CICRED'S SEMINAR

AN ANTI-POVERTY PROGRAM AND REPRODUCTIVE HEALTH NEEDS IN MEXICO'S INDIGENOUS POPULATION : CONTRASTING EVALUATIONS

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1. Public policies for the poor: Approaches to evaluating their impact

The struggle against poverty and for reproductive health have been intimately tied-up in Mexico's government programs since family planning became a part of the public health establishment in the second half of the nineteen-seventies.[2] In the 90's the integration of both fields of

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2. Mexico's Social Security Institute (IMSS) was the institution which developed the first program to aid regions that were designated "marginal" at the beginning of the 70's, and later referred to as "in extreme poverty". This program was called *Coordinación General del Plan Nacional de Zonas Deprimidas y Grupos Marginados* (COPLAMAR, National Coordination for Depressed Areas and Marginal Groups). Since 1977 the IMSS has had a leading role in family planning, in charge of serving 57% of new contraceptive users for the period 1977-1982. In May 1979 an agreement was signed between IMSS-COPLAMAR for the promotion of primary health care and

intervention became part of the general guidelines of the World Bank, which promotes and finances programs with this orientation in many countries.[3] There are many possible bases on which to evaluate these programs (cost/benefit analysis, consumer satisfaction with services, quality of services, accomplishment of goals over time, etc.), and in this paper I review the main ones applied to Progresa, the Program for Education, Health and Nutrition, Mexico's most important anti-poverty program, which has a very strong reproductive health component.

Actually, the most comprehensive reproductive health interventions for the poor undertaken by the Mexican government are carried out by Progresa, re-baptized "*Oportunidades*" under the present administration, 2000-2006. This might be a good enough reason to review the main results of studies which evaluate its impact, but beyond the detailed analysis of these results in and of themselves, I am interested in the unmet needs and problems reported in various studies which take into account the perspective of the beneficiary population and health service providers. This review, I hope, will show the importance of analyzing the effect of such programs on social relations and gender relations in particular, as gender equity is an often-emphasized goal of the official discourse on anti-poverty and reproductive health (Progresa, 2000*a-e*). This is so because research done world-wide has shown the various and complex ways in which gender relations have decisive consequences for reproductive health outcomes and the success of public programs (World Bank, 1995, 2001*a*).

Progresa was designed by the World Bank in collaboration with Mexican experts, relying on a long history of previous experience in Mexico's public health institutions and anti-poverty programs (Yaschine, 1999).[4] Since its start, at the end of 1997, Progresa has had funds specially

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family planning in rural and marginal areas, through the creation between 1979 and 1986 of 71 rural hospitals and 3,000 new medical posts to attend them. During 1979-1983, the IMSS trained 14,635 rural midwives, who were in charge of around one third of the family planning services provided by the IMSS in rural regions (Zavala de Cosío, 1992, p. 224-225).

3. The program which I present in this paper is in the process of being adopted in several countries, such as Argentina, Colombia, Honduras, and Nicaragua (Progresa, 1999).

4. Yaschine (1999) considers Mexico "an interesting case study because the government has been implementing anti-poverty programmes since the early 70's

budgeted for evaluating its performance. In March 2002 it changed its name to "*Oportunidades*", but since I will be reviewing evaluations done during the period between 1997 and 2000, I will address it by its original name.[5]

Several government-funded evaluations have looked at the program's impact on nutrition, education, health, community, work, and intra-family relations (Progresa 2000*a-e*). The techniques employed by these studies were diverse. On the one hand, a quantitative approach was applied to the analysis of the expansion of services delivered, as well as the cost/benefit of such services. On the other hand, government-sponsored and independent studies were undertaken to collect the points of view of program beneficiaries and health providers. A strong contrast between these approaches emerges from this overview. Government-financed studies tend to be more "optimistic" with regards to Progresa's achievements than independent studies, which are much more critical and point to what is still missing in the Program – that is to say, they underline the needs that

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(longer than many other developing countries)." She asserts that the anti-poverty policy guidelines "are the result of the confluence of ideology between the actors dictating the international trend and the technocratic political elite that has ruled Mexico since 1982." (p. 58). Santiago Levy is an outstanding representative of this technocratic elite, "credited for being the intellect behind the design of Progresa and of much of the restructuring of this administration's [president Zedillo's 1994-2000] social policy. Working for the World Bank, he produced a report in 1991 entitled "Poverty Alleviation in Mexico" which contains the basis for Progresa." (p. 55). Yaschine describes the main changes in Mexico's anti-poverty agenda since the 80's thus:

> "…the reduction of public investment from almost 11% of GDP in 1982 to almost 5% in 1989 was the initial factor leading to a drastic change of the social policy model… The education and health sectors were disproportionately hit, suffering reductions of 30% and 23% respectively… Initiatives directed at the poor were especially hard hit, such as basic education and health programmes within COPLAMAR and other rural and regional development programmes… Universal subsidies were substituted by targeted ones in order to maintain coherence with the new fiscal situation and the ideological approach guiding the economic model." (Yaschine, 1999, p. 48)

5. At present there are other government health programs aimed specifically at Mexico's Indian population, such as *Arranque Parejo en la Vida* and the Health and Nutrition Program for Indian Peoples (*Programa de Salud y Nutrición para los Pueblos Indígenas*) of the Health Ministry (*Secretaría de Salud*); but they are very recent and no studies about them have yet been made public.

remain to be fulfilled. These are the disparities which I want to address in this article.

As an anthropologist, my approach is holistic, thinking of reproductive health (RH) as the result of many interrelated dimensions: political, economic, social, and cultural. My particular interest lies in the social relations involved in the application of public policies, because these are crucial to the impact that RH programs have. This implies taking into account not only the Program's immediate impact on RH, but also those aspects of local life that are involved in and affected by it, particularly community and gender relations. Looking into these dimensions inevitably obliges us to go beyond the government's usually glorified image of the results achieved by its programs, measured mostly in increased coverage of services, and introduces such problematic aspects as insufficiency of services, the quality of services delivered, and unexpected negative side-effects.

I am particularly interested in the Indian population because cultural and ethnic dimensions add complexity to the problem of attempting to address inequality. Additionally, the indigenous population is the sector of the poor with the worse living and reproductive health conditions, due to historical and on-going discrimination and marginalization from public services – most notably health and education.[6] For a public program to be successful in Indian communities, one must not only take into account the magnitude of the resources involved in dealing with extreme poverty, but institutions must also understand and acknowledge cultural differences and the specificity of social relations. Otherwise, the result is unexpected negative side-effects, which local actors reveal when they express their own priorities and those needs that they feel are unmet.

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6. Discrimination has been a taboo subject in Mexican academic research. At the beginning of the 90's, Lozano *et al.* (1993) conducted the most comprehensive research to date on inequality in the distribution of health resources in Mexico and the relationship between poverty, lack of access to institutional resources, and health outcomes. Unfortunately, this study does not take ethnicity into consideration. Sepúlveda (1993) and Boltvinik (2001, 2003*a,b*) are among the very few that have begun to address this matter. For an excellent critical review of the relationship between the Mexican state and the Indian population in recent times, see Oehmichen (2000).

2. The beneficiaries of the Program

Progresa/Oportunidades aims at "the poorest among the poor", which consists of the rural and Indian population. Around one quarter of Mexico's one hundred million inhabitants live in rural settings, and almost 10% of the total national population is Indian. The 90's were characterized by strong rural-urban migrations, and by the year 2000 40% of Indians were living in Mexican cities or had migrated to the United States. Nonetheless, the majority still live as small producers of agricultural goods, for family consumption and for sale, in dispersed hamlets of less than 2,500 inhabitants.[7] It is one of the sectors of the Mexican population which has suffered the worst consequences of neo-liberal economic policies, particularly the North American Free Trade Agreement (NAFTA). NAFTA caused a decline in the price of small-scale agricultural products and the government cuts in the credit, subsidies, and technical assistance it used to provide as part of its "Welfare State" policies.

Various techniques for measuring poverty have been used in Mexico, with differing results according to the definitions and procedures applied. But in spite of the differences, all researchers agree that income distribution has become more unequal in the 90's and that the number of people living below the poverty line has tended to expand both proportionally and in absolute terms (Tuirán, 2001; Boltvinik, 2003*c*). Regarding the Indian population in particular, it should be noted that between 1990 and 1995 the number of municipalities in conditions of very high marginality and which had 30% or more Indian population increased by almost one third (Jurado *et al.*, 2001).[8] The totality of the Indian rural population lives below the poverty line and in worse living conditions than the non-Indian population living in the

7. According to the National Census of 2000, in that year 55.6% of the Indian population lived in settlements with less than 2,500 inhabitants, which officially qualifies these localities as rural. Almost 21% lived in localities having between 2,500 and less than 15,000 inhabitants, 8% in cities with populations between 15,000 and 99,999, 8% in cities with populations between 100,000 and 499,999, and 7.4% in cities of 500,000 and more. Living conditions improve for both the Indian and non-Indian poor in urban settings (Boltvinik, 2003*a*, p. 22).

8. Jurado *et al.* used the information provided by the Consejo Nacional de Población (CONAPO*), Indicadores socioeconómicos e índice de marginación municipal, 1993,* 1995.

same rural contexts.[9] According to the National Census for 2000, almost half of Indian homes did not have running water, while the figure was 30% for rural non-Indian homes and 5% for urban homes; 70% of Indian homes had no sewage, whereas the figure was 55.5% for rural non-Indian homes and 7.2% for urban homes (Boltvinik, 2001, p. 28).[10] Inequalities in the distribution of health services are similarly enormous:

> "In 1998, in the southern states of Chiapas, Hidalgo, and Oaxaca [which have a high proportion of Indian population], there was one physician for every 1,150 people, while the northern states [more urban and with small Indian populations] had one for every 625 people. Differences within states are even more severe. For example, in Chiapas [one of the states with the highest proportion of Indian population], the five municipalities with the lowest levels of marginality, that is, with better standards of living, had one physician for every 557 inhabitants, whereas municipalities with indigenous populations had one physician for every 3,246 people… Life expectancy stands at 55 years in rural areas compared with 71 years in urban areas." (World Bank, 2001*b*, p. 419)

One of the goals of the policy of de-centralizing public health services in Mexico, which began in 1983, is to contribute to the redistribution of resources, with the purpose of overcoming inequalities between urban and rural areas. But Nigenda's (2001) case study, dealing with the impact of decentralization on the reproductive health programs of four states, shows that at least in the states studied there has been no substantial improvement in the urban/rural gap.

The health infrastructure continues to be insufficient or non-existent in regions where the population lives in widely-dispersed hamlets with bad roads and poor communications. Here the greatest problem is access, together with deficiencies in medical instruments, medicines, and the training of personnel. One of the main problems with Progresa is that it services only those communities with easy access to pre-existing educa-

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9. Inequalities in income between the Indian and non-Indian populations are quite marked. According to the 2000 Census, 99.4% of the Indian population living in rural areas lived below the poverty line; 94.1% qualified as "extremely poor" and 5.3% as "not extremely poor". Figures for the non-Indian rural population were 98%, 81.1% and 16.9%, respectively (Boltvinik, 2003*a*, p. 22).

10. The data for rural non-Indian and urban homes corresponds to the *Conteo de Población y Vivienda 1995*.

tional and health facilities. The population living far away from these facilities does not benefit from Progresa, in spite of the fact that it has severe needs.

There is a notorious lack of systematic and specific information on health and reproductive health conditions in Indian regions. The scarce information available reveals an appalling situation. For municipalities with a majority Indian population, malnutrition,[11] anemia, and intestinal and respiratory infections are among the five first most common causes of death, even for adults, while the first five causes of death among the national population are all noninfectious. Indigenous municipalities have triple the national average of incidence of deaths from intestinal infections. They suffer from at least three times more maternal deaths, and these statistics are under-reported (Freyermuth, 2002, p. 31).

3. Progresa: The Program for Education, Health and Nutrition

Progresa/Oportunidades has been the main government program for "alleviating" or "combating" poverty in Mexico since 1997. It was based on the pre-existing public health infrastructure, which was reorganized and given a new orientation to extend the coverage of its basic package of health services. By the end of 1997 it was under way in 12,000 localities, providing benefits to 400,000 families. By the year 2000 it covered 50,000 rural localities and 2.6 million families, which is to say around 14% of Mexico's total population, and around 40% of the rural population (World Bank, 2001*b*, p. 587). In 2000 it had a 960 million dollar budget. It gives money to the extremely poor so that they can spend it on education, food and health. The aim is to develop human capital, under the philosophy that strengthening the capacities of individuals will help significantly improve their living conditions and promote their contribu-

11. The National Nutrition Survey for Rural Areas (ENAL 96) showed that the states with larger Indian populations were the ones which suffered from the highest levels of malnutrition. According to the size/age indicator, 51% of the children living in non-Indian communities were malnourished; the proportion is 59.5% in the case of children living in communities with a widely-dispersed Indian population, and 73.6% in the case of children belonging to communities with a high density of Indian population (INI, 2000, vol. 1, p. 282).

tion to national development. It expects to produce sustained changes in the short run, while at the same time cutting down the inter-generational continuity of poverty (Progresa, 2000*b*).

Progresa involves several government institutions, including the Health, Education, and Development Ministries, as well as the Social Security Institute. The Program has a complex system of targeting individual families to give them regular cash subsidies. The subsidies are turned over to women, both with the idea that this will help empower them and because they are considered to be better administrators than men. Women tend to invest all incomes in family needs, whereas men sometimes use part of those incomes in personal consumption (notably alcohol). Subsidies are provided in two ways: a) as scholarships so that children can complete primary and secondary school; b) as cash to buy food. The amount of money given as scholarships for girls is higher than that given for boys, to ensure that they graduate.

Monetary aid is conditioned on the mothers' participation in the following three activities, to promote family health and nutrition:

1) Administering nutritional supplements to children aged 0-2, and from 2 to 5 if they suffer from malnutrition. Pregnant or breast-feeding women also are given supplements.
2) Attending periodic medical checks for those members of the family considered most vulnerable: pregnant and lactating women and children under five (to control their weight and size, administer vaccines, etc.).
3) Attending a program of monthly talks on hygiene, family health, and food preparation, to reinforce prevention (Progresa, 2000*a*, p. 8-9).

If mothers don't comply with these requirements, the economic aid is withdrawn.

The maximum amount that a family could get during the January-June semester of the year 2000 was $790 per month (less than 80 dollars) if it had several children in school; the average amount given was around $250 (30 dollars) per month per family. This amount was considered too high by the World Bank, given that:

> "international experience suggests that amounts below the current salaries for children are sufficient to keep them in school because parents value school for altruistic reasons or because they expect benefits in the future" (World Bank, 2001*b*, p. 589).

According to a study done in a community in Oaxaca, the Progresa subsidy for food represents between one quarter and 35% of the monthly average expenditure in food by the majority of domestic units (Sesia, 2001, p. 118). This means that families come to rely on the subsidies as a very important component of their livelihood. As we shall see, this puts a high degree of pressure on mothers to adequately carry out the activities designed for them by the Program.

The health component of Progresa is carried out by the Health Ministry and the Social Security Institute (IMSS-Solidaridad, called IMSS-Oportunidades since 2002), which coordinate their work together with Conprogresa, the part of the Social Development Ministry (SEDESOL) in charge of implementing the program's objectives. Each medical unit of the Health Ministry has between 100 and 500 families under its responsibility (an average of 3,000 inhabitants), while the Social Security teams serve around 5,000 inhabitants of the town or village where they are established, plus three more localities. The IMSS-Solidaridad also has Mobile Units which look after between 5,000 and 7,000 inhabitants (Progresa, 1999). Progresa provides a Basic Package of Health Services consisting of 12 to 15 interventions, classified under three main headings:

1) *Promotion activities*, such as building basic sanitary facilities for families and delivering community talks about self-care in health, nutrition and hygiene.
2) *Prevention*, consisting of the following services: family planning; prevention and control of tuberculosis, high blood pressure, diabetes, and accidents; early diagnosis of cervical-uterine cancer; monitoring child nutrition and growth; and a vaccination plan.
3) *Delivery of health and rehabilitation services*, for individuals, families and the community. Pre- and post-natal care for mother and child, as well as care during childbirth. Treatment of diarrhea, acute respiratory infections, parasitic infections, and cholera.

Thus, the reproductive health component consists of family planning (information on and supply of contraceptive methods), pre- and post-natal care, child delivery, and cervical-uterine cancer detection. Up to the year 2000 the package did not address Sexually Transmitted Diseases (STDs).

4. Quantitative evaluations of the Program's impact

The evaluation of the Program is an on-going process which began in 1998 and is expected to continue, with the purpose of making corrections and adjustments. Furthermore, evaluations are supposed to be an indispensable part of social policy-making. Progresa has been evaluated by various actors: 1) The Program has contracted independent academics (researchers belonging to the Center for Research and Higher Studies in Social Anthropology, CIESAS, Mexico), the International Food Policy Research Institute (IFPRI, Washington), and other institutions. 2) Its own personnel, under the guidance of the IFPRI, have performed evaluations. 3) Independent women's NGOs have done studies of Progresa's impact. The sources of information have been the administrative registers of the Program, the Programs' periodic surveys, individual interviews, and focus group discussions.

Evaluations contracted by the program and using the program's surveys as a source of information,[12] show several fundamental achievements for the period 1998-2000: 1) There has been an increase in schooling and permanency in primary and secondary school, especially for girls (the female enrollment rate in secondary-level schools has increased by 21%). Overall, school attendance increased by one year. 2) The use of public health services has increased by 18% since the program began. 3) The diagnosis of cervical-uterine cancer has also gone up significantly. 4) Children aged 0-5 of participating families had a 12% reduction in their morbidity rate, compared to children belonging to non-participating families; and morbidity among children between ages 0-2 diminished by 22%. According to World Bank analysts, "These results alone would make the program cost-effective" (World Bank, 2001*b*, p. 587).

Communities where the Program began in 1998 were compared with those where Progresa started two years later, which served as a control

12. The Surveys are the *Encuestas de Evaluación de los Hogares (ENCEL) de Progresa*. Before the Program began, in March 1998, 505 of the 50,000 localities where it was going to operate were assigned to two groups: one was to begin receiving aid immediately, and the other, with the same socioeconomic characteristics, was to serve as a control group, being incorporated into the Program two years later, in 2000. Information was collected prior to the initiation of the Program, in 24,000 homes, corresponding to almost 125,000 individuals. Four surveys were given every six months to the same homes during the following two years (Gertler, 2000, p. 3).

group. According to their responses to the health survey questionnaires, adults aged 18-50 and living in localities in which the Program operated, had a calculated decrease of 19% less days where they had difficulty performing daily activities due to sickness; they reported that they were able to walk 7.5% more than before the Program started without feeling tired, and it was calculated that they spent 22% less days in bed, as compared to individuals living in the control communities. Also, the number of hospitalizations diminished (Gertler, 2000, p. 3-4).

With regard to the impact of family planning education, 88.6% of women beneficiaries (married or in union, 20-49 years of age) reported knowing at least one contraceptive method, by comparison with 84.5% of the non-beneficiaries (who also belong to homes in extreme poverty). Around 6% more beneficiaries than non-beneficiaries knew of methods such as the Intrauterine Device and sterilization, which are the ones most offered by the public health institutions. Nonetheless, the proportion of beneficiaries and non-beneficiaries of equivalent age groups who do not want another pregnancy is practically the same.

In May 2000, 45.4% of beneficiaries aged 20-49 were using a contraceptive method, whereas the proportion of non-beneficiaries was 42.7%. Although the difference between beneficiaries and non-beneficiaries might seem small, it was considered significant by Progresa evaluators. For both beneficiaries and non-beneficiaries the most used methods are sterilizations (around 45% of all contraceptive users) and IUD (24.4% of beneficiaries who use contraceptives and 19.8% of women in the control group who use contraceptives). 92% of all contraceptive users obtained them from a public health institution. Rural women are the ones with the highest fertility levels in Mexico and the main reasons they give for not using contraceptives is the opposition of their husbands and that they themselves do not favor their use. This negative attitude towards contraception is apparently in the process of changing among younger women. The unsatisfied demand for contraceptives is calculated to be around 30% in rural areas (Huerta and Hernández, 2000, p. 48-57).

With regard to prenatal care, the proportion of Progresa beneficiaries who went for medical checks increased from 84 to 89%, whereas in the control group the proportion was 84.4% in 1998, and 85.5% in 2000. The women with the highest parity, including Indian women, are the ones who have the least probability of using this service. In the case of Indian

women, researchers think that difficulties in the relationship with public health providers are not the explanation, because Indian mothers take their children for check-ups in a higher proportion than non-Indian poor women.

Concerning breast-feeding, the results of the evaluations show that the introduction of the Programs' nutritional supplements for infants aged 0-2 have not diminished this practice. Before and after the initiation of the Program, 90% of children of mothers in extreme poverty in both beneficiary and non-beneficiary communities, were breast-fed at least until they were nine months old. Also, the proportion of children aged 0-2 who were taken by their mothers for monitoring of their growth, increased 6% more in the beneficiary population (Huerta and Hernández, 2000, p. 58-66).

Considering that the Program was only two years old when it was evaluated, the changes just mentioned were seen as proof of improvement due the Program's preventive interventions and routine medical controls, as well as its impact on the beneficiaries' diets.

5. The experience of women beneficiaries

There are several studies done with women, interviewed individually and in focus groups, in which they were able to talk about the problems they have encountered as beneficiaries of the Program. I have organized the main findings of these studies under six topics, which I discuss here.

5.1. Insufficiency of services due to inadequate infrastructure, material and human resources

One of Progresa's main objectives is to expand the coverage given by already existing educational and health infrastructure. As new localities were incorporated into the program, new beneficiaries began to participate in the system of scheduled medical consultations. Given that no new investments were made into infrastructure and equipment, it is not surprising that several of the studies done with program participants have recorded their observations that the pre-existing institutional capacity was unable to guarantee adequate delivery of services. This happened, for

example, with the Program for the Detection of Cervical and Uterine Cancer. This program originally was not part of Progresa's Basic Health Package, but was included due to the insistence of women's NGOs. In 1999, Pap tests became mandatory for women whose families received Progresa benefits. But due to lack of equipment, visual explorations, rather than vaginal cytology, are the standard diagnostic tool in many localities, in violation of the Official Norm for this type of tests. Also, labs have insufficient capacity to process those samples that are actually taken, and there have been long delays in returning results. A study with women who had the Pap test taken found that, for lack of adequate information, many thought that the Pap smear in itself prevents cancer, while others thought that if no results arrived it meant that they were fine, when in truth their sample had often not been analyzed. Eventually thousands of samples did get processed and hundreds of cases were diagnosed; then the next problem was that many of the women who were told that they had cancer, for various reasons could not access treatment (Castañeda, 1999, p. 38). Evidently, extending diagnostic procedures is a very important step, but it does not necessarily mean that prevention has improved; nonetheless, the two concepts tend to be confused in Progresa documents, as we shall see later on.

5.2. The targeting of subsidies to individual families creates community divisions

The way the Program is targeted creates problems. To begin with, the poorest and neediest communities are left out of Progresa, because they do not have ready access to pre-existing medical and educational institutions. Then, once a community is selected, subsidies are targeted to individual families. This is one of the main complaints that people have, as they perceive that the community as a whole is poor and that differences are not so large as to justify the exclusion of some families. Studies done by Adato *et al.* (2000*a,b*) and Nahmad *et al.* (1998) interviewing beneficiaries and local authorities, revealed that the uneven distribution of aid creates much resentment.

Since colonial times, collective dynamics have provided a crucial survival strategy for rural Mexican communities, helping them make the most out of scarce resources. Throughout the second half of the

twentieth century, and in response to Welfare State programs, communities have decided through local assemblies how they will use government aid, for common purposes. With this background, it is not surprising that in the two communities of Oaxaca where she did field work, Sesia (2001) found that people did not accept passively those aspects of the Program which they found divisive, but rather devised ways of adapting them to their own interests and outlooks. For instance, scholarships assigned individually by Progresa/*Niños en Solidaridad* (Children in Solidarity), were transferred by beneficiary parents to local authorities, so that they could buy school materials and distribute them among all the children. Another example is that although Progresa has clear prescriptions for targeting food supplements to pregnant and lactating women, as well as to children under two years of age or with malnutrition, mothers always distribute all supplements, including their own, equally among all of their children. A third example is that, whereas the Program requires that the community appoint local supervisors to make sure that the aid is used exclusively for the planned purposes, supervisors don't really go around policing their neighbors, since there is a strong opposition towards this type of control (Sesia, 2001, p. 125).[13] Sesia underlines the fact that these examples clearly prove the local capacity for transforming a government program so that aid, which was designed to be given according to an individual logic, is in fact distributed according to the traditional collective and family logic.

5.3. Services are not free any more

For communities in extreme poverty, government services have always been free, and Progresa is supposed to be so. But now that families are given money, beneficiaries are asked by the personnel at the government clinics to pay fees that are called "voluntary contributions" to buy detergent, disinfectants and minor medical materials that are scarce. To

13. It must be pointed out that this varies from one community to another. Members of other communities belonging to Oaxaca and other regions of the country have reported that some supervisors are using their position to build up clientelistic relationships, based on the fear that they will produce negative reports, which can mean that aid may be withdrawn.

keep their subsidies, women also have to spend time cleaning the clinics and performing other public hygiene activities (Castañeda, 2001, p. 4-5).

5.4. Contradictory effects

Progresa hands the aid money to mothers under the assumption that this will empower them. At the same time, the program makes them responsible for the use the money is put to. One guiding principle is that the support received requires the co-responsibility of the beneficiaries. To continue receiving aid they have to participate in a series of periodic activities:

1) Once a month, participating mothers must attend talks given by medical personnel about health, nutrition, and hygiene so that they can detect and prevent health problems in other members of the household.
2) Mothers must also take their children to regular medical checks.

Continuing aid is also contingent upon the following set of *unofficial* requirements:

3) Many mothers have to travel to collect the aid given by the Program and then wait to cash it in. There have been complaints that traveling in itself means spending an important part of the funds.
4) They often have to clean and perform other tasks for the Health Center and for the schools their children attend.
5) The Program also relies on another form of unpaid female labor, which is the work done by Community Health Promoters (which are usually women). Acoording to Castañeda's calculations, promoters do an average of 29 hours of free service per month.

Clearly, in spite of its discourse on gender equity and women's empowerment, Progresa is conserving the traditional division of labor, in which women are the sole care-takers of the family's health. Furthermore, under Progresa they are also made responsible for part of their communities' health. Their workload is thus increased. Both facts did not escape the attention of many of the women who participated in Adato's focal groups (2000*a,b*). These women emphasized that they should not be the only ones responsible for family and community health, and that talks should also be given to men. They find that they do not have enough time to cope with all their responsibilities, which

usually include participating in agricultural production and generating whatever extra incomes they can.

In addition, women receiving economic support feel compelled to comply with the program's rules. If they don't observe the schedule of activities planned for them, the support is withdrawn. Castañeda's 2001 study[14] explores the pressures felt by the female beneficiaries, and finds that a high number reported suffering from insomnia and "*nervios*" as a result of the fear that they would not be able to live up to all of the Program's requirements and would lose the much-needed economic support. The pressures felt by these women may even be impinging on their reproductive rights: 14% of the women interviewed reported that they had agreed to being sterilized in order to keep Progresa's aid. Cases of conditioning of aid to the acceptance of sterilization or the implant of Intrauterine Devices have also been reported by Indian women participating in Reproductive Health forums (Memorias, 1999; Grupo, 2002).

On the other hand, participating in health talks may provide the women with the opportunity to interact in a public space, which could be important to the effort of building up their self-esteem and self-confidence as part of the process of empowerment. Yet Castañeda's study (1999) shows that, up to now, limited progress has been accomplished in this respect, since only 42% of the 309 women interviewed who attended the Progresa monthly meetings reported having talked to other participants, and only 36% had talked with others about their

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14. Castañeda led two studies which I use here: the first one (Castañeda, 1999) was aimed at the perceptions of the beneficiaries of the Program for the Extension of Coverage on community participation and the way in which the gender perspective is incorporated into the Program's actions. Male and female beneficiaries were interviewed in two Indian municipalities in extreme poverty, one located in Oaxaca's Isthmus region (Ayuuk or Mixe-speaking) and the other in the northern part of the state (Mazatec-speaking). The second study (Castañeda, 2001; Red, 2000) was meant to evaluate: 1) whether Progresa's goals were fulfilled, 2) whether the Program was able to improve the female beneficiaries' social position, and 3) what alterations the Program underwent in the field. 309 women beneficiaries belonging to a local NGO were interviewed in Indian municipalities belonging to eight states (Campeche, Chiapas, Guanajuato, Jalisco, Oaxaca, Puebla, Quintana Roo and Yucatán), as well as 129 non-beneficiaries, 27 health promoters, 19 teachers, 15 employees of health centers, 13 local authorities, and 13 persons representing social organizations.

problems. This is because the so-called "*capacitaciones*" (workshops) are in fact lectures and are not open or conducive to dialogue.

5.5. Lack of adaptation to local culture and human resources

The information derived from women beneficiaries emphasizes several important areas in which Progresa shows a lack of adaptation to local characteristics and needs. One has to do with the monthly medical talks themselves. In the original design, 25 different topics were supposed to be taught. But the women interviewed by Castañeda (1999) say that, except for family planning, the contents of the talks are always the same and have been repeated since they can remember: the emphasis is on boiling water to prevent infections, washing hands, building latrines, etc., all of which depend upon the availability of water, fuel and so forth. The scarcity and cost of these resources, rather than a lack of good will, are the reasons that the proposed measures do not become practice. Interviewees also point out that health talks are usually given in Spanish, a language not well understood by most Indian women. Studies such as Castañeda and Lerín (1999) and Cao (1998) have found similar difficulties in communication between the health personnel and the midwives who attend talks and workshops designed to improve their skills. The interviews highlight the fact that the women are dissatisfied both with the content of the talks and with the manner of communication. This information shows that programs such as Progresa should make a major effort to take local circumstances into account and to improve communication with the population they serve.

In spite of an institutional discourse which emphasizes respect for local culture, the medical personnel which works in the Program has not received specific training that would permit better understanding of, and interaction with, Indian patients. This has been a persistent complaint in Indian women's forums, and specialists (medical anthropologists in particular) have consistently demanded that cultural competence be part of personnel training (Grupo, 2002, p. 23; Aguirre Beltrán, 1980). This is still a very important unmet need.

Of equal relevance for reproductive health is the interaction between government programs like Progresa and midwives, given that in the ma-

jority of Indian communities midwives play a prominent role not only in childbirth but also in pre- and post-natal care. But although government programs for training midwives have existed for more than two decades (Parra, 1991), there are persistent problems in the relationship between Indian midwives and public health institutions and personnel.

In a meeting organized by a women's NGO (Grupo, 2002), around 50 midwives, representing their colleagues from several regions, talked about the lack of government recognition and support for the work they do. They complained that they are blamed for maternal deaths, as if malnutrition and a context of poverty, violence, and lack of basic services had nothing to do with these deaths. This blame of course does not appear in the official records, which are usually politically correct and uphold the idea that traditional medicine and biomedicine should play complementary roles. But actual practice is very distant from discourse. Midwives stressed that they are not given the full government support they need to do their specific work to their satisfaction. They are poorly subsidized or not subsidized at all and find it difficult to transport their patients to clinics when they realize that a birth will be complicated. Yet they are sought by Progresa to help lead other women in sanitation campaigns. The added responsibility which this implies might be diverting midwives from their main and specific contribution to pre- and post-natal care, as well as delivery, with consequent negative effects on the well-being of their clients (Loggia, in progress).

5.6. Lack of participation at the decision-making level

There are two main ways in which a population can participate in health programs: at the decision-making level of the community (through local government), and in the execution of a program. According to the Pan American Health Organization, social participation in the decision-making process on the policies that concern the population is a civil right, and it is the only valid way for government institutions and services to successfully carry out their programs (as opposed to more vertical and authoritarian approaches). In compliance with this principle, Progresa documents state that the local authorities, the Health Auxiliaries and Health Committees, should participate in the planning, implementation and evaluation of the Program. All members

of the Committees are supposed to receive training in how to plan and execute projects, as well as in how to administrate resources. Yet research done in several communities in the state of Oaxaca found that local authorities were not consulted about priorities or asked to share their experience. They were not informed about the functioning of the Program, but were simply invited to its inauguration so that a publicity photograph could be taken. Progresa established direct relationships with mothers and excluded the community Committee as a source of collective decision-making and control. Mothers' co-responsibility in the Program's functioning did not in any way imply the community's active participation in the design, monitoring, or evaluation of the Program (Sesia, 2001; Red, 2000).

A high level of participation is demanded by Progresa, especially from the female part of the population who work as Health Promoters and Auxiliaries,[15] but only at the level of execution of the program, not at the decision-making level.

6. What do Indian communities want? The National Indian Institute Forums, 2001

At the beginning of 2001, Mexico's National Indian Institute (*Instituto Nacional Indigenista*, INI)[16] organized a series of community meetings, with the purpose of complying with the constitutional mandate of holding public consultations before National Development Plans are submitted by the President to Congress. The intention of the INI community meetings was to document the demands of the Indian population for the 2001-2006 Plan. The INI organized 33 consultation forums in 23 States with around 3,000 participants, including traditional authorities, community leaders, teachers, and representatives of Indian organizations. The meet-

15. Another program, the Program for the Extension of Coverage (*Programa de Ampliación de Cobertura*, PAC) requires that communities appoint Health Auxiliaries to perform eleven activities, such as giving talks, sending patients to medical units, preparing monthly and daily activity schedules, carrying out epidemiological control, and so forth. For performing all of these tasks, Auxiliaries are paid around 27 dollars a month.

16. In 2003 the INI changed its name to *Comisión Nacional para el Desarrollo de los Pueblos Indígenas* (National Commission for the Development of Indian Peoples).

ings were structured around eight topics: bilingual and intercultural education, culture, health and nutrition, gender equity, environment, sustainable social development, administration of justice, and migration (INI, 2001).

The results of the forums showed that in most communities participants clearly perceived and stressed the interconnection between poverty, malnutrition, poor health and high mortality.[17] Given that good health requires good nutrition, the main demand in regards to health was for an economic policy which would reactivate regional development and improve prices for agricultural production, generating sustainable economic growth and decent incomes. Another generalized demand was that Indian cultural rights be recognized – in particular, that traditional medicine be respected, recognized, and given support in its own right and not as a mere appendix to institutional medicine (INI, 2001). This coincides with demands voiced in Indian women's forums on reproductive health and rights, particularly in connection to midwives' subordinate situation (Memorias, 1999; Grupo, 2002).

With regards to Progresa, the Indian communities consulted by the INI wanted the Program to be extended to all families in a given community. They argued that the standards of living of the extreme poor and the not-so-poor are not so different as to justify not distributing aid equally to all. Also, they consider the avoidance of intra-community divisions to be a priority. Furthermore, they made a generalized demand that Progresa expand its services to all the extremely poor and poor communities it has not yet reached, as they are in much need of support. In the same vein, representatives at the forums wanted the government to expand and improve its permanent health infrastructure and services at the local and regional levels. INI forum participants demanded more hospitals for Indian areas, better equipment in those that already exist, and better pay and training for medical personnel. Another much-repeated request was for the participation of Indian authorities and organizations in the planning of public programs and in the administration of resources. Finally, it is notable that in many of the forums, participants emphasized that Indian communities

17. One of the main demands of the Indian Zapatista rebellion which occurred in the state of Chiapas (the poorest state and that with the worse health and mortality indicators) in 1994 was that they did not want the Indian population to continue dying of preventable diseases and malnutrition.

are tired of always asking for the same things and never receiving them (INI, 2001).

7. The point of view of Progresa's health service providers

There are few studies dealing with what the Program's health service providers think about their work and their relationship with the beneficiary population, as well as their observations on the Programs' strengths and weaknesses. More research is sorely needed on this most valuable source of information, but there do exist at least three studies which have gathered important information that can serve as a departure point. One of the studies was done by the Program's own authorities, and the other two by independent researchers. The contrast between the results of the study done by the Program and the other two raises questions on how information is gathered: especially who asks what and in what context, since it is evident that the responses elicited can be constrained by these circumstances.

The government study is based on a questionnaire distributed to Social Security personnel (IMSS-Solidaridad) responsible for the health component of Progresa, during an annual meeting held in the city of Veracruz in February 2000. The respondents were doctors, supervisors, administrative personnel and directors of the hospitals which service Progresa beneficiaries in several states of the country. The questionnaires were anonymous and 408 participants agreed voluntarily to respond to them. The researchers analyzing the results thought it important to point out that not all questions were answered, and that they only considered those cases which had complete information. Fully 17.4% of the questionnaires – a very high proportion – were incomplete and therefore excluded. The questionnaire consisted of a total of 77 questions dealing with the following topics: I. Interinstitutional coordination for the health component of Progresa. II. The health services assistance register. III. Co-responsibility of beneficiaries in health matters. IV. Benefits of the educational health forums. V. Impact of the preventative health measures implemented by Progresa. VI. Distribution and impact of food supplements. VII. Effective strengthening of the supply of health services. VIII. Consequences of

the increase in the demand for health services since Progresa began operating. IX. General opinion of Progresa's performance.

The questions having to do with the last two topics were the ones that received fewer answers, and it can be speculated whether the cause was the delicate nature of the topics, or whether respondents had simply become tired of responding to such a long questionnaire.

In general, the analysts of the questionnaires find that favorable opinions are more frequent on most of the topics, which is interpreted as reflecting "that there is a positive attitude of the personnel towards the operation of Progresa's health component" (Murillo and Ortíz, 2000, p. 97). Unfavorable opinions did not exceed 12% of responses on any topic, but one out of ten seems to be a significant figure. What is even more remarkable is that on several topics the percentage of those who responded "undecided" surpassed 50%, making them the majority. This is the case with questions dealing with: 1) the functioning of the register of health services beneficiaries, which elicited almost 60% undecided opinions (and 12% unfavorable); 2) questions dealing with the co-responsibility of Progresa's beneficiaries in health matters, which got 46% undecided opinions; 3) questions about the Progresa's general performance, which recieved almost one half undecided opinions, and 11.6% unfavorable. Nonetheless, the majority of the health personnel has a clearly favorable opinion of the Program's results with regards to preventive actions (71%) and the distribution of food supplements (70.2%) (Murillo and Ortíz, 2000, p. 88-99).

An outstanding problem with this study is that, in an effort to get a global view of the personnel's general opinions, the technique of analysis[18] employed aggregates responses and, as a result, the richness and heterogeneity of the answers to specific questions is lost. Thus, a potentially useful tool for identifying the Program's unresolved problems or unmet needs is wasted, because the aim is exclusively to emphasize positive achievements, even if it means forcing the

18. One of the most frequently used scales for measuring attitude and global opinions of individuals (the Likert scale) was used. The respondent has to express his degree of acceptance or disagreement with regards to a statement. Answers are classified according to their coherence with a certain directionality and given marks, which are added to obtain the total qualification of the attitude of the respondent towards the object of the inquiry (Murillo and Ortíz, 2000, p. 85).

interpretation of results. The following citation of the study's closing remarks is an example of this tendency:

> "The positive directionality of the health personnel's perceptions [with regards to preventive actions] leads to the conclusion that the nutritional condition of children under five has improved, and that there have been advances in the prevention of cervical-uterine cancer, in the regulation of fertility, and in the decrease in family violence. The opinions expressed with regard to questions about nutritional supplements show that health personnel feel that their distribution works adequately, and that, from their point of view, they are accepted by the beneficiary population, fulfilling the objective of helping to prevent and overcome infant malnutrition." (Murillo and Ortíz, 2000, p. 99, my translation).

In this text, the authors confuse the Program's goals, the service providers' opinions, and achieved results. Although it is true that Progresa's quantitative evaluations showed that the nutritional condition of children under five improved in beneficiary families, these evaluations did not demonstrate an improvement in the prevention of cervical-uterine cancer. As the experience of women beneficiaries shows, an increase in Pap tests does not necessarily imply prevention. It also seems unwarranted to stress advances in the regulation of fertility in rural areas, when the unsatisfied demand of contraceptives continued to be almost 30%, according to the calculations of another researcher of the same government sponsored study (Huerta and Hernández, 2000, p. 57). Concerning family violence, this was not a topic researched by the evaluations, and up to the present there are no public programs to address it in rural areas, where it continues to have important reproductive health consequences.[19]

The text quoted illustrates a recurrent problem with institutional publications: the authors of the text tend to follow the official institutional discourse and expectations when they interpret the results of evaluations, giving an excessively contented image of the government program's achievements. The idea that evaluations should serve to uncover unmet needs and pending problems in a program is over-

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19. Freyermuth (2000) and González Montes (2001) show the direct links that exist between husbands' violence towards their wives and their reproductive health, in two different Indian regions.

looked. This is why Boltvinik (2003*b*), an outstanding researcher of poverty issues, has said that most of Progresa's self-evaluations seem closer to government propaganda than to true evaluations.

Other studies dealing with the service providers' point of view – done with a qualitative approach by independent researchers – give different results. Adato *et al.* (2000*a*) interviewed 17 doctors who worked for the Program in various regions, and of these, 13 showed coincidence with the beneficiaries' ideas that the fact that Progresa does not cover everyone in a given community creates gossip and divisions, because non-beneficiaries are angry at not being included and don't want to collaborate with collective tasks in which everyone participated prior to the introduction of the Program.

Another issue, brought up by Castañeda (1999, p. 28), is that the institutional emphasis on measuring performance in terms of the accomplishment of quantitative goals of extending coverage of services has put a lot of pressure on medical personnel. To fulfill quantitative goals, these staff must not only treat more patients, but they also take on added paper-work, because they must register what they do. In Oaxaca, for instance, Progresa doctors have to comply with pre-established productivity targets involving an increase in the number of women active in Family Planning, the number of births attended to, the number of children under five whose nutrition is monitored, the number of vaccines applied, the number of diabetics under care, and so forth. Doctors have to record their activities in five different paper forms, and they state that one of the main problems of institutional and community personnel is an excessive workload.

With this information in mind, we may hypothesize that the very high proportion of "undecided" opinions in the first study reviewed in this section (Progresa, 2000*b*), might be attributed to the fact that health personnel are aware of the problems mentioned in Adato's and Castañeda's studies but do not feel free to express this awareness. This may not be so much out of fear of retaliation (something to be taken into account because even if their responses were anonymous, they were still in a work-place context), but out of a general feeling of loyalty to the institution they work for and a feeling of identification with the Program's purpose. We may speculate that this might be a case of "cognitive dissonance", by which I mean that the individuals could not

come to terms with the contradictions created between their daily work experiences and their institutional training and perspective. If this were true, the "undecided" response could be interpreted as an expression of "mixed feelings".

8. Conclusions

The evaluations reviewed address a very disparate set of questions. On one hand, Progresa's self-evaluations look into institutional target performance, basically in terms of the expansion of its preventive actions and the impact of the services it provides. On the other hand, independent evaluations and forums which gather information on the beneficiaries' and providers' points of view call attention to important problems both in the availability and the quality of services. One preliminary conclusion could be that both approaches are complementary, one pointing to achievements, and the other revealing and underscoring unmet needs. Undoubtedly the second source of information would be most useful when planning to improve the Program and correct its deficiencies and side-effects (including some unintentionally harmful ones), as well as in setting future priorities. In this sense, a first recommendation would be that programs should establish mechanisms for recording the perspectives of both their health personnel and the populations they serve. The next question is what kind of mechanisms should be used for this purpose: Periodic opinion polls? A constant dialogue between policy-makers, administrators, service providers and the populations they serve?

The subject is complex and problematic. The World Health Organization, the Pan American Health Organization, and the World Bank have all made it clear that a local population's participation is important if programs are to be successful; otherwise "beneficiaries" simply become passive (oftentimes reluctant) targets/recipients of interventions. An additional question is what type of participation should be promoted. In the specific case of Mexico's Indian population this is a particularly pertinent question because there is a growing Indian movement that demands autonomy – that is to say, it aims at participating at the decision-making level, not just at the operations end of

affairs (Oehmichen, 2000). Thus, participation cannot be a matter of merely eliciting and collecting the perceptions and points of view of the Indian population (though this certainly needs to be done, and to a certain extent has been, as in the case of the INI consultations mentioned above). This is something we have to come to grips with as researchers in our future studies of policy-making and the implementation of programs: whether participation means active intervention in decision-making or consultations which can easily be manipulated and forgotten.

The World Bank (the most influential policy-making institution) has taken some first steps in acknowledging the problem and has been keen on looking into all evaluations of Progresa. Its New Millennium Agenda for Mexico, published in 2001 and based on the latest findings of these evaluations, recognizes that "there is a lack of fit of poverty programs with indigenous interests and needs" (World Bank, 2001*b*, p. 546). The Agenda has taken up many ideas of Progresa's critics and recognizes that "Progresa has sound features, but there may be areas for improvement" (p. 587-590). These include the following:

1) A recognition that conflict exists between the strongly individualistic and profit-maximizing approach followed by Progresa's subsidies, and indigenous values and lifestyle, in which extended family and community relationships continue to shape decision-making. Individual distribution of the subsidies will not work – at least not without incurring important social cost (p. 546).
2) In communities where the majority of the population lives in great poverty, the World Bank Agenda proposes the incorporation of all families into the Program, to avoid the cost of loosening social cohesion. "In these communities, rather than leaving a few families without access to the program, it may be better to grant it to all to avoid conflicts" (p. 588).
3) The Agenda recognizes that indigenous community dynamics should be taken into account and that community organizations should be asked to participate in the local management of programs. More control of services should be given to indigenous communities and neighborhoods. To carry this out, it is necessary to "train local government and local leaders in accounting, administrative, organizational, and negotiation skills" (p. 551).

4) Professionals must be trained in culturally sensitive planning and rural development. There must be improvements in the bilingual curriculum for bilingual empowerment, introducing a new national general curriculum based on a multicultural model (p. 551).
5) Mechanisms for decentralizing and improving regional planning should meet indigenous community and urban neighborhood needs (p. 551). In general, the idea is that indigenous peoples should be "key actors" and that government programs should adapt to local conditions and cultural characteristics (p. 551-552).

As can be seen, these proposals retrieve many of the ideas and demands voiced by communities and beneficiaries in the materials here reviewed. Nonetheless, some very crucial elements that affect reproductive health, brought up by the "key actors" involved, are still missing. These are:

1. The need to extend the aid and services provided by Progresa/Oportunidades to all those communities below the poverty line, especially those without access to clinics and schools, which are the ones that are worst-off and that are not covered at present by the Program. This point was framed as a demand by the representatives from Indian communities from various regions of the country who attended the forums organized by the National Indian Institute.
2. Both the INI forums and women's meetings and focus groups have consistently emphasized the need to expand and improve health infrastructure and personnel, to assure not only the availability but also the quality of services. Health providers also stressed this need, as insufficient material and human resources mean that their workload is increased and that they cannot provide the best services possible.
3. In communities below the poverty line, services should be free, as they were in the past. Having to pay for medical care with subsidy money reduces the proposed benefits of the subsidy for nutrition and education. On the other hand, paying with "volunteer" work means an increase in women's workload. Health and reproductive health programs in particular should not rely on unpaid (or quasi-free) female labor as a means of solving budget cuts or problems of insufficient institutional resources.[20] Unpaid or poorly paid providers of health services should

20. Espinosa (2002, p. 30) presents the evolution of cuts in the government's

have adequate incomes. The contributions to reproductive health care of midwives in particular should be taken into account and given adequate economic support.

4. Reproductive rights should be guaranteed. The delivery of subsidies and services should not be used to pressure women into accepting sterilizations they do not want. More funds should be allocated for family planning, to cover the existing unsatisfied demand. Open communication and respectful treatment should be the basis of the health providers' relationship with the Indian population.
5. More efforts should be made to build effective ways of contributing to gender equity, especially by encouraging the participation of men in health programs.

As can be seen, these are quite strategic proposals. More than that, they are actual demands on the part of the key local actors, for improving and expanding the Program. These points are not accounted for in the official evaluations of Progresa nor in the World Bank's Agenda, but they were registered by studies interested in investigating what the local participants had to say. The fact that points 3, 4, and 5 of this set of proposals derive from the specific concerns of independent researchers about Progresa's gender impact, highlights the importance of applying a gender perspective to the evaluation of programs.

But even if beneficiaries and health care providers have a decisive contribution to make to the identification of unmet needs, we can see that there are limits as to what was addressed in the studies reviewed. A prominent absence is the need for work on HIV-AIDS prevention, as part of an integrated approach to reproductive health programs in rural and Indian areas, particularly taking into account that migration has increased in recent years. Also, in spite of being very grave problems, maternal mortality and domestic violence did not come up or only came up tangentially in the studies based on the beneficiaries' and health providers' point of view regarding Progresa, which seem to have focused on what the interviewees considered to be their most urgent

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Reproductive Health budget for the period 1994-1997 (using the Ministry of Health's Bulletin of Statistical Information), and concludes that they result in a greater workload and added responsibilities for women.

and immediate needs and priorities with respect to what the Program offers.

The studies reviewed are quite pioneering, as they have opened a new road which requires further work. At the same time, they prove the importance of independent academic analysis, based on multiple sources of information. Developing a comprehensive framework for policy analysis requires acknowledging that seemingly-objective evaluations are not always free from political bias, either in the selection of the "facts" to be approached, or in the processing, interpretation, and use of those facts. The various approaches and methodologies followed by evaluations, and the results they arrive at, are in themselves a topic in need of research and debate, as are the Indian population's general morbidity, mortality, and reproductive health, inequalities in the distribution of institutional resources, and the availability and quality of public services for these same communities.

A final and disturbing question is: what does it take to meet the needs that research discloses, to move from the level of the "politically correct" rhetoric of articulating needs to the actual implementation of responses? The first three points of the local actors' demands which I have presented require expansion of the government's investment in programs like Progresa/Oportunidades. More funds are also needed for respectful family-planning, research on the evolution of Indian nutrition and reproductive health indicators, programs for training personnel in cultural competence and for improving and expanding reproductive health information and services for the rural population. It is evident that without adequate financial resources the availability and quality of services are jeopardized. Unfortunately, the current policy is to continue cutting public social expenditure (of which health care is a part), and further targeting the population already being served. This occurs at a time when economic policies, instead of diminishing poverty, have continued to produce more poor. Thus, the prospects for a positive response to local actors' demands do not seem encouraging.

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