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Complexities of the charitable and philanthropic landscape within Mexico's children's hospitals

Abstract

In today's Mexico, approximately 50% of children experience multidimensional poverty, with indigenous children particularly affected; half of them live in extreme poverty and nearly all lack access to social security. The current political landscape threatens to exacerbate these issues. Reductions in public spending and the dismantling of federal child health programmes are likely to further hinder children's development, well-being, and health by limiting access to vital services like childcare, education, and healthcare. Children's hospitals in Mexico may increasingly depend on philanthropy and civil society support, however, the relationship between the State and philanthropic sector is not without problems. This paper presents a case study of "social assistance" in Mexico, by exploring the structure and organisation of two non-for-profit groups and their relationship with a children's hospital and healthcare staff in the south-east of Mexico through semi-structured interviews and document analysis. It aims to explore the challenges and tensions that arise in the collaboration between the State and philanthropic organisations, particularly in the context of sustaining and enhancing children's hospitals. Our study reveals that the philanthropic sector has tried to compensate for some of the enormous needs that historical and more recent challenges imply to the most vulnerable families when seeking medical attention for their children. However, philanthropic efforts are ultimately sustained by the same families through a "co-responsibility model". There is an urgent need for public policies based on human rights and social reform, which simplify bureaucratic processes and support philanthropic organisations in aiding vulnerable groups beyond the healthcare system's scope. Our case studies suggest that today philanthropic organisations not only complement the activities of the public health system by giving support to the families of the patients; but also substitute the State in the delivery of very basic medical care people should have the right to receive.

Introduction

In today's Mexico, approximately 50% of children experience multidimensional poverty (CONEVAL 2022ab), with indigenous children particularly affected; half live in extreme poverty and nearly all lack access to social security (CONEVAL 2022ba). These inequalities are compounded by a shifting political landscape in which reductions in public spending and the dismantling of federal child health programmes are likely to further hinder children's development, well-being, and health by limiting access to vital services like childcare, education, and healthcare. In response, many children's hospitals in Mexico now increasingly depend on philanthropy and civil society support. However, the relationship between the State and the philanthropic sector is marked with tensions and ambiguity, particularly around the roles and responsibilities each assumes in guaranteeing children's rights.

This paper presents a case study of philanthropy within healthcare in Mexico. We define philanthropy as the voluntary donation of resources to support health-related causes, institutions, research, and patient care, encompassing charitable giving by individuals, foundations, and corporations. The article focuses on two non-for-profit groups and their relationship with a public children's hospital and its staff. Understanding how these groups operate today requires situating them within a longer history of social assistance and philanthropy in paediatric healthcare and broader patterns of healthcare provision in Mexico. This analysis aims to explore the challenges and tensions that arise in the collaboration between the State and philanthropic organisations, particularly in the context of sustaining and enhancing children's hospitals.

Historical origins of philanthropy in Mexico

Before the arrival of the Spanish in the sixteenth century, healthcare provision in Mesoamerica had a strong magico-religious component with priests often acting as medics (Frisancho-Velarde, 2012). Health needs were primarily addressed within the family using basic knowledge of medicinal herbs, roots, and minerals, which were readily available in markets and women played a crucial role in childbirth and maternal care (Gómez-Dantés and Frenk, 2020). Diarrhoea and dysentery were common ailments at the time, despite the availability of clean drinking water and good sanitary practices (Harvey, 1976). It has been suggested that bigger urban centres, such as Tenochtitlan, had hospitals to care for the elderly and people with extraordinary illnesses (Martínez- Moyado, 2017) and that the Aztec emperor Moctezuma housed the mobility impaired and terminally ill in his palace (Gómez- Fröde, 2017). These accounts point to the existence of organised, though not formalised, structures of care prior to European influence.

With Spanish colonisation, in the late sixteenth century, provision of healthcare in Mexico took a charitable dimension with great influence from the Catholic Church and the Spanish missionaries. (Guadarrama, 2007; Layton and Mossel, 2015). Religious orders established hospitals that aimed not only to provide care to indigenous populations, but also to convert natives to Christianity and aid cultural adaptation (Villanueva, 2004; Campos-Navarro and Ruiz-Llanos, 2001). Indigenous communities were often recipients of Christian charity and paternalistic protection; characterized as "defenceless children" necessitating guidance and care. This laid the foundation for the active involvement of the Catholic Church in healthcare and charitable activities in Mexico (Guadarrama, 2007; Layton and Mossel, 2015)

Following Mexican Independence in 1821, the Catholic Church continued to be the main source of social assistance, particularly as malnutrition and disease persisted among indigenous children. The Reform Laws of the mid-nineteenth century marked a precedent: by nationalising church assets and legally separating Church and State they redefined the terrain

of social welfare (Yturbe, 2010). While the State gradually assumed greater responsibility for healthcare, religious organisations continued to play a central role, particularly in children's hospitals, where Church influence persisted in both practice and ethos. (ibid)

Children's hospitals as charitable causes

Specialised medical care for children developed in the nineteenth century, a period when institutional childcare was underdeveloped, and most attention focused on abandoned children through public assistance.

Baeza-Bacab (2017) gives an account of the establishment of Mexico's first children's hospital, which took place in 1866 under the supervision of the General Council of Beneficence, with assistance of private donations and under the protection of Mrs. Luciana Arrazola de Baz, wife of the recently appointed governor of the Federal District (what we know today as Mexico City). Catholic religious orders, particularly congregations of nuns, played a central role in the development of paediatric hospitals often extending their work to associated children's homes. Education and moral instruction were integral to these efforts, and charitable activities were frequently led by elite women (wives of doctors, politicians and benefactors) who organised fundraising and volunteered their time (ibid). These gendered forms of philanthropy helped shape the institutional culture of children's hospitals.

According to Morales-Suárez (2009), the "Children's Hospice" was founded in 1905; and in that same year, the children's ward was founded at the General Hospital of Mexico. It was not until the post-revolutionary era, around 1928, that the National Committee for the Protection of Children was formed and on January 19, 1930, the Mexican Society of Paediatrics was founded. A few years later, members of the Mexican Society of Paediatrics started what we know today as Hospital Infantil de Mexico, one of the National Institutes of Health.

Philanthropy in Mexican healthcare system today

The twentieth century saw the advent of institutionalisation processes that consolidated the authoritarian practices of the ruling political party and resulted in policies that only benefited very few. It was within this context that assistance was consolidated as an "imaginary social institution that replaced public responsibilities with private and charitable initiatives, evidencing the State's neglect of guaranteeing economic, social and cultural rights" (Gil 2011, p. 190, own translation). However, at the same time, the emergence of philanthropic organisations in the country has been slow, incipient and complex.

In recent decades, the participation of civil society in philanthropy represented only 0.04% of GDP (lower than other Latin American countries) (Salamon and Sokolowski, 2004). Many of these are still linked to religious organisations or religiously motivated actors and bodies. However, religiously motivated philanthropy continues to embody an ambiguous relationship with the social problems they try to tackle (Grönlund and Pessi, 2015). Religion legitimises the poor and demands action for the social problems that affect them; but at the same time, it can suppress local cultures of solidarity and contributes to oppression when cooperating with the misuse of public power (e.g. Benton-Sheldon 2011, CSW 2022). This is especially problematic in a context where the State also has a long history of paternalistic and despotic relationship with its people.

For most of the twentieth century, a single political party- the Institutional Revolutionary Party (PRI)- held uninterrupted power through a combination of electoral dominance, corporatist control and state-led repression. The Peruvian novelist Mario Vargas Llosa famously

described this de facto authoritarian regime, which operated under the guise of democracy, as the 'perfect dictatorship'. Similarly, Mexican Nobel laureate Octavio Paz referred to the state as a 'philanthropic ogre', a term that highlights how social protection programmes were used as instruments of political control. This philanthropic ogre offered the promise of providing for its people, yet always under the implicit threat of withdrawal in response to dissent (Layton and Mossel, 2015). Such an approach reflects the clientelist nature to social welfare under the PRI, where benefits were vertically distributed by the federal government through official corporatist structures, including labour unions and confederations (Espinoza, 2021). The result was a fragmented system of social protection that primarily favoured supporters of the federal project, and instilled disorganisation, duplicity and opacity - ultimately provoking a response from Mexico's emerging and incipient civil society organisations.

Indeed, civil society organisations focused on promoting democratisation and the protection of human rights during the 1990s, but also contradictorily adopted the view of 'co-responsibility' purported by the new model of social policy and poverty alleviation programmes of the nascent neoliberal period (Layton and Mossel, 2015). Neoliberalism promotes economic liberalisation and the reduction of public spending on social welfare, while closely following the idea of co-responsibility between the State and society that involves a transformation in the conception of poverty. Before neoliberalism, poverty was perceived as a problem that resulted from the inefficiencies of the industrialisation model, with neoliberalism, poverty was portrayed instead as an individual deficiency in human capital. This view puts the focus on the poor and their families, who lack the health and education capabilities to promote their own development by entering the formal labour market. This shift in the conceptualization of poverty and its causes transformed Mexican social policy by reducing universal programmes and replacing them with compensatory, targeted programmes that left the responsibility of offering social protection to the family, the community and the private sector (Espinoza, 2021).

This outlook stigmatises the beneficiaries of social assistance by individualising the responsibilities of poverty and reinforcing the popular idea that aid and development programmes promoted conformism, laziness and minimum effort from the poor (Jaramillo-Molina, 2019). This can be seen in the idea of 'co-responsibility' still present in social programmes and in the practice of philanthropy today. The idea of co-responsibility tries to legitimise social assistance in front of the public by requiring beneficiaries to act for their own development. The wave of conditional cash transfer programmes that formed around the world in the 1990s, with the Mexican programme Progresa-Oportunidades-Prospera as the international flagship, put into practice co-responsibility through the conditions they imposed on their clients. These programmes require participants to comply with conditionalities to receive social welfare benefits. This included asking participants to invest time and money to attend workshops, health consultations and even getting involved in unpaid work at the service of the State (see Molyneux, 2006). The relationship that this creates between the State, philanthropic organisations and the recipients of social assistance is, at least, problematic as it halts the transition towards a rights-based perspective in social policy and philanthropy (Fox, 1994; Olvera, 2010). Together, the notion of co-responsibility rather than of empowerment, the view of the poor as lazy and conformist that need to prove deservingness, and the individualistic rather than structural interpretation of the causes of poverty and of need have been installed in the social imaginary of the country.

This problematic relationship with those in need is compounded with the invisible relationship between philanthropic organisations and the State. Layton and Mossel (2015)note that the Mexican State does not have a systematic policy to promote the participation of civil associations and organisations, on the contrary, the State hides/negates the need of

philanthropic efforts. The legal framework imposes barriers for the incorporation of organisations, the tax system disincentives philanthropic activities, accountability is limited, the institutional capacity of organisations faces financial uncertainty and inadequate training, and severely low levels of public and private funding opportunities and individual donations (Layton, 2009). As a result, Mexico has significantly low levels of public social spending and private social spending for a country of 130 million citizens and for one of the largest economies in the world (Layton, 2009). Today, Mexico's public social spending is the lowest among the OECD countries, with only 7.4% of GDP in 2019 compared to 19.6% of GDP in Chile, the lowest ranked Latin American country and 31.6% in France, the highest ranked country in the dataset. Similarly, private social spending is amongst the lowest in the OECD countries in 2019, representing only 0.5% of GDP in the case of voluntary spending and 0.3% in the case of mandatory spending from non-governmental entities including businesses and organisations.

Undoubtedly, philanthropic organisations have the valuable goal to change the world for the better, yet, in countries like Mexico they face significant barriers to reach this goal, including the incipient support from the State, the lack of private and public funding, the reproduction of dominant discourses and practices around social need, and a paradoxical relationship with their clients. This scenario within the philanthropic community in Mexico, together with the challenges of the healthcare system that will be discussed next, present a grim prospect for many children and their families facing health conditions.

Evolution of the Mexican healthcare system

To understand deeply the significance of philanthropy in the promotion of health in children and the challenges it faces in Mexico, it is important to know the contributions and the areas of opportunity that State-led healthcare services have. The role of State-led health promotion comprises three different but related activities: (1) public health activities that include prevention of risk behaviours, infection control and environmental protection; (2) the creation of public policy that support health; and (3) delivering health care services (Raphael and Bryant, 2006). The first two are focused on supporting overall population health and illness prevention, while the third is focused on treating those who are ill. In Mexico, the first activity has been primarily conducted by the Secretary of Health and the second by a combination of the Secretary of Health with other public agencies such as the former Secretary of Development or Secretary of Wellbeing. The latter, the provision and financing of public health services, has been offered by a fragmented system characterised by the coexistence of various subsystems of delivery, each with their particular norms of access and financed with different funding sources (Bossert et al., 2014; Gómez-Dantés et al., 2023).

Since its establishment in 1943, Mexico's health system has been divided into two large providers, private and public. Private health care provision serves the middle and upper classes that have the capacity to pay for private insurance and/or receive services in for-profit hospitals and clinics (including pharmacies, which are on the rise, offering basic medical attention with the intention of selling medication to people with all types of social security, (see Colchero et al., 2020). In 2020, only 2.8% of the population reported receiving private health services according to the latest census of the National Institute of Statistics and Geography (INEGI). In contrast, public health services are structured around the employment situation of the population, especially protecting salaried work in urban areas (except for vaccination). The latter system has remained largely unchanged and is composed of two large subsystems. First, the Mexican Institute for Social Security (IMSS) was created in 1943, covering private sector employees. A few years later, the social security agencies directed to public sector

employees were created in 1959, with the Social Security and Services Institute for Civil Servants (ISSSTE) as the main provider (other institutes cover the armed forces (Sedena), the navy (Semar), and oil workers (PEMEX); as well as local social security systems like ISSTEP). Both subsystems are funded by an alliance between the federal government through general taxation and the employer and the employee through payroll taxation. These institutions offer consultations by general health professionals and a broad package of interventions and their respective medicines. In 2020, these two types of public systems covered 62.1% of the population (INEGI, 2020). However, their focus on the formal employee left unprotected the informal sector, one that constitutes a significant percentage of the Mexican labour market, and which is mainly composed of women, rural and indigenous populations and their children.

After 60 years of the establishment of the social security system, the System for Social Protection in Health - executed through *Seguro Popular* - was formed to provide care for uninsured, low-income groups not protected by the existing systems. *Seguro Popular* granted access to a reduced package of health services (Valencia and Jaramillo, 2019), including 294 essential services and 66 high-cost services, such as vaccinations to pregnant and lactating women and 24 interventions related to pregnancy and the newborn (DGGSS, 2019). It reached a maximum coverage of 57 million people and implied a reduction in the percentage of children without healthcare from 39% to 13.3% in 2016 (UNICEF, 2023). Although the literature has not reached conclusive results, some studies suggest that *Seguro Popular* reduced out of pocket expenses on health services (Barros et al., 2008), expenses in prescription medications and catastrophic health expenditures (Gakidou et al., 2006). In 2006, the Medical Insurance Century XXI programme was created as part of *Seguro Popular* giving access to health care services to infants younger than 5 years. According to Celhay and colleagues (2019), this programme was not associated with early neonatal mortality (<1 week of age) but was associated with a reduction of 7% in late neonatal mortality (<28 days of age), a reduction of 5% in infant mortality in those conditions covered by the programme, higher height, lower incidence of influenza and diarrhoea, and better overall health status after 6 years of programme implementation. These positive effects in mortality rates were higher in those localities with worse initial outcomes. As a result, *Seguro Popular* was instrumental for reducing inequalities in the access to health services in Mexico, especially in rural and indigenous areas (M. Jaramillo-Molina, 2023).

In addition to *Seguro Popular*, the conditional cash transfer (CCT) program *Progresa-Oportunidades-Prospera* created in 1997 was essential for illness prevention and the expansion of healthcare to those living in poverty and extreme poverty. *Prospera* sought to reduce poverty through direct cash transfers that were conditioned to recipients attending regular medical consultations in first level clinics that would identify common illnesses like diabetes and hypertension, but also provide medical attention to pregnant and lactating women and their newborn babies and infants. This CCT was instrumental for the expansion of health treatment centres in rural and remote areas around the country in the end of the 1990s, and for the identification of health conditions that would require more complex medical attention in specialized hospitals through *Seguro Popular*. In 2005, *Progresa-Oportunidades-Prospera* provided 42.5 million preventive health consultations (Levy, 2006). By 2018, 35.5% of the population reported affiliation to *Seguro Popular* (INEGI, 2020) and 6.5 million families were recipients of Prospera.

However, in 2020, the COVID-19 pandemic put under significant pressure the health institutions reducing their capacity to give care to children in several programmes including vaccination. In addition to this, in 2018, the presidential administration of Andrés Manuel López Obrador (AMLO) and his interest in producing a ‘fourth transformation’ in the social and

political order of the country, executed important changes in the provision of health care that also affected children negatively. These changes included the dismantling of three programmes targeted to poor families and their children by January 2019: (1) *Estancias Infantiles* that offered childcare to approximately 350,000 families with children under 6 years of age, (2) the emblematic CCT *Prospera* and (3) *Seguro Popular*. First, *Estancias Infantiles* was substituted by direct transfers for families to decide how to obtain childcare services. Second, *Prospera* was replaced by a series of scholarship programmes that eliminated offering higher scholarships to girls (compared to boys of the same school year) and the health conditionality that required families to attend to preventive health care. Finally, *Seguro Popular* was substituted by the Health Institute for Wellbeing (*Instituto de Salud para el Bienestar* or INSABI). This institute had the purpose of centralising the delivery and financing of free health care within the Ministry of Health by negotiating with the 32 states of the nation the return of funds to the federation. INSABI would oversee the provision of free medications and outpatient and general hospitalisation services to people without social security (Gobierno de México, 2024). However, with the entrance of INSABI, the proportion of the budget allocated to children decreased from 40.5% in 2021 to 29.8% in 2023, this is significantly lower to the 50% of the total budget offered to child healthcare with *Seguro Popular* (UNICEF, 2023).

The motto of AMLO's presidential campaign was 'for the good of all, the poor first', offering a distinctive perspective to the too common approach of previous administrations focusing on economic growth. Despite the significant change in the narrative, some authors question the progressiveness of the transformations in social policy embarked on by this administration (Jaramillo-Molina, 2023). The lack of evidence-based decision-making process in the policy changes of his administration (Reich, 2020), led to disinformation in the population about their accessibility to health care (CONEVAL, 2022a) and inefficiencies in the negotiation of cooperation agreements with states about the recentralization of funds (Reich, 2020). As a result, in early 2022, the federal government decided to refurbish INSABI to the decentralised public body (OPD) *IMSS-BIENESTAR*.

The two main renovations brought by this new public body is, first, the centralisation of the medical attention to people without social security and second the independence from the Secretary of Health. The centralisation of medical attention involves that, in those states with cooperation agreement (as we are writing there are 23 entities), decisions of maintenance, equipment, supply, hiring and payment of health professionals and general policy decisions will be centrally taken by IMSS-BIENESTAR with the intention of homologating health services, thus increasing the bureaucracy needed to obtain basic resources for health care provision. However, the states will maintain control of the administration of public health and, thus, of prevention programmes. Second, the independence from the Secretary of Health implies a separation from the administration of disease prevention and health care services, which could create distorted incentives in how funds are assigned, neglecting the prevention of disease. Despite these changes in IMSS-BIENESTAR, the inefficiencies in resource allocation and the misinformation about the accessibility of services of INSABI continue.

Historically, the fragmented system that characterises Mexico's public health services has displayed important deficiencies in terms of quality of services, adequate infrastructure, chronic budget insufficiency, innovative organisational structures to equitably deliver and direct resources throughout the national territory. According to Gomez-Dantes et al. (2023), this fragmentation affects primarily the most vulnerable groups in society as they are assigned fewer public resources, they have less coverage, receive lower quality of care and, therefore, reach poorer health outcomes. This is the case of children, especially those living in poverty. Of the total population in Mexico, 26% are children, more than 33 million people (World Bank 2020); of these, 52.6% live in poverty and 10.6% in extreme poverty (CONEVAL, 2020). This

is above the percentage of poor and extreme poor of the general population with 40.3% and 7.6% respectively. Additionally, child poverty has not shown statistically significant reductions between 2008 and 2020 (UNICEF, 2019). Despite the creation of systems like *Seguro Popular* and *OPD IMSS-BIENESTAR,* the highest deprivations in social rights that children experience today is access to social protection schemes (58%) and access to healthcare services (27.5%) (CONEVAL, 2020). The levels in terms of poverty and in deprivation in terms of social security and health care is higher for girls, for indigenous children, and for the youngest of children. Children between 0 and 5 years of age depict the highest levels in all indicators analysed above (54.3%, 11.8%, 31.1% and 58.5% respectively) compared to older children. These worst outcomes for girls, indigenous children and infants, could be influenced by the disappearance of programmes like *Prospera* and *Estancias Infantiles* that offered cash transfers, healthcare and childcare to their families.

Overall, public investment in health care for children has also displayed mixed results in the last decades (UNICEF, 2023). Despite real terms increases in investment as millions of pesos (mdp) from just above $400,000 mdp in 2012 to around $850,000 mdp in 2023, investment in the health of children specifically has had an average annual decrease of 4.9%. This means that when investment in child health care was 26.1% of the total investment in health in 2016, by 2023 it decreased to 15.5%. The same occurs with public spending on child related health services which displayed a decrease from 2.6% of the total health spending in 2016 to 1.4% in 2023. (UNICEF, 2023) reports that these average drops were worse for early childhood services compared to services targeted to older children and adolescents. Several factors could lay behind these decreases, including the operational challenges of the implementation of the new health systems attempted by INSABI and *OPD IMSS-BIENESTAR*. Indeed, the transition from *Seguro Popular* to INSABI generated much bureaucracy in the administration of healthcare and increased confusion about the affiliation condition of children and their families, causing an increase of 13.17% in the percentage of all children lacking access to health services between 2018 and 2020 (CONEVAL, 2020)

The challenges that children face in terms of access to quality care initiate since gestation. In fact, according to Pfutze (2014), coverage during pregnancy is a more significant factor in reducing neonatal and infant mortality than coverage at birth. Pregnant women with private or contributive health care receive more prenatal consultations and quality care compared to women without social security (Heredia-Pi et al., 2013). This difference is even higher for indigenous women as they suffer multiple barriers to quality of health care such as discrimination and mistreatment from health professionals, the rejection to traditional practices, language barriers, higher distance to the nearest hospital, among others (UNICEF, 2016). Although *Seguro Popular* was essential to reducing some of these barriers, in 2012, only 81% of pregnant indigenous women received qualified medical attention during delivery compared to 99% of non-indigenous women (ibid). Qualified obstetric care such as adequate medical evaluations is essential to solve the direct (hypertension, haemorrhage, septicaemia) and indirect (HIV, anaemia, malaria and tuberculosis) causes of maternal mortality and morbidity (UNICEF, 2016).

On the opposite side of the spectrum, the experiences that children have of the medical attention they do receive, speak lengths of their real access to public healthcare. A qualitative study conducted with Mexican adolescents about their perspectives of public healthcare can bring some light into this issue (Hoffman et al., 2019). Hoffman's and colleagues' qualitative study in central Mexico finds that adolescents feel frustration about the lack of appointments and medications in their local clinic, the inefficiency of the system, the long waiting times, the reduced working hours, the inaccessibility of medical language to them, communication difficulties with the health professionals, and their experience of mistreatment and lack of

professionalism from the staff. Healthcare provision to the youth is fundamental to reduce obesity, promote positive health habits and reduce risky behaviours such as drug consumption and unsafe sex. However, if the youth feel neglected by the public health care providers, this can also influence the final effects of State-led care in health outcomes. These results are no different to the well-known dissatisfaction of the general population when confronting public health care.

The ambivalent relationship with health professionals identified by the youth above, has been widely documented in Mexico, not only in the case of children but also at first level health clinics (Ramirez, 2021) and in the context of obstetric care (Smith-Oka 2015). Health professionals constitute the most immediate link through which people access health programmes. Their role in meeting the gaps left by inadequate policy design and inefficient implementation and bureaucracy is well known in the policy literature. Lipsky defines these actors as street-level bureaucrats that act as "*public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work*" (2010, p. 3). As street-level bureaucrats, healthcare professionals in developing countries often work in complex contexts, with unclear directives, scarce resources and precarious working conditions. This gives space for the use of discretion in the execution of their work which can have both positive and negative consequences. Some benefits of discretion include the flexibility to adapt policies to the particular needs of their patients, increased client trust and improved outcomes through creative solutions to unexpected problems. Yet, some harmful effects of discretion include the inconsistent application of rules and resources, interactions with clients based on personal biases and stereotypes, and poor decision-making for personal gain (Evans and Harris, 2004).

This overview of public healthcare provision in Mexico points to a multiplicity of boundaries that children face today to access quality public healthcare since gestation. These include historical inefficiencies, reduced coverage, ever increasing bureaucracy and decreasing public investment. In the face of this reality, philanthropic organisations interested in the wellbeing of children and their families have surged, with much difficulty, but trying to meet some of the holes that the State has not been able to fill.

Methods

This paper explores the complexities of the charitable and philanthropic landscape within Mexico's children's hospitals through a review of historical documents, describing the evolution of paediatric healthcare and philanthropy in the country, as well as the role of religion in philanthropic efforts. In addition, it incorporates insights from three interviews conducted with members of two charitable organisations and a paediatrician, alongside an analysis of publicly available information on their charitable activities. We take a case study approach to explore "social assistance" around the healthcare provision of a children's hospital in central Mexico. Flyvbjerg (2006, p. 229) points at the "strategic selection" of the case or cases, that might lead to 'clarify the deeper causes behind a given problem and its consequences'. The Mexican Children's Hospital is a notable case given its original constitution with funding from public, private, and social sector donations, it is a high speciality hospital where low prevalence and high-risk conditions are treated, offers dozens of medical specialities and covers a population of 4.5 million people.

We used a combination of purposeful and convenience sampling to invite potential participants to a semi-structured interview. They are the leads of two charity organisations who support a children's hospital and a healthcare professional with experience of working at the same hospital. Both charity directors are upper-class women who started work as volunteers at the hospital, illustrating how long-standing gendered forms of philanthropic engagement continue

to shape institutional practices and hierarchies within paediatric healthcare in Mexico. To protect the identity of participants and organisations, we have chosen not to reveal the location of the hospital except for the region. Names of organisations, including the hospital, have been pseudonymised.

A qualitative interview was conducted with two of the participants at a convenient time following their provision of informed consent. Following the interviews, the audio-recordings were transcribed verbatim and the audio files securely destroyed. A third participant sent written answers to the interview questions via email. The interviews centred on participants' views on the characteristics of the relationship between philanthropic organisations and the State and the challenges and tensions that might arise in the collaboration between charitable organisations and State institutions, particularly in sustaining and developing children's hospitals. In addition to the interviews, we asked the two leads of charity organisations to share their latest activity report. This helped us build a profile of the activities covered by each organisation. The document review focused on how social assistance is structured and implemented around one children's hospital in a south-eastern region in Mexico and the role it plays today in supporting paediatric healthcare.

Data analysis was conducted using thematic analysis across both documents and interview data, following phases: 1) familiarisation with the data (via data transcription, reading, and notation of initial ideas); 2) the generation of initial codes (grouping similar data into codes from across the entire data set); 3) initial theme generation (collating codes into potential themes); 4) developing and reviewing themes (ensuring themes align with coded extracts and the full data set); 5) defining and naming themes; and finally, 6) producing the report of the analysis (Braun and Clarke, 2006). We triangulated data to integrate the information gained through the literature review, document review and interviews to gain a comprehensive overview of the multiple factors that underpin social assistance of paediatric healthcare provision in a children's hospital in Mexico. This allowed us to understand more about how philanthropic efforts complement or substitute State support in providing healthcare to children, and what implications this has for policy and practice.

Ethics approval was granted by the Institute of Education Research Ethics Committee REC2096. All participants received written information about the study and provided written consent.

Patient and public involvement

The study design and research questions for this study were discussed with a medical professional with extensive experience working in children's hospitals in the south-east of Mexico.

Context of the study

The Mexican Children's Hospital is one of the main referral centres in the area southeast of Mexico and provides medical care for the most vulnerable. Families travel up to eight hours to access services such as paediatric surgery, orthopaedics, intensive care for children and neonates, paediatric emergencies, ophthalmology, paediatric dentistry, diagnostic and treatment laboratories, and more than 25 surgical subspecialties of paediatric medicine. The hospital has a capacity of approximately 120 beds for patients' stay. Hailed one of the most important paediatric institutions in the country, the children's hospital opened in the early 1990's as a specialised medical institution and was established with funding from public,

private, and social sector donations. Its mission was to provide tertiary-level medical care to children lacking access to social security healthcare services. Initially, it operated as a decentralised public organisation but was later integrated into the State health services through IMSS-Bienestar.

The Caring Hands Collective (CHC) was founded to uphold the hospital's altruistic approach. Now an independent entity, the 37 active volunteers continue to support the hospital, patients and families. Their mission emphasises altruism, honesty, and transparency, aiming to enhance the well-being of children and families through high-quality and compassionate care. In addition to economic aid, the volunteers lead organised activities for children such as games, painting, and storytelling, easing the stress of hospital stays and fostering a nurturing environment. Volunteers also provide emotional reassurance to families, assist with logistics, and facilitate communication with medical staff. Educational talks on health and family planning are delivered to parents, promoting preventive care and community well-being. Families who arrive from distant communities have access to food and accommodation in the Caring Hands' shelter (located nearby) in exchange of a fee, determined by a socioeconomic classification of families set by the hospital's social work department. The organisation also contributes to improving hospital infrastructure and services, including funding medical equipment like haemodialysis machines and neonatal care tools. Donations also support programs like "Kangaroo Mother Care" and enhance patient care through projects such as the remodelling of facilities, equipping the blood bank, and providing annual supplies for neonatal patients. Sources of funding include donations, events, sale of food in a small cafeteria within the hospital, organisation of events such as raffles, fashion shows and lottery in communities.

Compassion in Action (CA) was established a few years later, initially promoting altruistic blood donation but expanded its programmes to address the needs of families with hospitalised children. These initiatives include providing food, clothing, hygiene products, medication subsidies, and funeral transfer support. Over the years, it has delivered over 601,000 services to resource-limited families, many of whom are non-local and face extreme hardships during hospitalisation. The organisation seeks to improve the lives of vulnerable families while addressing systemic gaps in care by adopting a culture of altruism and applying a co-responsibility model. This means that most of its funds are provided by the same resource-limited families (service users) who pay a "recoup" fee for services such as: meals, medical dispensary, hairdressing, second hand shop, showers and shelter. Other sources of funding include an annual ball and an annual race, as well as donations (both financial and in produce) from benefactors.

Findings and discussion

A *good neighbour* relationship

Though not the only volunteering groups supporting this hospital, CHC and CA play a central role in helping low-income families accessing essential paediatric medical care such as laboratory tests, medications, prosthetics, and funeral costs, besides the much needed food and shelter for parents. The organisations detect these needs through the expressed requests of families, as well as of doctors, nurses and social workers within the hospital.

> "They help us a lot in getting dialysis solution catheters. Getting medications, being able to provide support with special medications or covering chemotherapies, that is, in all of those ways, helps us, right?" (Medical Professional (MP)).

Reduced investments in children's healthcare, widespread poverty, and recent shifts in federal government programmes might contribute to a complex landscape, making it "*difficult to see how the Government has at least a little chance of responding to the needs of the people*

without help from philanthropic associations" (MP). In light of these urgent needs, philanthropic organisations "*...cover the holes, and we identify the priorities, and we are constantly attentive, that is why they do not close their doors to us*" (CA). Indeed, CA started by promoting blood donation and has now expanded to cover many other basic needs, even those that the hospital requires to provide indispensable medical attention to children.

Despite their tacit agreement, the relationship between the two civil society organisations and the State-run hospital is not without friction. Hospital authorities refuse to acknowledge the support, or even the existence, of volunteering individuals and organisations; *CHC and CA "...are outside the organisational chart, but they fulfil a very important function for the hospital… [their work] is a structural part of how a children's hospital works in Mexico"* (MP). This lack of recognition is not surprising in a country where governmental accountability has been characterised historically as opaque (Lomnitz-Adler, 2001) and the Mexican government has been criticised for abandoning public responsibilities towards children (see United Nations' Committee on the Rights of Persons with Disabilities, 2014, p. 3). Within this backdrop, charity leaders understand the frailty in the relation and strive for a balance when navigating the system

> "We try to respect the instructions of the authorities, but we are also firm with our values, ideals and regulations" (CHC).

To be allowed to help the families, organisations know they need to be on good terms with the hospital managers. The organisations have continued their activities, despite the constant changes in hospital executives primarily due to political interests and the federal modifications to the public health system. This has been achieved by having a good relationship with all hospital staff and without getting involved in the politics of the hospital administration:

> "I don't work for the director of the hospital, I do not work for the Secretary of Health, I do not work for the governor, whoever is from whatever party, I work for the people and if I need a certain closeness to allow me to work, I will be close, I am an ally" (CA).

In contrast with the reserved relationship with hospital directives, with the healthcare staff the relationship is more active and long-lasting.

> "It seems to me that the relationship [with the philanthropic organisations] is very good with social work, it is very good with nursing, with some of the doctors and some of the services within the same hospital. And it is a *good neighbour* policy with the managers, but it should be more than that" (MP)

Healthcare professionals at this Mexican Children's Hospital fulfil two roles within the intricate relationship. On the one hand, they act as gatekeepers or mediators between the organisations and the families by communicating the support that is available to them outside of hospital facilities. On the other hand, they mediate the relationship between the hospital managers and the organisations by "putting a good word" with the hospital administration, particularly in times of administrative transition, so as to ensure assistance is sustained. As discussed in the literature review, the staff thus function as street-level bureaucrats (Lipsky 2010), navigating a blurred boundary between public mandate and private initiative to ease the fulfilment of their work responsibilities and to meet the needs of their patients. (Tummers and Bekkers, 2014).

Volunteering to fill the gaps on an underfunded health system

For a long time, it has been recognised that "the family is the child's primary source of strength and support" in paediatric care (Eichner et al., 2012). Allowing children and parents to remain

together, for as much as possible, during the hospital stay aligns with a children's rights approach (Kelly et al., 2012) in particular with articles 3 (about the best interests of the child), 12 (respect for the views of the child) and 24 (about health and health services) of the United Nations Convention on the Rights of the Child. However, families coming from remote communities face the prospect of not having where to stay nor where to eat while their child is the Mexican Children's Hospital:

> "Public hospitals in Mexico are designed to care for patients, but not to care for family members… It is a big problem in the design of hospitals in Mexico, and in many parts of the world, not only in Mexico and more so in a children's hospital. In other words, of course it has to be taken into account that the child goes with a companion, someone has to be there next to him [sic]" (MP).

Both philanthropic organisations *"help with also those functions of feeding and giving, giving a home, a roof, a bed, a bathroom for family members"* (MP). In doing so, the organisations allow families to remain together and alleviate basic needs for parents when having to remain away from home for weeks or months. They provide to families "what the health system does not want to, cannot, is not interested, does not have resources to do" (MP). Indeed, shelter, food and access to services such as showers and laundry rooms is provided to families for a fee and, in most cases, in exchange of cleaning work, cooking and other maintenance tasks under the supervision of the organisation's staff. This is seen as the organisations as a way of ensuring co-responsibility in the relationship:

> "However, in covering the holes we involve the family, we ask them to cover part of the cost, but this is not always possible, and a child's life cannot be weighed against pesos [Mexican currency]" (CA)

Interestingly, however, it seems that the majority of the funding of these organisations, of which their sustainability depends on, comes not from private or individual donations, but from the fees that the families themselves pay in this "service model".

> "My 70% of income is the parents' recovery fees, my job is to make sure they are well cared for. We generate 10 or 12% ourselves. We sell lettuce, we sell tomatoes, right now we are making fritters to sell, right now I am going to launch a jewellery shop. I do a raffle, I do a breakfast with a cause, I do a gala, I do an annual race. (...). So with what I collect in fees, my two big events and the little things that we do all year round (...) it becomes 70 to 85%. Do you think it has an impact on me if I get a donation? At this point it doesn't make any difference to me. My donations come for growth. My donations come to implement, not to sustain.

Although this co-responsibility model recognises family members as individuals with duties rather than passive recipients of charitable aid, it also fails to acknowledge them as rights-bearing citizens and to acknowledge the State's responsibility towards its citizens. It continues to reproduce the co-responsibility model that characterises the public anti-poverty programmes in Mexico of the 1990s. A model that lasted 30 years, until the entrance of the presidential administration of Andrés Manuel López Obrador that eliminated the conditionality component of cash transfer programmes (Ramírez, 2021). Still, this model endures in the imaginary of society – including civil society organisations - about the deservingness of the poor. This narrative also reinforces the view that poverty is an individual rather than a structural problem, created by individuals themselves

> "We must generate this well-being; we must enter to fill the large gaps in social problems. But don't burden yourself with the entire social

> problem, because you are not generating them, you are solving them (...) (If we do not charge for the service), we continue to generate mental poverty among the people" (CA)

Paradoxically, "shelters", as both philanthropic organisations call their facilities, allow for a more dignified stay. In addition to offering key resources and services, shelters also become places where families from remote communities spend their time, rest and work, and make friendships while they "wait". In his ethnographic analysis of "poor people waiting" in the Latin American context, Auyero (2012) refers to a form of State domination of the poor in which street-level bureaucrats create and re-create continual episodes of waiting; and to which they themselves are subject. However, these *'temporal processes in and through which political subordination is reproduced'* (Auyero, 2012, p. 4) not only affects family members or healthcare professionals, but children themselves.

When urgency meets delay: children's health in bureaucratic systems

Public bureaucracies, such as public hospitals, are essential for the advancement of democracy, aiding processes that allow citizens to access healthcare services and exercise their social rights. However, Mexican bureaucracies have been criticized for their inefficiency and lack of transparency (see Dussauge Laguna, 2020); inefficient bureaucracies risk amplifying social inequality, rather than balance social disparities. Within this context, low-trust bureaucracies have been defined as "public organisations where the rights and obligations of citizens are subject to unreliable and unpredictable procedures and bureaucratic behaviour" (Peeters et al., 2018, p. 71). This "Mexican Children Hospital" was established to "guarantee health care for girls, boys and adolescents", however, the constant lack of basic resources, seemingly due to poor planning and extensive administrative procedures, make it difficult for healthcare professionals to fulfil this obligation and for families to access the medical care they so desperately need:

> "Sometimes we have patients who need special equipment or catheters or special devices so that the procedure can be done and so on. So, the health ministry has a bureaucratic way of solving these problems and sometimes, well… children's health timing is very different to the hospital's bureaucratic time, which is out of phase, and you have to move" (MP).

Peeters and colleagues (2018) suggest that resourcefulness is one of the strategies employed by citizens to respond to the lack of predictability in the system. Predictability, in process and outcome, is key to the well-functioning of bureaucracies (Gajduschek, 2003). It seems that, in the case of the "Mexican Children's Hospital", predictability is one of the main contributions of these two philanthropic organisations as State inefficiencies and changes in hospital management generate uncertainty in the access to services both for families and their hospitalised children. The organisations in our study grew the variety of programmes offered as they detected the needs of families.

As of today, CA offers accommodation, hot meals, washing machines, toilets and showers, a second-hand clothing store, a dispensary, counselling, and a hairdresser. These services are perceived as essential to 'give the dignity back to families' (CA), as well as to provide families with some basic medications and medical instruments at a lower cost. Its flagship programme promotes and facilitates blood donation. CHC offers accommodation, hot meals, toilets and showers and workshops for parents (such as knitting and sewing). Flagship programmes include in-hospital schooling, aid to children with cancer and aid to children with kidney failure.

Conclusion

This article has examined a case of social assistance in Mexico by analysing the structure and operations of two non-profit organisations and their interactions with a children's hospital and its healthcare personnel. Drawing on semi-structured interviews and document analysis, the article highlighted the challenges and tensions that emerge in the collaboration between the State and philanthropic actors, particularly in the efforts to sustain and strengthen paediatric healthcare.

The findings reveal how two philanthropic organisations play a critical – yet unofficial- role in supporting paediatric healthcare. They address urgent gaps left by an underfunded and bureaucratically constrained public health system by providing essential services to low-income families. While their collaboration with healthcare staff is close and enduring, their relationship with hospital authorities remains informal and unacknowledged. Healthcare professionals, as street-level bureaucrats, act as intermediaries between these organisations and both hospital management and families, navigating bureaucratic limitations to facilitate access to external support - a positive form of discretion. The philanthropic organisations operate under a co-responsibility model, where families contribute small fees and labour in exchange for service. While this model enables sustainability and involvement, it mirrors outdated conditional welfare frameworks and risks framing poverty as a personal failure rather than a structural issue. Despite this, the shelters offer families dignity and temporary community while they endure prolonged waits in a critical situation.

The role of the government in supporting health is unquestionable in today's global scenario. The COVID-19 pandemic reminded us of this fact. Public investment in health is fundamental to guarantee good-quality services for all, to reach the most vulnerable populations, to reduce inequalities in access and outcomes and to consolidate healthcare as a human right for all. Yet, the lasting inefficiencies of public provision, the increased role of private providers, and the individualisation of poverty and other wellbeing outcomes with the dominance of neoliberal thinking in public policy, have weakened the position of the Mexican State in the achievement of these goals. Moreover, the recent attempts to move into a universal system have been marked by deficient planning, lack of clarity in the assignment of responsibilities, low accountability and transparency in the data about financing and spending, and inadequate communication of policy decisions to the population.

The philanthropic sector has tried to compensate for some of the enormous needs that these historical and more recent challenges have implied to families when they try to obtain medical attention for their children. However, these organisations also face important challenges that weaken their achievements and threaten their sustainability, including lack of private and public funding and legal support from the State. Ultimately, it seems that it is primarily those families with severe deprivations that help sustain these valuable philanthropic efforts in the short and the long term. The co-responsibility model views citizens as active participants with duties rather than passive beneficiaries of charity but overlooks their status as individuals entitled to rights. Our study suggests that both the State and the civil society organisations in Mexico fall into this trap.

Public policies rooted in human rights and social reform are needed to provide and sustain patient- and family-centred health care, a fundamental right of all children. These policies need to pay particular attention to the simplification of bureaucratic procedures to make health care provision more efficient, as well as to the creation of a legal framework that supports and promotes the establishment and the activities of the philanthropic organisations that help the most vulnerable groups of society in those matters that do not fall within the competence of the health system. Our case study suggest that today philanthropic organisations not only complement the activities of the public health system by giving support to the families of the

patients; but also substitute the State in the delivery of very basic medical care people should have the right to receive. Ultimately, this study underscores a mismatch between the urgent, time-sensitive nature of children's health needs and the slow, unpredictable rhythm of hospital bureaucracy. In this void, philanthropy becomes an essential – if imperfect - pillar of paediatric healthcare provision.

References

Auyero, J. (2012). *Patients of the State: the politics of waiting in Argentina*. Duke University Press.

Baeza Bacab, M. A. (2017). Origins of institutional Pediatrics: Maternity and Childhood Hospital of Mexico City in the nineteenth century. *Boletín Médico Del Hospital Infantil de México (English Edition)*, *74*(1), 70–78. https://doi.org/10.1016/j.bmhime.2017.11.015

Barros, R., Jayachandran, S., Hoxby, C., De Giorgi, G., Pencavel, J., & Pistaferri, L. (2008). *Wealthier But Not Much Healthier: Effects of a Health Insurance Program for the Poor in Mexico* (Discussion Papers 09-002).

Benton Sheldon, A. L. 2011. "The Catholic Church, Political Institutions, and Electoral Outcomes in Oaxaca, Mexico". Revista Mexicana de Ciencias Políticas y Sociales. LVI (213), 125-155. ISSN: 0185-1918. https://www.redalyc.org/articulo.oa?id=42121582006

Bossert, T., Blanchet, N., Sheetz, S., Pinto, D., Cali, J., & Cuevas, R. P. (2014). *Comparative Review of Health System Integration in Selected Countries in Latin America*. https://publications.iadb.org/en/publication/11898/comparative-review-healthsystem-integration-selected-countries-latin-america.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Reserach in Psychology*, *3*(2), 77–101.

Campos-Navarro, R., & Ruiz-Llanos, A. (2001). Historia y filosofía de la medicina. *Gaceta Médica de México*, *137*(6), 595–608. https://www.anmm.org.mx/bgmm/1864_2007/2001-137-6-595-608.pdf

Colchero, M. A., Gómez, R., Figueroa, J. L., Rodríguez-Atristain, A., & Bautista-Arredondo, S. (2020). Aumento en la oferta de consultorios adyacentes a farmacias y atención en servicios públicos en México entre 2012 y 2018. *Salud Publica de Mexico*, *62*(6), 851–858. https://doi.org/10.21149/11547

CONEVAL. (2020). *Pobreza infantil y adolescente en México 2020 [Poverty in childhood and adolescence Mexico 2020]*. https://www.coneval.org.mx/Medicion/Documents/Pobreza_infantil_y_adolescente_en_Mexico_2020.pdf

CONEVAL. (2022a). *Evaluación Estratégica de salud. Primer informe [Strategic health evaluation first report]*. https://www.coneval.org.mx/InformesPublicaciones/Documents/Evaluacion_salud_web.pdf

CONEVAL. (2022b). *Pobreza infantil y adolescente en México 2022 [Poverty in childhood and adolescence Mexico 2022]*. https://www.unicef.org/mexico/media/8286/file/Pobreza%20infantil%20y%20adolescente%20en%20M%C3%A9xico%202022.pdf

DGGSS. (2019). *"Catalogo Universal de Servicios de Salud (CAUSES)."* https://www.gob.mx/salud/seguropopular/documentos/catalogo-universal-de-servicios-de-salud-causes-2018-153111

Dussauge Laguna, M. I. (2020). The Challenges of Implementing Merit-Based Personnel Policies in Latin America: Mexico's Civil Service Reform Experience. In *Regional Comparisons in Comparative Policy Analysis Studies*. Routledge.

Eichner, J. M., Johnson, B. H., Betts, J. M., Chitkara, M. B., Jewell, J. A., Lye, P. S., Mirkinson, L. J., Brown, C., Heiss, K., Lostocco, L., Salerno, R. A., Percelay, J. M., Alexander, S. N., Abraham, M., Ahmann, E., Crocker, E., DiVenere, N., MacKean, G., Schwab, W. E., & Shelton, T. (2012). Patient- and family-centered care and the pediatrician's role. In *Pediatrics* (Vol. 129, Issue 2, pp. 394–404). American Academy of Pediatrics. https://doi.org/10.1542/peds.2011-3084

Espinoza, M. I. M. (2021). Social policy in Mexico's Fourth Transformation. An assessment of López Obrador's first year in office. *Revista Espanola de Ciencia Politica*, *55*, 121–142. https://doi.org/10.21308/recp.55.05

Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry*, *12*(2), 219–245. https://doi.org/10.1177/1077800405284363

Fox, J. (1994). The Difficult Transition from Clientelism to Citizenship: Lessons from Mexico. *World Politics*, *46*(2), 151–184. https://about.jstor.org/terms

Frisancho Velarde, Ó. (2012). Concepción mágico-religiosa de la Medicina en la América Prehispánica. *Acta Médica Peruana*, *2*(29), 121–127. http://www.scielo.org.pe/scielo.php?script=sci_arttext&pid=S1728-59172012000200013&lng=es.

Gajduschek, G. (2003). Bureaucracy: Is it efficient? Is it not? Is that the question? Uncertainty reduction - An ignored element of bureaucratic rationality. *Administration and Society*, *34*(6), 700–723. https://doi.org/10.1177/0095399702239171

Gakidou, E., Lozano, R., González-Pier, E., Abbott-Klafter, J., Barofsky, J. T., Bryson-Cahn, C., Feehan, D. M., Lee, D. K., Hernández-Llamas, H., & Murray, C. J. L. (2006). Series Health System Reform in Mexico 5 Assessing the eff ect of the 2001-06 Mexican health reform: an interim report card. *Www.Thelancet.Com*, *368*. https://doi.org/10.1016/S0140

Gobierno de México. (2024). *Ley General de Salud*. https://www.diputados.gob.mx/LeyesBiblio/pdf_mov/Ley_General_de_Salud.pdf

Gómez Fröde, C. (2017). El Sistema de Salud en México. *Revista CONAMED*, *22*(3), 129–135. https://www.medigraphic.com/pdfs/conamed/con-2017/con173e.pdf

Gómez-Dantés, O., Flamand, L., Cerecero-García, D., Morales-Vazquez, M., & Serván-Mori, E. (2023). Origin, impacts, and potential solutions to the fragmentation of the Mexican health system: a consultation with key actors. *Health Research Policy and Systems*, *21*(1). https://doi.org/10.1186/s12961-023-01025-2

Gómez-Dantés, O., & Frenk, J. (2020). La atencion a la salud en Mesoamerica antes y despues de 1519. *Salud Publica de Mexico*, *62*(1), 114–117. https://doi.org/10.21149/10996

Grönlund, H., & Pessi, A. B. (2015). The influence of Religion on Philanthropy across nations. In P. Wiepking & F. Handy (Eds.), *The Palgrave handbook of global philanthropy* (pp. 558–569). Palgrave Macmillan.

Guadarrama, G. (2007). Tiempo, circunstancia y particularidades de la asistencia privada en el Estado de México [Time, Circumstance and the Peculiarities of Private Assistance in the State of Mexico]. *El Colegio Mexiquense*. https://www.researchgate.net/publication/46155049

Harvey, H. R. (1976). *Public health in Aztec society* (Vol. 57, Issue 2).

Heredia-Pi, I., Serván-Mori, E., Reyes-Morales, H., & Lozano, R. (2013). Brechas en la cobertura de atención continua del embarazo y el parto en México [Gaps of coverage in the continuum of care during pregnancy and childbirth in Mexico]. *Salud Pública de México*, *55*, S282-S8.

Hoffman, S., Rueda, H. A., & Beasley, L. (2019). Youth perspectives of healthcare in central mexico: An application of Massey's critical health literacy framework. *International Journal of Environmental Research and Public Health*, *16*(5). https://doi.org/10.3390/ijerph16050896

INEGI. (2020). *Censo de Población y Vivienda 2020*. . https://www.inegi.org.mx/programas/ccpv/2020/

Jaramillo-Molina, M. (2023). *Análisis de resultados de la Encuesta de Ingreso y Gasto de los Hogares (2022) desde un enfoque de desigualdad y redistribución*. https://www.indesig.org/wp-content/uploads/2023/08/Compartir-Resultados-preliminares-de-la-ENIGH-2022_PC.pdf

Jaramillo-Molina, M. E. (2019). "Sin intermediarios": La política social en la 4T. *Nexos*. https://www.eluniversal.com.mx/estados/el-sur-tiene-la-

Kelly, M., Jones, S., Wilson, V., & Lewis, P. (2012). How children's rights are constructed in family-centred care: A review of the literature. In *Journal of Child Health Care* (Vol. 16, Issue 2, pp. 190–205). https://doi.org/10.1177/1367493511426421

Layton, M. D. (2009). Philanthropy and the Third Sector in Mexico: The Enabling Environment and Its Limitations. *NORTEAMÉRICA. Year*, *4*(1), 87–120.

Layton, M. D., & Mossel, V. (2015). Giving in Mexico: Generosity, distrust and informality. In P. Wiepking & F. Handy (Eds.), *The Palgrave handbook of global philanthropy* (pp. 64–87). Palgrave Macmillan.

Levy, S. (2006). *Progress against poverty: sustaining Mexico's Progresa-Oportunidades program*. Brookings Institution Press.

Lomnitz-Adler, C. (2001). *Deep Mexico, silent Mexico : an anthropology of nationalism* . University of Minnesota Press.

Martínez Moyado, R. A. (2017). Apuntes de historia: Hospitales prehispánicos. . *Boletín CONAMED–OPS*, 1–25.

Molyneux, M. (2006). Mothers at the service of the new poverty agenda: the Progresa/Oportunidades Mexico's conditional transfer programme. *Social Policy & Administration*, *40*(4), 425–449. https://doi.org/10.1111/j.1467-9515.2006.00497.x

Morales Suárez, M. (2009). The medical assistance of newborn infants in the Maternity and Infant Hospital of Mexico. XIX Century. *Revista Mexicana de Pediatría MEDIGRAPHIC*, *76*, 271–277. www.medigraphic.comwww.medigraphic.org.mx

Olvera, A. J. (2010). The Elusive Democracy: Political Parties, Democratic Institutions, and Civil Society in Mexico. *Latin American Research Review*, *45*, 79–107. https://doi.org/10.1353/lar.2010.0037

Peeters, R., Trujillo Jiménez, H., O'Connor, E., Ogarrio Rojas, P., González Galindo, M., & Morales Tenorio, D. (2018). Low-trust bureaucracy: Understanding the Mexican bureaucratic experience. *Public Administration and Development*, *38*(2), 65–74. https://doi.org/10.1002/pad.1824

Pfutze, T. (2014). The Effects of Mexico's Seguro Popular Health Insurance on Infant Mortality: An Estimation with Selection on the Outcome Variable. *World Development*, *59*, 475–486. https://doi.org/10.1016/j.worlddev.2014.02.008

Raphael, D., & Bryant, T. (2006). The state's role in promoting population health: Public health concerns in Canada, USA, UK, and Sweden. *Health Policy*, *78*(1), 39–55. https://doi.org/10.1016/j.healthpol.2005.09.002

Reich, M. R. (2020). Restructuring Health Reform, Mexican Style. *Health Systems and Reform*, *6*(1), 1–11. https://doi.org/10.1080/23288604.2020.1763114

Salamon, L. M., & Sokolowski, S. W. (2004). *Global civil society: Dimensions of the nonprofit sector*. Kumarian Press Inc. .

UNICEF. (2016). *Informe sobre equidad en salud 2016. Análisis e las inequidades en salud reproductiva, materna, neonatal, de la niñez y de la adolescencia en America Latina y el Caribe para guiar la formulación de políticas*.

UNICEF. (2019). *Country Office Annual Report 2019, Mexico. Update on the context and situation of children.* . https://www.unicef.org/media/90541/file/Mexico-2019-COAR.pdf

UNICEF. (2023). *Análisis de la inversión pública en infancia y adolescencia en México 2012-2023.* . https://www.unicef.org/mexico/media/7626/file/An%C3%A1lisis%20de%20la%20Inversi%C3%B3n%20p%C3%BAblica%20en%20infancia%20y%20adolescencia%20.pdf

United Nations' Committee on the Rights of Persons with Disabilities. (2014). *Concluding observations on the initial report of Mexico*. https://digitallibrary.un.org/record/791482?ln=en

Valencia, E., & Jaramillo, M. (2019). "El Programa Progresa-Oportunidades-Prospera en el régimen de bienestar dual mexicano." In G. Hernández Licona, T. De la Garza, J. Zamudio, & I. Yaschine (Eds.), *El Progresa-Oportunidades-Prospera, a 20* .