The Public Budget and Maternal Mortality in Mexico:
An overview of the experience

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The dynamics of maternal death in Mexico: brief overview

One of the explicit goals established at Cairo, Copenhagen and Beijing, was the reduction of the maternal mortality rate by 2001 to half of the levels it had during 1990[1]. There are at least three aspects internationally recognized as factors that contribute to reduce maternal mortality:

1) Access to medical attention
2) Skilled medical attention
3) Effective and prompt transfer to health centers with problem solving capabilities in situations of obstetric emergency.

The Mexican Health Ministry Action Report 1999-2000 acknowledged that "maternal mortality keeps having a decreasing tendency from 5.4 by 10,000 registered born alive in 1990, to 4.9 to 10,000 registered born alive in 1999"[2]. Even taking this reduction into account, the goal established for 2000 has not been yet reached. Moreover, maternal mortality rates registered in different states are quite varied, thus showing the gap between poor, marginalized regions, and regions that provide adequate services.

According to the before mentioned report, 20.8 percent of maternal deaths take place at home, and the main causes are hypertension disorders related to pregnancy, child birth and its afterwards, and pregnancy and labor-related hemorrhage. 68.3 percent of the victims are women without social security. Consequently, prevailing rates of maternal mortality are directly related to problems of access to health services, as 49 percent of all cases happen in communities with less than 15,000 inhabitants[3].

Despite the fact that for the past 13 years there have existed 3 different programs aimed at advancing in this issue, Mexico is not yet able to escape the immobility of maternal mortality rates. The estimated rate for 2003 is of 6.2, which is the exact same rate as the one observed in 1990[4].

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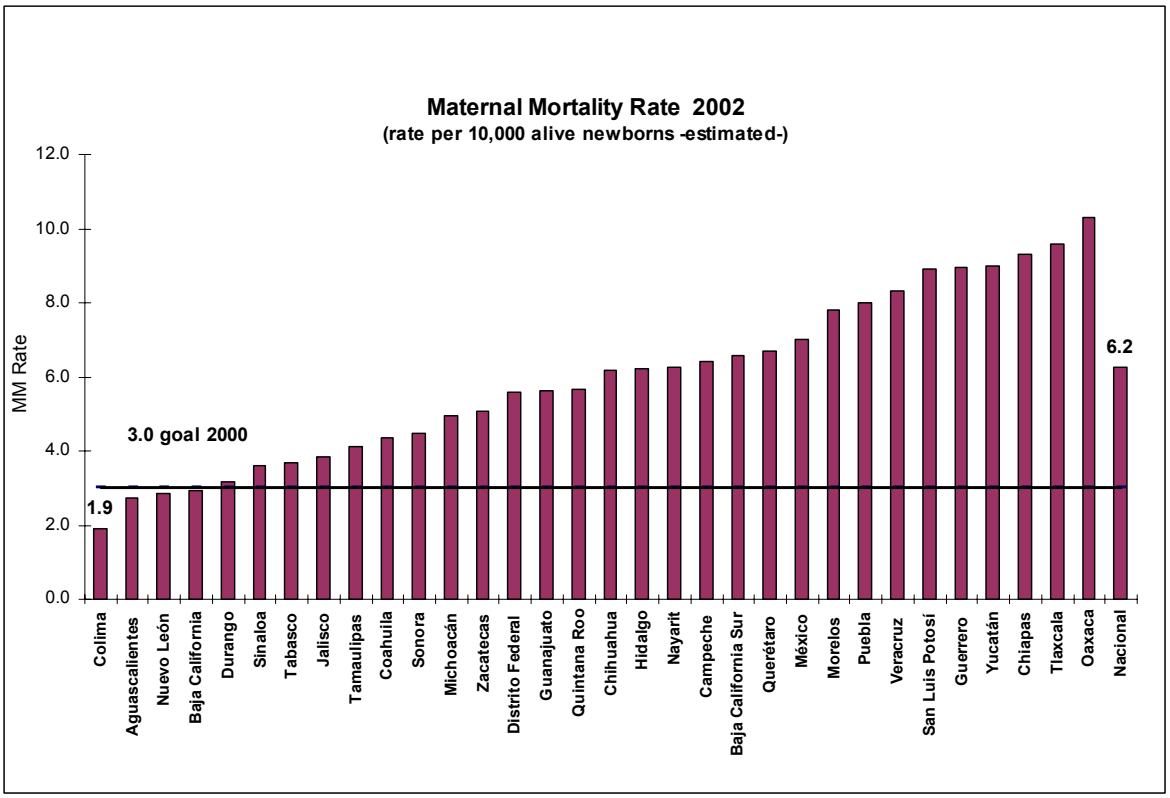
[1] See chapter 8.21 of *Cairo Program of Action*, paragraph 36d of the Copenhagen Program of Action, and action 106i of the Beijing Program of Action.
[2] Secretaría de Salud, *Informe de Labores 1999-2000*, p. 13.
[3] *Loc. cit.*
[4] Rate for every 10,000 births estimated by CONAPO (National Population Council). It is relevant to mention that with correction of non registered cases the rates are raised to 8.9 in 1990 and 7.3 in 2003. Executive Power, Third Annual Government Report, www.presidencia.gob.mx



Source: Self elaborated with data from SSA, *Salud: México 2002*, p.188, www.ssa.gob.mx
Rate of maternal mortality per 10,000 estimated alive newborns.
The rate of maternal mortality is not comparable with that of previous years due to the fact that since the year 2001 and back, the rates are calculated with a base of 10,000 registered newborns instead of estimated newborns.

Fundar's process of working on maternal mortality:

During 2002, Fundar, a center for analysis and research working on budget issues in Mexico, engaged in a project aimed at evaluating the extent to which public resources were being allocated to the reduction of maternal mortality. The Mexican government had committed itself to this goal at the international level, and it was enlisted as one of the government's main health objectives for 2000-2006. The sustained maternal mortality rate had also been one of the most persistent concerns of analysis and action for organizations and networks working on women's reproductive rights.

Despite having worked as one of the leading groups in Mexico's gender budget initiative[5], Fundar did not have the specific knowledge necessary to analyze to what extent the budget provided the resources needed to reduce maternal mortality. Fundar also lacked the leverage other groups had regarding the issue—due to their longstanding commitment and action for a safe motherhood. In order to carry out meaningful research and produce politically relevant information, the organization had to link up with groups that had substantial experience working on maternal mortality and reproductive health issues.

[5] The Mexican gender budget initiative started with the identification of reproductive health expenditures during 1998, carried out by the Foro Nacional de Mujeres y Políticas de Población. A year later, Equidad de Género, Ciudadanía, Trabajo y Familia, and Fundar started a joint initiative which has kept growing and involving diverse organizations, Congress and actors of the executive branch of government.

In order to achieve this, two paths were followed:

1. Formal collaboration with longstanding experts in the area of maternal mortality was established as a central part of the project. The objective was two-folded.

    a. On one hand, Fundar established an alliance with the researchers and activists, who best know the field, are respected for that knowledge and work in some of the most troublesome areas.

    b. On the other hand, by turning the project into a joint effort it was actually possible to go far beyond the analysis of the federal budget—combining findings with relevant information from the field. This was crucial in order to understand what was happening on the ground, and how resources were allocated in the most problematic areas.

2. In order to ensure the usefulness and appropriateness of the work, Fundar started its research by inviting CSOs and networks working on maternal mortality to provide their input. The research plan was outlined at a working meeting, at which basic premises where analyzed, discussed and validated. At the same meeting, women's organizations laid out the kind of information that would be useful to their efforts and campaigns.

Meetings and on-going exchange with the state-based experts and the wider group of CSOs were continued throughout the project, sharpening its political angles. Furthermore, a shared understanding of what was necessary to shed light on the issue of maternal mortality and prioritize resources towards its attention was developed.

The research document that resulted from the project offered more than a hundred pages of data, analysis and arguments. In order to turn this document into a tool for advocacy, several steps had still to be taken. As at the start of the project, a meeting was pulled together in order to discuss the findings and their policy relevance. The meeting clearly illustrated the arguments that had to be deepened, and the data and analysis that still had to be developed in order to make useful and strong arguments for maternal mortality advocates. It also established a plan for joint action and a deadline towards which to work.

An executive summary that responded to the interests of the groups that were going to engage in the political struggle regarding maternal mortality was designed. For Fundar, achieving this meant developing, building together and synthesizing many diverse arguments, in order to integrate the information needed for a politically acute struggle.

On part of the CSOs and networks involved in the topic, a series of meetings with both Chambers of Congress were arranged. One of these meetings was a public forum dedicated exclusively to the issue of maternal mortality, broadcasted on the Congress channel. The public officials responsible for the topic took part at the forum.

The capacity of these advocacy-experienced groups for opening up channels and making the findings of the research politically relevant was crucial. The right actors were convened—including federal health officials—and the information was disseminated in a meaningful and keenly strategic way previous to the discussion of the budget. Once the budget proposal for 2003 was tabled, further meetings were arranged in order to inform some of the decisions that were being made. Radio

interviews were broadcasted, and several articles appeared in national newspapers regarding the budget for maternal mortality.

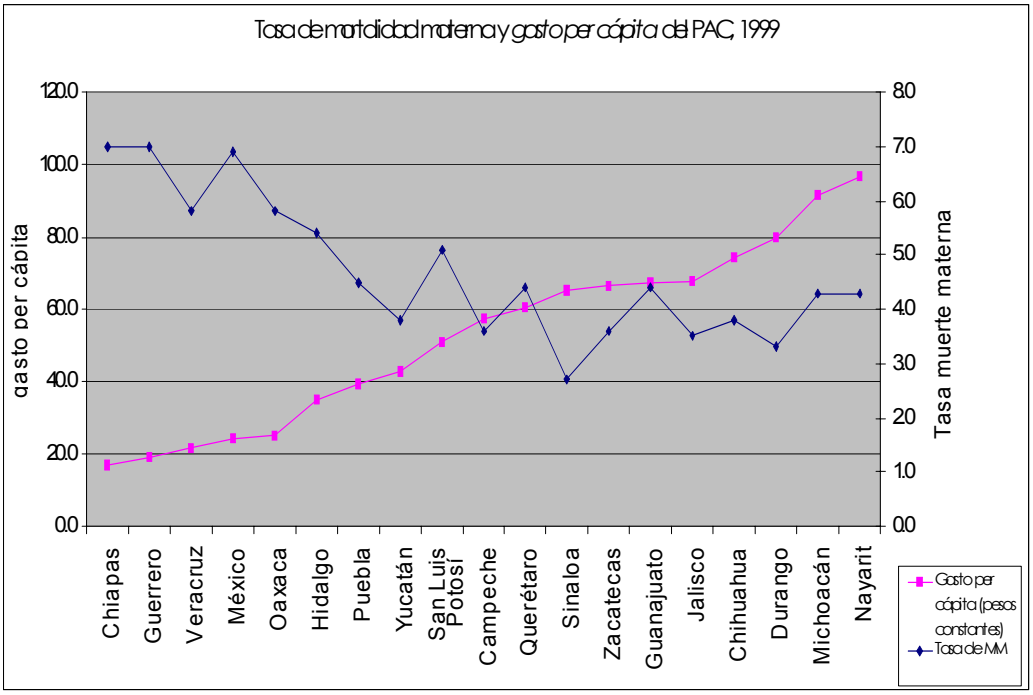
Initial findings—2002:

The monitoring activities that were undertaken revealed that the basic health services were thoroughly insufficient to face the challenge of reducing maternal mortality among the poor. This is mainly due to the fact that the basic health services provided to marginalized communities rely on mobile attention. This implies that they cannot offer the coverage and quality needed to guarantee a continual medical attention, effective and timely transfer of women to the second level of medical attention, real access to emergency services, and availability of blood transfusions.

This was clearly demonstrated with the analysis of the resources allocated to the Coverage Extension Program (PAC, "Programa de Ampliación de Cobertura"). Since one of the explicit goals of PAC was to provide "universal coverage" of basic health services, priority was given to the number of people reached, instead of putting emphasis on real access to health services. Therefore, every year the per capita allocation was reduced, decreasing from 4.6 to 3.8 US dollars per person between 1998 and 2001.

Consequently, the states with the highest amount of poor people had the lowest per capita allocations. As such, there is an inverse relation among the number of inhabitants and *per capita* spending by states. This inverse relation prevents the comprehensive attention of structural problems that have led some states to have alarmingly high maternal mortality ratios. Figure 2 depicts the maternal mortality rate in comparison with per capita allocation, clearly illustrating this disparity.

As a result of government's recognition of the insufficiency of health services that characterize the regions with higher indexes of poverty, as well as the urgency of attending the problem of maternal and child mortality, a new program had been launched during 2001: "Arranque Parejo en la Vida" (APV). This program specifically seeks to offer attention to the health problems during pregnancy, labor, and in the immediate period following birth. Its explicit goal is reducing maternal and child mortality. APV is linked to other programs that offer basic services to marginalized population, such as PAC.



Fuente: SSA, Programa Nacional de Salud 2001-2006, p. 40, www.ssa.gob.mx, SHCP, Cuenta de la Hacienda Pública Federal 2001.
Tasa por 10,000 nacidos vivos registrados en base a la población estimada por el CONAPO.
Pesos constantes con base año 1993.

Given the importance APV has as the only program focusing specifically on the reduction of maternal mortality, evaluating to what extent it can contribute to this goal was crucial. By highlighting its relevance, the initiative hoped to contribute to improve its budget allocation and its programmatic scope.

Nevertheless, the resources allocated to APV and the actions it proposed continued to be insufficient to solve the main causes of maternal mortality. Although this program puts emphasis on the continual treatment of pregnant women, it is not well prepared to face obstetric emergencies. The responsibility for medical attention falls on the medical staff which must also provide follow-up to other important programs of the Ministry of Health. Additionally, the responsibility for the transfer of women to second level attention falls on the community, which has limited resources to guarantee this. These shortcomings can only be addressed with an adequate allocation of resources.

For that reason, one of the objectives while talking with public officials and Congress members was to identify if the government would be able to allocate more resources. The table below, which compares PAC, APV and other expenditures, offered a view of the government's priorities.

Comparison between the allocations for PAC, APV and other programs or departments: 2002

Ministries	Program or Department	Total allocations (fixed currency)	APV as a proportion of the program	PAC as a proportion of the program
Ministry of Finance (SHCP)	Revenues collection and national fiscalization program	8,566,056,200	0.78	15.25
Ministry of Defense (SEDENA)	General Department of Administration	3,143,694,306	2.14	41.57
Ministry of Defense (SEDENA)	General Department of Sanitation	1,787,826,969	3.76	73.09
General Attorney Office (PGR)	General Department of Human Resources	1,443,800,499	4.65	90.50

Source: Ministry of Finance, Federal Budget 2002, Mexico www.sse.gov.mx

This argument was highlighted at public forums held together with SIPAM and "Foro Nacional de Mujeres y Políticas de Población", at the Senate and the House of Representatives. The discussions were carried further in the media, definitely contributing to inform the budget debate. As a result, important modifications to the resources allocated to APV at the decentralized level took place. In branch 33 of the budget, which encompasses decentralized health allocations, 600 millions were earmarked for APV during 2003, to provide information and attention in the field of motherhood-childhood health. Furthermore, Congress decided to allocate additional resources to APV at federal level, increasing the executive's proposal of 49 million to 75 million.

Second round—2003:

As a continuation of previous efforts, during 2003 the Mexican Government sought to extend the operation of the program *Arranque Parejo en la Vida* (APV) from 17 states to the whole country (31 states and the Federal District). Regarding maternal mortality, the program's goals for 2006 are to "diminish in 35% the mortality rate in relation to the one registered in 2000 and to reduce 30% the number of maternal deaths in relation to those registered in 2000"[6]. This means that by 2006 the maternal mortality rate should be reduced to 5.1 and the number of deaths to 1,090.

The research carried out during 2003, at federal level and in three states (Chiapas, Guerrero and Oaxaca), interlinked the health sector's human, material and financial resources for population without social security. The main conclusion reached was that the program cannot resolve the problem of maternal mortality. Hence, the goal of reducing the maternal mortality rate faces serious difficulties. These obstacles reside,

[6] SSA, Programa de Acción de Arranque Parejo en la Vida, p. 55.

above all, in the amount of resources allocated to APV and in the conditions of profound inequality between states—and between the sanitary jurisdictions and municipalities within the states.

- The program has a weakness in its very design: its dependence on the private sector to cover basic needs for its proper functioning. This endangers an effective and efficient continuity of the services it offers. For example, in the period 2001-2002 the contribution of the private sector in terms of equipment was 217.3 million pesos. This amount represents 156 times the public capital expenditure allocated to APV.

- The program does not incorporate resources for infrastructure. For the past three years the expenditure for public health infrastructure at state level, through the Health Services Contributions Fund (FASSA, decentralized health expenditures) has been decreasing.

- It does not contemplate hiring additional health service workers. This represents an initial weakness since one very important problem is the lack of sufficient personnel, especially gynecologists. In the states with the highest rates of maternal mortality the proportion of specialists in gynecology per women in reproductive ages (and without social security), is very low: 7,490 women per specialist in Chiapas; 6,895 in Oaxaca; 4,132 in Guerrero; 3,147 in Tlaxcala and 6,307 in Puebla.

- The program does not incorporate clear mechanisms to grant attention in emergency situations. It does not include means of transportation of patients to a medical institution or center of secondary care when required.

- Resources allocated to the program are not spent in a timely fashion: by June 30, 2003 only 33.45% of the resources had been spent[7].

- In 2003, the program's budget came from the Ministry of Health (Secretaría de Salud) and FASSA (decentralized health resources), and therefore registered a considerable increase. However, the resources earmarked for the program not necessarily represented an improvement of the conditions for attending women during pregnancy, birth and post-birth. The deficiencies in budget allocation criteria reproduced prevailing inequalities between the different states. For example, Chiapas, with a maternal mortality rate of 9.32 (per 10,000 estimated alive newborns), was allocated 980,192 pesos. In contrast, Nuevo León (with a rate of 2.85) received 23,968,069 pesos—practically 25 times the amount received by Chiapas.

- When analyzing the amount of resources allocated to Infrastructure in diverse ministries of the Federal Government, other priorities are made evident in terms of distribution of public expenditure. Important inconsistencies stand out when one analyzes the amount of resources given to Ministries that don't belong to the social area in comparison to resources allocated to the APV.

[7] Source: Secretaría de Hacienda y Crédito Público, Informe de Avance de Gestión Financiera Enero-Junio, 2003, www.shcp.sse.gob.mx.

Allocated Expenditure for Infrastructure in 2003 for Public Offices (current pesos)

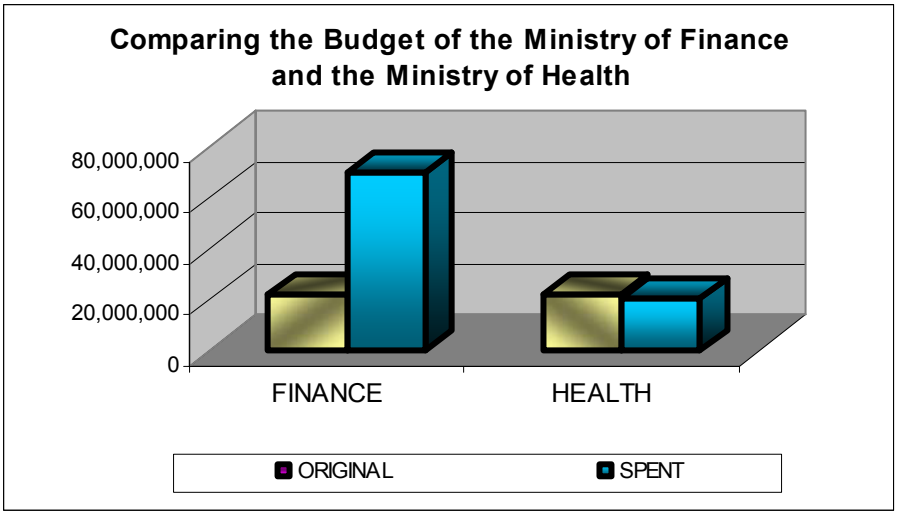
Public Office	**Spent by June 30, 2003**
Ministry of Treasure, SHCP (to administer and grant material resources to administrative offices)	11,883,000
Ministry of Treasure, SHCP (to carry out the institutional controls foreseen in the Annual Control Program (PACA)	9,037,000
Ministry of Interior, Gobernación (for the redistribution, conservation and maintenance of physical spaces and facility conditioning)	59,185,224
PGR (construction, conservation and maintenance of basic infrastructure)	60,000,000
Arranque Parejo en la Vida	0.0

This information was shared with diverse civil society groups, public officials and legislative staff along the year with the objective of influencing, in a coordinated and strategic manner, the discussion concerning the allocation of resources. In the 3rd Conference of Committee Promoting a Safe Motherhood, Fundar presented research advances. The budget analysis regarding actions aimed at reducing maternal mortality generated wide interest as a new indicator that sheds light on the reasons for sustained maternal mortality since 1990. Also, Fundar participated in the National Forum of Maternal Mortality, organized by the National Coordination of Indigenous Women (CONAMI) and K'inal Antzetik.

In the eve of the Minister of Health's official address to the Senate, FUNDAR in cooperation with other organizations such as "Salud Integral para la Mujer" (SIPAM) and Consorcio para el Diálogo Parlamentario among others, delivered a file posing specific questions and offering documents elaborated by a wide range of Civil Society Organizations. The outcome was that many of these questions were raised to the Minister of Health by the Senators.

FUNDAR, along with Consorcio, Foro Nacional de Mujeres, SIPAM and K'inal Antzetic, reached an agreement with the Gender and Equity Commission of the Chamber of Deputies, to organize a press conference. The participants were the media, legislators of diverse political parties and the representatives of the Civil Organizations; the meeting was transmitted by the Congress' T.V. circuit and published in the Chamber of Deputies' Bulletin. Finally, this information was presented to legislators from the Health, Gender and Budget Commissions within the Chamber of Deputies, in an informative session organized by FUNDAR, in order to discuss the Budget Proposal for 2004.

Again, one issue that was underscored was that the government had additional resources, which have been allocated year after year to expenditures that lack social criteria. As such, it continued to be a matter of prioritization to put more money into APV and health. It was highlighted that the expenditure balance of 2002 revealed that the Ministry of Finance had increased its allocation during that fiscal year by more than 200 percent.



This amount was 21 times more as the resources that had been allocated to the improvement of health infrastructure during 2000, 2001 and 2002 together. Furthermore, the Ministry of Health failed to use 2.9 % of its budget, an amount that would have allowed to multiply APV's resources by 9 times.

Latest perspective—findings 2004:

After monitoring the program implemented to reduce maternal mortality in Mexico, the budget 2004 brought an unpleasant surprise. The program had been "absorbed" into broader expenditure concepts, thus complicating its evaluation and follow-up. As a response on a formal information petition, it became clear that, once again, the way the government was dealing with the program had changed. The budget of APV was now composed of three different slots:

1. A part of the resources was coming through the National Center for Equity and Reproductive Health, a new structure in the Ministry of Health's organization.
2. A second part, and by far the largest one, was supposed to be allocated through a new scheme of health protection for people without social security.
3. A third part was, as before, allocated via decentralized resources (FASSA, branch 33); without being earmarked as such.

The lack of disaggregation and clear identification for the resources going into APV implies a series of steps backward. Some of the most important issues are the following:

1. First and foremost, there has been an alarming decrease in resources between 2003 and 2004.

2. The fact that the budget for APV has been integrated into the health protection scheme, which covers all possible diseases and illnesses, calls for caution. There is no way to ensure that these resources are actually channeled into maternal mortality related interventions, instead of just feeding a general bag of resources for basic health services.

3. This same lack of disaggregation has another shortcoming: when the budget 2004 was approved by Congress, its resources were cut back by 1,716 million pesos. There is no way of identifying the extent to which this cut back affected the resources that should be dedicated to the implementation of APV.

4. Furthermore, since the resources have been grouped in the more general health protection system, their distribution does not match criteria that are related to maternal mortality. No evaluation indicators for this specific goal are included, and the geographic dispersion of the areas in which the health protection system operates is not the same as the dispersion of the areas where maternal mortality is the highest. This is due to the fact that the health protection system operates primarily in urban and semi-urban areas, instead of in remote rural areas.

5. Last, but by no means least, the program does not render reports on its progress, and continues to be aggregated in the same way in the budget proposal for 2005.

Arranque Parejo en la Vida' s Expenditure 2002-2004 in the Public Budget (nominal pesos)

Ramos	2002	2003	2004	2005
ramo 12	63,466,100	59,078,809	**n.a**	**n.a.**
ramo 33	-	599,353,709	**n.a.**	**n.a.**

Source: Secretaría de Hacienda y Crédito Público, Cuenta de la Hacienda Pública, 2002 y 2003, PEF Aprobado 2004 y PEF Proyecto 2005, www.shcp.sse.gob.mx.

Arranque Parejo en la Vida's Expenditure 2004: Information Request through the National Insitute of Acces to Public Information (IFAI) (nominal pesos)

Source	Concept	2004
ramo 12 (SSA)	National Center of Gender Equity and Reproductive Health	49,342,789*
ramo 12 (SSA)	Social Protection System (Seguro Popular)	359,000,000
ramo 33 (descentralizad funds)	-	-

*Nota: This amount includes personal services (salaries) which is 20,770,684 pesos.
Source: Dirección General del Centro Nacional de Equidad de Género y Salud Reproductiva, oficio 2418, del 06 de mayo de 2004. Secretaría de la Función Pública, solicitud número: 000120000310

The overall results of the maternal mortality and budget work:

The research and advocacy that has been carried out has had several different results, which can be groups in 4 categories:

1. *Effect on the policy:* In 2002, the federal government earmarked a substantial amount of decentralized health resources to programs specifically targeting

maternal health. As such, the program *Arranque Parejo en la Vida*, a recent effort on part of the new government, increased from 62 to 602 million pesos—almost 900 percent. Furthermore, the arguments of Congress members working on gender, equity and health were bolstered, and the agenda of longstanding committed groups was reinforced with new information, and articulated in terms in which the government had no possibility of denying its validity.

2. *Moment building:* The strategic alliance between Fundar and the network of groups dedicated to the reduction of maternal mortality has been continuing uninterruptedly. All sides have benefited from the development of a shared perspective, as well as from understanding what they can offer to each other. The interaction and research has ensured that Fundar staff develops a deeper understanding of relevant issues related to gender and health, while solid budget information that is crucial for advocacy in the sector has been made available to activists working on the topic. Furthermore, the profile of maternal mortality was raised, building sustained momentum for advocacy. Health officials started to be interested in the project, examine its findings and ask for advice in order to defend their budget and make a case for the priority character it should have.

3. *What worked:* One of the important strategic choices made within the wider network was to contrast the money allocated to maternal and reproductive health with other areas of spending. As such, we decided to highlight that resources were indeed available, but had been spent on something else—in detriment of health expenditures. This made our argument defendable even for officials of the health ministry themselves, because they felt backed up against outside decisions to reduce their budget. In a similar way, Congress people working on health and gender felt backed up by the information provided to them, in order to call the executive to account for its budget decisions.

4. *Lessons learned:*
   - The research responded to the issues identified by the groups working on the topic on a daily basis. This made the results meaningful to their efforts.
   - The information was presented in a timely fashion, making use of the political opportunities offered by the discussion of the budget—as well as by the strength stemming from a broad coalition.
   - A shared perspective and a common understanding were built, thus allowing for a constructive alliance and future collaboration.
   - The different strengths of different actors were made use of, in order to achieve better results.
   - The ground was established for further collaboration with the Health Ministry, in order to turn the effort into a continued struggle.

5. *Outside factors that contributed to the success of the strategy:* On the normative or institutional side, there were several factors that contributed to the strategy, and that have strengthened it further throughout the following years:

   a. The Mexican government had committed itself at the international level to the reduction of maternal mortality; this commitment was also enshrined in the administration's health program. As such, the analysis carried out could be directly related to what this government was saying and expressing as concerns.

b. In 2003 an access to information law was passed in Mexico. This has made it possible, in subsequent efforts, to request more information and access more detailed data.
c. In 2003 as well, a change in the structure of the Ministry of Health contributed to a stronger interaction and discussion within the Department.