GRB Work in Fundar (Mexico).
A Brief Presentation of our Experience

Budgeting for Reproductive Rights
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⇒ Fundar has been working with GRB for at least 5 years now. In the beginning of the initiative we focused on the analysis of anti-poverty programmes from a gender perspective. Later, we began approaching the issue of health and working directly with the Ministry of Health.

⇒ General Observations on GRB.

- *We have taken a particularistic/disaggregated approach to gender and budgets*. Neither gender issues, nor budgets, are monolithic, unitary categories. Our methodology stresses the distinctiveness of each sector, policy, and issue, and the specific political context surrounding it.

- We don't treat gender rights as a block or single-issue area. *Gender rights are not one issue but many;* reform in one area does not necessarily bring about a transformation in others.

- Gender not as an attribute of individuals or an identity, but as part of social structures and social processes.

⇒ Ministry of Health. The Mexican health system is divided among three sectors:

- IMSS and ISSSTE = social security institutions. Offer health services to formally employed persons (roughly half of the population – 65 % budget funds)
- SSA = Health Department. Offers health services to unemployed and informally employed; FASSA = conditional grants for the same purpose at provincial level (another 50 % - 35% of budget funds).
- Private hospitals = physicians charging for services.

⇒ In the years of 2002 and 2004 we published, in conjunction with other civil society organizations and the Ministry of Health, two guides on gender and budgets. The fist guide is a general introduction of the relationship between gender, budgets, and health. Above all, the intention is to *analyze* budgets and programmes taking into account gender criteria. The second guide goes a step beyond in order to approach a methodology to *design* policy and budgets in a gender sensitive way. We focused and worked directly with the HIV/Aids public institution responsible for designing policy on this matter (Consejo Nacional para la Prevención y Control del SIDA en México, CENSIDA).

⇒ Maternal Mortality Project. Overall context: 65% of the women that died lacked access to social security (unemployed or informally employed), 49% of all cases

occurred in communities with less than 15,000 inhabitants, 21% of maternal deaths took place at home, due to hypertension and hemorrhage, 67.3% of the pregnant women registered were located in the southern and southeastern states of the country, where a significant number of inhabitants are indigenous and reside in conditions of extreme poverty in rural areas. The estimated MM rate for 2003 was the same as for 1990. Focus on 3 states: Chiapas, Guerrero, Oaxaca, and the Federal level. (See Figure 1)

⇒ MM Activities: Budgetary follow up of programs that offer maternal health care to unemployed population living in small communities in the southern states of Mexico –population with the greatest risk. The Ministry of Health has implemented several targeted programs (Basic Health Package) that have reproductive and infant health components: PAC, Oportunidades, Seguro Popular; and specific efforts to reduce maternal mortality, Arranque Parejo en la Vida (*Even Start in Life*).

- ensure that: safe motherhood policies find adequate reflection in the budget,
- monitor and assess delivery of services,
- increase transparency and accountability and put priorities into perspective.

⇒ Some Conclusions:

- MM targeted programmes' budgets represent a small percentage of the total health expenditure. It is difficult to identify and track the evolution of the allocations. Need to petition the info and documents –sometimes by law, sometimes by will.

- PAC budget experienced real growth of 13.27% (1998-2002) and the extension of services was constantly increased, but per capita allocations were very uneven among states, *being the lowest in the most problematic areas.*

- The skilled care indicator does not account for the quality of the attention during the whole pregnancy process. It also doesn't show emergency actions.

- Qualified health personnel is scarce in states with higher rates of MM: one doctor per 14,555 persons in Chiapas, in contrast to one doctor per 2,430 persons in Durango.

- Many states lack a federal law on Transparency and Access to Information.

- We have fostered alliances and coalitions with a variety of sectors, including NGOs, academics, legislators, and health officials themselves.

⇒ A Different Approach: Emergency Obstetric Care. The research team decided to focus on a different direction: the strategy of Emergency Obstetric Care (EOC, designed by UNFPA and CU). The aim was to determine the extent of

financial resources needed to implement the EOC paradigm, in order to reorient policy strategies and budgetary allocations.

⇒ In Mexico, as official data reveals, maternal deaths occur in emergency situations. Most obstetric complications can neither be predicted nor prevented, but if women receive adequate treatment on time, almost all of them can be saved. Around 15 percent of deliveries will present an obstetric emergency, even if the pregnancy was normal and did not present any previous complication. For this reason, and considering the most relevant maternal death causes, we decided to take two elements into account:

- Monitoring and assessment of the *delivery of services* in situations of obstetric emergencies, based both in the program resource allocations and in the implementation of said resources. Field research was carried out.

- The *cost of drugs and medical supplies* needed to attend the three main maternal death causes (hypertension, hemorrhage, and infection) in both the fist and second level of attention.

⇒ <u>Costing EOC.</u>

- Costing out of drugs and medical supplies used in the first and second level of attention in cases of EOC for 5 top maternal death causes (eclampsia, hemorrhage, infection, obstructed birth, abortion) for same 3 states and Federal level. We used the highest cost, the estimations of expected pregnancies and expected birth rate.

- Official estimations of morbility (obstetric complications). In cases were these were not public, the information was requested.

- Other sources: Sistema de Información en Salud para Población Abierta (SISPA) and World Health Report 2005.

- Cost per case and per expected cases for one year.

- Results based on SISPA and WHO data are different, as they take into account different symptomatologies.

- Research found that the cost to attend every woman is relatively low. (See Figure 2) We still need to determine the cost of capacity training in EOC for the personnel working in the first level. This training has to be continued and sustained, as medical personnel have a high mobility rate.

Figure 1. Maternal Death Rates in Mexico, 2003-2004

	2003	2004
National	63.20	62.6
Chiapas	112.1	103.2
Guerrero	119.2	99.8
Oaxaca	65.70	86.9

Note: Oaxaca's great increase is due to the betterment of maternal death registries.
Source: Ministry of Health, *Salud: México 2004. Información para la rendición de cuentas*, 2005, www.salud.gob.mx

Figure 2. National: Estimation of EOC Costs (in Pesos) for 2004, SISPA and *World Heath Report 2005*.

Morbility	Drug and medical supplies cost by case (pesos)	Annual total cost (SISPA)	Morbility	Drug and medical supplies cost by case (pesos)	Annual total cost. *World Health Report 2005*
Preeclampsia – eclampsia*	968.64	14,604,181.02	**Preeclampsia – Eclampsia**	968.64	37,994,617.28
Hemorrhage prior to delivery*	304.10	2,982,058.12	**Hemorrhage after delivery**	333.04	42,864,266.22
Hemorrhage after delivery*	333.04	3,265,848.86	**Infection**	131.00	7,065,349.81
Infection**	131.00	2,264,123.46	**Obstructed birth**	80.00	4,510,840.96
Abortion syndrome***	453.52	39,191,804.28			----------
	Annual total cost (SISPA)	**62,308,015.74**		**Annual total cost ()*World Health Report 2005*)**	**92,435,074.27**

* Elaborated by Hilda Reyes and Carlos Neri.
** The percentage of incidence was calculated on the total number of deliveries attended for the first time.
*** The percentage of incidence was calculated on the total of pregnancies attended for the first time.

Fundar's publications of gender budgets and maternal mortality can be found on line at:

http://www.fundar.org.mx/secciones/publicaciones/pub_analisisyseguimiento.htm#3
(publications on gender budgets)

http://www.fundar.org.mx/secciones/publicaciones/pub_analisisyseguimiento.htm#5
(publications on maternal mortality)