demands of 12 healthcare facilities is a daunting task. Most microclinics have small stores or cooperatives that raise money for the pharmacy and pharmaceuticals are purchased as a line item in the Zapatista healthcare system budget. Pharmaceuticals are also acquired through donations and funding from non-governmental organizations and from various national and international donors (interview with a health promoter, August 13, 2006). Unfortunately this is creating a dependency on resources outside of the Zapatista system and is increasingly detrimental to the autonomy of the healthcare system. There are issues with the donations as well. It is not unusual for clinic coordinators to receive several cases of donated pharmaceuticals only to discover the shipment does not contain needed items or all of the contents are past the expiration date. One afternoon a clinic coordinator showed me a garbage bag full of pills, capsules, and prenatal vitamins that was on its way to the incinerator because all of the medications were expired and useless. The Zapatistas refuse to accept second-class healthcare, so they reject donations of goods that would not be considered for use by other healthcare systems. These are just a few examples of the challenges of acquiring sufficient supplies of pharmaceuticals.

Because the recovery of the use of traditional medicine is still in the early stages, health promoters remain largely dependent upon allopathic pharmaceuticals. In cases of serious illnesses and emergencies, health promoters

tend to employ allopathic pharmaceuticals as the first course of treatment and they are clearly saving lives. However, health promoters complain that patients increasingly come to the microclinics simply asking for a "pill to cure them," regardless of the illness and rejecting alternative traditional methods in many cases (interviews with health promoters, January 5, 2007, January 11, 2009). In spite of substantial efforts to decrease dependency on allopathic pharmaceuticals, their use remains a critical component of the Zapatista healthcare system. Unfortunately, allopathic pharmaceuticals are not available, affordable, or sustainable.

Traditional healing methods are an important link in achieving a healthy and sustainable healthcare system and may be the answer to the allopathic pharmaceutical shortage. Hundreds of years of oppression have resulted in the loss of substantial traditional knowledge, healing methods, natural medicines, and midwifery. The Zapatistas realize the importance of recovering these practices and view this as one of the most essential aspects of a successful, long-term, autonomous healthcare program. They emphasize that traditional healing methods must be incorporated and considered in all treatments at the microclinics. As one woman mentioned, if they go to war again, access to allopathic pharmaceuticals will be impossible, but they can always find what they need in the forests (Ruiz 2005). Chiapas is home to hundreds, perhaps thousands of medicinal plants; however recovering the ancient knowledge of their use is a formidable challenge. Results of one study of traditional healing in the Tenejapa region of Chiapas found that 75% of the people with knowledge of medicinal plants learned from their parents or friends and most traditional medicinal healing knowledge is passed from parents to their

children (Casagrande 2005). Additionally, most people in the study were aware of at least some medicinal plant species and their medicinal uses. This indicates that the passing of knowledge from generation to generation has not been lost. Rather there seems to be a resurgence of enthusiasm and a commitment to recover traditional medicinal knowledge and a desire to put it into practice (Berlin and Berlin 1996:82).

The Zapatistas have developed an intensive training program to recover traditional medicines and healing methods by tapping the knowledge of Indigenous parteras, curanderos, and iloletiks and then passing that knowledge on to health promoters. They are learning to identify and harvest plants as well as the indications and treatment applications for hundreds of medicinal plants. Always aiming toward autonomy, new knowledge is passed on to other health promoters.

The healing energy of plants is useful in curing diseases as well as injuries. Much attention is focused on the sustainability of plant resources through proper spiritual practices and harvesting procedures. For example, before harvesting the plant is asked for forgiveness so it is not frightened as a frightened plant loses medicinal potency because it sends its energy to its roots to hide. Plants that are treated with respect and affection give up part of their energy in order to offer help and cures to the people. Only small pieces of plants are harvested in order to preserve the plant and the health promoters are instructed in both spiritual and sustainable harvesting techniques. Plants are only harvested from seven to ten o'clock in the morning and from four to six o'clock in the afternoon when the plant's energy is at its highest point. Freshly harvested plants are carefully washed, then shade dried and stored in small plastic bottles, boxes, or plastic and paper bags.

Medicines retain their energy and potency for 12 to 18 months (interviews with nine health promoters August 2005, December 2007, December 2008).

Traditional medicines are employed in the treatment of respiratory infections, all types of internal and external hemorrhage, miscarriage, postpartum bleeding, retained placenta, gastrointestinal, genitourinary and respiratory infections, wounds, sexually transmitted diseases, hypertension, menstrual discomfort, eye and skin infections, arthritis, fractures, pain, and a multitude of other medical conditions. Health promoters estimate that deaths due to parasites may decrease by as much as 70% with the use of traditional medicines. Currently all of the microclinics incorporate at least some degree of traditional medicine and healing methods and the Oventic, Estación, and Magdalena clinics have extensive traditional pharmacies (interview with a clinic coordinator August 1, 2005). At the Magdalena microclinic several elderly women operate the traditional pharmacy and are educating health promoters and community members about the methods of traditional healing. They are racing against time to pass their knowledge on to the next generation before these methods are lost (interview with a health promoter, August 1, 2005).

Health promoters are also conducting their own studies of traditional medicines and treatments as compared to allopathic pharmaceuticals. They are hoping to determine which methods work better, faster, and whether or not there are any side effects. They are combining traditional and allopathic methods and evaluating those results as well (interview with health promoters August 2005, January 2007, December 2008). This demonstrates another important step toward

an increasingly autonomous system. The fact that the studies are being conducted by Zapatistas rather than an outside organization provides the opportunity for the health promoters to learn by trial and error. They control the study, thus they will ultimately understand and own the knowledge themselves. Additionally, they can apply the lessons learned to the next study. Clearly the recovery of traditional Indigenous knowledge could be the key to gaining power and control over their own healthcare. Many challenges must be met before a fully functional system of traditional medicines and healing methods will be a viable and sustainable option for the microclinics but much progress has been made.

**Emergencies**

Emergencies are a primary concern and challenge in the Zapatista healthcare system. The Oventic Clinic serves as the central location for medical emergencies in this caracole with 41 communities utilizing the clinic for primary emergency care. The most common emergencies treated in this caracole are related to women's health such as miscarriages, complications of childbirth, and post partum bleeding (OSIMECH 2004). In 2007 the Zapatistas obtained an ambulance, which is stationed in Oventic and is used to transport patients from surrounding communities and microclinics to the Oventic Clinic. Extremely critical patients are transported via ambulance to medical facilities in San Cristóbal de Las Casas, about one hour away. However, hundreds of Zapatista communities are situated deep in the highlands and 148 are only accessible by walking (OSIMECH 2004). In these remote communities patients must travel on foot or be carried to the nearest road where they try to find a ride to Oventic or a hospital in a nearby community or city. Health promoters

accompany patients during travel (interview with a health promoter, August 3, 2005). It is not always feasible for the ambulance to travel the long distances to the more remote microclinics to pick up patients, leaving many patients with little or no access to advanced emergency medical treatment. Some of the microclinics have vehicles that serve as ambulances but they are not stocked with emergency equipment so they serve only as a mode of transportation (interviews with four health promoters, August 16, 2006, January 3, 2009).

All of the microclinics provide emergency services; however, this is an area that needs to be developed. Most do not have a designated emergency room or capabilities to treat severely critical illnesses or injuries. A rapid means of transportation to advanced critical care facilities, increased health promoter education, and more sophisticated emergency room medical equipment and supplies are urgently needed in order to improve the outcomes of critical patients. Zapatista health promoters are receiving emergency training and many microclinics have requested help from international supporters for ambulance vehicles, but to date most of these requests have been unfulfilled.

**Vaccination Program**

Prior to the Zapatista rebellion, few Indigenous children in Chiapas had ever been vaccinated for infectious diseases. Today all of the microclinics have regular vaccination programs and children are vaccinated for tetanus, diphtheria, measles, mumps, whooping cough, rubella, and polio. When vaccines are available children may also be vaccinated for hepatitis B, tuberculosis, and influenza. Health promoters schedule regular vaccination days at the microclinics and also travel to

rural communities and set up on-site vaccination programs. The vaccination schedule varies, with some microclinics holding clinics every two months and others every three to four months. A number of health promoters specialize in the vaccination program and are in charge of keeping detailed records of each child who has been vaccinated (interviews with eight health promoters August 2005, August 2006, January 2009). In 2009, health promoters reported that 90% of the children in almost every microclinic region had been vaccinated. In some communities 100% of the children had been vaccinated. Every microclinic has refrigeration for vaccine storage and back up solar or gas generators in case of an electrical interruption (interview with two health promoters (January 7, 2009).

I was in the community of Polhó one afternoon when the health promoters were conducting a vaccination clinic. Although hundreds of children were lined up for vaccines the health promoters were a running a very efficient program. Each line had one promoter who administered the vaccine and another who recorded the medical records for each child. I noted they were using preloaded syringes or non-reusable syringes and they were diligent about the proper disposal of the needles and vaccination vials.

Although vaccinations are always in short supply the program is working very well. Using vaccination specialists keeps the program focused, organized, and on schedule. The specialists track each child and ensure they complete the full vaccination series (interview with a health promoter, August 11, 2005). The fact that families can come to the microclinic to be vaccinated or attend on-site community vaccination clinics is convenient and keeps children from falling through

the cracks. Additionally, parents who have their children vaccinated encourage other parents to do the same.

**Health Promoter Training**

Health promoter training is a crucial aspect of the success of the Zapatista healthcare program. The communities of Oventic, Polhó, Estación, and Magdalena have formal training facilities that serve as regional education centers for health promoters. All of the health promoters participate in an intensive medical training program provided by physicians from two international, non-governmental medical organizations. These organizations have provided comprehensive and carefully planned training curriculums for the health promoters for a number of years. The curriculum includes three training levels, each with specific goals and requirements. Health promoters are evaluated after each phase before advancing to the next level. Each training level takes about eight months to complete; however, sometimes obstacles and hardships cause delays and prolong this process (interviews with international medical professionals, August 2005, August 2006, January 2008).

Level I training requires the mastery of human anatomy and all of the bodily systems including the digestive system, respiratory system, circulatory system, cardiovascular system, urinary system, nervous system, male and female reproductive systems, musculoskeletal system, and the endocrine system. This level also includes obtaining skills to assess and interpret vital signs including blood pressure, pulse, body temperature, and respirations. Additionally, health promoters learn to teach preventative healthcare, hygiene, practices, and wellness to patients and members of their communities. All of the microclinics have posters and/or

murals that demonstrate models for a healthy lifestyle. For example, no animals should be corralled inside the house, the importance of hand washing and always boiling drinking water, children should be vaccinated, no consumption of alcohol, urinate and defecate away from living areas, no fires inside the house, regular bathing, eating a healthy diet including fresh fruits and vegetables, and no domestic violence. Health promoters are taught to incorporate discussions of health and wellness with every patient consultation.

Level II training includes more detailed lessons in anatomy and physiology and improves health promoter diagnostic skills. Health promoters learn to diagnose and treat common medical problems such as malnutrition in children, parasites, dehydration, diarrhea, respiratory emergencies, gastrointestinal issues, and skin infections. About half way through the second level of training the health promoters begin treating patients.

Level III is the most advanced training level and health promoters fine-tune their diagnostic skills and patient treatments for all medical conditions. They focus on physiology and pathology as well as chronic diseases such as diabetes, anemia, and tuberculosis, then they advance to fractures, dislocations, trauma, and shock. Level III also includes advanced techniques and skills such as intravenous therapy and resuscitation practices. Women's reproductive health and sexual relations are also discussed. Although the current program does not provide in-depth training in women's health issues such as pre-natal care, childbirth, or newborn care, health promoters who are interested in specializing in women's health are placed in advanced training. Some health promoters also specialize in managing vaccination

programs. One of the most important aspects of the Zapatista philosophy of autonomy is exemplified in Level III training when health promoters return to their communities and pass on their knowledge. They recruit new health promoters and help existing promoters advance in their training. A number of health promoters proudly explained, "We multiply by teaching one another." This ensures sustainability of the healthcare system, gradually reduces dependency on outside sources, and increases autonomy (Interview with four health promoters, 2008).

Lesson plans are derived from a series of Spanish editions of textbooks including, "Where There Are No Doctors," "Where Women Have No Doctor," and "Where There Are No Dentists." Currently most of the microclinics only have copies of "Where There Is No Doctor." The series is based on villager-run health programs designed to be taught by instructors who may not have a formal education. The textbooks provide a practical, sustainable, grass roots approach to health care and wellness for people living in remote areas without access to medical care (Werner 2005). Scenario based hands on exercises, role-playing, and colorful visual aids contribute to learning and retention. The activities are fun and engaging and students practice real life scenarios taking turns acting as the "patient" and as the health promoter. They practice taking vital signs, conducting patient assessments, inserting intravenous catheters, and giving each other injections. As they advance through training the scenarios become more lifelike as students feign various signs and symptoms, illnesses, and injuries and then simulate treatments and interventions.

The health promoter training program is one of the most successful aspects of the Zapatista healthcare system. The fact that the same two organizations have created the curriculum and organized the training for several years has provided significant progress and continuity to the level of expertise of the health promoters. As health promoters advance to leadership positions as clinic coordinators, new promoters are continuously filtered into the program. With practice and experience the Zapatistas look forward to a time when healthcare training will be taught exclusively by Zapatistas and completely sustainable. Passing knowledge forward from generation to generation is one way the Zapatistas are recovering traditional ways of teaching and mentoring. Traditionally healing knowledge was passed to special people who were believed to have talent or a predisposition to understand and care for medicinal plants and the knowledge of healing. A clinic coordinator told me that true Mayan healers such as iloletiks and curanderos can heal with the love in their hearts (interview with a clinic coordinator, 2005). Recovering and developing traditional medicines and healing knowledge could contribute significantly to the autonomy of the Zapatista healthcare system.

Several aspects of the Zapatista Oventic caracole healthcare system are of particular note. By design the microclinic system of community based health clinics has significantly reduced the distance and time to reach medical care and made access more attainable. Healthcare is a cooperative venture with health promoters providing medical care while the community supports their needs. The commitment to the development of women's health programs is quite remarkable and demonstrates that women are increasingly accepted as an important and

valuable aspect of Indigenous society. Women have a voice and rights over their own bodies and reproductive health as well as positions of authority as health promoters and Zapatista leaders. Education programs promote health and wellness that should lead to a significant reduction in parasites, illness, and the spread of infectious disease. The recovery of traditional medicines and healing methods are of primary importance. As Indigenous knowledge of medicinal plants is recovered communities can cultivate, harvest, and process their own pharmaceuticals, which are sustainable and readily available. A syncratic approach to healing by employing a combination of traditional and western medical knowledge and the use of traditional and allopathic pharmaceuticals will materially increase the autonomy and sustainability of the healthcare system. Health promoters are advancing in medical training and have initiated programs to train new students themselves. This will eventually decrease the dependency on outside sources for education and streamline training for new recruits. The Oventic healthcare system is working well. For the first time Indigenous people are receiving medical treatment in their own communities, children are being vaccinated, and health promoters are working independently. In spite of the highly militarized environment of the Oventic caracole, the Zapatistas are successfully providing quality, accessible healthcare to thousands of people living in or near the Zapatista autonomous zones.

## CHAPTER 5

## A VISIT TO SANTA CATARINA – LA NUEVA FLOR MICROCLINIC

During my research one experience that truly exemplified the Zapatista struggle and healthcare in the Oventic caracole was a visit my son Alex and I made to the Santa Catarina microclinic. The La Nueva Flor (The New Flower) microclinic is located in the Zapatista autonomous municipality of Santa Catarina in the territory of Pantelhó. Alex and I had been in Chiapas for almost eight weeks before the Junta de Buen Gobierno scheduled our trek to Santa Catarina. We had heard the microclinic was a long and rugged trip and the Junta and Oventic health promoters had been playfully teasing us about how difficult it would be to get there. Santa Catarina is the most remote microclinic in the Oventic caracole and is only accessible by walking. The microclinic serves over 38 very isolated communities situated deep in the Chiapas highlands. Even the patients who walk three to five hours to reach the microclinic find it significantly more accessible than traveling outside of the region to government clinics.

On the morning of our trip to Santa Catarina Alex and I woke up early in Oventic, flagged down a collectivo and headed toward the highlands with one of our Zapatista friends. In addition to the two Mexican army bases we passed enroute, the Pantelhó territory is home to a number of active paramilitary organizations. It is

not a Zapatista friendly zone in any sense. After several hours of travel we arrived at the community of Pantelhó where we met up with a group of Zapatistas who had hired a farm truck to take us the rest of the way. Alex and I crowded into the back of the pickup with our new Zapatista escort Antonio, 18 men, five piglets, a mountain of soda pop, and about a dozen gunnysacks full of beans. Most of the pickups have tall side rails and we learned long ago that being crunched together like sardines in the back of those trucks has its advantages; it helps us keep our balance and one can actually sleep standing up without falling over. This trip I stood next to the guy with the piglets and one of them wiggled his nose out of the gunnysack and chewed a hole in my pant leg. We traveled at about ten miles an hour on a very rough dirt road through the most spectacular mountains I have ever seen. Tiny Zapatista communities dotted the landscape deep in the valleys below and high on the mountainsides above us. Coffee, corn, peppers, beans, and squash were thriving in terraced fields one after another.

Antonio explained that his father is a coffee grower in these mountains. Prior to the Zapatista rebellion, individual campesinos had little bargaining power and were forced to sell their coffee at a loss, or risk not selling it at all. Greedy buyers called coyotes still rush to the mountains at harvest time and try to persuade desperate growers to sell their crops under the pressure of "one time only deals and quick cash." However, the Zapatistas found a solution to this problem when coffee growers and communities joined together and formed coffee cooperatives. Presenting a united front, the growers have been successful in negotiating fair trade prices for their coffee and have established several international markets. The Santa

Catarina region is home to several cooperatives including one called the Yachil Co-op, which sells coffee to fair trade outlets in the United States. Other coffee cooperatives throughout the caracole market coffees such as Café Para La Vida Digna, Rebel Coffee, and Zapatista Coffee to fair trade outlets and on the Internet. Although the cooperatives are becoming more successful, they continue to be targets of paramilitary groups who have assaulted and even murdered coffee growers. Some growers have had their fields burned and their crops stolen. Sometimes coyotes select one or two growers and offer them exorbitantly high prices for their coffee in an attempt to create animosity and undermine the cooperatives. Antonio says the coffee growers remain united and support one another. "The government can do what they want, but the Zapatistas are stronger of heart" (interview with Antonio, August, 2005).

We rode deep into the mountains for over two hours and then abruptly, the road ended. There was a small Zapatista store about the size of a garden shed next to the road where we unloaded three of the piglets and most of the supplies. There was no time to rest so Antonio shared a handful of corn paste and we donned our backpacks and headed into the jungle. Antonio, two other Zapatistas, and an elderly gentleman who carried the last two piglets accompanied us.

It was almost dusk and we had been traveling for about nine hours. The walk was long, hot, slippery, steep, and humid. Vines wrapped around our ankles and tripped us along the way. Antonio was sure footed and passed the time telling us stories about the jungle, and his father, and the Zapatistas. He explains the symbiotic relationships of the chili peppers, corn, squash, beans, coffee, and tobacco

all growing together, then offers Alex and I a bite of the hottest pepper I have ever tasted...I choke...Antonio and Alex have a good laugh.

Corn, beans, and coffee are the primary crops cultivated in this region and the fields are overflowing (OSIMECH 2004). Antonio notes that the Zapatistas are working to protect Indigenous corn from being genetically altered by Canadian and U.S. companies, but he says some strains have already been contaminated in Oaxaca and Puebla. In 2005 United States based Monsanto purchased Seminis, a Mexican agricultural company. Monsanto is responsible for 94% of the world's areas that have been cultivated with genetically modified seeds (CIEPAC 2003, 2004). Although Mexico banned the cultivation of transgenic corn in 1998, it has not prevented the import of corn seed. Every year over five million tons of North American corn is imported to Mexico and most of it is transgenic. The Zapatistas responded by creating a program called, 'Sme' Ts'unubil ta Ts'ikel Vokol ta Jlumaltik, Chiapan' (Mother Seeds in Resistance from the Lands of Chiapas). Zapatista education promoters and students in autonomous schools are establishing seed banks and learning how to store and preserve these ancient strains of "Mother Corn." They have already secured and stored over 60 local varieties. A Zapatista education promoter explained, "We are people who are made of corn and earth," (National Forum in Defense of Mexican Corn 2002). Antonio says the corn will always be a part of Indigenous people. "If the corn were to disappear the people would disappear, but because now we have the knowledge to protect the corn this will not happen" (interview with Antonio 2005). Antonio picked an ear of corn from

the field and says we would soon be eating tortillas at the microclinic, grown from ancient Mayan corn seed! We walk on.

The elderly gentleman tells us the piglets are for a special celebration in the springtime when they will be slaughtered for everyone in his community to eat. He hints that Marcos will be the guest of honor. Then he asks us to pose for a photo with him and we part ways. Antonio points out more varieties of coffee and tobacco plants and promises to roll a cigar for us when we arrive at the microclinc. The walk is beautiful but as night falls we traipse on in complete darkness. It is a strange feeling to be led blindly to a place with no idea where you are or how far you are traveling. This had become the routine of our experience in Chiapas. Following the 1994 rebellion the Zapatistas renamed most of the communities in the autonomous zones and 15 years later the Mexican government refuses to recognize those names or to update the Chiapas state maps. So it leaves travelers such as Alex and I with no vision of where we are geographically or how long our journey will be. Day after day we have this amazing blind trust for the Zapatistas who show us the way and keep us safe. Antonio tells the story of some paramilitaries who chased a Zapatista pickup all the way up the mountain but when the Zapatistas started to hike into Santa Catarina it was too far and they were lazy, so the soldiers gave up and turned back. The autonomous zones are made up of a maze of secret trails in and out of all of the Zapatista communities, purposefully designed for the safety of the people and for quick, efficient escape routes in and out.

Suddenly we see a tiny light way off in the distance. It is a single light bulb in the middle of the mountains, lit up on the veranda of the microclinic! We would

spend a lot of time on that veranda over the next few days. Santa Catarina is so isolated that neither the microclinic nor this community has access to electricity; the microclinic operates on solar power. However, 74% of the communities surrounding Santa Catarina have electricity, which they pirate from the Mexican Comisión Federal de Electricidad (OSIMECH 2004).

We walked another half hour and finally reached the microclinc. Marten, the clinic coordinator was waiting to welcome us. Late as it was, the health promoters had a meal waiting; black beans with an egg on top, coffee with sugar, and corn tortillas. We sat inside the health promoter dormitory at a small table and ate by the light of one tiny candle. The most common foods consumed in this region are corn tortillas, beans, fruits and vegetables; people rarely have milk, eggs, or meat (OSIMECH 2004). So when I noticed the health promoters did not have eggs in their bowls I realized they were sacrificing their food for us. Those sorts of kindnesses happened all the time, and Alex and I never really reconciled how to feel about that; mostly we felt guilty and undeserving. We scooped up our eggs and shared them with Antonio and the other health promoters. There were not enough spoons or coffee cups for all five of us to eat at the same time so we took turns eating and washing dishes in between. The fresh pineapple Alex had carried in was a refreshing treat for all of us. Every microclinic kitchen we visited lacked the most basic necessities and the pantries were usually bare, but Santa Catarina was the worst we had ever seen. The pantry was practically out of food and the health promoters only had the clothes on their backs. When we returned to San Cristóbal

de Las Casas, with the permission of the Junta de Buen Gobierno, we sent boxes of kitchen supplies and food to all of the microclinics.

After everyone had eaten we sat outside on the veranda where other health promoters and community members had gathered. We spent the evening getting to know one another and drinking coffee from the community's own coffee fields. Two women health promoters seemed shy and spoke Tzeltal but by the end of the evening we were exchanging lessons in Spanish, English, and Tzeltal. Antonio taught Alex how to roll cigars with the tobacco his father had grown in these very mountains. The experience of all of this was overwhelmingly perfect...and we have some really funny photographs of all three of us standing on the veranda in the middle of the night smoking those cigars.

The health promoters slept in the dormitory and Alex and I were given a special room in the microclinic. We shared a single bed made of plywood set atop cinder blocks. We had packed our sleeping bags expecting the weather to be cold so high in the mountains but it was hot and muggy instead. We fell asleep to the sounds of the forest and the excited voices of the health promoters across the way.

The following morning we got down to business and toured the microclinic, walked around the community, and conducted several interviews. Antonio and Marten shared the story of the history of the microclinic. Prior to the Zapatista resistance there were no healthcare services in this region and patients were forced to travel extremely long distances to hospitals in San Cristóbal de Las Casas or Pantelhó. In 1994 when the Zapatistas began to organize they established the first casa de salud in this region. It was a modest mud building with a corrugated steel

roof and dirt floor. The intention was to provide medical treatment specifically to comfort dying children and the elderly. The health promoters say it was very important to have an autonomous space so patients had a safe environment and did not have to face the dangers and hardships of traveling while they were ill or dying. Initially traditional medicine was primarily practiced although some allopathic pharmaceuticals were used when they were available. Volunteers collected money from the surrounding communities and charged patients small fees in order to purchase medical supplies and pharmaceuticals to equip the casa de salud. The Mexican government did not provide vaccines for Indigenous children and the community could not afford them so none of the children in the region had ever been vaccinated prior to the Zapatista rebellion. By 1997 the casa de salud was receiving support from the French Red Cross and a physician visited every two to three months to provide patient care and to teach basic first aid training to the health promoters. Eventually, Marten says, without explanation the physician stopped visiting and they were left to struggle alone (interviews with Antonio and Marten, August 2005). Today Zapatista health promoters train one another and they "pass their knowledge forward" so eventually they will no longer be dependent upon outside sources. They are also recovering ancient traditional healing methods and are working to distance themselves from dependency on westernized allopathic pharmaceuticals. Antonio says if the Zapatistas go to war again, they will not have access to allopathic medicines, but they can be sustained by traditional healing practices and plants (interviews with Antonio and Marten, August 2005). It is not unusual to hear the stories of well-meaning volunteers, or foreign aid groups who

start projects in Zapatista communities then do not ever return. This is evidenced by medical equipment left unmaintained in the microclinics or the broken sewage system in Santa Catarina that no one knows how to repair.

Marten explains that the casa de salud had many dedicated volunteers, but they were not experienced or well trained in medicine. They used the limited resources available including many traditional healing methods and herbal medicines but the ability to impact and improve healthcare was very limited. They had good hearts, but that was not enough to save the people in this community (interview with Marten, August 2005).

In 1999 four visitors came to Santa Catarina. Marten is uncertain but he thinks they were from Italy. They were saddened by the conditions at the casa de salud and about two years later they sent funds to build and equip a new microclinic. The Zapatistas built the microclinic "brick by brick," carrying concrete blocks, timber, and other building supplies through the mountains on their backs. Antonio described how people were injured during the construction from falls and also how the skin on their backs "was ripped off," from carrying the heavy construction supplies. He said the health promoters treated many patients who were injured during the construction. Hundreds of people from all of the surrounding Zapatista communities worked together to build the microclinic. Marten says many campesinos sacrificed their work in the fields to help and their families went hungry. It took over eight months to complete the new building, which was put into service in 2001. Marten describes that it was a hollow shell at first but everyone in the community pitched in and helped to build hospital beds,

desks, exam tables, and benches. The former casa de salud was converted into a gathering place that is currently used for the Zapatista authorities. Antonio tells me they do not need "such a place for dying anymore" (interview with Marten and Antonio, August 2005).

The Santa Catarina microclinic building is constructed of concrete block with a full-length veranda. A separate wood frame dormitory and kitchen is situated next door for the health promoters. The microclinc has one consultation room, an allopathic pharmacy, a storage room for medical supplies, a vaccination room with refrigeration for vaccines, one examination and patient treatment room, two in-patient hospital rooms with a total of four beds, a latrine, and one sleeping room for health promoters. A traditional pharmacy is being planned and there are a few traditional medicines on the shelves of the allopathic pharmacy. The microclinic is equipped with oxygen, bandages, suturing supplies, an examination table, and a few other basic medical supplies. Many of the shelves are bare and it is evident they are in need of all types of medical equipment and pharmaceuticals. Health promoters provide general consultations, emergency care, gynecological and obstetrical services, natural healing methods, and vaccinations. Antonio emphasizes that patients are taught good sanitation practices, wellness, prevention, and safety as a part of every patient visit.

Throughout our stay patients arrive at the microclinic at all times of the day and night. There are no nine to five business days for the Zapatista microclinics. Unlike the government clinics that are only open twice a week during daytime hours, the Santa Catarina microclinic is open 24 hours a day 365 days a year

(interview with Marten and Antonio, August 2005). Marten explains that people do not get sick on certain days or at certain times; so the Zapatista microclinics are always open. No one is ever turned away from the microclinic and Marten says even people from opposing political parties prefer the Zapatista microclinics over the government clinics. Arriving patients are welcomed and escorted to the consultation room where they speak privately with a health promoter and receive appropriate medical care (interview with Marten and Antonio, August 2005). I observed several patients being tutored on how to live a healthy lifestyle in front of a huge teaching mural on the microclinic wall. The health promoters also acknowledge that many people still walk several miles for treatment so they are offered food, water, and rest before returning to their homes (interview with Marten and Antonio, August 2005). The atmosphere of the microclinic is welcoming and people stop by on their way to fetch water from the community faucet to visit or to ask the health promoters questions. Handmade wooden benches are standard at every microclinic and they are well used by families, children, and elders alike. The microclinic along with the community faucet seem to be the centers of this community. There is often the sound of music playing mixed with the exited voices of children and adults speaking two or three different languages.

Santa Catarina microclinic is the primary health care facility for over 2,100 people living in 38 communities (OSIMECH 2004). Marten said the Santa Catarina microclinic treats about 70 patients per month. Four casas de salud also operate in this region and each one serves a population of approximately 500 people. In 2004 the most common medical conditions treated in order of frequency were respiratory

infections, gastrointestinal infections, skin infections, genitourinary infections, and malnutrition (OSIMECH 2004). Because this is an agricultural area, Marten said they often treat severe injuries from machetes. Infectious disease rates were also increasing with 24 communities reporting cases of tuberculosis and 33 communities reporting cases of malaria. In 2005 Marten expressed concern over the high rates of children suffering from malnutrition. His concerns are well founded. Malnutrition is the seventh leading cause of illness and the tenth leading cause of death in Chiapas. Chiapas has the second highest rate of malnutrition in Mexico and in 2006 96 municipalities reported severe to serious cases of malnutrition. Almost 72% of the Indigenous population in Chiapas suffered from malnutrition in 2008 (Cuarto Poder 2008). Every microclinic I visited was struggling with the high rates of malnutrition in children.

Clearly the remote location of this microclinic poses significant challenges in cases of medical emergencies. Patients from surrounding communities have to walk or be carried for miles to reach the microclinic and if the patient requires more advanced care the health promoters carry the patient out of the mountains to the nearest road. With no ambulances in this region they must flag down a vehicle or wait for a Zapatista truck to arrive before traveling the rest of the way to a hospital. This is a common scenario for many of the microclinics, but of utmost concern for Santa Catarina.

The health issues of pregnant women are also a high priority concern in Santa Catarina. According to Marten, complications of pregnancy were the leading cause of death in 2004 and 2005 in this region. Although the 2004 maternal

mortality rate was reported as zero, Antonio and Marten questioned if that statistic included women who died in route to, or at government hospitals in Pantelhó and San Cristóbal de Las Casas. Marten said women die walking the long distances to the road or in the car during transport. Paul Bausch, in "The Textbook of International Health," argues that infant and maternal mortality statistics in poor countries are often inaccurate and many such deaths go unreported (1999). There is little incentive to travel the long distances to government offices to record births or deaths of loved ones in rural communities. Furthermore, in some cultures deaths are not discussed, especially with strangers. Mothers also may not want to remember or focus on the trauma of losing her infant; thus these occurrences often go unrecorded (Basch1999). Marten and Antonio were very concerned about women's health issues, especially related to childbirth. Some time ago a nurse from a women's health clinic in San Cristóbal de Las Casas made regular visits to the microclinic. She treated patients and provided some training to the health promoters. However, Antonio says she "lost heart" because it was so difficult and she does not come any more (interviews with Antonio, August 2005).

Health promoters do not usually attend childbirths in family homes; however, sometimes women come to the microclinic in labor and the health promoters are called upon to deliver babies. Often these are women who have been unable to deliver due to the position of the infant in utero so the delivery becomes an emergency. In these situations the long distance to a hospital for a cesarean section is generally prohibitive so health promoters sometimes work with parteras. Marten and Antonio said they believed the traditional way of childbirth with

parteras is best, but in cases when the mother is having an emergency they need to combine their ideas and resources to save the lives of the mother and the child. I was having difficulty understanding the exact role of the parteras so Marten was kind enough to explain.

When a woman becomes pregnant, she seeks out a partera and asks for her services. The partera never approaches the woman first. Once asked, the partera is available to the woman and her family day or night throughout the entire pregnancy. She often visits the mother at home and gives her advice. The partera may also prescribe traditional herbs to ensure good physical and emotional health of the mother and the baby. If complications occur during the pregnancy the partera employs the use of traditional medicines and healing methods. At the time of birth, the husband is an essential part of the birthing process. The husband sits in a chair and the woman kneels on the floor facing him. She positions herself between his legs and he embraces her. The partera sits behind the woman and wraps long strips of colored cloth around her waist to apply pressure and to gently encourage and help the contractions. She also waves a machete around the woman, symbolizing cesarean section. The woman's hair is taken down from her traditional braids and draped loosely across her shoulders to symbolize letting go of the baby. The partera applies hand pressure and massages the abdomen to push the baby downward and the baby is delivered from behind into the waiting hands of the partera. The partera uses herbs and other plants to control post partum bleeding. Later, the placenta is buried in the dirt floor of the house (interviews with Antonio and Marten, August 2005).

The deep cultural history and tradition of giving birth could certainly explain why Indigenous women do not travel to hospitals to give birth. Western medicine conflicts with traditional ideas of medicine and women prefer to stay in their own communities and have the knowledge and nurturing care of a partera during pregnancy and delivery. While the combination of health promoters and parteras working together may be the best solution for this remote microclinic, there is still great concern for the mother and child in cases of prolonged labor and complicated childbirth. In my former career I taught classes in emergency medicine so after hearing the stories, and the fears and concerns of Antonio and Marten I offered to teach them some emergency childbirth techniques. One afternoon Marten, Antonio, Alex and I had a class on breach births, limb presentation, and other complications of childbirth. During the training session Marten presented the single copy of the microclinic book, "Where There Is No Doctor," and asked me to read from it. Marten is literate, but I discovered he could not see. I offered him my reading glasses and he was shocked. Marten said he had not been able to study because his eyesight was so bad. I gave him my reading glasses and everyone teased him that he was the new professor!

Living in a civilian targeted warfare zone presents unique challenges for the Santa Catarina microclinic. When the microclinic was first built the Mexican government spread rumors about the health promoters and the microclinic. They told patients the health promoters were not trained and that the medicine was bad. Paramilitaries and Mexican soldiers also threatened the lives of the health promoters and their families. Sometimes soldiers stopped women on their way to

the microclinic and intimidated them so they would turn back. Marten said 24 out of 28 health promoters were driven away during that time and the microclinic basically had to start over. Now, however, people have learned to trust the health promoters and the care they receive at the microclinic. Marten says the government and the soldiers can talk all they want because no one pays them any attention any more (interviews with Marten, August 2005).

According to Marten, in 1996 and 1997 the Mexican army attempted to expand the militarization of the Santa Catarina region. However, they were unable to move military equipment and troops into the communities because there were no roads. When the government sponsored paramilitary groups to harass the Santa Catarina community they did not have the energy to hike into the communities either. Marten says, "It is a good thing sometimes to be so remote." Checkpoints on the roads leading into the area have slowed or prohibited supplies from reaching the microclinic by traditional routes but the Zapatistas have found other means of transporting the goods. Antonio makes a point of mentioning that from the outside these remote areas may be perceived as more vulnerable than places like Oventic, but he says that is not true. They are ready, they are prepared, and they are diligent (interviews with Marten and Antonio, August 2005).

After a few days it was time to say our goodbyes and depart from Santa Catarina to travel back to Oventic. Leaving our new friends was especially difficult, knowing we may not see them again for at least a year. All of us took a long time drinking our coffee that morning and then we finally headed down the trail with Antonio. Alex and I had two special escorts that day....a couple of little boys

followed us for miles, ducking behind trees and calling out to us with "chhhh, chhhh" sounds, then running up to catch us, and hiding again. Eventually they turned back leaving Antonio, Alex and I to walk alone. Antonio told stories of jaguars, and the Zapatistas, and showed us medicinal plants growing in the forest. He pointed out a plant I had never seen before and cut it up for us to munch on while we walked. I had anticipated a difficult hike back up the mountain, but was surprised to learn the hike out was mostly downhill. After a couple of hours we broke out of the forest at a new rendezvous point on the road far below Santa Catarina. Of course this made sense. We had traveled on just two of the many strategic routes in and out of Santa Catarina....all carefully designed for quick escape in wartime. At the end of the trail there was one more little ledge to climb and Antonio took my hand and pulled me up. We were smelly, dirty, muddy, and exhausted. Antonio looked down at my bleeding feet, wiped the mud off my face and said; "Now you have Zapatista feet." I laughed and he added, "And...you have a Zapatista heart." Blinking back tears we said our goodbyes and climbed into the back of the waiting farm truck. Thankfully it was packed with Zapatistas so Alex and I knew we could get one of those "standing up" naps...all the way back to Oventic.

## CHAPTER 6

## DISCUSSION AND ANALYSIS: THE EFFECTS OF MILITARIZATION ON HEALTH CARE

This chapter provides a discussion and analysis of the influences of neoliberalism, militarization, and civilian targeted warfare on Indigenous health in Chiapas, Mexico. Using a political ecology theoretical approach, Leatherman suggests "Political ecology links issues of power and inequality with humans and environmental issues. This gap between the rich and poor, the powerful and powerless sometimes leads to collective actions of revolution and violence in order to change these conditions" (Leatherman 2005:59). In spite of the dedication and resolve of the Zapatistas to provide quality, accessible healthcare, the neoliberal political agenda of the Mexican government and the sustained presence of the Mexican army continue to influence the health and wellbeing of Indigenous people living in Chiapas. While billions of dollars are being spent on mega development projects such as Plan Puebla Panama and for construction of military bases, the poor and Indigenous people of Chiapas are being displaced, terrorized, and evicted from their ancestral lands.

### Neoliberalism and the Zapatista Struggle

In 1997 Subcomandante Marcos wrote an essay called, "The Fourth World War Has Begun." Marcos proclaimed, "the war which neoliberalism is conducting against humanity is thus a planetary war, and is the worst and most cruel ever seen"

(EZLN 1999). He argued that neoliberalism is, "Rather like a bullet fired inside a concrete room, the war unleashed by neoliberalism ricochets and ends by wounding the person who fired it. The first casualty of the war was the national market....and the new international capitalism will render national capitalism obsolete, effectively starving nations' public powers into extinction" (Hayden 2002:273). Marcos posits that neoliberalism and economic globalization will destroy the cultures and histories of people around the world. "All the cultures which nations have forged, the noble past of the Indigenous people, the brilliance of European civilization, the cultured history of the Asian nations, and the ancestral wealth of Africa and Oceania are under attack..." (Hayden 2002:275). Marcos' essay also describes the purposeful marginalization of Indigenous people, arguing that "all persons who are of no use to the new economy, Indigenous people for instance," would be excluded from the new neoliberal world (Marcos 1997). Indeed, Mexico had already begun fast tracking huge development projects throughout Mexico, particularly in the resource rich state of Chiapas. Of course development on such a massive scale is problematic with thousands of Indigenous communities occupying prime real estate, along with the embarrassing, unresolved issue of the Zapatista rebellion. The implementation of NAFTA helped the government's agenda. When Indigenous farmers found they could no longer negotiate fair prices for their crops many men were forced to abandon their land and seek wage labor jobs. This provided a cheap, desperate work force to fill the low paying jobs in the maquiladoras along the U.S./Mexico border. Men left their families to seek work in the north and women remained at home to tend the crops and care for the children alone. The Mexican

government, however, needed a permanent solution. "Progress" could not be obtained until the state had control of the land. Part of the solution came in the form of a sustained military occupation and assault designed to drive people and communities off their land once and for all. This solution was costly.

**The Cost of Militarization**

By 1999 over 70,000 military forces were stationed in Chiapas, representing almost one third of the entire Mexican army. More than 15 years have passed since the Zapatistas laid down their weapons and negotiated the San Andres Accords, yet the Mexican military continues to employ overt methods of civilian targeted warfare tactics against the Zapatistas, their supporters, and innocent, unarmed civilians. Today, thousands of forces remain in Chiapas and most of the original military bases are still in operation. In addition, the state is swarming with state security forces, judicial state police, federal police, migration police, and paramilitary groups. The actual cost of low intensity and civilian targeted warfare cannot be measured simply in terms of money; warfare also has a sweeping effect on social programs, education, food security, human rights, and health (Leatherman 2005). Martin Donohoe notes, "Three hours of world-wide military spending is equal to the World Health Organization's annual budget. Three weeks of world arms spending could provide primary health care for all individuals in poor countries including water and hygiene" (Donohoe 2005:65). Supporting and sustaining this enormous military machine costs millions of dollars that could be allocated to infrastructure projects such as procuring clean water, electricity, and sewage systems for the people of Chiapas. Clearly the money spent on militarization could provide solutions to many

of the Zapatista demands but instead the cost of militarization has actually led to reductions in government spending on social programs such as healthcare, education, and food resources (CIEPAC 2004).

**Government Projects**

The Mexican government has built seven hydroelectric dams on the Grijalva River and its tributaries but Indigenous communities receive little benefit. All of the hydroelectric plants are owned and operated by the Comisión Federal de Electricidad, giving the Mexican government absolute control and power. This is evidenced by the fact that Chiapas provides over 56% of the country's hydroelectric power and over 20% of its electricity. Yet eight out of ten families in Chiapas have no electricity and nine out of ten families have no water or sewage systems. Projects such as dams and hydroelectric plants serve as demonstrations of power and control over natural resources. This symbolizes the wealth and political authority of the government while paying little attention to the people who are marginalized and displaced in the path of these mega projects (Bryant and Bailey 1997). In the case of the Zapatistas, electricity is available in the Oventic caracole only because the Zapatistas pirate power from the Federal Electricity Company, yet many rural Indigenous communities still do not have access to electricity. As part of the Mexican army's civilian targeted warfare campaign, soldiers are regularly deployed to disconnect electricity to Zapatista communities. Even a transient loss of electricity can impact the microclinics and affect the viability of vaccines and other pharmaceuticals that require refrigeration. Additionally, interrupting electricity might necessitate treating patients in darkness or the inability to use medical

equipment and facilities. Characteristically, the Zapatistas responded to these threats by equipping all of the microclinics with solar power and backup generators.

Two of Mexico's largest rivers and 30% of Mexico's surface water are found in Chiapas, yet 12 million people do not have access to piped water. More than 50% of the Indigenous population does not have access to any source of potable water (CIEPAC 2002). In the Oventic caracole 70% of the communities have some sort of access to water such as a well, spring, river, or public faucet but less than 2% have purification systems. Some communities have water transported by pickup and stored in community water tanks. In times of increased militarization determined Zapatistas have carried water into communities on their backs (OSIMECH 2004).

International companies such as Coca-Cola contribute to water issues in Chiapas. It takes two liters of water to make just one liter of Coke and Coca-Cola has obtained rights to extract water from 19 aquifers and 15 rivers since 2000; some are located on Indigenous lands. Additionally, Coca-Cola has procured concessions to dump their waste in public waters (Wooters 2008). Unfortunately, due to the lack of access to other beverages, Indigenous people may spend up to 17.5% of their daily minimum wage on Coca-Cola products, which ironically includes bottled water (Wooters 2008).

Adults and children suffer from waterborne diseases and parasites such as diarrhea, cholera, schistsomiasis, trachoma, typhoid fever, and intestinal worms. The Mexican government appears unconcerned about Indigenous children who are dying from diarrhea while they forge ahead with the Plan Puebla Panama water

parks and golf courses. Undoubtedly those projects will have water purification systems.

Government funds are also used to build roads for the construction of the forthcoming infrastructure projects, military bases, and for military access into Zapatista regions. The roads pass through traditional Indigenous lands and communities with no consideration for the displacement of families or the destruction of grazing lands, crops, and forests. In the midst of these mega construction and militarization projects the Mexican government blames Indigenous land practices and life ways for the degradation of the environment. For example they accuse Indigenous communities of deforestation from fuel wood gathering or slash and burn farming. In turn they use these accusations to justify seizing control of natural resources "in order to protect the environment" (Bryant and Bailey 1997). Governments introduce restrictions on traditional Indigenous life ways regarding where they may collect fuel wood or graze their animals. Indigenous community members argue that the government and environmental groups make false claims about the sources of environmental degradation in the forest and charge that government-sanctioned exploitation of resources is to blame. They assert that years of logging, road building, oil exploration, bioprospecting, cattle ranching, military bases, and commercial land use are responsible for deforestation, loss of traditional Indigenous medicinal plants, and pollution.

In reality it is the neoliberal machine that is at work here. Billion dollar globalization projects will not include nor benefit the poor. Plan Puebla Panama and the North American Trade Agreement do not address healthcare, education, clean

water, or the dislocation of Indigenous communities and families, except that they are a barrier to progress. Soon the rain forests, rivers, and ancient Maya historical sites will be "protected," as ecotourism touts the pristine preservation of the landscapes...without mention of the cost to the people who lived there. Since the Zapatista rebellion there has been a strange curiosity and romanticism surrounding the Zapatistas. Tourists have descended on Chiapas seeking a look at the "quaint," masked revolutionaries and to experience what has become known as "revolutionary tourism." San Cristóbal de Casas has become the focus of international travelers who sip coffee in places like Café Revolution, snap photographs of reluctant Indigenous children, and take jeep tours into the jungle hoping to catch a glimpse of Marcos. Remarkably, tourists seem fascinated rather than concerned about the hundreds of armed soldiers who stand on street corners and at roadblocks with M-16 assault rifles in hand. Almost half of Mexico's tourism is already directed toward protected areas and archaeological sites. Eco-tourism could potentially serve as a tool for the conservation of natural areas such as the Montes Azules Bio Reserve but it appears more likely that tourism will increase the evictions of Indigenous communities and open these areas to new development. A solution would be to develop sustainable, community-based tourism controlled by local Indigenous communities (Primack 1998). However, it is unlikely the government will respond to the ideas or concerns of Indigenous communities.

**Civilian Targeted Warfare**

It is notable that the United States has a vested interest in the political, social, and environmental situations in Mexico. NAFTA and other development projects

are directly linked to U.S. interests. The United States army has an official definition of low intensity conflict. It is defined as a "limited politico-military struggle to achieve political, social, economic or psychological objectives. Low intensity conflict is generally confined to a geographic area and is often characterized by constraints on the weaponry, tactics and level of violence" (Dunn 1996:20). Under the guise of the war on drugs, the United States has assisted the Mexican government in the militarization of Chiapas by providing military training, equipment, satellite-guided helicopters, and intelligence instruments to the Mexican army (National Catholic Reporter 1998). According to the National Center for Democracy, Liberty and Justice, the U.S. government has also donated 73 Huey helicopters, ten million dollars worth of radio and night vision equipment, and two Knox class naval ships. Additionally, the CIA reportedly provides satellite images of Zapatista insurgent camps and communities (Evans 1998). Over 3,000 Mexican troops have been trained at U.S. military bases including the controversial School of the Americas and Fort Bragg Air force Base. Soldiers return to Mexico to train paramilitary recruits in techniques of low intensity and civilian targeted warfare (National Catholic Reporter 1998).

Autonomous communities are under constant surveillance by battalions of soldiers, helicopters, airplanes, and military patrols. The persistent military presence disrupts the daily routines of Indigenous families and impacts their ability to plant and cultivate their gardens or to care for livestock. Soldiers destroy harvests and food stores, kill livestock, poison water supplies, pollute rivers, spray fields with vegetation killer, and set up camps in grazing areas, gardens, and coffee

fields. The result has been a severe food shortage and increased malnutrition in women and children. Gathering firewood, retrieving drinking water, or walking to the river to bathe have become daily risks for women and children (Eber and Kovic 2003). One community reported, "children were so frightened by the soldiers with machine guns who routinely pass through that they become physically ill," (Pastors for Peace 1996). In some areas, military forces have cut off food and water supplies completely, forcing people to drink contaminated river water. Roadblocks also inhibit people from selling their crops and having access to markets, healthcare, medicines, and food sources. During this study I witnessed Indigenous people being detained, searched, and harassed by armed soldiers at military roadblocks. Their belongings were ransacked and the soldiers exhibited very threatening postures to men, women, and children alike. Twice I was riding in the back of farm trucks when we were detained at checkpoints; curiously when I jumped out of the truck and demanded they let us pass we were flagged on by. Although I am uncertain why this approach worked, I assume they did not want to have an incident with an American.

One woman reported, "We are sick with fright. Sometimes the soldiers come during the night and fire their guns in the road. Sometimes they come during the day when the men are away in the fields. They interrogate the women demanding to know who the community leaders are, where they live, and who their families are. We can no longer drink from the river because the soldiers defecate in it. There is no wood for cooking because the trees have been cut down to build army camps" (Ortiz 2001). According to reports from the Women's Delegation to Chiapas, the number of patients at a clinic in San Carlos has doubled since the Mexican army

occupied the area. Doctors are treating substantially greater numbers of women suffering from anxiety, high blood pressure, depression, hysteria, rape, and malnutrition (Pastors for Peace 1996). Leatherman notes, "Unequal access to environmental resources and environmental degradation are some of the most significant factors effecting health" (Leatherman 2005:58).

**Civilian Targeted Warfare and Women**

Feminist political ecology theory posits that poor women suffer the most when basic resources are threatened. For example women are usually responsible for fetching water and fuel wood for the family. Fuel wood is used for boiling drinking water, hand washing, bathing, and for cooking. Because of the military presence in many Zapatista communities women may walk more than three miles to find a safe water source. As the access to resources diminishes women travel longer distances and work longer days to gather wood, carry water, and find grazing areas for livestock. With less food and fuel for the household women tend to feed their husbands and children first and often go hungry themselves. This results in a decrease in the woman's caloric intake and she is unable to compensate for the extra energy she spends acquiring resources to feed her family. "Eventually many women succumb to illness and malnutrition" (Bryant and Bailey 1997). Reduced availability of fuel wood and water also results in a need to conserve resources so the family may opt out of boiling drinking water which in turn effects personal hygiene as practices such as hand washing and bathing decrease. The family is less likely to wash fruits and vegetables as well. These situations often result in compromises and shortcuts that expose families to increased vulnerability to illness, especially in

women and children. Children who do not have access to clean drinking water are much more likely than adults to suffer from malnutrition. Later these children are more susceptible to developmental problems and other life long health issues. Statistically, children have the highest rates of diarrhea and death from malnutrition (Basch 1999). My research found that malnutrition, diarrhea, and dehydration were the leading causes of illness in children living in Zapatista communities. Additionally, many health promoters reported that even they were sometimes unable to purify their drinking water because of the hardship of finding and collecting fuel wood to burn for purifying drinking water (interview with 4 health promoters 2007).

Violence against women has increased with the militarization of Chiapas, and Indigenous women have experienced a disproportionate number of attacks. Women have endured a dramatic increase in the occurrence of rape and prostitution and the constant disruption of family and community values has further placed women in jeopardy. Men worry about going to their fields for fear of what might happen to their women and children during their absence. Some health promoters resigned from microclinics when paramilitaries threatened to rape their wives (interview with a health promoter, August 8, 2005). Soldiers and paramilitaries have continually subjected women to humiliation, harassment, and threats. According to reports from the human rights group Flag Blackened, one government official was quoted as saying, "The daughters of Zapatistas will be raped. First the wives, then the daughters" (Flag Blackened 1998). Prior to military occupation in 1995, most

Indigenous women knew their attackers, but today there is a striking increase in unknown assailants and gang rapes.

Rape has been widely used as an historical weapon in armed conflicts throughout the world for centuries. Uganda, Rwanda, Darfur, Haiti, Kuwait and Columbia have faced this issue in the past 50 years. Women and girls are the most frequent victims. According to the United Nations Department of Public Information, "Such acts are done mainly to trample the dignity of the victims... rape is the symbolic rape of the community, the destruction of the fundamental elements of a society and culture" (United Nations 1996)

According to Grupo Mujeres, an organization offering support to Chiapas victims of domestic violence and rape, most rapes go unreported, untreated, uninvestigated, and unpunished. Women fear reporting rape for a number of reasons. The Mexican authorities are indifferent and the victim's names are publicly released. Since assailants are released within two to three days, women also fear retaliation (Grupo de Mujeres 2001). Furthermore, the punishment for a convicted rapist in Chiapas is less than the punishment for stealing livestock (Ross 1995). Mujeres de San Cristóbal reported at least 50 women were raped within the first 18 months after the Mexican military arrived in Chiapas and today the number is well over a thousand. The Mexican army reportedly uses rape to "teach lessons" to Indigenous girls and women (CIEPAC 1998). Women are raped in their homes and young girls are followed home from school and raped. In one case, two sisters aged 11 and 13 were kidnapped, tortured, sexually abused, and finally murdered after being

held for ten days by Mexican soldiers (CIEPAC 1998). To date, no one has been charged in the murders.

Prior to the establishment of the Zapatista microclinics, long distances to clinics and hospitals prohibited women from seeking medical or psychological attention, leaving most women to cope with the trauma of rape in isolation. Grupo Mujeres reports that women who become pregnant as the result of rape frequently abort or place their infants up for adoption. Clandestine abortions are performed in Chiapas and are an extremely secret practice of the women. Little research is available regarding the statistics, mortality rates, or methods of these underground practices (Grupo de Mujeres 2001).

Prostitution is another consequence of the military occupation of Chiapas. Although prostitution is not traditional within Indigenous Mayan cultures, the deployment of thousands of soldiers into the area has resulted in the recruitment of many young girls and women into this new profession (Agencia EFE 2000). Children as young as 11 years old are sold or leased by their fathers to the military in trade for desperately needed food and supplies. Prostitutes earn between 30 and 50 pesos for every 10 to 15 soldiers while virgins bring a slightly higher price (CIEPAC 1998). Soldiers demand unprotected sex, which has resulted in increased cases of cervical cancer and sexually transmitted diseases. Many sexually transmitted diseases are so new to Chiapas that women did not know they existed, have no defense system, and no information about treatment (Eber and Kovic 2003). When condoms are used, they are carelessly discarded and children are seen "blowing up freshly used condoms like balloons" (CIEPAC 1998).

The importance of the women's health programs in the Zapatista healthcare system is immeasurable. The Zapatistas recognize the unique experiences of women and the long-standing oppression and marginalization Indigenous women have faced in Chiapas. For many women who visit the microclinics, "it is the first time any attention has been focused on the health of their bodies except as being baby machines" (interview with female Zapatista insurgent, December 30, 2008).

Women have been empowered by the passage of the "Revolutionary Law for Women" and the rebellion has changed the relationships amongst Indigenous women who have long been lonely, isolated, and without time to form friendships or social groups. Zapatista women have united and formed successful cooperatives, many of which support the microclinics and others that contribute small incomes to their households. Perhaps the most important benefit of the formation of women's groups has been the opportunity women have had to share their experiences regarding domestic violence, rape, birth control, and women's rights. The resistance has instilled an awareness and intolerance of violence against women and solidarity among women who have experienced generations of common oppression. Although reproductive health is discussed in Zapatista communities, family planning is not yet widely practiced. The Catholic Diocese believes family planning should only be taught to married couples and although the Zapatistas and feminists resist, most communities ultimately accept the church's rules (Eber and Kovic 2003). One progressive method used to teach women about their bodies involves sculpting clay figures of each woman, and then asking, "whom does your body belong to?" After discussions about the "parts" women give to their husbands, children, fathers,

mothers, priests, and God, there is nothing left. Then women are taught that they own their bodies and each woman is unique and beautiful. They learn that women have the right to take control of their minds and bodies. Women learn to communicate with men about equality and power, and the right to exercise their own sexuality. Furthermore, women learn they do not need to obey religious leaders who insist that they submit to their husband or the church's rules on family issues and birth control. Instead, women make their own decisions about marriage and maternity and that they need not exchange power for the security of a man (Eber and Kovic 2003). Women assumed positions in the Junta de Buen Gobierno and the EZLN command from the beginning of the rebellion. They work as teachers and health promoters and after an outbreak of typhus in Oventic several years ago it was the women who took charge and built latrines and a sewage disposal system.

New activists have been born in the villages. Women supporting the Zapatista struggle participate in new social movements, organize marches, boycotts, and hunger strikes. They have faced the Mexican army by closing city halls and forming human chains. In one community after three men were kidnapped and murdered by the army, the women sent their men to hide in the mountains and stayed behind to defend their homes. When the Mexican military returned for more of the men, women and children brandishing sticks and hurling stones turned the soldiers back (Flinchum 1998).

**Eviction and Displacement**

Hundreds of men have disappeared and tens of thousands of Indigenous men, women, and children have been displaced. In many cases, entire communities

have been forcibly removed from their ancestral lands (United Nations Commission on Human Rights 1999). Characteristically, the Zapatistas have responded by moving deeper into the mountains or fleeing to the Lacandon Jungle in the lowlands. Several years ago over 8,000 displaced Zapatista villagers settled in a remote refugee community of Polhó in the highlands of Chiapas. Food and healthcare were initially supplemented by the International Red Cross but in response to increased political pressure from the Mexican government and the war in Iraq, the Red Cross abandoned Pohló in 2004 leaving the community without a reliable source of food or medical care. The Zapatistas have a microclinic in Polhó which I visited a number of times during this study. This microclinic has the daunting task of providing health care for an estimated population of 12,000 to 16,000 thousand refugees.

**The Acteal Massacre**

In order to provide a perspective on armed conflict worldwide, "In the last 20 years 90% of all casualties in armed conflicts took place off the battlefield" (Leatherman 2005:63). Indeed, one of the most deadly incidents of militarization in Chiapas occurred in the Oventic caracole in the Polhó region on December 22, 1997. Paramilitary groups murdered 45 men, women and children at a chapel in the small community of Acteal. Most of the victims were women and children. In addition to the dead, at least 25 others were wounded. With no ambulances or access to immediate emergency medical care, the victims suffered greatly. Five of the women were pregnant and their attackers reportedly cut the babies from the women's wombs and tossed the bodies from bayonet to bayonet. The victims were members of a neutral group called, Las Abejas (The Bees). Although several people witnessed

the massacre and identified the assailants, no one was held accountable for the murders until 2002. Eventually 86 people believed to be members of a paramilitary organization with connections to the Mexican army were convicted and sentenced to 36 to 40 years in prison. Unfortunately, the intellectual architects of the massacre, believed to be Mexican army commanders, remain free (Mexico Solidarity Network 2007). On August 26, 2009 the Mexican Supreme Court ruled that 20 of the convicted murderers would be released based on grounds of "irregularities in the collection of evidence during the investigation and trial" (Mexico Solidarity Network 2009). Thirty additional prisoners convicted in the massacre are expected to be released at any time (Mexico Solidarity Network 2009).

**The Disruption of Healthcare**

Warfare also interrupts preventative healthcare programs such as early childhood vaccination programs, increasing the risk of dying from preventable disease. Clearly, most children do not die directly from conflict, but rather from diseases such as diarrhea, respiratory infections, and malaria when they lose access to preventative healthcare (Basch 1999). The World Health Organization reports that "Infectious diseases kill 15 hundred people every hour; the majority succumbing to just six groups of diseases: HIV/AIDS, malaria, measles, pneumonia, tuberculosis, and dysentery and other gastrointestinal illnesses" (Eyles and Consitt 2005). One of the three leading causes of death in the Oventic caracole in 2004 was gastrointestinal infection (OSIMECH 2004). Additionally, 77 communities reported cases of tuberculosis and 93 communities reported cases of malaria (OSIMECH 2004).

Although Indigenous children in Chiapas were largely denied vaccinations prior to the Zapatista rebellion, just a few days after the ceasefire was called in 1994, Mexican soldiers appeared in communities offering free vaccines in exchange for the names of Zapatistas. They also told mothers that they must return with their husbands to the vaccination clinic in order to have their children vaccinated (Interview with a clinic coordinator, December 28, 2008).

The vaccination program was one of the first major projects initiated in the Zapatista healthcare system. The Zapatistas are always in short supply of vaccines and a few years ago the vaccination program almost came to a standstill, however the program recovered with the aid on an international non-governmental medical organization. Today approximately 90% of children living in autonomous communities have been vaccinated for most childhood diseases (interview with a clinic coordinator, January 17, 2009).

**The Zapatista Response**

The Zapatistas have responded to the persistent threat of civilian targeted warfare through a number of strategic plans. Human rights observers are positioned in every community in the autonomous zones to observe and report harassment, intimidation, crimes, and human rights violations to the world...and the world is watching. Perhaps one of the most powerful weapons of the Zapatistas is their intensive international media campaign.

The Zapatistas have become accustomed to the subversive attempts of the government to divide communities by spreading rumors, gossiping, and trying to bribe leaders. One Zapatista told me it is difficult but they simply try not to respond

or be provoked by these tactics. Instead, she said, they unite and support one another and move forward, un poco, un poco (interview with a Zapatista, July 19, 2005).

As the army and paramilitaries continue their threats and attacks in order to impede humanitarian aid and medical care for Zapatistas and Indigenous communities, the Zapatistas mobilize. For example, when one community lost access to their traditional water source due to a military camp nearby, insurgents, Zapatistas, and Zapatista supporters carried water through the mountains for weeks until the soldiers moved on.

Of course the design of the Oventic Caracole healthcare system itself and the dedication of the clinic coordinators and health promoters are the strongest aspects of the healthcare system. After 15 years of civilian targeted warfare tactics, the Zapatistas are still here and the microclinics are still here. The strategic locations of the microclinics allow relatively easy access for patients from throughout the caracole to receive quality health care in or near their own communities. Health promoters continue to learn and train the upcoming generation of promoters. The system is working, and the Zapatistas are tenacious and unwavering in their goal of achieving a strong, organized, efficient health care system. As one health promoter told me, "No matter what the tactics they try, we are united, we are here, we will fight, and they can not make us disappear anymore" (interview with a health promoter, July 30, 2005).

# CHAPTER 7

## RESEARCH CONCLUSIONS

The Zapatistas are establishing a successful healthcare system that provides quality health care services to thousands of impoverished Indigenous people living in Zapatista autonomous zones. Following a political ecology approach, I considered the historical and contemporary political, social, cultural, environmental, and economic processes that effect Indigenous healthcare. I also examined the impact of globalization and neoliberal economic and political influences that threaten Indigenous rights, lands, natural resources, cultures, and life ways including the events that precipitated the Zapatista rebellion. In order to gain a comprehensive understanding of the challenges of creating and maintaining the Zapatista health care system, I examined the role of government-sponsored militarization and civilian targeted warfare. Special emphasis was placed upon the roles of health promoters, the microclinic model, the recovery of traditional medicines and healing methods, women's health programs, and the Zapatista's pursuit of autonomy. I assessed the overall healthcare system in the Oventic caracole and identified the strengths and weakness of the system.

It is likely that Indigenous people in Chiapas will continue to face many hardships and struggles. The neoliberal agenda of the Mexican government is moving forward and thousands of people in hundreds of communities stand in the

way of this perceived "progress." The 15-year Zapatista conflict continues as the Mexican army and paramilitary groups persist in employing methods of civilian targeted warfare against innocent men, women, and children. In spite of international protests against the Plan Puebla Panama multi-billion dollar mega-development plan, roads are already being forged through the Lacandon jungle and Indigenous communities continue to be evicted. International corporations such as Coca-Cola and Monsanto are increasing their land holdings and interests as they prepare to benefit from new development, access to natural resources, government contracts, and cheap labor. Little thought is given to the people who are struggling to save their culture, land, and centuries old way of life. But the Zapatistas continue to resist and continue to build their autonomous society. As one Zapatista remarked, "We won't go away in the darkness of the neoliberal shadow, the world knows our struggle and we will not give up the future of our children" (interview with the Junta de Buen Gobierno, January 14, 2007). The tenacity of the Zapatistas is demonstrated in their own development projects. They have established a government representative of the people, schools, cultural preservation initiatives, seed preservation programs, community cooperatives, small businesses, and health care. This study focuses on the goal of the Zapatista struggle to establish autonomous, sustainable, and accessible healthcare for thousands of Indigenous people living in Zapatista zones and surrounding rural areas.

One significant challenge of the Zapatista healthcare system is the growing dependence upon allopathic pharmaceuticals, which are largely provided by foreign sources. Although these pharmaceuticals are a valuable asset to the healthcare

system they are expensive and chronically in short supply. The Zapatistas do not intend to eliminate their use; however, they are striving to decrease the systemic level of dependency. The quest to recover traditional medicines and healing methods is a cornerstone of Zapatista autonomy. At the "Meeting of the Zapatista Peoples with the Peoples of the World" in December of 2006 a health promoter named Roel told delegates, "Great wisdom is not learnt in schools or in books but is the inheritance that has been left to us by our grandfathers and grandmothers..." (Villarreal 2007). For example many health promoters believe that western medical methods combined with the ancient art of midwifery could save the lives of many women and newborns. Health promoters in some communities are building alliances with parteras in order to increase their knowledge of women's health. This partnership exemplifies the desire to restore historical medical practices and honor the knowledge of the Zapatista ancestors. Health promoters and community members are trying to recover the use of traditional medicines, which are abundant and readily accessible. Significant progress has been made in the past five years and today traditional medicines and healing methods are used in patient care about 40% of the time in the Oventic caracole (OSIMECH 2004). The incorporation of these medicines is a critical step in achieving an autonomous healthcare system while preserving Mayan culture and identity. However, the recovery process is being threatened by the decimation of natural resources throughout Chiapas. Development projects such as Plan Puebla Panama will cut through some of the richest and most diverse natural resource areas in the world. The continued development and destruction of rain forests could destroy valuable traditional bio-

resources that have been used by Indigenous people for centuries.

The Zapatista healthcare system also recognizes the unique health needs of women and has incorporated women's programs in every microclinic. Women have been empowered to make decisions regarding their own health and bodies including reproductive issues, sexual relations, and wellness. The Zapatista rebellion unexpectedly became a movement for women's rights and changed the lives of thousands of Indigenous women living in Chiapas. After all, how could the Zapatistas proclaim their outrage at being oppressed and marginalized if women within their struggle continued to be oppressed and marginalized? Today in Zapatista communities' men and women work together in leadership roles and as health promoters, soldiers, teachers, and activists.

Hundreds of health promoters have completed intensive medical training and are engaged in educating the next generation of promoters. They continue to focus on wellness and preventative medicine while ensuring that every patient receives the best possible treatment at the microclinics. As health promoters become more proficient in their teaching skills the health promoter education system will be managed entirely by Zapatistas. The success of the Zapatista healthcare system can be largely attributed to the commitment and dedication of the health promoters.

Overall, the Oventic caracole microclinic system model has provided an important solution the problem of access to health care in rural communities as well as a civilian targeted warfare zone. People generally pass freely to the microclinics due to their strategic locations and as more microclinics are established patients

will travel even shorter distances. The microclinics are staffed 24 hours a day by health promoters who understand the unique health issues faced by people who share the same struggle and live in the same communities.

The Zapatistas have responded to the sustained militarization of the Mexican government in many ways. Within hours of the 1994 rebellion, the Zapatistas dispatched communiqués all over the world, telling the story of the Zapatistas. Subcomandante Marcos quickly became the spokesperson and face of the Zapatistas with his articulate speeches and eloquent manifestos. The massive international public relations campaign won the support of thousands worldwide. The Zapatistas continue to communicate their struggle through radio broadcasts (Radio Zapatista), music, documentary films, manifestos, newsletters, and internet sites. Funds from support organizations in France, Ireland, and other countries have helped with the construction of microclinics, infrastructure projects, and the purchase of medical supplies and pharmaceuticals. Medical professionals have responded by volunteering their time to work in the microclinics and train the health promoters. This support is likely due to the extraordinary efforts of the Zapatista communication system, which keeps the Zapatistas in the hearts and minds of their supporters.

The Zapatistas have also responded by shear tenacity. They work, un poco, un poco, focusing on the next step. They are patient and methodical. Human rights violations are documented and reported by international human rights observers who take turns living in Zapatista communities. The reports are posted on internet sites and in Zapatista communiqués. The Zapatistas maintain an army. The Mexican

government does not appear to wish to engage in another official armed conflict with the Zapatistas; just the fact that the Zapatistas are prepared for war may be a deterrent. The Zapatistas work toward autonomy by refusing any help from the Mexican government. Instead they have established their own government, schools, cooperatives, small businesses, and health programs.

Although the Zapatista caracole healthcare system faces many challenges, it is working. The system is expanding and addressing the needs of thousands of Indigenous people in Zapatista autonomous zones as well as non-Zapatista Indigenous communities. Plans are in place to build at least two more microclinics and some communities are working to acquire ambulances to meet the demands of emergency transportation in rural areas. Vaccination and wellness programs are increasingly effective and issues of clean water and sanitation facilities are being addressed. The Zapatista healthcare system is clearly saving lives and improving the quality of life of the Zapatistas.

Little primary research has been conducted regarding the Zapatista healthcare system and few if any researchers have traveled to all of the microclinics in the Oventic caracole or conducted studies of the microclinics. In addition to the study provided to the Zapatistas, this unique research has the potential to inform non-governmental organizations, human rights groups, scholars, and health workers about the Zapatista health system. It may contribute to a better understanding of the many healthcare issues faced by the Zapatistas regarding their health and access to healthcare. Organizations and individuals who wish to assist the Zapatistas in the acquisition of medical supplies and training may benefit from

this study and it may also serve as a baseline for future research in order to measure developments and progress as the healthcare system grows. Hopefully this work will provide an understanding of the goals of the Zapatistas regarding the future of healthcare. Physicians, medical personnel, and educators may benefit from this research if they are preparing to work in Chiapas or in other civilian targeted warfare zones. It is also my hope that this research will contribute to the understanding of people who may not know about the Zapatista struggle. Perhaps it will influence readers to learn more about the Zapatistas and to support them in their efforts.

A great deal of information related to the Zapatista healthcare system remains to be learned. Research of this kind can be of direct importance to the Zapatistas and to Zapatista supporters. Future research would be especially valuable if one could acquire more empirical quantitative data regarding each individual microclinic. This information could become readily available when all of the microclinics acquire computers. A useful database would include the following information on every patient contact: patient age, gender, community of residence, total number of pregnancies, number of live births, number of surviving children, chief complaint, medical history, family medical history, current medications, immunization history, height, weight, vital signs, physical exam findings, diagnosis, treatment including allopathic or traditional/herbal medicines or treatment, and patient counseling upon dismissal. This data would provide valuable demographics as well as important statistical medical information regarding disease trends, causes of death, infectious disease, vaccines, and overall health and wellness of

communities. A computer database could also track medical supplies, pharmaceuticals, and other microclinic business. This information would have contributed significantly to my research.

Examining the topic of healthcare is complex, and by definition doing so in a civilian targeted warfare zone presents very special challenges. I had to consider my own safety well as that of the Zapatistas at all times while protecting the confidentiality of my research. I worked and traveled in highly militarized zones and was subjected to roadblocks and the presence of rifle-toting soldiers in the city and in the rural areas throughout my research. The care and assistance of the Zapatistas helped to ensure my safety and the integrity of this work.

I set out to conduct applied research, a work that would provide a direct contribution to the Zapatista struggle. That commitment extended my research into a six-year project. As I conclude this work, I realize that every moment was well spent and I look forward to returning to Chiapas to resume my work for the Zapatistas. In addition to this thesis, I have constructed extensive studies, descriptions, and evaluations of the Oventic Clinic and each of the eleven microclinics. This information may be available to Zapatista supporters, non-governmental organizations, humanitarian aid groups, medical professionals, and other individuals who are working with the Zapatistas and have permission from the Junta de Buen Gobierno. Please contact me at Julie.Sullivan@colostate.edu with requests for information.

# APPENDIX

## The Revolutionary Laws of Women

*(Written someplace in the jungle, March, 1996)*

In their just fight for the liberation of our people, the EZLN incorporates women into the revolutionary struggle regardless of their race, creed, color, or political affiliation, requiring only that they share the demands of the exploited people and that they commit to the laws and regulations of the revolution. In addition, taking into account the situation of the woman worker in Mexico, the revolution supports their just demands for equality and justice in the following Revolutionary Women's Law.

First: Women, regardless of their race, creed, color, or political affiliation, have the right to participate in the revolutionary struggle in a way determined by their desire and ability.

Second: Women have the right to work and receive a fair salary. Women have the right to decide the number of children they will bear and care for.

Third: Women have the right to participate in the affairs of the community and to hold positions of authority if they are freely and democratically elected.

Fourth: Women and their children have the right to primary attention in the matters of health and nutrition.

Fifth: Women have the right to education.

Sixth: Women have the right to choose their partner and are not to be forced into marriage.

Seventh: Women shall not be beaten or physically mistreated by their family members or by strangers.

Eighth: Rape and attempted rape will be severely punished.

Ninth: Women will be able to occupy positions of leadership in the organization and to hold military ranks in the revolutionary armed forces.

Tenth: Women will have all the rights and obligations elaborated in the revolutionary laws and regulations.

## GLOSSARY OF ACRONYMS, DEFINITIONS AND TRANSLATIONS

| | |
|---|---|
| Campesino | Subsistence farmer, peasant farmer; usually Indigenous, generally associated with economic, social, and political marginalization |
| Caracole | In 2003 the Zapatistas created five caracoles (literally meaning spiral shells) and symbolic of all things coming together at the center; the caracoles serve as the places of communication for the five regional Juntas de Buen Gobierno (Assemblies or Councils of Good Government). |
| Casa de Salud | House of Health; small community based healthcare facility with very limited medical resources |
| CCRI | Clandestine Revolutionary Indigenous Committee<br>General Command of the Zapatista Army of National Liberation |
| CFE | Campañia Federal de Electricidad<br>Federal Electricity Company |
| CIEPAC | Centro de Investigación Economicas y Politicas de Accion Comunitaria<br>Center for the Economic and Political Investigation for Community Action |
| Collectivo | Small van or bus; usually carries 12-16 passengers; public transportation; economical method to travel long distances |
| Comisión Federal de Electricidad | Federal Electricity Commission (CFE) |
| Compañero/a | Companion, partner, friend, member of or supporter of the Zapatista struggle |
| Corazo'n Ce'ntrico de los Zapatistas Delante del Mundo | The Central Heart of the Zapatistas in Front of the World |
| Curandero | Traditional Indigenous Healers |
| Ejidos | Communal lands |

| | |
|---|---|
| EZLN | Ejercito Zapatista de Liberación Nacional<br>Zapatista Army of National Liberation |
| Fiche | Small card that verifies the carrier is a Zapatista or Zapatista supporter; presentation of the fiche provides free access to healthcare at Zapatista autonomous casas de salud, clinics, and microclinics; each microclinic region has a unique symbol or identifying mark |
| FLN | Fuerzas de Liberación Nacional<br>Forces of National Liberation |
| FZLN | Frente Zapatista de Liberación Nacional<br>Zapatista National Liberation Front |
| Iloletik | Traditional Indigenous healer |
| Juntas de Buen Gobierno | Assemblies of Good Government |
| Las Abejas | The Bees; a Catholic pacifist group comprised of Indigenous people from 48 communities in Los Altos in the Chiapas highlands |
| Maquiladora | A foreign-owned manufacturing plant in Mexico, generally near the border. Maquiladoras typically import materials and equipment duty-free and use low-paid employees to manufacture and export finished products or semi-finished products (American Heritage Dictionary of Business Terms 2009) |
| Municipality | A geographical area similar to a county |
| NAFTA | North American Free Trade Agreement |
| NGO | Non-governmental organization |
| OSIMECH | Community Health Organization of Indigenous Maya of Chiapas |
| PAN | Partido de Acción Nacional<br>National Action Party |
| Partera | Traditional Indigennous midwife |
| PPP | Plan Puebla Panama |

| | |
|---|---|
| PRD | Partido de la Revolución Democratica<br>Party of the Democratic Revolution |
| PRI | Partido Revoluciónario Institucional<br>Institutional Revolutionary Party |
| PROFEPA | Federal Agency for the Protection of the Environment |
| PRT | Partido Revoluciónario de los Trabajadores<br>Revolutionary Workers Party |
| Rebeldía | Official, authorized publication of the Zapatista resistance |
| Universal Precautions | Term used in the medical field that encompasses the steps taken in order to prevent the cross-contamination of air and bloodborne pathogens such as HIV, AIDS, Hepatitis B, Hepatitis C, etc.; through body fluids including blood, semen, vaginal, synovial, cerebrospinal, pleural, peritoneal, pericardial, and amniotic fluids |
| Zapatismo | Influential political tradition and way of thinking; emphasizes the restoration of rights of the dispossessed and social justice; so called in honor of Emiliano Zapata who was a beloved commander and agrarian reformer in the Mexican Revolution |
| Zapatista | Indigenous people and their supporters who are part of the resistance movement in Mexico; named in honor of Emiliano Zapata who was a beloved commander and agrarian reformer in the Mexican Revolution |

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