Mexico Case Study: Civil Society and the Struggle to Reduce Maternal Mortality

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I. Introduction and conceptualisation

In 1987 at the First International Safe Motherhood Conference, in Nairobi, Kenya, the Director General of the World Health Organization, Dr. Halfdan Mahler, described maternal mortality as:

> A neglected tragedy, neglected because those who suffer it are neglected people, with the least power and influence over how national resources shall be spent; they are the poor, the rural peasants, and above all, women.[1]

Maternal mortality – defined as death that results from pregnancy, while giving birth, or within 42 days of childbirth or the termination of a pregnancy – is a tragedy as it results not only in the loss of a human life than could be prevented in most cases, but also in the break up of a family. Although at first it could be construed as a narrow public health concern, maternal mortality is actually a complex issue and an excellent indicator of a country's democratic and social health, as it intertwines with a variety of problems such as gender equality, poverty, marginalization, and a State's ability to effectively deliver basic services to all its citizens.

In the last two decades there have been truly impressive efforts at the local, national, and international levels to reduce maternal mortality. Yet the problem persists in the developing world where 98 percent of these deaths occur.[2] Nongovernmental organizations, primarily in the area of women's reproductive rights, have been key leaders in this struggle. These organizations benefited from having the reduction of maternal mortality as one of the Millennium Development Goals (MDG), with a targeted reduction by three quarters of the maternal mortality rate of 1990 by year 2015. This should be an attainable goal, as it does not rely on the discovery of new medicines nor treatments, only access to adequate health care: the fact that these deaths persist is a grave social injustice and a violation of human rights of the most vulnerable people at one of the most sacred moments of life.

In Mexico, the issue gained relevance in recent years as an unusually high rate of maternal mortality underscored the fact that this was a problem where more could be done: this was not the result of the limitations of modern medicine, nor the inevitable result of underdevelopment, as even with limited resources much headway could be made. It was principally a failure of political will and attention, as reflected in poor policy design and inadequate budget allocations. Nationwide, the women, families, and communities who suffer the highest rates of maternal mortality are poor, rural peasants, indigenous peoples, many of whom do not speak Spanish. Most are in much the same situation today as they were in 1990, the benchmark year for the MDG. How can organized civil society offer a vehicle for these communities to overcome this neglect and address this social injustice? How can these communities and their advocates not only win policy commitments from the State, but also turn those policy commitments into actual reforms, increased spending, and improved governmental practices?

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[1] G. Mahler statement, First International Safe Motherhood Conference, in Nairobi, Kenya, 1987.

[2] Kimberli Keith-Brown., 'Investing for Life: Making the Link Between Public Spending and the Reduction of Maternal Mortality'. Fundar, Centro de Análisis e Investigación, A.C., International Budget Project, Population Council, Mexico, 2005, p. 11.

The campaign under study in this paper is the long-term effort by civil society organizations, (women's organizations, policy and budget analysts, and health specialists) to prod government to take this issue more seriously and to provide the leadership, programmatic changes, and the funding necessary to reduce the high levels of maternal mortality. In recent years this campaign concentrated on the analysis of the federal budget and on the reproductive health policy design, and revealed the possibilities and limitations of national level policy advocacy in Mexico. This has been complemented by research at the state level and followed by more recent efforts at advocacy on service delivery and the use of funds at the state and local levels. In spite of the enormous difficulties that this campaign has had to overcome in such an adverse and complex environment, it is the argument of this paper that these efforts were successful in achieving their short-term goals (placing maternal mortality on the political agenda, improving health care policy, increasing budget allocations) and offering initial progress in the ultimate goal of reducing the rate of maternal mortality. This effort therefore offers important lessons for other civil society movements in Mexico.

The goal of this study is to describe and analyze the key factors underlying the impact and limitations of citizen engagement in modifying public policy in Mexico related to the reduction of maternal mortality. In addition to highlighting the conditions under which citizen engagement can contribute to the formulation and implementation of national polices that have a positive impact on the poor, this case study will offer some preliminary observations about the limitations and trade-offs involved in such efforts, in a context of extreme marginalization, the decentralization of state services, and uneven democratization.

II. Maternal mortality in a broader political and socio-economic context

Democratic transition and the unequal geographic spread of this transition in Mexico

For seven decades, Mexico was characterized by a dominant, single-party State. The country's first opposition party president was elected in 2000, marking an important moment for the country's still ongoing democratic transition. This transition had begun at the sub-national level, where the ruling party, the Institutional Revolutionary Party or PRI, had lost a series of mayoral and gubernatorial elections as early as 1989 and then lost its majority in Congress in 1997. The electoral decline of the ruling party at the national level was driven by a specific set of factors: the recurrence of economic crisis that had undermined the regime's legitimacy and its ability to co-opt dissidents, as well as changes in the international context after the end of the Cold War that increased external pressure for democratization, the break up of the political elite and the mobilization of social groups, civil society organizations, and civic alliances representing different sectors and ideologies but commonly committed to free and fair elections.

The alternation of party in the Executive was a major breakthrough in Mexico's democratization, raising many expectations among both nationals and foreigners. However, it was soon evident that this was only one step forward, and that many more advances should be made in order to consolidate Mexican democracy. It is important to point out, for example, that this democratic transition has been uneven, and in many cases state and local politics are dominated by caciques, and civil

society is often under-developed, on the defensive, and has limited capacity to engage in the public policy process.[3] As Susan Franceschet and Laura McDonald point out:

> Despite the rise of a citizenship discourse, it is important to emphasize the distinct nature of the transition to democracy in Mexico […] Mexican democratization was more a result of a decomposition of the previous order than the result of a massive opposition between state and civil society. No strong organized opposition with roots in labor or peasant movements emerged to challenge the dominant regime.[4]

This lack of a firm social basis for the democratic transition has also continued to characterize Mexican civil society more generally, as well as the effort to reduce maternal mortality.

The last decade presented the first real opportunity for civil society organizations to attempt to engage in policy debates. As a neophyte operating in a newly democratic and open context, civil society's influence upon public policy has been uneven. This novel environment has also influenced the Fox administration, which also has suffered from its incapacity to advance public issues on its agenda with the legislature. Indeed, one of the most important challenges to the Executive has come from the Congress, where none of the three major parties has held a majority since the PRI lost theirs in 1997.[5] For decades the legislature was little more than a rubber stamp for presidential initiatives. But over the last decade this relationship has changed, as the Executive no longer dominates the policy-making process and the legislature has not fully developed its capacity to act as an effective counterweight, creating an odd mixture of deference and defiance in the legislative process.[6] Members of Congress cycle in and out every three years in the lower house and every six in the Senate, undermining their ability to develop a strong legislative

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[3] Chappell Lawson explains that 'democratization has not proceeded at the same pace across all regions or spheres of government. As a result, Mexico's new political order comprises a series of authoritarian enclaves in which the old rules of the game still operate. These include the federal bureaucracy, the judiciary, and portions of the mass media, as well as local fiefdoms dominated by unreconstructed elements of the ruling party'. Chappell Lawson. 'Democratization and Authoritarian Enclaves in Mexico'. Massachusetts Institute of Technology, Mexican Studies/Estudios Mexicanos, Summer 2000, http://web.mit.edu/polisci/research/lawson/democratization_and_authoritarian_enclaves.pdf (accessed 4th September 2007). Jonathan Fox makes the same point. Jonathan A. Fox. 'The Difficult Transition from Clientelism to Citizenship: Lessons from Mexico'. *World Politics*, Vol. 46.2, January 1994, pp. 151-184. Also available at: Center for Global, International and Regional Studies. Reprint Series. (Paper CGIRS-Reprint-2005-5), http://repositories.cdlib.org/cgirs/reprint/CGIRS-Reprint-2005-5 (accessed 4th September 2007).

[4] Susan Franceschet and Laura McDonald 'Hard Times for Citizenship: Women's Movements in Chile and Mexico'. Citizenship Studies, Vol.8.1, March 2004, p.17.

[5] The Chamber of Deputies at the end of Fox's administration was divided 40.8 per cent for the PRI, 29.6 per cent for the PAN, and 19.4 per cent for the PRD, while the Senate was divided 45.3 per cent for the PRI, 36.7 per cent for the PAN and 11.7 per cent for the PRD. The legislature elected in July 2006 is even more equally divided: 42.2 per cent for the PAN, 32.8 per cent for the PRD and 22 per cent for the PRI in the lower house; and 42.2 per cent for the PAN, 28.9 per cent for the PRD and 27.3 per cent for the PRI in the Senate. 'Obligados a negociar'. *Reforma* (Congreso), 3 July 2006.

[6] Defiance occurs between key leaders of opposition parties and secretaries or the president. For example, the head of the lower chamber of the PRI blocked major fiscal reform during the Fox administration and accused the Treasury Secretary of 'fiscal terrorism'. Within the committee context, however, in the process of drafting legislation members of Congress are often much more deferential to experts from the relevant administrative department.

capacity, weakening any ties of accountability with their constituencies, and concentrating power in the hands of party leaders.[7] The shifting role of Congress can be traced via indicators of legislative productivity. The legislature passed more of its own bills, while the percentage of executive-sponsored bills gaining passage has declined, and the executive now uses the veto with increasing frequency.[8] The result was reflected in the lack of progress on major structural reforms – fiscal, labor, State – and became a constant criticism of the administration.[9]

The growing independence and importance of the legislative branch, combined with its lack of capacity and longevity, create an important opportunity for civil society organizations. Advocates can find points of entry with sympathetic representatives, and policy experts can offer critical skills, analysis and data to relevant committees. The legislature can thus look to NGOs and their expertise to generate proposals, data, and analysis, and see them as a potential resource and ally, as was the case of the NGOs that campaigned to reduce maternal mortality. This opportunity, however, is tempered by the strength of parties in the legislature and the tendency to vote in cohesive blocks.

The state of civil society and the opportunities it has for input and influence at the level of the national government

While official sources and some international studies such as the Johns Hopkins Comparative Nonprofit Sector Project regard civil society in Mexico as relatively small and under-developed, it is clear the sector has played an important role in the country's democratic transition.[10] Despite this role and despite being heavily concentrated in the Federal District, the seat of the federal government, civil society organizations have not yet built a strong track record in influencing national policy. This is largely because the opportunity to influence policy is relatively new and the channels that do exist are ill defined and limited in scope. In addition, as often occurs in 'transition' democracies, many civil society organizations (CSOs) in Mexico have had difficulty moving from protest to proposal, or finding their place in the spectrum of possibilities that lie between these two extremes. National civil society networks exist but tend to be tenuous and coalition work is still not as common as in other countries.

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[7] See Alejandro Poiré. '¿Democracia y Legalidad sin Reelección?'. Conference at the Asociación Iberoamericana de Gobierno y Políticas Públicas, Mexico, April 28 and 29, 2003, http://www.ibergop-mx.org/documentos/1/2/7/art/archivos/3brynibr.pdf (accessed 4th September 2007).

[8] The percentage of executive-sponsored bills gaining passage has declined from 99 per cent in the two sessions prior to 1997, to 72 per cent during the most recent legislature The veto was never used in the decade preceding 2000, but wielded by Fox ten times during his term. Jeffrey A. Weldon. 'Poder Legislativo, tiempos de cambio', *Este País*, No. 181, Mexico, Abril 2006, pp. 36-40.

[9] This is best exemplified by the Fox administration's failure to pass a fiscal reform aimed at strengthening the national government's ability to collect taxes. Nonetheless, a number of important initiatives related to the democratic transition did pass, including: the Federal Law to Encourage Activities of Civil Society Organizations, Absentee Voting Rights, and Access to Public Information and Transparency, which is discussed below.

[10] See Lester M. Salamon, H. Anheier, R. List, S. Toepler, S. W. Sokowolowski *et al*. *Global Civil Society: Dimensions of the Nonprofit Sector*. Johns Hopkins Center for Civil Society Studies, Baltimore, 1999; and Alberto J. Olvera. 'Civil Society in Mexico at Century's End'. In: Kevin J. Middlebrook. *Dilemmas of Political Change in Mexico*. Institute of Latin American Studies, London, 2004.

Informed observers view a number of exceptions to this characterization of civil society in Mexico: human rights and democratization groups, advocates for access to public information, and women's rights organizations and networks. Democratization networks, with Alianza Cívica being the most well-known and documented example, played a key role in bringing about free and fair elections in Mexico – no mean feat. The groups that advocated for and won passage of the Federal Law for Transparency and Access to Public Information in June of 2002[11] also helped to create (and staff) the Federal Institute for Access to Public Information (Instituto Federal de Acceso a la Información Pública, IFAI).[12] Finally, women's groups and their coalitions, particularly, advocates for women's reproductive rights, have a long track record and longstanding support from international funders and allies. [13]

The campaign to reduce maternal mortality engaged two of the three strongest networks in Mexico, women's groups and those that had been working on budget analysis and public funds transparency. This partnership proved to be strategic. On the one hand, the transparency movement contributed budget research, documentation, and monitoring of governmental policies; on the other hand, the policy expertise and wide-ranging skills of the women's groups provided the substantive policy foundation of the campaign a high level of political acumen.

Provision of Health Care

Access to healthcare is a basic right guaranteed by the Mexican constitution and the general health bill, the legal framework that sets the guidelines for healthcare.[14] In addition, this right is stated in several international human rights agreements, to which the Mexican government is a signatory. These include the International Covenant on Economic, Social and Cultural Rights (1981), and the Convention on the Elimination of all Forms of Discrimination Against Women (1979), in articles 11 and 12. How well the government fulfills these obligations is a key indicator of its progress in the democratic transition.

For decades, the healthcare system in Mexico was based in three pillars: (1) the mandatory health insurance for all employees of the private sector, which is financed by contributions from employees, employers, and the government, and administered by the Mexican Institute for Social Security (IMSS)[15]; and its counterpart for employees of the public sector, administered by the Institute of Social Security and

[11] See 'Ley Federal de Transparencia y Acceso a la Información Pública Gubernamental', in Instituto Federal de Acceso a la Información Pública, www.ifai.gob.mx (accessed 4th September 2007).

[12] The principal advocate for the law was the Oaxaca Group, consisting of eight lawyers. Despite its name, the Group was largely centered in the Federal District and the negotiation of the law took place at the elite level with important support from journalists. This offers an interesting contrast to the case study of India where advocacy for public information is a more grass roots and popular movement. Juan Francisco Escobedo. 'Movilización de opinión pública en México: El caso del Grupo Oaxaca y de la Ley Federal de Acceso a la Información Pública'. *Derecho Comparado de la Información*, No.2, Jul-Dec 2003: http://www.juridicas.unam.mx/publica/librev/rev/decoin/cont/2/art/art3.pdf ,(accessed 19th September 2007).

[13] Murdock interview and Family Care International. 'The Safe Motherhood Initiative: A Review 1987-2005'. Family Care International working paper, New York, 2006.

[14] Helena Hofbauer and Gabriel Lara, with the collaboration of Bárbara Martínez. 'Health Care: A Question of Human Rights, not Charity'. Fundar Working Paper, 2002, p. 6, http://www.fundar.org.mx/secciones/publicaciones/PDF/doc-healthcareaquestionofhumanrights.pdf.

[15] Instituto Mexicano del Seguro Social. It would be the equivalent of Medicare in the US.

Services for the State's Employees (ISSSTE)[16]; (2) private medical services, financed by the users; and (3) medical services for the general public, which generally serve those without access to either public or private insurance. This third pillar consists of hospitals and clinics that mainly serve those who are either unemployed or those who work in the informal sector. Although the government provides the bulk of the financing, it also charges a 'recovery fee' (*cuota de recuperación*), which is needs-based and is often little more than a token payment.[17]

More recently, the Health Ministry promoted an initiative to expand healthcare to those who have been traditionally excluded from social security programs. The program covers roughly half of the Mexican population, according to some estimates, and includes groups such as independent workers, housekeepers, campesinos, and others in the informal economy. In 2003, Congress enacted the legislation to create the Seguro Popular de Salud (Popular Healthcare), which entitles the beneficiaries to medical attention in public hospitals, outpatient care, some medications, surgery, key forms of ongoing care (gynecology and obstetrics, pediatrics, geriatrics) and annual preventive exams. The *Seguro Popular* is financed by the Federal and state governments, along with a needs-based contribution from the participants, which may be as low as zero in the case of the most impoverished sectors of the population. [18]

Healthcare provision for the general public was originally administered by the Federal Ministry of Health (SSA), but during the late 1980s it underwent a decentralization process transferring responsibility for service delivery and funding, creating in practice 32 health services, one for each state.[19] This increased power and responsibility at the state level, however, has not been matched by greater accountability and transparency. In the words of Fuentes and Montes, the '[strong] efforts made at the federal level in this regard were not followed at the same pace as they were at the state and municipal levels'.[20]

Ironically, the process of decentralization in Mexico, viewed by many as a critical aspect of strengthening democracy, has placed greater power and resources at the state and local levels and out of public scrutiny. The Federal Law for Transparency and Access to Public Information, for instance, is – as its name indicates – restricted to the federal government and not all states have such laws, limiting the ability of civil society organizations to monitor state spending on health and other social policies at a time of increasing decentralization.

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[16] Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado. There are also separate health care institutions for the army and the navy, and for employees of the national oil company, PEMEX.

[17] Vicente Paqueo, Christian González. 'The Health Sector', in: Gillette Hall (coord.). *Development Strategy for the Mexican Southern States*. World Bank, October 2003, Ch.9, pp.1-2, http://wbln0018.worldbank.org/LAC/LAC.nsf/0/541D538865DA825A85256DC5007A7BC8?Opendocument (accessed 4th September 2007)

[18] Instituto Nacional de Salud Pública. 'El Seguro popular', http://www.insp.mx/Portal/seguropopular/seguro01.html (accessed 4th September 2007)

[19] Mariana Pérez, Daniela Díaz and Helena Hofbauer. 'The Life of Every Woman Counts: Using Budget Analysis to Monitor the Reduction of Maternal Mortality. A Case Study of the Mexican Experience'. Fundar, Centro de Análisis e Investigación, A.C., April 2005, p.3.

[20] Ricardo Fuentes and Andrés Montes. 'Country Case Study Toward the Millennium Development Goals at the Sub-National Level: México'. UNDP, Human Development Report Office, March 2003, p. 30.

There are still numerous obstacles to the government's fulfillment of its constitutional and legal obligation to protect the health of its citizens, including the lack of resources and capacities in the state level where most of the health care programs are implemented. In an important analysis of health care, John Scott found high levels of inequality between states in terms of health measures and funding, and a relatively low level of public spending when compared to other Latin American countries.[21] The Secretary of Health himself complains that, as a percentage of GDP, Mexico spends less than the average of Latin American countries.[22] Although Mexico has made some progress in allocating a greater share of public spending on healthcare to the poor, its impact is vitiated when such spending is not complemented by other programs to improve housing, nutrition, education, and the like.

In addition, health care workers unions are a major obstacle to reforms aimed at improving the quality of health services, especially at the local level. Once an integral part of the PRI's corporatist structure, the major unions include: the National Union of Social Security Employees (SNTSS)[23], which organizes the IMSS workers; the SNTISSSTE (National Union of the Institute of Social Security and Services for State Employees)[24], which represents the ISSTE workers; and, the Health Ministry National Workers Union (SNTSSA)[25]. Their leaders are a holdover from the 'old regime', embodying its elements most resistant to change. This has led to the persistence of 'blackmail, corruption, corporatism, untouchable power groups and political concessions'[26] in the sector, undermining even the most basic changes in health care policy and practices.

The SNTSSA, for instance, was one of the main obstacles to the decentralization process in the 1980s. Although the union may have had legitimate concerns, several authors believe that its objections had more to do with the fear of its leaders that when the process of contract negotiation took place at the state level, the national union would lose its affiliates and its immense influence. The SNTSSA continued struggling to limit the reach and objectives of the decentralization process in the 1990s, making sure that 'rights acquired by workers should be guaranteed', rights that included 'no-dismissal' clauses, among other prerogatives.[27]

In a study sponsored by the World Bank, Vicente Paqueo and Christian González identify serious problems related to the prerogatives exercised by the union workers in the health sector. This is particularly acute in the southern states, where 'corruption that diverts health resources from legitimate objectives has been a common complaint'; so is the complaint of staff being absent from their posts or not fulfilling their working hours. In Guerrero, the state with highest maternal mortality

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[21] John Scott. 'Desigualdad en salud y en los recursos para la salud en México'. CIDE, Working Paper no.302, Mexico, June, 2004. .
[22] Patricia Uribe interview.
[23] Sindicato Nacional de Trabajadores del Seguro Social.
[24] Sindicato Nacional de Trabajadores del Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado.
[25] Sindicato Nacional de Trabajadores de la Secretaría de Salud.
[26] Gustavo Nigenda, José Arturo Ruiz. 'The Decentralization of Human Resources and the Health System in Mexico'. World Health Organization, Human Resources Development Journal, Volume 3, Number 2, p.4. http://www.who.int/hrh/en/HRDJ_3_2_04.pdf (accessed 4th September 2007).
[27] *Ibidem.*, p.5.

rate, the study found that 'in urban areas, where doctors have private practices, they work only three hours instead of the official workday of eight hours'.[28]

Moreover, the union's right to nominate replacements has led to the practice of nepotism, and affected the high ranking officials' ability to improve the quality of their own staff. 'It is also notable that the federal–labor union agreements are forcing states to pay much higher salaries and more generous fringe benefits to health staff at the expense of being able to hire more workers and buy medicines'.[29]

The problem of maternal mortality in Mexico: patterns of exclusion and inequality

In a recent report, the Mexican Ministry of Health states the national maternal mortality rate has steadily decreased in the past 15 years, from 89 deaths per 100 thousand live births in 1990, to 83.2 in 1995, 72.6 in 2000, and 63.3 in 2005. This decrease, although positive (almost 30 per cent), is far from fulfilling the target set by the Millennium Development Goals to 22.3 deaths by 100,000 births.[30] Moreover, many analysts suspect that there is a severe under-reporting of the maternal mortality rates, since many of them occur in isolated communities where pregnancies are not registered by governmental authorities, or instances in which deaths are not properly registered as maternal mortality, as in the case of illegal abortion, for example. Although the national level remains high, it masks even higher rates of maternal mortality in certain parts of the country and in certain social groups. These disparities remind us that this phenomenon in Mexico – and around the globe – is inextricably linked to the question of social justice.

Maternal mortality is not simply a health care problem but an issue of social exclusion that affects the most marginalized sectors of the population: globally, poor women living in rural areas in the lesser developed countries.[31] In Mexico, these are indigenous women, living in small villages in the Southern regions of extreme poverty. The phenomenon has been well documented in states as Chiapas, Guerrero and Oaxaca. As Gisela Espinosa Damián puts it, maternal mortality 'is not an expression of the impotence of science in the face of the inevitability of death, but rather the limitations that are imposed on certain social groups in their access to resources, decision-making power, and social and human rights.' [32]

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[28] Vicente Paqueo, Christian González, *op cit*, p.11. These problems were also identified by Patricia Uribe (Uribe interview).
[29] *Ibidem.*, p.12.
[30] Secretaría de Salud. 'Salud: México 2001-2005 - Información para la rendición de cuentas'. Secretaría de Salud, Subsecretaría de Innovación y Calidad (Dirección General de Evaluación del Desempeño), Mexico City, 2005. http://evaluacion.salud.gob.mx/saludmex2005/sm2005.htm (accessed 4th September 2007).and Gobierno de la República. 'Los Objetivos de Desarrollo del Milenio en México. Informe de Avance 2005', Gabinete de Desarrollo Humano y Social, Gobierno de la República, http://bibliotecas.salud.gob.mx/greenstone/collect/publin1/index/assoc/HASH5b09.dir/doc.pdf (accessed 20th September 2007)
[31] Family Care International, *op cit*, Ch.1.
[32] Gisela Espinosa Damián. 'Doscientas trece voces contra la muerte. Mortalidad materna en zonas indígenas', in: Martha Castañeda, Daniela Díaz, Gisela Espinosa et al. *La mortalidad materna en México. Cuatro visiones críticas.* Fundar, Centro de Análisis e Investigación, A.C.; K'inal Antzetik, A.C.; Foro Nacional de Mujeres y Políticas de Población; Universidad Autónoma Metropolitana; Coordinadora Nacional de Mujeres Indígenas, Mexico, 2004, p.169.

Indicators very clearly demonstrate that the women who live in conditions of poverty and marginalization have the highest maternal mortality rates, revealing acute differences within the country.[33] Hence, national-level statistics hide vast inequalities between states. While the national maternal mortality rate is 63.3 deaths per 100,000 births, in the impoverished southern state of Guerrero the number more than doubles, rising to 128.22 deaths for every 100,000 births, nearly five times the rate of Nuevo León (a more developed northern state) where the number is only 26.9 deaths, very near the target established by the MDG. [34]

These sharp differences between states reflect different levels of development that have deep social, cultural, and historical roots. Ironically, in many southern states with the highest incidence of maternal mortality, the presence and impact of civil society organizations is largely under-developed. Both in absolute numbers and relative to population, most of these states tend to have fewer organizations than those in the north. In the case of the two states abovementioned, for example, Nuevo León has a density of civil society organizations that is about seven times that of Guerrero.[35]

It is no accident that the risk of dying of causes related to pregnancy, childbirth or postpartum is three times higher in the indigenous communities than in the rest of the country[36]; indigenous women suffer precisely those risk factors that increase the possibility of maternal mortality. Data from CONAPO (National Population Council) indicate that out of the 346 indigenous municipalities of the country, 209 have a 'very high', and 133 a 'high' degree of marginalization[37]: this means that more than 98 per cent of the indigenous municipalities are characterized by 'high levels of out-migration, subsistence economy, limited communication, poor transportation access, a dispersed population, and environmental degradation'[38]. The interplay of these factors impede a woman's access to sanitary living conditions, educational opportunities, and basic health information and care, much less emergency medical interventions, one of the key factors to reducing maternal mortality. Shortcomings regarding access to health services are not the only problem. The precarious conditions in which indigenous people live also increase the risk of contracting

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[33] María de la Luz González. 'Requiere muerte materna enfoque integral'. *Cimac Noticias*, August 24th 2005, http://www.cimacnoticias.com/noticias/05ago/05082412.html

[34] Official data from the Health Ministry, for 2005. Secretaría de Salud. 'Salud: México 2001-2005 - Información para la rendición de cuentas', *op. cit*, p.191.

[35] According to the Mexican Center for Philanthropy (Centro Mexicano para la Filantropía, Cemefi), Guerrero has 71 civil society organizations, or 0.2 organizations for every 10,000 inhabitants. In contrast, Nuevo León has 553 civil society organizations: 1.4 organizations for every 10,000 inhabitants. This characterization has important exceptions, like Oaxaca, which has 1.0 organizations for every 10,000 inhabitants. Cemefi. *Directorio de Instituciones Filantrópicas*, Centro Mexicano para la Filantropía A.C, 2005, http://www.cemefi.org/ (accessed 4th September 2007); and Instituto Nacional de Geografía y Estadística (INEGI), http://www.inegi.gob.mx/est/contenidos/espanol/rutinas/ept.asp?t=mpob02&c=3179 (accessed 4th September 2007);

[36] Gisela Espinosa Damián, *op cit*, p.175.

[37] CONAPO. 'El rezago demográfico entre la población indígena'. Consejo Nacional de Población, press release, August 8th 2002,http://www.conapo.gob.mx/prensa/2002/2002ago01.htm (accessed 4th September 2007).

[38] Secretaría de Desarrollo Social. 'Microrregiones: ¿Qué es una microrregión?', http://www.microrregiones.gob.mx/estrategia.html?func=txt2&im=micro3. (Accessed 17th September 2007).

infections that could complicate a pregnancy: for example, 40 per cent of their housing has dirt floors and lack plumbing.[39]

In addition to poverty and marginalization, cultural factors also underlie the high rates of maternal mortality. Indigenous women generally have limited control over their reproductive lives: indigenous traditional practices 'pressure women into childbearing that begins very early, lasts very late into the childbearing years, and entails having many children, putting their health and lives at risk.'[40] Often women are married and expected to bear children well before they turn 18 years old: 22.7 per cent of women living in indigenous communities are married by the age of 15; which is three times the percentage of non-indigenous women[41]. A woman who speaks an indigenous language has on average 3.4 children, almost double the rate of those who do not. While nationally 98 per cent of adult women report knowing some method of birth control, only 79.5 percent of indigenous women report knowing at least one method. Use of birth control follows a similar pattern: 70 percent nationally while the rate among indigenous women is less than 50 per cent.[42] In Guerrero the rate does not even reach 15 per cent.[43] Not only are methods of contraception not widely known nor used, they are frowned upon.[44]

Another cultural factor that impedes not only the prevention of maternal mortality but also the statistical tracking of the phenomenon is the reluctance of indigenous women to consult a medical doctor to confirm the fact that they are pregnant. Aside from the logistical difficulties of going to a health center, there are again cultural factors that impede the provision of routine medical attention. Indigenous women view being pregnant as a natural life process and do not see the need of any 'extraordinary' care, such as a visit to the doctor.[45] When it is time to give birth they most commonly use traditional midwives (*parteras*), and only in the case of emergency do they go to a health center. In addition, indigenous women and their spouses are very reluctant to allow a male doctor to undertake gynaecological examinations. A series of factors therefore tip the balance in favor of the use of traditional midwives: they charge less; they are immediately available in the community; and, they share gender, culture, and language with the woman.[46] The relative merits of traditional *parteras* and modern medicine for childbirth are hotly debated, but for the purpose of this discussion, the key issue is whether the necessary interventions are available to save a woman's life during childbirth. Giving these factors, health authorities often do not recognize the women as being pregnant, and therefore official statistics underestimate maternal mortality by anywhere from 30 to 50 per cent.[47] This means that, ironically, as the government

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[39] Comisión Nacional Para el Desarrollo de los Pueblos Indígenas. 'Indicadores socioeconómicos de los pueblos indígenas de México, 2002'. http://cdi.gob.mx/index.php?id_seccion=397 (accessed 4th September 2007).
[40] Gisela Espinosa Damián, *op cit*, p.167.
[41] CONAPO. 'El rezago demográfico entre la población indígena', *op cit*.
[42] CONAPO. 'Indicadores de Salud Reproductiva en la República Mexicana. Práctica anticonceptiva'.http://www.conapo.gob.mx/00cifras/00salud.htm (accessed 4th September 2007).
[43] Gisela Espinosa Damián, *op cit*, p.187.
[44] Gisela Espinosa Damián, *op cit*, pp.190-193.
[45] Gisela Espinosa Damián, *op cit*, pp. 203-5.
[46] Gisela Espinosa Damián, *op cit*, pp. 206-7.
[47] Graciela Freyermuth has undertaken the study of the phenomenon and has offered a systematic, comparative analysis of death rates in Chiapas in order to reach these estimates and call attention to this problem. Daniela Díaz, Dora Sánchez-Hidalgo, Graciela Freyermuth and Martha Aída Castañeda. 'La Mortalidad Materna: Un

and health advocates work to register pregnancies more accurately, in the short run the net result is higher reported rates of maternal mortality.

Another cultural issue that influences maternal mortality is violence against women. International studies estimate physical and sexual violence affects one out of every four pregnant women, heightening the potential of an at-risk pregnancy, although it is seldom recognized as a leading factor in maternal mortality.[48] Studies have shown that such violence not only fails to diminish during pregnancy but in many cases actually increases at this moment of heightened vulnerability: 'direct mortal traumas, abdominal traumas that produce obstetric complications that in turn can become lethal, [and] psychological stress'[49], are among the risks identified by the Pan-American Health Organization. In Mexico, the National Institute of Geography and Statistics (Instituto Nacional de Geografía y Estadística, INEGI) reports that nearly half of all women who live with their partner suffer some type of violence.[50] A more specific study, the National Survey on Violence against Women, applied in 2003, revealed that, of the women who had been pregnant, 14.1 per cent reported having experienced violence during pregnancy, and 4.4% reported being hit in the abdomen.[51]

The final and most controversial socio-cultural factor related to maternal mortality is that of abortion. Although it is identified as the fourth leading cause of maternal mortality in Mexico, to which eight per cent of such fatalities are attributed[52], many women's organizations express concern that the major government initiatives to address the problem do not include this key cause in their strategies. [53] Although the government does not keep official statistics, it is estimated that the number of illegal abortions in Mexico ranges between 500,000 and a million every year.[54] A study

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Problema Sin Resolver'. Fundar, Centro de Análisis e Investigación, A.C., Mexico, 2002, www.siyanda.org/docs/muerte_%20materna.pdf (accessed 4th September 2007). See also Cimac. 'Inamovible, la cifra negra de mortalidad materna en 13 años', February 13th 2004,: http://www.cimacnoticias.com/noticias/04feb/04021301.html (accessed 4th September 2007).

[48] Lori Heise, Mary Ellsberg *et al.* 'Para acabar con la violencia contra la mujer'. Population Information Program, Center for Communication Programs, The Johns Hopkins University School of Public Health. http://www.infoforhealth.org/pr/prs/sl11/l11chap4_4.shtml (accessed 4th September 2007). See also, Sofía Cuevas-Bahena, Julia Blanco *et al.* 'Violencia y embarazo en usuarias del sector salud en estados de alta marginación en México'. *Salud Pública de México*, Vol. 48, suplemento 2, pp. S239- S249, 2006. http://siid.insp.mx/textos/com-1883620.pdf (accessed 4th September 2007).

[49] Organización Panamericana de la Salud. 'Muertes maternas y violencia intrafamiliar contra las mujeres: repensando la salud materna en los Objetivos de Desarrollo del Milenio' www.paho.org/Spanish/AD/GE/MM-violencia-MDGs.pdf (accessed 4th September 2007).

[50] INEGI, 'Mujeres y porcentaje de mujeres con al menos un incidente de violencia en los últimos doce meses por grupos de edad, 2003' (Women and percentage of women with at least one incident of violence in the past 12 months, by age groups), http://www.inegi.gob.mx/est/default.asp?c=2380 (accessed 4th September 2007).

[51] Gustavo Olaiz, Rosalba Rojas et al. 'Prevalencia de diferentes tipos de violencia en usuarias del sector salud en México'. *Salud Pública de México*, Vol. 48, suplemento. 2, pp. S232- S238, 2006. http://siid.insp.mx/textos/com-18871023.pdf (accessed 4th September 2007).

[52] The three leading causes of maternal mortality in Mexico are toxemia during pregnancy (31 per cent), hemorrhage during childbirth (22 per cent), and complications during puerperium (10 per cent). Cimac. 'Persisten índices de mortalidad materna en México', http://www.cimacnoticias.com/noticias/04may/04051413.html (accessed 4th September 2007).

[53] Cimac. 'Pese a programas oficiales, persiste la muerte materna en México', http://www.cimacnoticias.com/noticias/03mar/s03032501.html (accessed 4th September 2007).

[54] Cimac. 'Acuerdos internacionales sobre derechos de la mujer, un avance', http://www.cimacnoticias.com/noticias/04ene/04012303.html (accessed 4th September 2007); and Cimac. 'Pese a programas oficiales, persiste la muerte materna en México', *op cit.*

undertaken by IMSS, found that shocking 63 per cent of women admitted with problems related to their pregnancy were the secondary results of an abortion.[55] Due to the clandestine nature of the practice it is difficult to measure its full impact upon maternal mortality, as deaths contributed to hemorrhage or infection might well be linked to an abortion that the woman sought illegally, which both she and her physician would be reluctant to report.

The risk arising from illegal abortion is accentuated by the lack of information available to doctors concerning the situations in which abortion is legally permissible. In a 2002 survey carried out by the Population Council regional office for Latin America and the Caribbean, and applied to gynaecologists and general practitioners working in hospitals and clinics operated by both the Ministry of Health and the private sector, more than 80 per cent of the doctors reported that they lacked adequate information about abortion. The study stated that, 'Even though state law established the conditions under which abortion is legal, many states have not formulated adequate policies and processes to insure access to the procedure,' and that, 'state Health Ministries have not established medical guidelines for hospitals in order to insure access to legal abortions'.[56]

The theme of abortion is more important to the campaign to reduce maternal mortality than it might appear at first blush: in fact, in the negotiations around the inclusion of reducing maternal mortality as one of the Millennium Development Goals, the decision was taken to eliminate reference to access to abortion in order to avoid opposition by more conservative nations.[57] At this time, some women's organizations saw the failure to include a more expansive notion of reproductive health in the goals as a major flaw: the 'missing link', as one researcher describes it.[58] (The politics of this decision are discussed at greater length below.)

In Mexico, practically no member of the Chamber of Deputies publicly stated any opposition to increasing the federal budget to reduce maternal mortality. Nevertheless, Diva Gastelum, a deputy and leader of the Gender Equality Legislative Committee, claimed that the greatest resistance behind the scenes came from groups of the 'extreme right' with connections to conservative politicians. She was referring to what many perceive as the growing influence of the Catholic Church and conservative groups since the arrival of Fox and the PAN to power. This influence has been made manifest in incidences like the deviation of public funds marked for

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[55] D. Hernández, O. Mojarro, J. Fuentes, J. Martínez-Manatou. 'Consideraciones sobre las muertes maternas en el IMSS y sus causas'. Instituto Mexicano del Seguro Social, Mexico, 1991. In: Ana Langer-Glas. 'Embarazo no deseado y el aborto inseguro: su impacto sobre la salud en México'. *Gaceta Médica de México*, Academia Nacional de Medicina de México, A.C., 2003, http://www.medigraphic.com/pdfs/gaceta/gm-2003/gms031b.pdf#search='aborto%20legal%20excepto%20m%C3%A9xico' (accessed 4th September 2007)

[56] Cimac. 'Demanda personal médico información de marco legal sobre aborto en México', http://www.cimacnoticias.com/noticias/04jun/04063012.html (accessed 4th September 2007)

[57] Family Care International. 'The Safe Motherhood Initiative: A Review 1987-2005', *op cit*.

[58] Sharon Bissell, interview; Barbara Crossette, 'Reproductive Health and the Millennium Development Goals: The Missing Link', Population Program of the William and Flora Hewlett Foundation, December 2004, http://www.hewlett.org/NR/rdonlyres/EDEF4032-44BB-4896-9ECE-06AC40108045/0/ReproductiveHealthandMDGs.pdf (accessed 4th September 2007) and Stan Bernstein and Charlotte Juul Hansen. 'Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals'. UN Millennium Project, 2006. http://www.unmillenniumproject.org/documents/MP_Sexual_Health_screen-final.pdf (accessed 4th September 2007).

women's health and AIDS prevention to a pro-life non-governmental organization, and the open opposition to the 'morning-after' pill by the Minister of Interior, who attempted to overrule the Ministry of Health's decision to include it in the list of medicines available to the public.[59] These examples highlight the fact that throughout the struggle to reduce maternal mortality there has been an underlying tension between the universally acknowledged right to adequate health care, i.e. safeguarding the lives of women giving birth, and more controversially, reproductive rights, particularly the right to have an abortion.

III. Evolution of the campaign

At the end of 2002, the campaign to reduce maternal mortality in Mexico was on the eve of achieving its first clear-cut impact on government policy. The 2003 budget, agreed on the previous December by the main political parties in Chamber of Deputies, earmarked, for the first time, the resources allocated to *Arranque Parejo en la Vida* (A Fair Start in Life, APV), the newly created program designed to reduce maternal mortality and improve early childhood health.[60] Although in the end this represented a paper rather than a real increase in funds, as discussed below, the advancement in making transparent the allocation to state governments was the first achievement linked to the campaign promoted by a coalition of civil society organizations, who took advantage of political conditions to influence public policy. Although national events made this accomplishment ephemeral, this first battle inaugurated a period of progressive influence of civil society organizations on public policy concerning the reduction of maternal mortality at the federal level.

In this section, we analyze the evolution of the maternal mortality campaign: the definition of the problem and the policy framework; the various actors and their roles; the nature of the coalition and its dynamics; and, the main results achieved during the process. We divide the story into two periods. In the first period, during the eighties and nineties, international events played an important role in defining the problem of maternal morality, setting the policy framework, and influencing key national policy actors. In the second, we focus upon the advocacy process during the Fox administration. At this point, the coming together of civil society actors with complementary capacities around a narrowly defined objective, i.e. increasing the federal budget, allowed them to enter into the policy process in a very effective manner. This led to a successful and well-targeted campaign, obtaining results in a very short time and opening new lines of advocacy work at the state level.

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[59] In the first case, Fundar and other organizations brought to light the misuse of 2.9 million USD from the Health's Ministry budget by the anti-abortion organization Provida, to whom the funds had been assigned by a PAN Deputy. In the second, the Minister of Interior, Carlos Abascal, got into a dispute with the Minister of Health to try to remove the morning-after pill (which is not considered to be an abortive method by specialists and doctors) from the list of basic medicines available in the Health System. *Agence France-Presse*. 'Antiabortista mexicano deberá desmentir compra de tangas con dinero federal', November 25th, 2004, http://www.aegis.com/NEWS/AFP/2004/AF0411G8_ES.html (accessed 4th September 2007); and La Crónica. 'El PAN se alía con Abascal contra píldora del día después', July 20th 2005, http://www.cronica.com.mx/nota.php?idc=192764 (accessed 4th September 2007)

[60] It is important to note that this was a re-allocation within the Federal Fund for Health Services (*Fondo de Aportaciones para los Servicios de Salud* or FASSA), and did not represent an increase in the budget of the Health Ministry. (Helena Hofbauer, personal communication).

Maternal mortality and the international agenda

For more than a decade, Mexican women's organizations had been actively participating in international forums on reproductive health and women's rights. Since the end of the eighties, the events organized by United Nations agencies and a large number of international organizations provided these groups with a policy framework that would help them develop arguments to prod the Mexican government to face the appalling problem of maternal mortality. Their participation in these events also gave activists important ties to international actors such as the World Health Organization and the United Nations Population Council. If Mexican feminist groups were once considered marginal actors advocating on behalf of the most controversial issues in a traditional Catholic country (e.g. legalization of abortion), their taking part in the international debate gave them a newfound level of legitimacy with the Mexican government.

After five years of worldwide activism on the subject, Mexico joined the International Safe Motherhood Initiative (ISMI) and held the first National Conference on Safe Motherhood, which took place in Cocoyoc, in 1993. The event gathered, for the first time, representatives of international agencies, NGO leaders, government officials and researchers, for the discussion of the issue of maternal mortality. The gathering produced a 'Declaration on Safe Motherhood', which endorsed the international goal of reducing maternal mortality to 50 per cent by the year 2000.[61] This document became an important reference in the Mexican agenda, since the government officially acknowledged that it was a problem that deserved attention. Nevertheless, the diagnosis of the problem was far from identifying the right strategies to tackle it, since maternal mortality was mistakenly believed to be strongly associated to high-risk pregnancies, which in turn favored preventive interventions.[62]

The event also opened the door to Mexican activists as legitimate actors of the policy arena. In order to follow the recommendations of the ISMI, representatives of government, researchers and international and women's organizations created the National Safe Motherhood Committee (NSMC), which would become the first space for civil society participation around maternal mortality and a direct link to the Initiative.[63] Two more national conferences on the issue have since taken place (in 1998 and 2003), and each event has re-issued and updated the 'Declaration on Safe

[61] This was the first time the reduction of maternal mortality reduction was established as a goal, set by the 1987 Safe Motherhood Conference, Nairobi, Kenya 1987. Family Care International, *op cit*, pp. 7-8.

[62] The 1987 International Conference outlined three strategies to achieve safe motherhood, which were strongly based on a risk screening conception of the problem: a) strengthened community-based health care by improving the skills of community health workers and traditional birth attendants, and screening high risk pregnant women for referral for medical care; b) improving referral-level facilities to treat complicated cases and serve as a back up to community-level care; c) developing an emergency transportation system to serve as a link between the community and referral care. Family Care International, *op cit*, p.7.

[63] Family Care International has played a key role in the work of the NSMC, from its foundation through its financing and as a direct link to the ISMI (Murdock interview).The NSMC is made up of 31 members: eight from government, eight from civil society and six from international agencies, plus nine from the State-level Committees. Elsa Santos Pruneda. 'Una década del Comité Promotor por una Maternidad sin Riesgos en México', in: María del Carmen Elu and Elsa Santos Pruneda. *A lo largo del camino*. Comité por una Maternidad Sin Riesgo (CPMSR); IMES A.C., Mexico, 2005, p. 113.

Motherhood', contributing to public awareness of the issue and tracking policy advances. Furthermore, these proceedings constituted a channel for a continuous dialogue among the primary actors of the maternal mortality problem. They were the first formally constituted forums on the subject among government, academic, and civil society actors.[64]

As part of the international movement working on the reduction of maternal mortality on both the international and national levels, a bilateral exchange of information and experiences began to develop through the NSMC. Successful strategies and research findings from Mexico have since then enriched the research and documents of the Inter Agency Group of the Global Safe Motherhood Initiative (recently transformed into the Global Partnership for Safe Motherhood and Newborn Health).[65] Thus, Mexican research and health initiatives have been disseminated in the region contributing to the evolution of the definition of the problem and to maintain widespread international attention. Conversely, the international agenda has nurtured the Mexican debate with the latest findings on maternal mortality, whose terms and arguments are transmitted through both its documentation and the participation of Mexican activists. In fact, several of the most active feminist leaders in Mexico are members of the NSMC and many women's groups have participated in the official delegations to the main international events related to women's issues that set off the debate leading to the recent changes in gender-based health action programs.[66]

Three international conferences in particular helped Mexican activists to frame the issue of maternal mortality, as well as the strategies to reduce it: the International Conference on Population and Development (ICPD), Cairo 1994; the Fourth World Conference on Women, Beijing 1995; and, most recently the Millennium Development Summit, New York 2000. Mexican delegations composed of governmental and non-governmental members participated in each of these forums. The debate that took place in these meetings led to a significant shift in the scope and conceptualization of the maternal mortality problem, and gave activists additional leverage with government officials.

The Cairo ICPD contributed to generate the social consensus needed to disentangle the core problem, by establishing the priority of sexual and reproductive health rights over demographic objectives. This contrasted with the 1974 United Nations Population Conference, where women were considered a vehicle to reduce world population. The ICPD Program of Action formally included, for the first time in a United Nations document, an explicit goal to reduce maternal mortality by 75 per cent, by 2015. This reflected the shift on the maternal mortality issue from an 'overlooked health problem to a central development goal.'[67] By agreeing to the goal the UN and its signatories also had to endorse the proper means to achieve it, i.e. proper health services and programs, as stated in the Action Program:

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[64] *Ibidem.,* pp. 111-112.
[65] Murdock interview.
[66] Pilar Muriedas, 'En la búsqueda de nuevas estrategias contra la mortalidad materna y a favor de la salud reproductiva', in María del Carmen Elu and Elsa Santos Pruneda, *op. cit.,* pp. 118-119.
[67] Family Care International, *op cit*, p. 11.

> [Maternal health] services, based on the concept of informed choice, should include education on safe motherhood, prenatal care that is focused and effective, maternal nutrition programs, adequate delivery assistance that avoids excessive recourse to Caesarian sections and provides for obstetric emergencies; referral services for pregnancy, childbirth and abortion complications; postnatal care and family planning...[68]

This new perspective was a consequence of the adoption of a rights-based approach, in which women are acknowledged as individuals with their own needs and having an importance beyond their role as mothers.[69] The inclusion of reproductive rights, including a women's right to choose, as a factor affecting safe motherhood was also a critical step in highlighting structural factors conditioning individual decisions. In Mexico, the adoption of this focus, associated with social and economic development, was widely promoted by the Mexican civil society groups and gradually accepted by public officials. An example of the impact of such activism in the public administration is shown by the fact that in 1994 the General Directorate of the Health Ministry focused on these issues changed its name from *Family Planning* to *Reproductive Health.*[70]

Furthermore, the Cairo meeting decisively strengthened Mexican feminist groups actively involved in the battle to promote women's reproductive and sexual rights. At the end of 1993, the Foro Nacional de Mujeres y Políticas de Población, FNMPP (National Forum of Women and Population Policies), a national network of women's organizations, was formed with the explicit objective of advancing the policy debate on the women's agenda. After taking part in the ICPD, the FNMPP included as part of its objectives to monitor the agreements contained in the ICPD 1994 Action Program. Similarly, the Coordinación de Organizaciones Civiles por un Milenio Feminista (Coordination of Civil Organizations for a Feminist Millennium) was created in the same year with the purpose of influencing the outcomes of the Beijing Conference,[71] A year later, both groups participated in this event, where the framing of maternal mortality as a matter of rights was ratified.[72] Thus, the Cairo and Beijing conferences enhanced the legitimacy of the Mexican feminist movement and reinforced their rights-based arguments. At the same time, this conjunction attracted

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[68] ICPD-Program of action (POA), cited in. Family Care International, *op cit*, p. 8.

[69] This outcome resulted from the growing influence of civil organizations participating at the conference. 'During the ICPD preparatory process, a large coalition of NGOs focused on sexual and reproductive health was formed. This coalition, which eventually numbered more than 1,000 organizations from all regions of the world, focused its efforts on lobbying for strong commitments to a comprehensive approach to sexual and reproductive health, of which safe motherhood was intrinsic.' *Ibidem.*, p. 12.

[70] Uribe interview. Muriedas also claims the fusion of family planning and maternal and child health programs, in the Reproductive Health Program, was an achievement of feminist organizations. Pilar Muriedas, *op cit.*, p.118.

[71] 'The FNMPP network is made up of more than 80 women's groups of 17 states, as well as academics and even governmental organizations. Of these, 66 per cent are involved in poverty reduction; more than 90 per cent work in favor of the autonomy of women and against discrimination and violence, or undertake activities benefiting girls'. Milenio Feminista was formed by 23 state coordinating committees (now 19) of 150 organizations working on sexual and reproductive rights, democracy and citizenship, development, globalization and human rights. Originally conceived as a committee after Beijing, it was reorganized into a National Coordination to participate in and monitor international forums with a gender perspective. See www.laneta.apc.org/foropob/ (accessed 4th September 2007).

[72] Family Care International, *op cit*, p. 8.

women to struggle for safe motherhood as an explicit and central objective of reproductive health.

Subsequent international forums continued to enhance the policy framework that would set the stage for a maternal mortality campaign in Mexico. As part of the activities for the celebration of the tenth anniversary of the Safe Motherhood Initiative, the Technical Meeting that took place in 1997 in Colombo, Sri Lanka, recognized the unequal and very limited advances achieved in one decade, as well as the multi-faceted nature of the problem.[73] The discussions focused on agreeing on the ten most effective strategies to reduce maternal mortality rates. The analysis revealed a problem in the policy design based on risk pregnancy screening – one of the central recommendations of the 1987 Initiative — since research demonstrated that many cases of deaths occur in emergency situations, which are difficult to predict. This evidence confirmed that the debate should be directed towards the reasons why women were denied quick access to proper attention and the larger social, economic and political factors indirectly contributing to maternal mortality.[74] As a response, the Emergency Obstetric Care (EmOC) proposal emerged, based on the premise that access to skilled attention should be made the priority if maternal mortality indicators were to be reduced.

In the second half of the nineties, the renewed drive of Mexican feminism, coupled with the international momentum on the issue, continued in the form of a reorganization of existing groups and the creation of new ones. In 1998, three women's organizations came together and formed a new actor in the policy process. The Consorcio para el Diálogo Parlamentario y la Equidad AC, CDPE (Consortium for Parliamentary Dialogue and Equity, Civil Association) was formed at the culmination of nearly two decades of feminist activism. The CDPE's special character was its explicit focus on developing the lobbying capacity in the legislative arena to promote the women's agenda. The decision to create this new vehicle was taken after the PRI had lost its majority in Congress and feminist groups anticipated increasing opportunities to influence public policies. The CDPE later became affiliated with the FNMPP, as they share key elements of their agenda and enjoy privileged access to the Congress.

The oldest of its sponsors was originally called the Popular Action of Social Integration, APIS, now Fundación para la Equidad AC (Foundation for Equity, Civil Association), a grassroots organization formed in 1981 to promote community development and to improve poor women's quality of life from a gender perspective. By means of workshops, self-help groups and development projects, it has worked in Mexico City to reduce violence against women and, in Yucatan, Merida, to organize indigenous and rural women.[75] Also, Salud Integral para la Mujer, SIPAM (Integral Health for Women, Civil Association) was formed in 1987 with a strong inclination to community-based women's health work in Mexico City and to political activism. It is a feminist organization promoting sexual and reproductive rights, citizen participation and public policy activism. Finally, Equidad de Género, Ciudadania Trabajo y Familia AC (Gender Equity, Family and Work, Civil Association), was created in 1996, also

[73] Santos Pruneda, *art, cit*., pp. 111-112.
[74] Family Care International, *op cit*, p. 10.
[75] See their overview document, 'APIS – Fundación Mexicana para la Equidad', www.e-mexico.gob.mx/work/resources/LocalContent/15244/1/APIS.pdf (accessed 5th September 2007)

with a clear political agenda on a number of controversial issues: women's right to abortion, AIDS and sexual transmitted illness, gender violence, diversity and a secular State. It promotes public education campaigns and, together with the Red por los Derechos Sexuales y Reproductivos de Mexico, DDESER (Network for Sexual and Reproductive Rights of Mexico) monitors legislative work on gender in the national and state governments.[76] Since its inception it has also worked within the framework of the Cairo and Beijing conferences to promote the feminist agenda among female mayors.

The sense of urgency manifested in the ISMI 10th anniversary was vindicated by the 2000 Millennium Summit, where the goal of maternal mortality was endorsed as the sixth specific objective in the Millennium Development Goals, establishing as a goal a 75 per cent reduction by 2015 from the 1990 level. In part, the inclusion of this narrower goal was a more limited way to deal with reproductive health without incurring a conservative backlash. This, as well as the restrictions upon the participation of NGOs in the event, may be considered as drawbacks, compared to the Cairo and Beijing agendas which endorsed the link between maternal mortality and women's rights to choose, and the incredible margin of activism of civil society in the early events.[77] Nevertheless, in terms of gaining visibility and legitimacy for the issue of reducing maternal mortality, its inclusion as a MDG represents a valuable asset for the campaign. As a goal repeatedly endorsed at key international forums and in international conventions signed by the Mexican government, the recognition of maternal mortality as a middle range objective in the world struggle against poverty meant the issue had a legitimate and undeniable place on the national agenda. This definition of the problem would later help Mexican activists to emphasize the socioeconomic and cultural dimensions affecting safe motherhood indicators in the country.

Furthermore, since one technical reason to include maternal mortality in the MDG is that it proves to be a rich indicator that reflects effective access to health care, advocates turned their attention toward the state of public health services. As part of its action plan, the Task Force on Child Health and Maternal Health – one of the committees established under the auspices of the MDG to provide governments and members of civil society with a concrete plan for their achievement – emphasized strengthening full access to healthcare for the poor in contexts of socio-economic and political inequality.[78] Mexican activists soon took advantage of the full implications of such mandates, as advocates would identify shortcomings in public health services as a serious obstacle in the reduction of maternal mortality.

Recently, even the objective stated in the MDG has been challenged by Mexican activists, arguing that its indicators 'are inadequate to assess whether or not

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[76] Román González. 'Sipam: 15 años de compromiso con los derechos reproductivos'. *Cimac noticias*, Mexico, November 2002.http://www.cimacnoticias.com/noticias/02nov/02112203.html (accessed 5th September 2007); Salud Integral para la Mujer (Sipam), www.sipam.org.mx (accessed 5th September 2007); and Equidad de Género: Ciudadanía, Trabajo y Familia, www.equidad.org.mx (accessed 5th September 2007)

[77] '…the safe motherhood goal was seen by some as a 'substitute' for the reproductive health goal […] A small minority of conservative governments threatened that, if the reproductive health goal was included…they would block the consensus' Unlike the Cairo and Beijing conferences, NGOs had little opportunity to intervene, due to the predominance of formal diplomatic negotiations. See Family Care International, *op cit*, p. 13. See also Crossette, and Bernstein & Hansen, op cit.

[78] Family Care International, *op. cit.*, p. 10.

conditions are present to assure a lasting improvement in the reduction of maternal mortality, especially in the case of poor, indigenous women in their child-bearing years'.[79] Thus, although the inclusion of maternal mortality as an MDG represented a very useful resource for feminist lobbying, its restricted scope is currently being questioned because it does not take into account the lack of access to health services in rural communities, the scarcity of medical resources, nor the qualifications of health care providers.

As described in this section, there were (and are) two axes of civil participation in the public policy debate in Mexico, in close association with the international evolution of the maternal mortality problem and policy framing. On the one hand, the NSMC acted as an official mechanism of inter-change between the national and international arenas, as well as a highly specialized forum promoting dialogue between the Mexican government and civil society. Its focus is on the reduction of maternal mortality, period. On the other hand, and with some participants in common, the FNMPP, an organization born in the light of the Cairo Conference where the maternal mortality and sexual reproduction debates began to emerge, acts as an umbrella organization that covers a broader feminist agenda and embraces a wider conception of reproductive rights.

Furthermore, nearly two decades after the 1983 ISMI meeting took place, events in the international arena offered Mexican civil society organizations a series of important tools with which to advance their agenda: a definition of the problem supported by an international consensus emphasizing the lack of access to skilled health attention; a policy grounded in human rights in general, and women's rights in particular; and, an emphasis on access to effective health services. But it seems unlikely that any of these resources would have been of use without a number of other factors being present, most importantly: the previous dialogue between government officials and Mexican activists, together with a growing group of politically and technically specialized activists and organizations who became professional along with their participation in international and national forums.

Although they enjoyed greater formal participation during the mid-nineties summits than in the New York summit in 2000, organizations have benefited from the MDGs, which have provided important political legitimacy and weight to women advocacy organizations. Also, in Mexico the MDGs have brought clear and direct benefits to the cause of reducing maternal mortality: the number of donor agency programs and their funding to support safe maternity has increased, reflecting the political importance of the global commitment to address this problem.

Maternal mortality as a priority for a new government

The activism of international actors to reduce maternal mortality, in close conjunction with national feminist leaders and researchers, has had a meaningful impact upon the design of health policy in Mexico. During the administration of President Ernesto Zedillo (1994-2000) the government created the *Programa de Ampliación de*

[79] Daniela Díaz cites researchers Graciela Freyermuth and Marta Castañeda, who assert that using the percentage of births attended by skilled personnel, hides the reality of rural, poverty and indigenous regions, where an important number of births are attended by traditional *parteras.* Daniela Díaz (coord.). *Muerte materna y presupuesto público.* Fundar, Centro de Análisis e Investigación, A.C., México, 2006, pp. 12.

Cobertura (Coverage Expansion Program, PAC by its Spanish acronym) within the National Program of Reproductive Health and Family Planning, in order to bring health services to the population living in rural areas and in conditions of poverty, where most maternal deaths occur in Mexico. The PAC reflected the government's endorsement of the ISMI goal of a 50 per cent reduction of maternal mortality by 2000 and other international commitments.[80] Although this was an important step, the rate of maternal mortality did not improve significantly in the nineties.[81] Thus, the commitments made by the Mexican government to achieve the goals established by the Cairo and Beijing conferences, as well as the NSMC-ISMI, were not themselves enough to reverse the high rate of maternal mortality.

After his historic electoral victory in 2000, the Fox administration identified the reduction of maternal mortality as one of its chief public health policy objectives for the 2000-2006 term, a priority that corresponded directly with the United Nations General Assembly's Millennium Development Declaration. In May of 2001, this commitment was translated into *Arranque Parejo en la Vida* (A Fair Start in Life, APV), a program focused on women during their child-bearing years and children under two years old. Although the arrival of the first opposition party in government was considered as an opportunity for change, the early years of the administration reflected a proclivity to use a progressive discourse, especially if promoted by the international agenda, without undertaking the necessary policy actions to achieve results.

The APV program was an initiative promoted by members of the transition team focused on health care. It has been attributed by journalists to the Sub-Secretary of Prevention and Health Promotion, Roberto Tapia, and by the Secretary of Health, Julio Frenk, to the Transition Team that formulated policies leading up to Fox's inauguration.[82] In any case, from the start, the APV has been officially and unofficially acknowledged as the administration's response to the commitments made under the auspices of the MDG. Like the PAC, this initiative was part of the both the National Health Program and the National Program to Overcome Poverty. The Health Ministry was made directly responsible for its implementation as part of

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[80] See Martha Castañeda, 'Atención de urgencias obstétricas en clínicas rurales: una propuesta factible', in: Daniela Díaz (coord.). *Muerte materna y presupuesto público*, *op. cit.*, pp. 82-83. According to Dora Sánchez and Daniela Díaz, the PAC's focus on vulnerable groups did not reflect solely the recommendations arising from Beijing, although it was created in this context', but derived primarily from proposals made by the World Bank in its document 'Investing in Health'. [Informe sobre el Desarrollo Mundial, July 1993]. 'Mortalidad materna: un problema sin resolver', in Martha Castañeda *et. al*., *op. cit.*, pp. 26-27.

[81] The PAC's failure to reduce maternal mortality significantly can be explained by the fact that the expansion of services to the rural population was not accompanied by a sustained budget allocation; although there was a 13.6 per cent increase in the program's budget for the period 1996-2002, between 1998 and 2001 the per capita expense decreased, from 45.9 to 37.5 pesos per beneficiary. Helena Hofbauer. 'Reflejo de las prioridades nacionales en la disposición de los recursos públicos: cuentas pendientes', in María del Carmen Elu and Elsa Santos Pruneda, *op. cit,* p. 182.

[82] See Julio Frenk's speech during the celebration of the Fifth Anniversary of the Program Arranque Parejo en la Vida, May 9, 2006, available in: Marta de Fox website, 'Diversas intervenciones durante el evento del V Aniversario del Programa Arranque Parejo en la Vida', Press release, http://marta.fox.presidencia.gob.mx/csw_saladeprensa_doc.php?art_id=3545 . httrrp://martadefox.presidencia.gob.mx (accessed 18th September 2007). Also Yazmin Alessandrini. 'Encuentros Fugaces'. *El Universal*, September 26th, 2006. In: www.eluniversal.com (accessed 5th September 2007)

the free services the government offers to those with no affiliation to the social security system.

The APV includes a set of sixteen basic actions to insure: healthy pregnancy, safe delivery and postpartum, healthy newborn and early childhood development. It also involves a support package made of sixteen other actions covering human development, an active social support network, community participation, monitoring and evaluations as well as the strengthening of the health services structure.[83] A number of them may be considered as answers to socioeconomic factors leading to maternal mortality, such as providing childcare so that a pregnant woman can go to her doctor appointments, transportation to medical facilities, and lodgings next to hospitals with food provided by the community.[84] Some of the other key aspects of the program are intended to improve the sensitivity of the health sector staff who deal directly with patients and to improve the equipment and infrastructure in areas of greatest need.[85]

Although the long list of the actions comprised by the program make APV appear to reflect the recommendations made by the international forums and promoted by civil society groups, it lacked many of the key elements necessary to guarantee its success, beginning by the lack of formal operating rules. Other critical flaws revealed by activists include its dependence on private funds for key infrastructure needs and its reliance on the coordination by 'first ladies' of state and local governments of local social networks for key services: this has implied that many key interventions do not receive a governmental appropriation, thus endangering their provision and their continuity.[86] Subsequent research revealed the importance and impact of these flaws: the reduction of resources allocated in 2002 to infrastructure, affecting the states with the worst equipped health services; the unclear criteria used to allocate capital expenses between states, and the sharing of scarce medical staff among multiple programs run simultaneously by the different units of the health care service, a common occurrence in the states with the worst incidence rates.[87] Its deficiencies would later become so evident, that one of the researchers who evaluated the program found that APV is 'a strategy within health services rather than a formal public program'.[88]

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[83] Secretaría de Salud, *Arranque Parejo en la Vida*. www.salud.gob.mx (accessed 5th September 2007)

[84] The program included components such as "casitas AM" (AM little homes), "Transporte AM" (AM transportation), "posadas AM" (AM inns) where, as explained by a health official, AM refers to the initials of Maternal Attention and, at the same time, to the first two letters of the Spanish verb 'to love' (AMar). Uribe interview.

[85] Uribe interview.

[86] The public capital expenditures for APV represented 3.02 per cent of the private contribution in 2002-2003. The categories missing public resources are infrastructure, medical equipment, medicines and transportation. On its 2003 Annual Report, *Vamos México*, reports an in-kind donation by *Fundación Telmex* (created by the biggest telephone company, Teléfonos de México), equivalent to nearly 14 million USD, representing 33 times the budget allocation to APV in 2002 and 2003. Nevertheless, field research in Oaxaca, Chiapas and Guerrero found that the medical equipment was not always used and tended to be concentrated in hospitals, limiting access to municipalities with the worst rates of maternal mortality. Fundar. 'Muerte materna y presupuesto público: seguimiento al programa Arranque Parejo en la Vida'. México, Fundar, Centro de Análisis e Investigación, A.C., 2004, pp. 17-18.

[87] Daniela Díaz. 'Presupuesto público y mortalidad materna: seguimiento al Programa Arranque Parejo en la Vida'. Fundar, Centro de Análisis e Investigación, Mexico, 2003, pp. 3-6.

[88] Interview with Daniela Díaz.

In spite its shortcomings, the program was announced with great fanfare in the media by the President and First Lady, Marta Sahagún. Sahagún adopted the program as part of her official activities and as an active member of 'civil society'.[89] She joined the Secretary of Health and/or the President Fox for the launch of the program in many of the states that were incorporated, frequently appearing as an official speaker. Her efforts to raise private sector funds to improve the infrastructure for APV through her *Vamos México Foundation* contributed to the politicization of the program, given the public perception that she was abusing her privileged position as First Lady to attract attention and funds to her cause at the expense of other organizations that had much longer track records, and with the ultimate purpose of advancing her own political career and running for President in 2006.[90]

The First Lady's involvement in the cause of fighting maternal mortality was not the only sore point between the Fox's administration and the women's movement. Sahagún and her party's political orientation, the National Action Party (PAN by its Spanish acronym), clearly conflicted with the agenda of the most important women's network, the FNMPP. The former are firmly opposed to abortion, whereas the latter support it with equal tenacity. This deep disagreement has clear implications for the operation of health services, among them, the above-mentioned undercount of maternal deaths and the lack of proper means to provide abortions via public health services, even when the law states that they should be available. Emphasizing this hot button issue could have threatened the consensus gained by maternal mortality policy framing of recent years. Meanwhile, the politicization of the program and the distance between the feminist movement and the government agendas turned the APV into a focal point for civil society organizations.

Confrontations between feminists and the PAN emerged early in Fox's term and continued unabated, not only concerning the party's stand on abortion but on many other women's issues as well. In spite of the tensions, there were some advances that cannot be denied and that turned out to be of great importance to the women's agenda. As Franceschet and MacDonald, point out, 'The one area in which Mexican women's citizenship struggles are registering some important advances lies in the growing institutionalization of gender issues within the Mexican state and electoral system'.[91] This is an advance whose relevance to the maternal mortality campaign and to the development of a more consolidated democracy should not be underestimated: institutionalization is a key factor as it gives more certainty to civil society organizations and the population in general, enshrining key rights and interests beyond the term of any particular elected official.

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[89] Sahagún declared that APV was her 'pet program' and defended philanthropic contributions to it. See, for example, Sahagún's speech during the fifth anniversary of the APV. Marta de Fox website (May 9th, 2006) 'Diversas intervenciones durante el evento del V Aniversario del Programa Arranque Parejo en la Vida', *op cit*, and Elena Urrutia (November 2nd, 2005) 'Entrevista. Marta Sahagún, Presidenta de la Fundación Vamos México. Trabajo de Fondo: la articulación social con las organizaciones', *La Jornada*„ http://www.jornada.unam.mx/2002/11/02/012n1pol.php?printver=1 (accessed 18th September 2007)

[90] Throughout the first four years of her husband's presidency, the political ambitions of Sahagún were a matter of great speculation. But when the *Financial Times* published an article questioning the financial management of her foundation, *Vamos Mexico*, Sahagún replied that the criticisms represented an attack on feminism. Established feminist activists, however, did not support her. John Authers and Sara Silver, 'A flirtation with power: Marta Fox', *The Financial Times*, July 14, 2004, www.ft.com(accessed 5th September 2007)

[91] Franceschet and MacDonald, *op cit*, pp.18-19.

Indeed, Fox's administration took significant steps to institutionalize the importance of a gender perspective in public health policy, even if, ironically, APV did not attain a more institutional status as a health program. In September 2003 he created the National Center for Gender Equity and Reproductive Health (Centro Nacional de Equidad de Género y Salud Reproductiva). The Center sought to incorporate a gender perspective in the Ministry over a wide range of issues: viewing women as key in health care provision, addressing bulimia and other diseases that primarily affect women, and making sure that for the first time health statistics were disaggregated by sex.[92] The Fox administration is recognized for having expanded the institutional space for women's policy machinery *within* the state, even if this was not done out of ideological agreement with the feminist agenda but based on a pragmatic political orientation and honoring the pro-citizenship rhetoric that had characterized its campaign.[93] Another key step was the inclusion of many civil society leaders into government offices. Many staff of the National Center for Gender Equity and Reproductive Health, for example, came from CSOs and the Center established an advisory body called the Consortium for Women and Health to facilitate the participation of civil society leaders.

The maternal mortality advocacy coalition

In 2002, the MacArthur Foundation contacted Fundar, a center for analysis and research, in order to evaluate the level and use of public resources allocated to the reduction of maternal mortality.[94] The organization had ample experience working on health and gender issues from a variety of perspectives, but its core focus and strength was budget analysis. Given its background, Fundar found it 'natural' to engage in the subject from a budgetary analysis perspective, but linked up with local partners with expertise in the particular area of maternal mortality 'from day one'.[95] Looking for partnerships wherever possible and appropriate became Fundar's *modus operandi* as it entered into the reproductive health debate, which in Mexico is led by sophisticated organizations and with strong political commitments.

Budget analysis is a tool increasingly used to monitor how public money is spent in order to assess the congruence between the government's stated priorities and the resources directed to address them.[96] It is considered to be a useful tool to promote governmental accountability on specific public problems. In countries like Mexico, this type of research and advocacy work is being developed as a response to 'poor transparency and weak accountability' as it can illuminate whether and how the government is complying with its commitments.[97]

Fundar began its work with an initial analysis of the effectiveness of the previous administration's *Programa de Ampliación de Cobertura* (PAC, Program to Expand Coverage). By the end of 2002, when the organization completed the program's evaluation, a number of troubling discrepancies were revealed. While the PAC's

[92] Uribe interview.
[93] Franceschet and MacDonald, *op cit*.p.19.
[94] Interview with Sharon Bissell.
[95] Interview with Helena Hofbauer..
[96] See the web site for the International Budget Project, http://www.internationalbudget.org/ (accessed 5th September 2007)
[97] Keith-Brown 2005, *op. cit*, p. 16.

objective was to reach out to rural areas where health services are insufficient to cover the population in most need, those states with the highest incidence of maternal mortality received the lowest per capita levels of public health spending.[98]

While PAC included the reduction of maternal mortality as one of its many goals, APV was specifically designed for that purpose. The newly created APV program had some basic features that made it a suitable subject for budget monitoring: an explicit universe of beneficiaries (pregnant women, women post-delivery, and children under the age of two); quantitative goals (to reduce by 35 per cent the maternal mortality rate and by 30 per cent the number of maternal deaths, with respect to the year 2000); as well as a geographical focus on the states and municipalities with the highest maternal mortality incidence, starting in seven states in 2002 and reaching eighteen by 2003.[99] Fundar's renewed project for the period 2003-2006 included as specific goals: to insure that the annual debate in Congress over the federal budget included the issue of maternal mortality; and, to strengthen the actions of programs focused to reduce maternal mortality.[100]

This posed an enormous challenge to the organization, which, in spite of having become a respected research center with budget expertise, did not have the specialized knowledge on maternal mortality. In order to accomplish its goal, it had to find a way to obtain the political support of the actors involved in this arena of public policy. Its first step was to identify local partners in Chiapas and Oaxaca who had knowledge and credibility on the issue. In addition Fundar formed a 'reference group' integrated by additional civil society actors with a long track record and wide recognition on reproductive health issues and maternal mortality. These included: leading feminists with experience in international forums and public policy activism during the nineties; the reproductive health specialists Population Council and the NSMC; feminist networks with lobbying expertise, including the FNMPP and CDPE, as well as their founding organizations Equidad de Genero and SIPAM.[101]

Another member of the group was K'inal Antzetik (Land of Women in the Mayan language) which is probably the strongest grassroots organization that collaborated closely with the coalition, in the activities of lobbying and training rural indigenous communities.[102] Founded in 1991, it has a marked indigenous and rural profile. The organization originated in women's cooperatives in the Los Altos region in Chiapas, where the Zapatista movement originated. The organization has engaged in a wide range of activities, including everything from technical assistance in the commercialization of local crafts to mental health workshops. In recent years, it has developed community work on health issues and has cultivated links to the health

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[98] See note 88.

[99] See Secretaría de Salud. 'Programa de Acción. "Arranque Parejo en la Vida"'. Mexico, Secretaría de Salud (SubSecretaría de Acción y Protección de la Salud), 2002, http://www.generoysaludreproductiva.gob.mx/IMG/pdf/Arranqueparejo-3.pdf (accessed 20th September 2007) and Daniela Díaz, 'Presupuesto público y mortalidad materna: seguimiento al Programa Arranque Parejo en la Vida', México, Fundar, Centro de Análisis e Investigación, A.C., 2003, p. 2.

[100] Fundar, *Presupuesto público y mortalidad materna: seguimiento al programa Arranque Parejo en la Vida*. Reporte Final 2003-2006, *mimeo*, p. 14 [This document will be referred to as *Reporte Final*].

[101] Since 1998 Equidad de Género has worked on budgetary analysis from a gender perspective, with the objective of influencing the budget process at the Federal and state levels.

[102] The research and training type of work done by K'inal and its local parties is described in Graciela Espinosa Damián, 'Doscientas trece voces contra la muerte', *op cit*., pp. 161-238.

agencies of the state governments of Chiapas and Guerrero. In the latter state, it has strong links to the Coordinadora de Mujeres Indígenas de Guerrero, CMIG (Guerrero Indigenous Women's Coordination), one of the few women indigenous organizations of the state, where the authoritarianism, poverty and the lack of strong civil society organizations go hand-in-hand.[103]

Members of these groups were to become the core of an ad-hoc coalition formed around the objective of reducing maternal mortality. In the beginning, these organizations had the role of advising Fundar on the relevance of the research findings for the public policy debate. The implicit collaboration agreement meant that research work should be of use to the advocacy agenda, that Fundar would seek to remain a nonpartisan research organization and that other actors would undertake lobbying activities. Daniela Díaz, a Fundar researcher, was responsible for this work at the federal level. The group came together whenever it was necessary to meet government officials and congressmen.[104] Thus, by means of this alliance, Fundar was able to gain legitimacy and policy expertise as a newcomer in the maternal mortality policy arena. The group established its own relationships and connections within the decision making process, which appears to have been the most valuable resource to inform public policy.

Other actors strategically joined the campaign as well. As previously mentioned, Fundar had partners in the states where the PAC's evaluation showed the worst incidence of maternal mortality (Chiapas, Oaxaca; and later Guerrero) in order to provide input and compare the results of the APV program and the incidence of maternal mortality at state and national levels.[105] These partners were three medical doctors who were trained in budget analysis by Fundar and Gisela Espinosa, a leading expert in the field and a researcher from the Universidad Autónoma Metropolitana; these three doctors were two researchers belonging to grassroots organizations of the FNMPP in Oaxaca and Chiapas respectively, and a third researcher in Guerrero with previous experience in humanitarian relief efforts.[106] Although their main task was to produce research, they would also become increasingly linked to those engaged in political activism related to the issue, since they either were or gradually became the leaders of the advocacy process at a local level.

Another key member of the coalition was Integral Communication for Women (CIMAC), a feminist organization specialized in media from a gender perspective, which also obtained international funding to undertake a project linked to the campaign. Their project included training journalists with a gender perspective and

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[103] See K'inal's web site: http://www.laneta.apc.org/kinal/ (accessed 5th September 2007)

[104] Hofbauer interview.

[105] For example, while the 2004 national matemal mortality ratio was 62.6 per 100 thousand living births, in Chiapas, Guerrero and Oaxaca the numbers were 103.2, 99.8 and 87.9, respectively. Daniela Díaz (coord.). *Muerte materna y presupuesto público, op. cit.* [2006], pp. 8-9.

[106] The researchers were: Graciela Freyermuth, an academic of the Centro de Investigación en Antropología Social del Sureste, who also belongs to Asesoría, Capacitación y Asistencia a la Salud AC, ACASAC of Chiapas (Assistance, Capacitation and Assistance in Health); Dr. David Meléndez in Guerrero; and Martha Castañeda, member of a an organization affiliated with the FNMPP, Nawiin Center for Women's Human's Rights, in Oaxaca. Gisela Espinosa is a researcher at the Universidad Autónoma de México-Xochimilco, in Mexico City. Díaz and Freyermuth interviews.

providing them information on the maternal mortality issues.[107] The organization also developed a communication strategy to reach out to the most important national media outlets. The organization's website features daily news and articles on maternal mortality and gender issues and has produced specialized communications materials and press releases for most of the campaign public events, which were later distributed through feminist networks.

Other feminist organizations strengthened the coalition's appeal, mainly by attending public events and contributing to build up political support. Nevertheless, having an issue focus much wider than maternal mortality, they did not collaborate as closely as the organizations previously discussed. One of the strongest organizations that fell into this category was the Grupo de Información en Reproducción Elegida, GIRE (Group for Informed Reproductive Choice), an organization created in 1991 with the goal of generating a public debate that deals with abortion as a social justice and public health problem. They supported the campaign as a specialist in the generation and dissemination of information. Also, with a very specialized niche, the organization Catolicas por el Derecho a Decidir AC, CDD (Catholics for the Right to Decide) attempts to work within the church and its membership to advance an agenda of reproductive rights based on gender equality and ethics.[108]

The previous description gives us an idea of the very plural nature of the coalition and the specialized character of the organizations participating in the campaign: health and budget experts, women lobbyists and researchers, media specialists, grassroots organizations and members of international organizations.[109] In spite of the difficulty entailed in sustaining a coalition of this diversity and creating appropriate synergies to make it effective, this particular group managed to work together for five years (and counting) and achieved many of its immediate goals. According to one of its leaders, the key to achieve this has been the establishment of 'manageable and useful agreements for all members' of the coalition[110].

The basis of this consensus among the coalition members was the universally agreed upon goal of reducing maternal mortality. For example, whereas one organization will always speak of maternal mortality as a result of illegal abortions, another one would point out the health service's responsibility for addressing the fact that illegal abortions lead to maternal deaths. 'Thus, the perspective and the specific issue of relevance are different', but the general problem of reducing maternal mortality is shared and represents the basis for the coalition. Each organization

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[107] Lovera and Cervantes. 'El desafio de los medios de comunicación y la mortalidad materna', in María del Carmen Elu and Elsa Santos Pruneda, *op. cit.*, pp. 124-127. Also, Comunicación e Información de la Mujer, A.C. (Cimac), www.cimac.org.mx (accessed 5th September 2007)

[108] Other organizations who collaborated with the effort in a more peripheral manner included the Mexican chapter of the international IPAS and Milenio Feminista, previously mentioned. See www.ipas.org, www.gire.org.mx, www.catolicasporelderechoadecidir.org (all accessed 5th September 2007).

[109] 'I believe it is a very diverse group, where a variety of experiences from different perspectives converge. On the one hand there are economists who understand the management – or what should be the management – of funds and know what to ask. And on the other hand the technicians, medical doctors in this case […] contributing with information to support their search for medical attention that may be extended to the first level of attention, and a search that does not stop at an elitist prescription […] How would I describe the coalition? As a plural organization which has a very clear purpose, with a multidisciplinary perspective, and where there is a larger project but each one contributes from her own perspective.' Hilda Reyes interview.

[110] Hofbauer interview.

'stretches the arguments' towards its own cause and there is 'no need to reach a consensus' because that wears out relationships, rendering them 'bureaucratic' and 'less productive'[111] Thus, although all participants had wider purposes of their own, they also had good reasons to support the intermediate objective of increasing the budget allocation to prevent maternal mortality.

The maternal mortality issue has been in recent years at the core of the feminist agenda, not only because it is a central factor to achieve reproductive health, but also because – as it has been argued from the beginning of this paper – maternal mortality rates reflect the level of women's exclusion, marginalization, poverty and lack of empowerment. Reducing maternal mortality was a fundamental interest for all participants, which gave the campaign a unique character. On the one hand, it was extremely flexible, allowing each of the member organizations to pursue their own advocacy objectives and means to undertake them; on the other hand, the central goal was absolutely shared and gave them the needed cohesion. This meant that the coalition was rather loose and flexible with each member independently going ahead with its own actions, while some coordinated actions were undertaken from time to time. The campaign also appeared to lack clear programmatic content, at least for some periods of time, and this was probably a key factor to success[112].

As mentioned above, the PAC and the first APV monitoring research results revealed the fundamental contradiction between the government's rhetorical commitment to reducing maternal mortality and its failure to allocate adequate spending to achieve that end. The research confirmed that, for 1999, rates of maternal mortality varied widely between states, with a handful of wealthier northern states at or very near the national goal for 2000 of 27 deaths per 100,000 live births, and most of the center and southern states with ratios above 50 and up to 70. The deaths were further concentrated if analyzed from other perspectives: 68.3 per cent occurred among women without social security, and 49 per cent occurred in communities with less than 15,000 inhabitants.[113]

With this basis, the coalition began a dialogue with policy makers in the federal government, particularly the Ministry of Health and the Congress, with the aim of improving the program's design and increasing resources. By offering informed budget analysis, policy expertise, and political support, the organizations also developed important alliances with government decision makers. This was facilitated by the fact that more professional and sympathetic officials had entered the government after the 2000 election. The Ministry of Health, for instance, was headed by an acknowledged public health specialist, Julio Frenk, who has no ideological ties to the party in government (the PAN). Frenk turned out to be an important ally to the feminist agenda, being described by civil society actors as professional, committed,

[111] Hofbauer interview.

[112] When interviewed, most of the participants had a different perspective on who were the main actors and what were the main strategies, and they even had different names for the 'coalition' or 'campaign'. This was a sample of how loose and flexible it was.

[113] Dora Sánchez-Hidalgo y Daniela Díaz, 'Mortalidad Materna: un problema sin resolver', Martha Castañeda, *et. al*., *La mortalidad materna… op. cit*., p. 31 and 33. The publication of this book in co-edition with a prestigious national university, the *Universidad Autónoma Metropolitana (UAM)*, containing the results of this first research period (1996-2002) and an article by a full time researcher of this university gave the work a much wider distribution and greater prestige.

and open to dialogue, and with a trajectory in the field of health that firmly established his credentials as an expert rather than a partisan.

Also, heading the area in charge of maternal mortality, the Center for Reproductive Health and Gender Equity, was Patricia Uribe, a medical doctor with a strong commitment to the women's agenda and a long career in the public health sector. Uribe had previous experience collaborating with civil society organizations, which made her receptive to the work done by the coalition. Given Uribe's openness and the credible research the groups had already produced, this government office became another important ally, by providing information on the APV program, not available to the general public.[114] This collaboration with government officials, however, did not prevent the coalition from criticizing government programs and holding the government accountable for the deficiencies found in the APV. The relationship between the coalition, specially Fundar, and the Health Ministry, was simultaneously one of cooperation and tension, as discussed below.

Although the Congress is considered by members of the coalition as the 'most difficult' arena to penetrate, the campaign was very successful in making headway in the national legislature.[115] Within both chambers, the APV program is subject to oversight by the Health and the Gender Equity Committees. These committees, the last one made up mostly by female representatives, became another target of intense education and lobbying efforts. The advocacy process engendered greater interest among several representatives and became a personal commitment of a few female Deputies and Senators. They became the standard-bearers for the issue of maternal mortality in the congressional agenda and budget discussions.[116]

For the coalition, this meant facing two main challenges. This first one came from the lack of technical knowledge and accurate information on the maternal mortality issue among the Committee members and their staff, which implied that the coalition members had to provide this knowledge and the arguments to guide the debate. The second challenge was the PAN representatives' agenda which, as mentioned above, conflicted with some elements of the organizations' agendas. This implied that, in spite of the great legitimacy that maternal mortality reduction enjoys, there were certain difficulties in obtaining the support of some representatives from the PAN.

When the 2003 budget was debated in December of 2002, the Gender Equity Committee pushed the issue forward and an allocation for APV was approved, demonstrating the level of commitment among the Deputies. The coalition's effort to inform the debate and lobby members of the relevant committees generated the momentum to pass this and related measures. Key support came from the PRD and PRI representatives, and despite misgivings on the part of some PANistas.[117] While the 2002 budget assigned APV 63,466,100 pesos through the so-called 'Ramo 12-Health Ministry' category, the 2003 budget included 59,078,809 pesos through this

[114] Uribe interview.
[115] Díaz interview.
[116] Gastelum interview.
[117] See http://www.cimacnoticias.com/noticias/02dic/02121607.html (accessed 5th September 2007). The 2003 Proyecto del Presupuesto de Egresos de la Federación was voted on as follows: 427 legislators in favor, 41 against and 3 abstentions. Gaceta Parlamentaria, LVIII Legislatura, Cámara de Diputados, Mexico, DF., http://gaceta.diputados.gob.mx/Gaceta/Votaciones/58/tabla3or1-100.php3 (accessed 5th September 2007)

same line item as well as an additional 599,353,709 pesos through the 'Ramo 33-FASSA' (Fondo de Aportaciones para los Servicios Salud), the federal fund aimed at supporting health services through the state health agencies.[118] Although it is not clear whether these amounts represented a real increase in the resources for the program, which would be equivalent to 900 per cent, the detailing of these amounts would allow the coalition to document enormous inequalities in the criteria for the distribution of resources among the states, and to continue to monitor the APV program.

Thus, in 2003 Fundar and its research partners continued monitor budget allocations and expenditures. For example, the distribution of resources to the states for 2003 revealed that whereas Chiapas obtained 980,192 pesos for APV with a 93.2 maternal mortality ratio (per 100,000 born alive) Nuevo Leon received 23,968,069 pesos with a ratio of only 28.5.[119] This led to point out other deficiencies, such as the failure to use clear indicators (i.e. maternal and infant death) and specific goals to evaluate the program and allocate resources. Furthermore, it was possible to document the failure of the state governments to spend the money they were allocated: by June of that year, only a third of the total APV resources had been spent; in Chiapas, research work confirmed that of the highest budget ever allocated to the state in 2003, only 45% of the resources had been exercised by the end of October.[120]

As their achievements during the budgetary process the Congress were leading to such monitoring progress, the coalition published a series of informative documents and organized meetings in order to position the reduction of maternal mortality in the budget discussions in the autumn of 2003. The new President of the Gender Equity Committee of the Chamber of Deputies, Diva Gastelum, agreed to present the results of the coalition's research and its critique of the design of APV in a press conference that took place on the 21st of October, a day before the annual testimony of the ministry of Health. The event gained public attention as it was shown on the television channel for Congress and published in the official legislative proceedings. For the hearing, the coalition prepared an information dossier and a list of questions on reproductive health strategies and the APV program, some of which were submitted to Julio Frenk by the members of the Health Committee in the Senate.[121] These and other documents produced by the coalition were distributed to the heads of this and other Committees and were published in Cimac's web page.[122]

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[118] Daniela Díaz, *Muerte materna y presupuesto público*. México, Fundar, Centro de Análisis e Investigación, A.C.[2005 reprint], , p. 12

[119] Fundar, Centro de Análisis e Investigación, 'Mortalidad materna y presupuesto público ¿qué nos dice el programa Arranque parejo en la vida?' Presentation at the 7th Annual Meeting of the Women's Parliament of Mexico, Puebla, March 11th 2004, p. 3.

[120] Daniela Díaz, 'Muerte Materna. Presupuesto público y mortalidad materna: seguimiento al Programa Arranque parejo en la Vida', México, Fundar, Centro de Análisis e Investigación, 2003, p. 6; Graciela Freyermuth Enciso, 'Chiapas. El programa Arranque Parejo en la Vida y sus tropiezos con las inequidades de la realidad', Daniela Díaz (coord.), *Muerte materna y presupuesto público*, *op. cit.* [2005 reprint], p. 29

[121] See FNMPP, 'Interrogantes ciudadanas sobre las políticas de salud en el ejercicio del año 2003'. September 2003, in: http://www.laneta.apc.org/foropob/boletines/Interrogantes%20a%20Frenk.doc (accessed 5th September 2007)

[122] In the beginning of December, the bulletin *Pe$o y ContraPe$0$*, was handed to all the members of the committees involved in the debate over the budget in the Chamber of Deputies. Also, the public events were complemented with presentation of the results of the research. The organizations specifically involved in organizing and attending these events were the Consorcio para el Diálogo Parlamentario y la Equidad AC, the

But this time around the coalition was disappointed by the results of their efforts. In spite of the clear benefits of greater transparency in the use of public resources, the national budgetary structure changed, aggregating the resources of APV and other health strategies into one spending category, and the resources assigned to the states through the Ramo 33-FASSA into another. This last change meant that APV resources were not specifically earmarked. All this was result of the launch of a new public health financial scheme, the *Sistema de Protección Social en Salud* (Health Social Security System, or Seguro Popular) into which the APV was absorbed.[123]

The changes in the formulation of the budget put at risk the central objective of the campaign, as it implied that funds could not be monitored any more and that the progress made during the recent years in narrowing the focus of public policy to address key issues might be reversed. The situation was worsened by a decentralization process that left the Federal Government with few mechanisms with which to hold the states accountable.[124] The uneven progress of the local transparency processes were of no help either, as the three states involved in the project – Oaxaca, Guerrero and Chiapas – lacked laws assuring access to public information. The fragility of budget allocation monitoring became a central worry for the coalition. As the reversal in transparency made monitoring and research incredibly difficult, a revision of the research and advocacy strategy was required. This turn of events encouraged the coalition to embark on a new approach to the problem of maternal mortality.[125] This promising avenue for advocacy was inspired by research on best practices at the international level and coincided with research findings produced at the state level. As several of the coalition's members had been active participants in international forums, including the Technical Meeting of the tenth anniversary of the ISMI, the international maternal mortality policy framing increasingly influenced the campaign and vice versa.[126] The new strategy concentrated on applying the *Averting Maternal Death and Disability Program* of the UNFPA and Columbia University, which developed the Emergency Obstetric Care proposal (EmOC) in 1997.[127] The campaign thus moved on from influencing the budget allocated to APV to influence program policy design, by persuading the Center for Reproductive Health and Gender Equity of the Health Ministry on the importance of introducing the EmOC protocol in the local health services delivery.[128]

As the EmOC core proposal focused on the provision of rapid and skilled attention, and this was adopted as a criteria to evaluate the conditions for policy implementation, particularly the access to health infrastructure, medical equipment

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Foro Nacional de Mujeres y Políticas de Población, SIPAM, K'inal Antzetik AC, Equidad de Género AC, and Fundar. Fundar, Centro de Análisis e Investigación, A.C., *Reporte Final* 2003-2006, *mimeo*, p. 26.

[123] Fundar, *Reporte Final* 2003-2006, *op. cit.*, p. 3. Also, Also Díaz and Hofbauer interviews.

[124] Uribe and Díaz interviews.

[125] Apparently, Graciela Freyermuth encouraged the coalition to adopt this approach: 'In the beginning there was a bit of resistance because they did not see its link to the budget.' Freyermuth interview. But the coalition soon acknowledged the benefits of the approach: rather than simply looking at budget figures, endorsing EmOC 'widened and strengthened the content and arguments that resulted from research'. Fundar, *Reporte Final, op. cit.*, p. 30.

[126] Díaz interview.

[127] Fundar, *Reporte Final, op. cit.*, p. 14; see also http://www.fhi.org/en/RH/Programs/AMDD_rp.htm (accessed 5th September 2007)

[128] Hofbauer interview.

and skilled staff, i.e. the institutional capacity to resolve obstetric emergencies. Furthermore, Fundar contacted researchers of the National Institute of Perinatology to undertake a detailed estimation of the cost of medicines needed to provide the scheme of attention recommended in the three states where the incidence of maternal mortality had been highest.[129] The research findings under this new approach proved that the EmOC protocol was less expensive to provide than the traditional high-risk pregnancy monitoring procedures, opening the door to its inclusion in the official protocol of health services. At the local level, the need to establish an effective network of services among the three levels of government – to link the first and the second level of attention, so that emergencies could be dealt with – was confirmed.[130]

With even more field research under its belt, the coalition came well prepared for the next round of budget discussions. In November of 2004, the groups were instrumental in organizing a public forum, 'Maternal Mortality and Public Budget' together with the Coordinating Committee of International Events in the Senate. The forum served as a highly visible arena to criticize the shortcoming in the design of the APV program. The event was chaired by the president of the Equity and Gender Committee. Its speakers included three members of the coalition and two high-level Health Ministry representatives, and its audience was comprised by members of all relevant committees of both chambers and members of civil society. In the event, the 'disappearance' of APV and other programs from the 2004 and 2005 budgets was hotly debated among the government and non-governmental representatives. The coalition members questioned the supposed priority of APV when it did not even appear in the budget, and pointed out how the revised budget structure obstructed accountability.[131]

This time, these events coincided with a larger dispute between the Congress and the Executive on budget priorities. On the 18th of November it was announced that the budget proposal sent by the president was substantially modified by a coalition of five opposition parties: they sought to increase the amounts allocated to social spending in general and to gender programs in particular. In the case of APV, the Gender Equity Committee intervened to reverse a reduction proposed by the Executive in the resources allocated for gender related social programs. These disputes ended up in the courts, in the form of a law suit that was only resolved many months later.[132]

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[129] Hilda Reyes interview. She is a specialist in women's public health and founder of *Afluentes*, another organization involved in the campaign; Carlos Neri, her collaborator in this research, is an obstetric-gynecologist. The medicines included in the cost estimate were those needed to treat the five causes of maternal deaths in the first and second levels of attention: preeclampsia-eclampsia, obstetric hemorrhage, puerperal sepsis, obstructed birth and abortion. Fundar, *Reporte Final 2003-2006*, *op. cit*, pp. 14-15. Also Díaz interview.

[130] See Hilda Reyes and Carlos Neri, 'Atención Obstétrica de Emergencia. Costeo de la AOE', pp. 87-96; Martha Castañeda, 'Seguridad de las mujeres para dar vida: infraestructura sanitaria, presupuesto y cuentas claras. Monitoreo al programa Arranque Parejo en la Vida. Oaxaca', p. 83; D. Meléndez, 'Guerrero. El programa Arranque Parejo en la Vida y la disponibilidad de la atención obstétrica de emergencia; un análisis de los recursos financieros, humanos y materiales a nivel estatal y en una jurisdicción sanitaria', pp. 61-62; G. Freyermuth, 'Chiapas. El programa de Arranque Parejo en la Vida y sus tropiezos con las inequidades de la realidad', pp. 31-33; all in D. Díaz, *Muerte materna y presupuesto público, op. cit.* [2005 reprint].

[131] Cimac, 'Desapareció la muerte materna del Presupuesto de Egresos de la Federación', *DDeser Informa*, Red por los Derechos Sexuales y Reproductivos en México, Num. 40, November 17th, 2004.

[132] In the modified Budget, $935 thousand million pesos were allocated to social spending (almost 12 per cent more than in 2004), out of which $34 thousand million corresponded to the Health Ministry (62 per cent more

Nevertheless, the problem of the use of block grants in the budget remained unresolved and the coalition kept making public demands on the need to modify its structure to facilitate program monitoring. They even took the issue to the 2005 National Budget Convention (Convención Nacional Hacendaria) sponsored by the National Conference of Governors.[133] This forum was one of many tries to advance a broad fiscal reform, which had consistently failed in the face of complex political negotiations and conflicting interests. Such reform would necessarily require the approval of the Secretaría de Hacienda y Crédito Público, the most powerful Ministry in Mexico, which integrates the budget and fiscal laws.[134] But this institution is characterized by its highly technical and closed policy process and was never reached by the campaign as an advocacy arena.

Although the new budget process precluded the earmarking of public funds to maternal mortality, the coalition's budget campaign helped the Health Ministry's internal budget negotiations. This was most clear in the 2005 budget debate, when the coalition proposed that the legislators increase the 2006 budget allocated through the Ramo 12 to the Center for Reproductive Health and Gender Equity, charged with the oversight of APV and other gender programs, from 10 to 100 million pesos, in spite of inside opposition under arguments that it was not needed. Nevertheless, the Gender Equity Commission managed to get the proposal included and approved in the budget package, by a margin of 21-to-3 in the committee.[135]

The results of the latest research on the cost of medicines needed to offer EmOC allowed the campaign to influence the design of programs in the Health Ministry. Its

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than the previous year). The allocation of only 10.5 million to APV was a decision made by the Gender Equity Committee, to amend the omission of the budget presented by the Executive. But this allocation to APV do not correspond to the information of the Ministry of Health – later on obtained by Fundar through the information system – estimating 49.34 millions through the Ramo 12-Center for Gender Equity of the Ministry of Health and 359 through the *Seguro Popular*, in the same item. This confusion confirms the obstacles to accountability created by the budget structure. Cimac, 'Más recursos para atender salud femenina'. *DDesser informa*, Num. 42, December 20th, 2004; D. Díaz, *Muerte materna y presupuesto público, op. cit. [2004]*, p. 12; and Lucía Pérez Fragoso. 'Proyecto de presupuesto destinado a la salud 2004. ¿Declaración de compromisos con las mujeres?'. Consorcio para el Diálogo Parlamentario y la Equidad, in: http://www.consorcio.org.mx/articulos_agenda/27/proyecto_presupuesto.pdf. The Federal Executive tried to modify the approved budget through the legal resource of 'observations', which was rejected by the Chamber of Deputies. The controversy was taken to the Supreme Court, which ten months later was resolved, in its 109/2004 October sentence against the Legislature, ordering the liberation of 80,176 million pesos retained by the Congress. Andar, Alianza Nacional por el Derecho a Decidir, Mexico, August 2005. http://www.andar.org.mx/prensa/prensa41.html (accessed 5th September 2007).

[133] Fundar, *Reporte Final, op. cit.*, p. 28.

[134] In her interview Patricia Uribe argued that efforts to segregate spending to distinguish programs combating maternal mortality would be extremely difficult due to the requirements and intransigence of the Treasury.

[135] According to Diva Gastelum, the resources allocated to the Center for 2006 were increased from the $25.9 proposed by the Executive to the $100.9 million approved by Congress. She saw this as fulfilling the commitment 'to earmark and make the budget transparent' that was made in the Declaration of San Luis Acatlán, a forum organized by the coalition and the Chamber of Deputies in Guerrero in 2005. Gastelum Interview. Even the Director of the Center later on acknowledged the benefits of this result, although when the proposal was made without consulting her, she denied the money was needed, probably responding to internal pressures. (Díaz interview). Patricia Uribe acknowledged, 'I know that this budget work helped to increase the budget to the Center, the National Center of Gender Equity and Reproductive Health, because it demonstrated that more money was needed […] That has helped us … to undertake new projects [and] strategic research […] Besides, thanks to that additional funding I can hire immediate attention groups for maternal deaths'. Uribe interview.

ongoing dialogue with the National Center of Reproductive Health staff allowed Fundar and its partners to influence the preparation of the 2006 Annual Operative Program of the Secretary of Health, which included the spending proposal to the Executive and other internal working documents related to the cost estimation of the causes of obstetric emergency. As a result of these negotiations, EmOC was included among the medical interventions covered by the Seguro Popular.[136]

Last but not least, the latest research demonstrated the fact that the federal authorities had inadequate statistical data on maternal mortality. For example, they had no information on the impact of obstructed births nor abortion as morbidity factors, as well as the percentages of maternal morality deaths among indigenous and urban women. Although Uribe suggested that the change in the focus of government action came before Fundar started its project, she recognized that her Center began to generate data on how much the various public health strategies spent on maternal mortality because of the campaign's pressure. She feels that some of the data used by civil society was flawed, leading to 'incorrect conclusions on the amounts distributed to the states'. This encouraged her to 'elaborate on accurate *cuentas nacionales'* and thereby provide 'solid information' on how much each of the key actors (i.e. the Health Ministry, IMSS and ISSSTE) were spending on the reduction of maternal and child health.[137] The advocacy process thus produced major advances in the information generated by the Health Ministry, which also led to the restructuring of the way the budget assigned to maternal mortality was reported in the 2006 Catalogue of Medical Services of the Seguro Popular.[138]

Thus although the Health Ministry shared data and programmatic information with the coalition, this engendered tension between the Center and Uribe. She opposed the coalition's concentration of pressure at the federal level, arguing that the Ministry of Health, in its oversight role, did not have the legal capacity to interfere in the state governments, who have the real power to earmark and spend money and the true responsibility for the provision of health services.[139] She also questioned the narrow focus of the maternal mortality campaign, arguing that this problem has an intricate link to cultural issues and gender inequality and that the government has a wider responsibility over women's health problems.

But these tensions are indicative of larger problems in the provision of public health in Mexico. The lack of clear responsibilities among the different levels of government in the recently decentralized federal system of health provision is well described by one of the state researchers:

> 'The problem is that people don't like to be criticized, and this is particularly true about state governments, and that causes conflict. With the federal government it is easier because you go, lobby, speak about the states, and that is not their

[136] Fundar, *Reporte Final 2003-2006, op. cit.*, p. 29.
[137] Uribe interview.
[138] Fundar, *Reporte Final, op. cit.*, p.31.
[139] Uribe interview. See also the Bulletin of the National Center of Gender Equity and Reproductive Health, 'Salud Materna y Perinatal en el Estado de Guerrero', where these arguments are laid out: 'It is incorrect to assume that the federal budget is the main source of financing of maternal and perinatal health, since it only accounts for 0.3 per cent of total expenditure'. Centro Nacional de Equidad de Género y Salud Reproductiva. 'Salud Materna y Perinatal en el Estado de Guerrero'. Press release, June 9th 2005, http://www.generoysaludreproductiva.gob.mx/IMG/doc/160605-boletin.doc (accessed 5th September 2007)

> responsibility – because of decentralization it is the states who are at fault, but I believe they [federal authorities] have part of the responsibility. If I am the [federal] Health Ministry and I fund the states, then I have to be accountable. Thus there is a great ambivalence in them blaming the state governments. You always go on blaming the other one and do not assume your own responsibility. Also, another complicated issue is, for example, that I am in a post and I criticize a situation, but suddenly I realize I will not be able to change it. Then I get out and pretend I don't see it, and I say that things are fine. There has been a lot of that'.[140]

Besides these challenges, the coalition faced its own internal difficulties in the management and dissemination of information. At times the reporting on the efforts of the collation seemed to run counter to the objectives of the campaign.. Several members of the coalition suggested that reporters would resort to sensationalistic or yellow journalism in order to raise interest in the issue, often at the expense of alienating government officials or other key actors.[141] Thus, CIMAC, the feminist organization focused on the media, made a key contribution in the training of journalists involved in the theme of maternal mortality in several states.

As previously mentioned, field research on state health services had been undertaken from the start of the project, in spite of the great challenges in its execution. The results of this research had a valuable impact on the public policy advocacy. For example, researchers found that contributions of state-level resources to reproductive health are not significant, whereas the federal *per capita* allocation of resources through the traditional health systems, *IMMSS* and *ISSTE,* are almost four times those assigned by the Health Ministry. Also, until 2005, almost nothing was known about the precise amount of the budget allocated for maternal mortality reduction through APV.[142] Other findings of this research included: the centralized allocation of resources at the state-level operation of services, where the local Health Jurisdictions (the operative bodies under the local Health Ministry) have no decision-making power to reallocate earmarked resources among municipalities; the inability of municipalities to pay for transportation expenses, critical in cases of obstetric emergencies; the lack of resources to hire translators in indigenous communities where many speak only the indigenous language; and the lack of year-round, 24-hour attention, as recommended by international standards.[143]

These findings, combined with the response at the federal level on the need to pressure the states (consistent with our interview with Patricia Uribe), led the coalition to concentrate its attention and advocacy work at the state level. During the 2005 event, 'Maternal-Infant Mortality: Each mother, each girl and boy counts!' sponsored by the FNMPP, K'inal Antzetik, and Fundar in the Chamber of Deputies, it was agreed to organize the first public forum at the state level.[144] This event, which

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[140] Freyermuth interview.
[141] Hofbauer, Freyermuth and Palomo interviews.
[142] Daniela Díaz (coord.), *Muerte materna y presupuesto público, op. cit.* [2006], pp. 14-17.
[143] Fundar, *Reporte Final…, op. cit.,* pp. 15-16.
[144] In this forum, the coalition's activities achieved their greatest exposure, since the forum was not only covered by the official channel of the Congress, the press, and the radio, but also included as part of a special report on maternal mortality transmitted to a national audience by one of the two largest television networks, Televisa's channel 2 *Morning News.* Fundar, *Reporte Final, op. cit.,* p. 27.

included the participation of the families of women who had died giving birth, members of communities affected by maternal mortality, and local public health personnel, represented the strengthening of the local focus of the campaign. The coalition targeted conducted advocacy efforts with the state governments in Oaxaca, Guerrero and Chiapas. Since political local contexts are quite different, the work of the coalition would encounter new challenges and its members would learn new lessons.

The table below offers a systematization of the different civil society actors involved in the campaign. The first column shows the type of expertise contributed by the different feminist organizations. The next two columns show the phase of the policy process and advocacy arenas where the expertise appears to have had more influence, and the last ones the strategies dominating each group of actor's *modus operandi*. The table was constructed for abstraction purposes, but it should be clear that many of the persons involved in each group share different expertise and activities and the iterative character of the policy cycle.

Table 1. Civil Society Actors and Public Policy Strategies

Civil Society Actors	**Policy process**	**Advocacy Arenas**	**Strategies**
Media Grassroots	Agenda setting	Public opinion	Media Information Health training
Budgetary Research Lobbying Health & rights	Monitoring Government agenda Policy design (budget)	Budget players/ Federal Health Ministry Congress Committees	Research Lobbying Accountability Pressure
Budgetary Research Health & rights Grassroots	Policy design (EmOC) State-governments agenda Implementation	Federal Health Ministry State Executives	

Also, the strategies were displayed simultaneously over the years, though each group of them appears to be directed towards different policy objectives and actors.

Working at the state level

Perhaps the most important lesson from the recent years of the campaign is the importance of working at the state level. This reflects two key contextual factors: the incidence of maternal mortality is concentrated in a few key states, and within select communities within those states; and, the decentralized nature of the health care system in Mexico. In its budget and policy analysis work Fundar applied this understanding from the beginning, working with local partners in those states with the highest incidence of maternal mortality – Chiapas, Oaxaca, and Guerrero. These states fall along a continuum of how successful the local campaigns have been. It is important and instructive to assess the lessons learned at this level as well, as the only way to reform health care services in order to have the desired impact is through state level interventions.

In late 2004 Fundar and K'inal Antzetik, together with the Gender Equity Committee of the federal Chamber of Deputies and local partners, planned to do local forums on the issue of maternal mortality in each of the three states. What happened in each case illustrates nicely the opportunities and obstacles of state-level campaigns.[145]

Chiapas: improving services, reducing maternal mortality

Of the three states, Chiapas has advanced the most in terms of addressing the provision of emergency obstetric care. In part this is due to a strong chapter of the Safe Motherhood Committee (CSMC), with a number of capable leaders such as Graciela Freyermuth, a leading researcher in the field. Sadly the effort to reform medical services was given a major boost by a tragedy. Following the deaths of 34 newborns in less than two months in the Comitán hospital in December 2002 and January 2003, the governor, Pablo Salazar, and the federal Secretary of Health, Julio Frenk, sought to correct the gaps in health care provision.[146] One result of this effort was the integrated program, Better Life, which aims to improve local hospitals, nutrition efforts, and transportation. Unfortunately it did not target local health centers, particularly in the Highlands (Altos) of Chiapas, with the highest incidence of maternal mortality. Preliminary data shows a reduction of maternal mortality of nearly 10 per cent over the last few years.

When the state forum took place in August 2005 it attracted a diverse audience including governmental representatives, indigenous women from a number of states, and national leaders. Advocates sought and won improvements to the Better Life program so that it would better serve the indigenous communities it had not yet reached and where maternal mortality had not yet been reduced. In this case a responsive and receptive state government and a strong, diverse array of local civil society organizations made all the difference.

Oaxaca: cautious advances

There has yet to be a forum held in Oaxaca. The local leadership, drawn from the local chapter of the NFWPP and including Fundar's local partner, Marta Castaneda, decided that the timing was not right. They had been engaged in prolonged negotiations to reach an agreement with the state secretary of health for a program similar to Better Life, and they believed that a forum – even if it were slightly critical of the PRI-dominated local government – would ruin any chance they had of concluding and implementing the agreement, upon which support from the MacArthur Foundation was predicated. The political environment in Oaxaca was highly charged, and in the context of the pending presidential election in July 2006 tensions were especially high. A month before the election the state teacher's union took over the main plaza in the capital, and unsuccessful efforts by the state police to evict them turned into a pitched battle. This in turn generated a local movement linked to the teachers union that is calling for the ousting of the governor. After months of a bloody stand-off in which protesters and others lost their lives, Federal

[145] Díaz interview

[146] Juan Marcial. 'Chiapas: La muerte tiene permiso'. *Imagen Médica*, February 2003. http://www.imagenmedica.com.mx/datos/modules.php?name=Sections&op=printpage&artid=100 (accessed 5th September 2007)

forces evicted the protesters from the central square. At the time of this writing the situation remains tense and the central issues unresolved.

Although the local women's organizations bring a high degree of credibility and experience to the issue, they have to act with caution in such a context. Although politically the state has been a PRI stronghold, its hold on power is tenuous. Oaxaca has a strong collection of organizations with a high level of credibility, but all attention is focused on resolving the dispute over the governor and bringing back a level of order to the state.

Guerrero: laying the groundwork

The forum in Guerrero was held in July 2005, and brought together over 400 participants. Leadership from local villages attended en masse, as well as groups from half a dozen other states and key national organizations. The three levels of government were represented, including the Secretary of Health from Chiapas. The most glaring absence was the Secretary of Health for Guerrero, who sent a sub-secretary to represent him. The national Chamber of Deputies paid the transportation cost of journalists from the capital, which insured coverage of the event. The immediate impact of the event was limited due to the particular context in Guerrero. The state government is not responsive to its poorest communities. Civil society is severely under-developed: there is only one clearly identified NGO working on health issues, San Luis en la Salud, a new organization formed by health professionals. The mix of political caciques, armed insurgency, and narco-trafficking poisons the political and social context, weakening the prospects for citizen engagement. This is the only case in which Fundar's local partner, Dr. David Meléndez, is not affiliated with a local network or group - because there isn't one. Daniela Díaz viewed this event as laying the groundwork for the future, promoting the issue with local leaders and beginning to cultivate ties between the state and national networks.[147]

IV. Accomplishments and lessons learned

Accomplishments

This section offers a reflection on what the campaign to reduce maternal mortality has achieved in recent years, as well as the limitations of those achievements, and the lessons learned.

The campaign to reduce maternal mortality has had three clear accomplishments. The first is that the issue has been firmly placed on the federal agenda as well as the agendas of many state governments. Advocates have successfully challenged the federal government to move beyond simply signing international agreements to debating how those commitments can be fulfilled. In the words of Fundar's director, Helena Hofbauer, 'From being a theme that had zero relevance in budget debates and no relevance in the design of policies related to maternal health, what we wanted was that each year when the budget was considered by the President this issue had to be taken into account…this goal was completely achieved.'

[147] Interviews with Díaz and Meléndez.

Not only were advocates successful in highlighting the issue, they also succeeded in achieving key budget and policy gains. Expert analysis revealed that those commitments could not be fulfilled given the levels of funding and the design of programs. In terms of the federal budget and programs, Fundar together with its collaborators established that levels of federal support were inadequate to achieve the reduction of maternal mortality and that the key health initiatives did not reflect international best practices, specifically the provision of emergency obstetric care. At the state level field research revealed that commitments to service delivery were not being fulfilled and that programs designed at the national level often did not take into account local realities, especially in terms of marginalization and cultural diversity. [148]

Although budget gains in terms of targeting health care dollars to the reduction of maternal mortality achieved in the 2003 budget seemed to be nullified with changes in the budget reporting format the following year, advocates succeeded in working with members of the Gender Equity Committee in Congress to achieve a dramatic increase in funding for the Ministry of Health's Center for Gender and Equity for the 2006 budget. This funding meant that the Secretary of Health – as well as civil society organizations – was in a position to better monitor the performance of state governments in their use of federal funding to reduce maternal mortality, as well as offer training and other support. In addition, through a regulatory change, the Health Ministry now requires the states to report each maternal death, opening the way for an immediate inquiry and substituting for the lack of transparency and data at the state level.[149]

The third and single most important policy impact was the 'paradigm shift' in preventing maternal mortality, from monitoring high-risk pregnancies to insuring the provision of emergency obstetric care. This change was made possible by citing international best practice as well as providing field research demonstrating the importance of such services. The Health Ministry is now seeking to change the protocol in the basic health regulations to provide for emergency obstetric care: this would represent an important institutional change. This shift in the state of Chiapas, as discussed above, has already demonstrated its effectiveness.

Have these advances resulted in the actual reduction of maternal mortality? At the national level there has been steady if unspectacular progress over the last five to ten years. But it is perhaps unrealistic to think that they could overnight. As discussed below, there are significant socio-economic and cultural barriers beyond changes in state policy that need to be overcome to truly change the factors underlying maternal mortality.

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[148] See Daniela Díaz,. (coord). '*Muerte Materna y Presupuesto Público*, *op cit*.

[149] According to Daniela Díaz: 'The Center published a regulation in the Federal Register…in November 2004…that required the states to report each case of maternal mortality to the federal authorities, thanks to the support of the National Health Council. The fact that this Council promulgated a regulation this quickly – given its normal slow pace – is thanks to the National Center for Gender Equity. The Center also proposed a modification to the Protocol for Healthcare during Pregnancy, Birth, and Puerperium to the National Health Council, in order to incorporate elements of Emergency Obstetric Care. It can take three or four years to modify a protocol, but these are institutional changes. This is due to the hard work of NGOs within the health sector…and the leader in this process is the National Center.' (Díaz interview)

Lessons Learned

What can be learned from the successes of the campaign, and how can one assess its weaknesses? One can look at factors within the coalition as well as contextual factors. The loosely formed coalition had three key elements that gave it strength. The first was its diversity. There was a wide range of knowledge and abilities that were highly complementary and allowed the coalition to operate successfully on a number of fronts. These included policy expertise, knowledge of the federal budget, field research, political communication and lobbying, media skills, and organizing and mobilizing skills. (As discussed below this final element was somewhat limited and has been a point for critical reflection among participants in the campaign.) In addition, the work has brought together a mix of actors at all levels, international, national, state, and local, although national level NGOs and networks clearly took on a leading role. A second key strength was its flexibility, both in terms of its ability to respond to opportunities and obstacles in the environment, as well as its capacity to accommodate the preferences and needs of its members. This flexibility meant that little time was spent on formal processes and bureaucracy and the focus remained on the advocacy work.[150] The third key factor was tenacity: each participant brought an unwavering dedication to goal of reducing maternal mortality. This shared commitment prevented the diversity and flexibility of the coalition from devolving into atomization.

Another key element related to the success of the work at the organizational level was the ability to undertake the research necessary to document the critical assessment of governmental initiatives and to substantiate policy proposals. To develop this analysis, to cultivate the capacity to produce them, and the political capital and expertise to make the most of such analyses, all this takes time. A key lesson is the importance of long-term funding to cultivate the skills and relationships necessary to effect political and social change. In this case such funding has come mainly from foreign sources, particularly the MacArthur Foundation in terms of longstanding support for reproductive rights and the Ford Foundation for budget analysis.

A final condition for the success of the campaign was its link to the international level, manifested in a variety of ways. The fact that the United Nations, over time and in a variety of forums, had endorsed the reduction of maternal mortality, and that the Mexican government was a signatory in all these initiatives, gave the cause both social and political legitimacy. This commitment gave the organizations a moral lever by which to criticize the government, contrasting what it had promised to do with what it was doing, using – and at times correcting – the very indicators the government published to show how far its actions diverged from its commitments. The international connection also gave organizations the standards by which to review and critique governmental programs designed to reduce maternal mortality: the most important shift was from monitoring at-risk pregnancies to providing emergency attention, and this recommendation originated at the international level.

[150] Hofbauer interview.

This link to the international scene contrasts strongly with the lack of a strong social basis for the effort. One limitation in the advocacy work was the lack of mobilization at the grass roots level. This is a not uncommon observation of civil society organizations in Mexico, and the women's movement in particular.[151] Although the coalition included an organization of indigenous women, K'inal Antzetik, A.C.,[152] its director, Nelly Palomo, voiced the concern that, 'The achievements could not be sustained, because we got lost in technical issues and we were not able to involve the people'.[153] Throughout her interview she stressed the tension between mobilization of indigenous women at the grassroots and the utilization of technical and media-oriented strategies.

But this is clearly a double-edged sword. This technical skill at the national level, the capacity to bring sophisticated analysis and data to inform policy debates, also supports state and local efforts that enjoy community support: although there is a tension between highly technical research skills and grassroots mobilization, there is also a complementarity that makes for a powerful combination.

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Conclusion

Perhaps the most important outcome at the federal level of these forums was that when the Gender Equity Committee returned to the next session of congress in the fall of 2005, it fought for a substantial increase in the funding for the Ministry of Health's Center for Equity and Gender. Since funds for health services via Universal Healthcare (Seguro Popular) disappear into a 'black box', the Deputies earmarked the increases for a special program of the Center called, 'Integrated Healthcare for Women': Daniela Díaz asserts that this increase was 'completely a result of the forums and the advocacy on the part of the organizations.'

V. Conclusion: Mexico's difficult transition and opportunities for citizen engagement[154]

What does this campaign reveal about the opportunity for citizen engagement in Mexico? How does the Mexican State respond to the demands and needs of its people? It is important to recognize that the State has become increasingly responsive over the last few decades. That said, moving from citizen demands to actual change in governmental performance and then to actual change in the living conditions of its most disadvantaged citizens is a long, arduous, and complicated process. In this case, each success brought the struggle to a new level, revealing the limitation of each advance and outlining the next step forward: getting the national government to sign international accords did not assure governmental programs to achieve the stated goals of the accords; programs whose stated aim was to reduce maternal mortality did not necessarily entail that they could achieve their aim, either

[151] Martha Zapata Galindo. 'The Feminist Movement In Mexico: From Self-Awareness Groups to Transnational Networks'. Presented at the Center for Global Justice, 'Women & Globalization Conference', 2005. http://www.globaljusticecenter.org/papers2005/zapata_eng.htm (accessed 5th September 2007)

[152] The name signifies 'Land of Women' in the indigenous Mayan language. It is a multi-faceted organization with offices in Chiapas and Mexico City. K'inal Antzetik, A.C., http://www.kinal.org.mx/ (accessed 5th September 2007)

[153] K'inal Antzetik, A.C., http://www.kinal.org.mx/ (accessed 5th September 2007)

[154] Jonathan A. Fox. 'The Difficult Transition from Clientelism to Citizenship: Lessons from Mexico', *op cit.*

through faulty design or insufficient funding; even improved public policies did not matter, absent adequate levels of spending; gains in funding and policy design at the federal level could disappear, either due to changes in the way federal spending is reported or through decentralization; implementation of health initiatives at the state level varied in their success due to decentralization; and, federal revenue sharing with states is good in theory, but in practice often lacks budget transparency and other mechanisms for accountability.

But the inroads that have been made into the legislative process and groundwork laid in the executive, it is hard to imagine a complete reversal at the federal level. Now the struggle to reduce maternal mortality has its main arena the states, and the next array of more profound and intransigent obstacles are coming into focus.

The struggle to reduce maternal mortality has begun to achieve its ultimate objective: over the last 15 years, the rate of maternal mortality in Mexico has gradually been declining: almost 30 per cent according to the Health Ministry. Not as quickly as advocates would like, and when the lives of women are at stake, the slow pace of change is especially frustrating. Now that the campaign has succeeded in influencing federal policy and has made progress at the state level, advocates have encountered the most entrenched barriers to citizen participation and policy change in the very states with the highest incidence of maternal mortality. These factors overlap and are mutually reinforcing.

The first of these is Mexico's uneven political and socioeconomic development. As health statistics demonstrate, some states have levels of maternal mortality equivalent to those of the developed regions, while others are at the level of Northern Africa countries.[155] In terms of political development the scenario is the same: some states have free and fair elections, alternation in office, and a basic respect for human rights, while others are dominated by single parties and local caciques, and face guerilla insurgencies to promote change. The challenges facing advocates in the latter context seem close to insurmountable, and are likely to change only slowly over time.

A second factor is the emphasis upon reinvigorating federalism and decentralized governmental authority. Given the context described above, this trend has contradictory effects: in some states it means greater accountability and more innovative government, while in others it means reinforcing the power of authoritarian governments. Thus, the opportunities for and impact of citizen engagement can be greatly enhanced or severely curtailed, depending on the local situation.

A third factor is the high incidence of maternal mortality in marginalized communities. Such small, isolated villages are not integrated into the modern economic and social context, and the promotion of economic development and the provision of basic social services such as health care present a daunting challenge, even to the most well-intentioned state. In addition, these communities tend to be concentrated in states that are more authoritarian.

[155] See United Nations. 'The Millennium Development Goals Report 2006. Statistical Annex'. UN, New York, 2006, in: http://millenniumindicators.un.org/unsd/mdg/Default.aspx (accessed 5th September 2007)

Women's organizations in general and indigenous women's organizations in particular have taken major strides in opening spaces, promoting and advancing their policy agenda. While they represent an important new avenue for citizen engagement, they clearly face serious cultural challenges both in terms of attitudes in government and the population as a whole.

In an influential essay on the Mexican transition Jonathan Fox wrote of the transformation of clientelism to citizenship: in many communities in various states this transformation has barely begun.[156] The struggle to reduce maternal mortality is slowly being transformed from one in which advocates, principally from Mexico City and principally NGOs, have argued on behalf of the rights of indigenous women to have access to adequate health care, to one in which state and local advocates join with indigenous women to argue on their own behalf. Through struggles such as this one the opportunities for citizen engagement are being expanded and the state is becoming more responsive, albeit slowly.

The trajectory of this campaign brings to mind the verses of the Spanish poet, Antonio Machado: 'caminante, no hay camino / se hace camino al andar'. Roughly translated, 'Traveler, there is no path / the path is made by walking.' The advocates involved in this struggle have won important breakthroughs, only to see that a subsequent challenge loomed ahead. Their tenacity has begun to bear fruit, not only reducing the number of women who die giving life but bringing about a more just society and opening opportunities for greater citizen engagement for those who have been historically neglected and ignored.

[156] Jonathan Fox. 'The Difficult Transition from Clientelism to Citizenship: Lessons from Mexico', *op cit*.

Table 2.	
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Graciela Freyermuth	Researcher, Fundar, Centro de Análisis e Investigación; Academic, CIESAS-Chiapas: Member of ACASAC (Asesoría, Capacitación y Asistencia en Salud A.C.)
David Meléndez	Field researcher (Guerrero), Fundar, Centro de Análisis e Investigación; Medical doctor
Hilda Reyes Zapata	Technical consultant, Afluentes, S.C.; Researcher, Instituto Nacional de Perinatología; Medical doctor
Erika Cervantes Pérez	Journalists network coordinator, Comunicación e Información de la Mujer, A.C. (CIMAC).
Nelly Palomo	Director, K'inal Antzetik
Patricia Uribe Zúñiga	Director, National Center of Reproductive Health and Gender Equity (Centro Nacional de Equidad de Género y Salud Reproductiva), Medical doctor
Helena Hofbauer Balmori	Director, Fundar, Centro de Análisis e Investigación
Daniela Díaz Echeverría	Researcher, Fundar, Centro de Análisis e Investigación
Martha N. Murdock	Program director, Family Care International, Latin America and the Caribbean program
Sharon Bissell Sotelo	Program Officer for the Population & Reproductive Health area, MacArthur Foundation (Mexico Office)
Diva Hadamira Gastelum Bajo	Deputy Federal Congress, Institutional Revolutionary Party (PRI); head of the Gender Equality Committee

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