The Problem of Maternal Mortality: Access to Information and Accountability Put to the Test

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Introduction: Maternal Mortality, A Tragic Reflection of Gender Inequity

The World Health Organization defines maternal mortality as, "the death of a woman during pregnancy, labor and childbirth, or within the 42 days afterwards, for whatever reason related to or aggravated by the pregnancy, childbirth or postpartum period, or its management, but not due to accidental causes."[1]

To a large extent, maternal death is due to inadequate health services as well as unequal access. It is no coincidence, then, that in Mexico most maternal deaths occur among poor women (in many cases indigenous women), who do not have insurance, and who live in very under-served rural areas or in under-served suburban areas. At the same time, maternal death is one of the most extreme and dramatically illustrative aspects of gender inequity—because in nearly every case, it is avoidable.

Mexico has ratified a number of international agreements establishing timeframes for reducing rates of maternal mortality. The most recent such document to incorporate international goals for reducing maternal mortality rates is the, "Millenium Development Goals," drawn up as one of the objectives of the Millenium Development Summit of 2000.[2]

During the 1990's, however, the maternal mortality rate in Mexico did not change, which meant the country was nowhere near meeting its commitment for the year 2000. In view of that gap, maternal mortality was defined as a high-priority problem in the National Health Plan for President Fox's term (2001-2006), and a specific program was established to address it: "Get a Fair Start in Life" ("Arranque Parejo en la Vida", or APV in Spanish).

[1] Elsa Gómez, *La salud y las mujeres en América Latina y el Caribe: viejos problemas y nuevos enfoques* (Santiago de Chile: Serie Mujer y Desarrollo, CEPAL, 1997).
[2] Objective 5 and Goal 6 of the Millenium Development Summit, held in 2000. The objective is to improve maternal health in general, and the specific goal is to reduce the rate of maternal death by 75 percent between 1990 and 2015.

Table 1

Rate and Number of Maternal Deaths 1990 and 2000; Goal for the Year 2000; and Millennium Development Goal for 2015

Indicator	1990	2000	Goal for the year 2000	Millennium Development Goal for 2015
Maternal death rate per 100,000 births*	90.4	72.6	45.2	22.3
Number of Deaths	2,189	1,543	1,094	547

Source: Mexican Government, Appendix of the *Sixth Annual Government Report*, 2006, p. 92. Available at: http://sexto.informe.presidencia.gob.mx/docs/anexo/pdf/P092.pdf. (Viewed September 2006). Response received via SISI information request 0001200088006.
* This includes correction for under-reporting.

During the three years that researchers monitored the APV, both at the federal level and through field research in Chiapas, Guerrero and Oaxaca, it became clear that tools for demanding transparency and accountability were crucial. They were needed to trace how public resources were being used in the program, and to be able to see, ultimately, how the program was actually working: what kinds of strategies were being implemented in the health system to reduce maternal mortality rates?

Progress: Persistence is the Key

Using the new Federal Law for Transparency and Access to Information (LFTAIPG in Spanish), researchers submitted what was essentially the same information request each year, for data crucial to the analysis of maternal mortality and the APV. The cumulative results yielded information on the use of public funds that are invisible in ordinary budget documents. Other unexpected information emerged as well, providing a much clearer picture of the problems around maternal death and the APV program.

There were two main types of findings:

1) Fundar carried out a project to promote a change in the existing model of maternal health care. Currently, this model focuses on monitoring high risk pregnancies and providing medical attention during childbirth. This paradigm has determined public policy towards women's health care during pregnancy, childbirth and the

postpartum period.[3] The new paradigm, now in place, is known as emergency obstetric care and is based on the idea that all pregnant women may experience complications, given that 15 percent of all pregnancies include some kind of urgent care situation, regardless of whether they have been assessed as high-risk.[4] When requests were made for information that would demonstrate the incidence of the different causes of maternal death (conditions which, if they are handled badly or not at all, result in the woman's death), it became clear that morbidity records were incomplete.[5] Such record-keeping, of course, is essential for finding policy solutions to maternal mortality.

2) Continual information requests for budget information about the APV program revealed some interesting characteristics of the overall system.[6] Although the APV does not show up in the Federal Budget Law (Presupuesto de Egresos de la Federación, or PEF) past the year 2003 (see Table 2 below), and is not labeled as a category of the Seguro Popular—Mexico's government insurance program for the low-income population—the program does appear in the Health Ministry's budget lines 12 and 33. Here it should be pointed out that funding for the APV, which has never been actually established as a program per se, is designated as medical care during pregnancy, childbirth and the postpartum period.

Table 2

Budget Allocations for Arranque Parejo en la Vida 2002-2006 as Established in the PEF (constant values, base year 2006*)

Budget Allocation Categories	2002	2003	2004	2005	2006
Category 12	79,631,242	68,299,201	N/A	N/A	N/A
Category 33	-	692,894,461	N/A	N/A	N/A

Source: Secretaría de Hacienda y Crédito Público (Ministry of Finance and Public Credit), *Cuenta de la Hacienda Pública (Public Finance Account),* 2002, 2003, 2004 y 2005, and *Presupuesto de Egresos de la Federación (Federal Expense Budget)*, 2006. Available at: www.shcp.gob.mx.
N/A: no information was available on the APV for these years.
* The base year 2006 value was taken from INEGI, Mexico's National Statistics Institute 1988-2004. Available at: http://dgcnesyp.inegi.gob.mx/cgi-win/bdientsi.exe/NIVMI00002000I00I00006#ARBOL.

[3] This is outlined specifically in *Norma Oficial Mexicana (Offical Normative Standards for Mexico*) *NOM-007-SSA2-1993:* Care for women during pregnancy, labor and birth, postpartum; and care for the newborn. *Diario Oficial de la Federación,* Mexico, D.F., October 31, 1994.
[4] Daniela Díaz, (ed.), *Muerte materna y presupuesto público* (Mexico, 2005), p. 3. Available at www.fundar.org.mx.
[5] The information was requested from the Ministry of Health. In Mexico, the primary complications that result in death are: preeclampsia-eclampsia, bleeding before and after birth (hemorrhage), postpartum infection, obstructed birth and abortion syndrome.
[6] Requests were made in the context of general opacity on behalf of the PEF and with the knowledge that funds are channeled through the Seguro Popular.

Table 3

Budget Assigned to Arranque Parejo en la Vida in 2004 and 2005, as Reported via Information Request (value of peso is constant)

Budget Allocation Category	Delivery System	2004	2005
Category 12	National Center for Gender Equity and Reproductive Health	21,184, 027*	33,342,380*
Category 12	Social Protection System (also called "Seguro Popular")	-	441,882,834
Category 33	Fondo de Aportaciones a los Servicios de Salud (Health Services Fund, or Fassa)	63,296,771	233,478,283
Total		**84,480,798**	**708,703,496**

*Note: The calculation of the peso as a constant value corresponds to the methods used in the following budgets: the budget for the National Center for Gender Equity and Reproductive Health, received in response to SISI request # 0001200088506, July 28, 2006; and the one for Seguro Popular and Budget Category 33: National Commission for Social Protection in Health, Executive Office of Health Services, received in response to SISI request #0001200062106, June 8, 2006.

Aside from the fact that the budget structure was apparently modified during these years, which affected a number of health programs in addition to the APV, these findings make it clear that there is extraordinary leeway in the manner in which public resources are distributed. Such fluctuations are linked to the APV's weak definition, and difficulties in distinguishing its overall strategies. As a program, it lacked structural tools, both for its implementation and for the adequate financing of strategies and specific actions that would decrease maternal mortality.[7]

Limitations: Opacity in Public Budgets at Federal and State Levels

As the Ministry of Health has become progressively decentralized, more and more responsibilities—operational as well as financial—have been delegated to the states. However, this process has not been accompanied by a sense of obligation, much less accountability, to citizens.[8] The matter becomes even more complicated when a particular state does not have a law for government transparency and citizens' right to access state information, which was the case in Chiapas, Guerrero, and Oaxaca.[9] [10] On top of this, the public budget structure was modified in 2004, which is why the APV disappeared from

[7] Daniela Díaz, *Mortalidad materna: una tarea inconclusa* (Mexico: Fundar, 2006). Available at: http://www.fundar.org.mx/PDF%20Avances%20y%20Retrocesos/03.pdf.
[8] Daniela Díaz (ed.), *Muerte materna y presupuesto público* (Mexico: Fundar, 2005) p. 16. Available at: www.fundar.org.mx.
[9] In Guerrero, such a law was approved at the end of 2005.
[10] Editor's note: At the time this study was carried out, these states had not yet implemented their own Transparency Laws. All three states have now passed local transparency legislation.

the PEF document. These contextual factors slowed the work being done by women's organizations to correlate indicators of access and quality of maternal care to budget categories in the PEF for such care. Also, the budget modification happened at the same time that maternal health care was re-routed, within the Ministry of Health, to be provided through the Social Protection System for Health (better known as Seguro Popular).

The central problem, however, is that between 2004 and 2006 the structure of the PEF does not specify any funds earmarked for maternal health care in general, nor to programs, actions or specific strategies designed to reduce maternal deaths. Another basic problem is that during the 2000-2006 presidential term, the federal Ministry of Health stopped reporting on the budgets it had proposed—specifically, in this case, for women's health care programs. The closest it came was to write up and distribute a report in 2004, called *Mexico: Health,* a document consisting merely of a whole list of basic health indicators.[11]

Consequently, there is essentially no report that would account for the activities and results of public health policy in relation to reducing maternal mortality, or health care for women during pregnancy, childbirth and postpartum, although year after year, the PEF defines these as a high-priority problem.

Perspectives: The Social Protection System for Health and the Health Services Fund (FASSA): Does More Money Equal Less Transparency?

Most of the fiscal resources earmarked for women's maternal care in the general population are routed through the government's Social Protection System for Health. Another minor part is distributed through the Fondo de Aportaciones a los Servicios de Salud (Health Services Fund, or FASSA in Spanish). Due to the budget structure, and especially given the opaque presentation of accounts through these two agencies, there is no way to trace peso amounts or criteria for allocating them, nor how these resources are used.

It is urgent, therefore, that the Basic Health Care system begins to develop and incorporate data on what kind of health care is actually being provided into their bi-annual reports; currently, these reports only include enrollment data. The Ministry of Health or one of its sub-agencies could be responsible for the collection and compilation of such information.

[11] Available at: www.salud.gob.mx. Indicators on maternal mortality were notoriously absent for the first year, but thanks to pressure from NGOs linked to the women's movement, they were included the next year.

The same kind of accountability structure should be replicated in the State Public Accounts and in the regular state-level Government Reports.

Conclusions and Recommendations: the Basic Health Care System and Maternal Mortality

First of all, the states of Hidalgo and Tabasco must adopt laws and regulations on transparency and access to information.

In terms of transparency, it is crucial that the Seguro Popular move beyond its role as a simple insurance program. The bulk of public resources for maternal health are channeled through this system. However, since the system's accountability indicators focus on national aggregated enrollment data instead of how the money is actually being spent on health care, this is a setback, returning to a situation of opacity in which federal and state transparency laws are insufficient.

It is crucial to move forward with the idea that accountability is a governmental obligation, and that it is a central part of public sector work. It should be understood in terms of the production and delivery of useful information that links objectives in government programs (at whatever level) with their actual implementation and outcomes.

Cross-cutting Issues: Social Actors Participate in the Maternal Death Issue

The basic goal of having this information is to know whether Mexico is making progress in reducing maternal death, and in providing better maternal care. Driving this is an even more basic motivation: the organizations and research projects involved in this work want to prevent more women from dying. It is not clear that all the efforts on the part of organizations to compel government accountability (at state and federal levels) have been successful. However, the non-governmental sector has moved from a reactive and quick-response approach to institutionalized practices that are now considered normal and positive. Social organizations need to continue to play a proactive and vigilant role in promoting constructive change.