August 2026
Number 22

Accountability Working Paper

Governing Childbirth: Imbalanced Participation and Debate in the Creation of a Public Policy on Midwifery in Mexico

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Please cite this work as follows: Freyermuth Enciso, Graciela, and Hilda E. Argüello Avendaño. 2026. "Governing Childbirth: Imbalanced Participation and Debate in the Creation of a Public Policy on Midwifery in Mexico." *Accountability Working Paper* 22. Accountability Research Center. https://doi.org/10.57912/32984006.

Cover photo: Pre-natal care being provided by a traditional midwife in San Cristóbal de Las Casas, Chiapas.

Photo credit: Juan Carlos Martínez

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Acknowledgments

The authors would like to thank Fabiola Hernández López for her assistance in compiling the social media database; Esther Vázquez-Peñate for her contributions to the compilation and organization of the databases of public comments and official responses; and Jonathan Fox and Walter Flores for their insightful comments on successive drafts of this paper. They are also grateful to the members of the Anthropos Salud Seminar for their valuable feedback on the final draft of the manuscript. Special thanks go to Juan Carlos Martínez Pérez, communications specialist and photographer at the Observatory on Maternal Mortality in Mexico, for generously providing the photographs used in this publication. The authors also thank Isabel Rodríguez Ramos for her careful copyediting and for ensuring compliance with ARC editorial guidelines, and Karen Brock for her editorial supervision throughout the publication process. Our thanks also to Margaret A. Cargill Philanthropies for their financial support through their Maternal and Child Health program.

AI was used to validate codes in the latest versions of the databases, to check spelling and punctuation in the interviews, to generate summaries of social media posts for database creation, and to review the writing. This version was translated from the original Spanish using DeepL, and the translation checked and copyedited by Karen Brock, Chat GPT, and Claude.

Abbreviations

CCNNSP	Comité Consultivo Nacional de Normalización de Salud Pública
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CONAMER	Comisión Nacional de Mejora Regulatoria
CNEGySR	Centro Nacional de Equidad de Género y Salud Reproductiva
DOF	Diario Oficial de la Federación
ICM	International Confederation of Midwives
IMSS	Instituto Mexicano del Seguro Social
INEGI	Instituto Nacional de Estadística y Geografía
INMUJERES	Instituto Nacional de las Mujeres
INPI	Instituto Nacional de los Pueblos Indígenas
LPR	Salas de labor-parto-recuperación
NOM	Norma Oficial Mexicana
ONG	Organizaciones no gubernamentales
OIT	Organización Internacional del Trabajo
OPS	Organización Panamericana de la Salud
PRONACES	Programas Nacionales Estratégicos
ReNaPa	Registro Nacional de Parteras
SEP	Secretaría de Educación Pública
SINAC	Subsistema de Información sobre Nacimientos
UNFPA	Fondo de Población de las Naciones Unidas

Summary

This paper analyzes the drafting, public consultation, review, and publication of NOM-020-SSA-2025, the official Mexican standard on health facilities and the recognition of midwifery in maternal and neonatal care. Using a socio-anthropological approach, the paper examines the controversies, arguments, and institutional responses that emerged throughout the regulatory process, paying special attention to the positions of professional, traditional, and autonomous midwives, service users, civil society organizations, and public officials.

Midwifery in Mexico has been marked by tensions between community knowledge and the biomedical model. Since the mid-20th century, medicalized approaches to childbirth have displaced traditional midwives. By the end of the same century, social and human rights movements challenged this model due to obstetric violence and cultural exclusion. Since 2018, professional midwives have pushed for institutional recognition, successfully incorporating their demands into the draft standard. In contrast, traditional midwives blocked a previous draft standard through social mobilization, but their refusal to join the working group limited their influence.

The study uses actor-network theory (Latour) to trace controversies, and Toulmin's argumentation model to analyze these controversies and examine how different actors interacted in the construction of midwifery as a regulatory object. The qualitative data analyzed in this study includes: versions of the NOM, databases with 593 official responses, comments with 1,554 arguments and 1,489 citizen proposals, a database of 694 social media observations, as well as interviews and observation.

Public participation was widespread but uneven. Only proposals aligned with the government's legal and technical requirements (legal compatibility, administrative feasibility) were accepted. 100% of responses submitted to the the official consultation by public health service users were rejected, because they were considered individual experiences and therefore lacked a legal basis. Autonomous midwives secured minor modifications, but their core demands (autonomy, community governance) were rejected. Traditional midwives gained rhetorical recognition, but received no response to their demands for indigenous consultation and independent certification procedures. Civil society organizations made progress on human rights, gender, and intercultural approaches. Civil servants faced significant rejection when they proposed altering the core structure of the regulatory model.

Engaging technical groups from early stages is crucial. Public consultation favors arguments that can be translated into legal language, excluding experiential knowledge. Social mobilization brings problems to light, but does not transform policy content without sustained institutional dialogue.

NOM-020 reflects ambivalent participation: it expands formal spaces and discursively recognizes diversity, but maintains state control over validity criteria. The standard mentions, but does not fully consult; it incorporates some adjustments, but does not transform power relations. Rather than closing the debate, it opens a new phase on reproductive governance, midwifery autonomy, and justice in Mexico.

1. Introduction

In Mexico, Mexican Official Standards (*Normas Oficiales Mexicanas*, NOMs) are legally binding technical regulations that establish specifications, rules, and requirements to ensure safety and quality in areas such as health, labor, food, and the environment. In the health sector, they establish standards for the diagnosis and treatment of specific health conditions and other aspects of healthcare delivery. Issued by the Ministry of Health, they are intended to ensure the quality and safety of health services. Their legal basis is the Quality Infrastructure Law—formerly the Federal Law on Metrology and Standardization until 2020—which makes compliance with these standards mandatory throughout the national territory (Government of Mexico 2009, 2020).

Beyond their technical function, NOMs constitute a key tool in the Mexican government's regulatory policy, with the potential to open avenues for citizen participation, transparency, and accountability. In the health sector, they define how certain care processes must be carried out, which supplies are acceptable, and what requirements health facilities and healthcare personnel must meet. They are formulated in committees involving various entities—government agencies, academic institutions, professional associations, and representatives of the private sector and business organizations—which gives them an appearance of pluralism, although in practice they maintain a technical-corporate logic that limits the participation of citizens and civil society organizations (CSOs). However, the formal drafting procedure includes a public consultation during which any citizen or organization may submit comments, and official responses must be published in the Official Gazette of the Federation (DOF). This feature, unusual in citizen consultation mechanisms, allows for the traceability of decisions and enables observation of how the State justifies, adjusts, or discards its regulatory criteria.

This article analyzes precisely that process in the case of the Draft Mexican Official Standard PROY-NOM-020-SSA-2024 and its final version, the Mexican Official Standard NOM-020-SSA-2025, regarding health facilities and the practice of midwifery in comprehensive maternal and neonatal care (CONAMER 2024; Government of Mexico 2024a, 2025b). Furthermore, this marks the first time in Mexico that a regulatory document has been drafted that encompasses midwifery as a whole, making this process a landmark in the regulation of midwifery in Mexico.

The objective of this study is to analyze how the aforementioned NOM-020 was produced and legitimized as a mechanism for governing childbirth, and to what extent its final text incorporates the demands of midwives and users regarding their rights. To this end, we pose two central questions: How did different actors participate, negotiate, and contest the terms of this regulation throughout its drafting process? And how did the State process—by accepting, modifying, or rejecting—the demands that emerged during the public consultation?

These questions point to broader debates on governance, citizen participation, and the limits of state recognition of community knowledge. As for the formal public consultation mechanisms surrounding the NOM, they offer a unique window into how different actors—midwives, health service users, CSOs, academic institutions, and government agencies—participate in the development of maternal health policies, and into identifying the power asymmetries that structure that process.

This paper draws on Bruno Latour's (2008) actor-network theory as its analytical framework. Rather than starting from fixed definitions of midwifery, it follows the controversies surrounding NOM-020, treating human and non-human actors—different versions of the standard, digital platforms, social media, and administrative mechanisms—symmetrically, and observing how identities, positions, and alliances are constructed and contested within the process itself. In this study, controversies are understood as the differences or disagreements between what is set forth in the text of the NOM and the viewpoints of the individuals, collectives, or institutions that participated in the public consultation.

The paper is organized into ten sections, including this introduction. The second section presents the methodology: the sources, the databases created, and the analytical frameworks that guide the findings and discussion. The third section describes the heterogeneous field of midwifery in Mexico and the actors that comprise it, as a necessary context for understanding the regulatory debate. The fourth section reconstructs the genesis of NOM-020 and the political and institutional background that made it possible. The fifth section analyzes the first draft of 2022 and the response from traditional midwives that led to its stalling. The sixth section examines the shift in the regulatory focus between 2022 and 2024 and the changes introduced by the Working Group prior to the draft's publication. The seventh chapter tracks the public debate on social media during the consultation period and on the official platform of the National Commission for Regulatory Improvement (CONAMER), where various stakeholders debated the final content of the regulation. The eighth chapter analyzes the official responses to public comments, identifying patterns of acceptance and rejection based on the type of stakeholder and the nature of the arguments presented. The ninth section examines how the debate evolved on social media and digital platforms after the publication of the final standard, identifying continuities, new configurations, and the two divergent interpretations that coexist regarding NOM-020-SSA-2025. The paper concludes with the tenth section, dedicated to the conclusions, which highlights the implications of this process for citizen participation, intercultural governance, and the design of maternal health policies, and includes concrete lessons for organizations seeking to influence similar regulatory processes.

2. Methodology

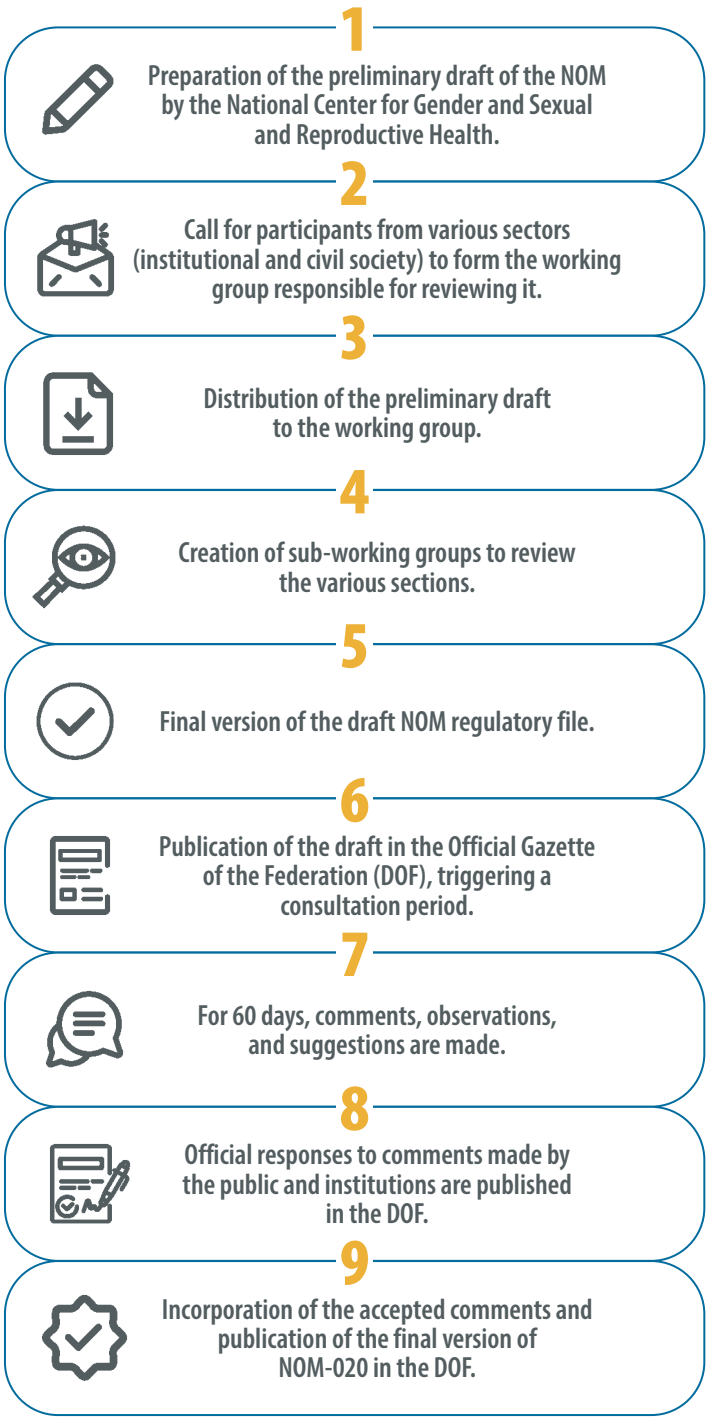
This study analyzes the controversies surrounding NOM-020 throughout its entire development process, from the first drafts to the publication of the final version, as well as the reactions it generated. The creation of a NOM involves a series of steps or stages, which are described in Figure 1. Identifying this sequence will allow the reader to pinpoint the key moments when the various stakeholders involved prompted changes to the standard's content, leading up to its final version.

The significance of this work lies in the fact that, although a procedure for public participation in the development of NOMs has existed since 1992, there are no studies that account for the implications of each stage of this process.[1] In this regard, this analysis may be relevant for decision-makers, public policy scholars, and civil society representatives, as it not only documents the process through which the technical content of the regulation is constructed but also how the public participates and how the State responds—that is, whom it listens to and how it holds itself accountable to society.

The body of data was compiled between January and December 2025 from four main sources. The first source was the regulatory file itself, comprising four versions of the NOM: the cancelled 2022 preliminary draft, the 2023 preliminary draft, the draft published for public consultation in 2024, and the final version of NOM-020 issued in 2025. This source also included the laws, decrees, regulations, and reports that framed the development of the regulation, from which a summary document on the regulatory process was prepared. A review of previous studies on the NOM was conducted using PubMed, Google Scholar, and SciSpace.

The second source consists of the comments submitted during the public consultation on PROY-NOM-020-SSA-2024 on the CONAMER platform. This source yielded four complementary

Figure 1. Summary of the development process for NOM-020-SSA-2025



Source: Hilda Argüello, based on the drafting process for the Draft Mexican Official Standard PROY-NOM-020-SSA-2024 and NOM-020-SSA-2025.

databases. The first systematizes the arguments and proposals of the 284 signatories (1,554 arguments and 1,489 proposals). The second records the stakeholders and organizations that participated in the debate: of the 284 signatories, 210 (74 percent) could be identified, which allowed for the construction of a stakeholder map. The third holds the profiles of the 52 participating organizations, reconstructed through searches on Google, ChatGPT, and Perplexity. The fourth was constructed from the official responses to comments published in the DOF on February 17, 2025 (Government of Mexico 2025a), and includes for each entry the assigned number, the identifier, the name of the commentator, the comment, the institutional response, the level of acceptance, and the modifications or clarifications made (593 observations). This database is central to the analysis, as it allows for the systematic identification of which arguments were accepted, which were rejected, and with what justifications.

The third source consists of public debate on social media and digital platforms, which developed in parallel to the formal public consultation: a systematic search was conducted for posts on X, Facebook, Instagram, TikTok, YouTube, and news sites between 2022 and 2025 (Freyermuth and Hernández 2025). The posts were selected, summarized with the help of ChatGPT while respecting the original text, and organized into a database with predefined analytical categories —platform, date, type of actor, text, reactions, main topic, and position regarding the regulation—which allowed for their systematic comparison (694 observations).

The fourth source consists of interviews and dialogue sessions with fifteen individuals who participated in different stages of the process, supplemented by informal conversations and a roundtable discussion with nine people (682 data sheets).

All datasets were processed in Excel using pivot tables and thematic coding. Code validation was performed with the support of ChatGPT, which involved some recoding of the database of actors and organizations.

The analysis relies on two conceptual tools. The first is Bruno Latour's (2008) actor-network theory, which allowed us to treat human actors—midwives, civil servants, service users, researchers, legislators, and media managers—and non-human actors—versions of the standard, digital platforms, birth certificates, registries, protocols, and administrative mechanisms—symmetrically, to observe how their identities and alliances are constructed within the very process of the debate. We use this lens toe understand the controversies between what was proposed in the NOM text and the viewpoints of those who participated in the public consultation. Such controversies do not occur in a single space: they unfold in forums, assemblies, public consultations, health services, and social media—settings where what midwifery is, who can be recognized as a midwife, and under what conditions their participation in the health system is legitimized or not, are explicitly and implicitly negotiated.

The second tool, applied to the analysis of official responses, is Stephen Toulmin's (2003) argumentation model. This model allows us to identify what claims an authority makes, what data it considers valid, and what rules it uses to accept or reject an argument. Toulmin's model was particularly helpful in highlighting the asymmetries between the arguments advanced by users, midwives, and CSOs—often framed in terms of rights and lived experience—and the institutional responses, which filtered them through technical and legal criteria.

Finally, it is important to note that, rather than classifying midwives or imposing analytical categories in advance, our aim as researchers was to follow the controversies and examine how different actors define themselves, contest one another, and form alliances throughout the process.

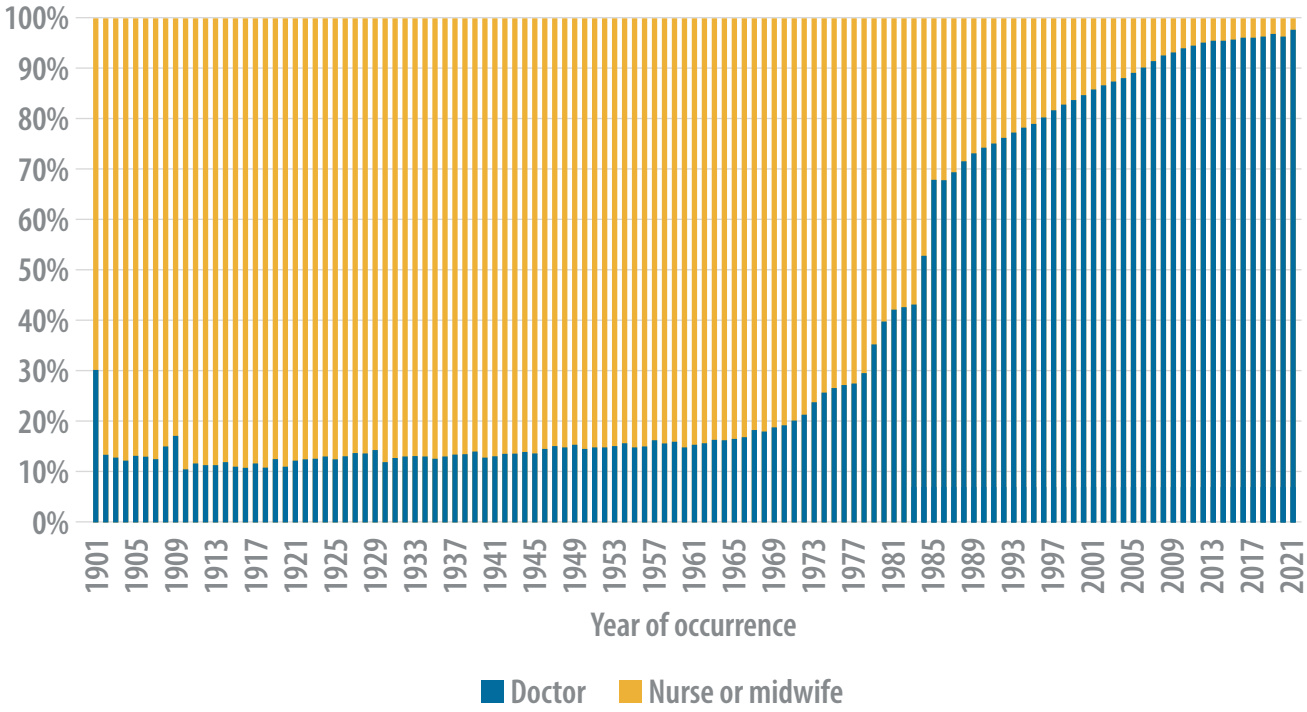
3. Configurations of Midwifery in Mexico: A Field in Dispute

In Mexico, childbirth care has historically been linked to different categories of midwives, whose position within the healthcare system has changed drastically throughout the 20th century and into the early 21st century. Until the first half of the 20th century, midwives were responsible for attending most births, primarily in the home setting. With the expansion of hospital-based medicine and the mass training of doctors, childbirth care gradually shifted toward institutional settings; by the end of the 20th century, the dominant model was hospital-based childbirth led by medical staff. Through this long process of change, the practice of midwifery has been progressively marginalized.

Current figures illustrate this marginalization, although they should be interpreted with caution. In 2024, at the national level, 98 percent of births registered through birth certificates were attended by physicians, according to the Birth Information Subsystem (SINAC). Only 1.8 percent were recorded as attended by midwives and 0.2 percent by nurses (Ministry of Health 2024). This proportion changes for the national-level Indigenous population, among whom 10 percent of births are attended by midwives. In the state of Chiapas, midwives also attend 10 percent of all births—a figure substantially higher than the national average (1.8 percent). When only the state's Indigenous population (around 35 percent) is considered, this proportion rises to 27 percent. It is important to note that SINAC data are published annually and, although they continue to be updated, they generally underestimate the actual prevalence of midwife-attended births.

The birth databases published by the National Institute of Statistics and Geography (INEGI) are generated using birth certificates. Birth certificates are usually easier to obtain when the birth takes place in a hospital or with medical personnel. They can be issued at a later date when parents need the document for administrative purposes. But midwives attending births do not issue birth certificates, and this can be one cause of delayed registrations. INEGI statistics indicate that 93 percent of births were attended by medical personnel (a lower percentage than that reported by SINAC) and that midwives and nurses attended just one percent. However, when reviewing data from Chiapas, births attended by midwives account for 22 percent and those attended by medical professionals account for 58 percent; in the remaining 20 percent of cases, it was not specified who was in attendance (INEGI 2024). The differences between the databases highlight the complexity of the records and, overall, do not fully reflect a practice that persists, especially in indigenous and rural communities, outside of official records.

Figure 2. **Mexico. Persons who attended births, 1985–2021**



Source: Freyermuth and Vázquez (in press), based on the INEGI 1985–2021 birth database.

Note: The series corresponds to records systematized starting in 1985, when national coverage was achieved. Previous extemporaneous births provide a proxy for earlier trends, although they represent only a portion of the population.

Throughout this process of change, three major groups of actors linked to midwifery emerged, sometimes in conflict: (a) traditional midwives, (b) obstetric nurses, and (c) contemporary professional midwives. This latter category includes midwives with formal technical training linked to the public sector and autonomous or traditional midwives practicing in the private and community sectors. Each of these groups has followed distinct historical trajectories, developed different forms of organization, training pathways, and political agendas, resulting in a highly heterogeneous field of midwifery. Understanding this diversity is essential for interpreting the regulatory scope of NOM-020 and the controversies surrounding it. The following sections therefore examine each of these groups in turn.

3.1 Traditional midwives: community knowledge and state control

The most enduring figure throughout the 20th century has been that of the so-called traditional midwives—indigenous or mestizo, rural or urban—recognized by their communities and possessing knowledge acquired through observation, experience, and intergenerational transmission. Since the 1930s, the state has implemented various programs to "train" these midwives: first as maternal care assistants, then as family planning promoters in the 1970s, and later as intermediaries in maternal and child health programs. Their inclusion, however, has been fundamentally instrumental: midwives have been useful for addressing structural gaps in the health system, but they have rarely been recognized on their own terms or incorporated as individuals with professional rights and autonomy.

Traditional midwife Doña Petrona in her clinic, looking at keepsakes of the women she has treated.

Credit: Juan Carlos Martínez

Beginning in the 21st century, the policy of institutionalizing childbirth in hospitals—reinforced in Mexico by Seguro Popular[2] and conditional cash transfer programs—further marginalized the presence of midwives by imposing new regulatory, technical, and legal barriers that threatened their continued practice (Freyermuth 2024). On the technical-organizational level, primary care was progressively excluded from the management of childbirth, a practice that became concentrated in hospital units and consolidated hospitalization as the predominant model, displacing other forms of care. In the legal-administrative sphere, Mexican law requires a medical birth certificate, issued by authorized health personnel, in order to obtain the child's civil birth registration. In practice, this requirement was much easier to fulfill within institutional health services than in midwife-attended births, creating additional barriers for traditional midwives (Freyermuth 2024).

In this context, traditional midwives began to organize in various spheres. First within the broader framework of traditional medicine; later, in the late 1990s, some joined indigenous women's movements, such as the National Coordination of Indigenous Women, even though midwifery was not the central focus of the agenda. In 2014, in response to policies aimed at institutionalizing childbirth, the Nich Ixim Movement of Traditional Midwives was formed in Chiapas. Subsequently, the National Agenda for the Defense and Promotion of Traditional Midwifery in Mexico was created, bringing together traditional, autonomous, Indigenous, and mestiza midwives—both rural and urban—the Indigenous Women's Houses (CAMI[3]), and allied CSOs. Its main objectives are: to defend traditional midwifery as a genuine and comprehensive health system that is culturally respectful and non-violent; to demand the right to practice without harassment or prohibitions; to ensure that midwives can issue birth certificates or birth

records recognized by the Civil Registry; and to demand their participation in the drafting of any regulation or law intended to govern their practice, based on collective rights, intercultural social justice, the autonomy of peoples, and respect for ancestral knowledge.

Table 1a. Comparative table. Mexico. Contemporary midwifery: traditional midwives

Dimension	Traditional midwives
Historical origin	Persistent historical practice; pre-dates the institutionalization of childbirth
Training	Intergenerational transmission, observation, and community practice
Predominant type of knowledge	Traditional, empirical, and community-based knowledge
Relationship with the health system	Historically subordinate, instrumental, or marginal
Legal and administrative status	Community recognition; constitutional legal recognition
Primary setting of care	Community, home, community spaces
Model of childbirth care	Community-based, culturally situated
Relationship with women and families	Close, long-term, based on community trust
Relationship with cultural and spiritual practices	Central (rituals, language, worldview)
Organizational integration	Some are organized into traditional medicine movements and networks; the vast majority are unorganized
Main demands	Right to practice without criminalization; legal recognition; birth certification
Position on NOM-020	Critical due to the risk of exclusion, criminalization, and regulatory control
Section in NOM-020 that regulates them	Traditional midwives: 7. Linking the Health System with Traditional Midwifery

Source: Graciela Freyermuth based on Goodman and Torres 2015; Coronado 2015; Rosenthal 2015; Galante 2015; Freyermuth and Argüello 2015; Sesia and Berrío 2023; Freyermuth 2024; interviews 2025 regarding the NOM-020 draft.

3.2 Obstetric nurses: From a central to a subordinate role

The history of obstetric nurses in Mexico tells the story of a profession that once played a central role in maternal care but was later systematically sidelined. In 1905, nursing training with an emphasis on maternal care began at the General Hospital of Mexico, initially aimed at widows. These nurse-midwives attended births and handled minor complications. University training in obstetrics reached its peak between the 1920s and 1950s, in line with international recommendations: in 1952, the World Health Organization Committee of Experts on the Professional Training of Midwives suggested that nursing staff be trained in midwifery, particularly in settings with underdeveloped maternity services (WHO 1955). Based on these guidelines, the profiles and fields of midwifery—traditional or empirical, assistant, graduate/nurse-midwife—and institutions such as the National School of Nursing and Obstetrics at the National Autonomous University of Mexico and the Higher School of Nursing and Obstetrics at the National Polytechnic Institute were established.

Despite this momentum, professional midwives in Mexico ceased to be hired after 1950, and by 1960, they were prohibited from attending births. Midwifery training as a bachelor's degree program disappeared as such, and graduate obstetric nurses went on to occupy primarily administrative and managerial positions. The creation of university medical specialties and the mass training of obstetrician-gynecologists reinforced this shift: it was believed that general practitioners and specialists could perform the functions previously carried out by midwives, and as a result, obstetric nurses were relegated to a subordinate role within the hospital model (WHO 1966).

At the same time that childbirth was becoming increasingly institutionalized, and within the context of an international effort to strengthen midwifery in Mexico (UNFPA 2011, 2012), efforts were made to build a professional association for midwives, initially bringing together perinatal nurses. Following an initial associative experience marked by internal tensions and by the blocking of professionalization initiatives intended to enable the association to become a member of the International Confederation of Midwives (ICM), a decision was made to transform a pre-existing association of obstetric and perinatal nurses, founded in 2005, into an association of professional midwives that would bring together the different traditions of midwifery in Mexico. Through the revision of its bylaws, the organization of conferences, and the development of technical instruments required by the ICM, a new association was established in 2019 with between 250 and 300 members—including formally trained midwives, university-trained midwives, autonomous practitioners, and some traditional midwives—which, while not formally regulating the profession, seeks to articulate this diversity and prevent professional fragmentation.[4]

Table 1b. Comparative table. Mexico. Contemporary midwifery: nursing and obstetrics graduates / perinatal specialists

Dimension	Nursing and obstetrics graduates / perinatal specialists
Historical origin	Derived from the university professionalization of nursing and obstetrics in the 20th century
Training	Formal university education (bachelor's degree in nursing and midwifery and a specialty or postgraduate degree in perinatal nursing)
Predominant type of knowledge	Institutional and hospital-based biomedical knowledge
Relationship with the healthcare system	Fully integrated into hospital settings
Legal and administrative status	Full legal recognition as healthcare personnel
Primary setting of care	Hospitals, medical units, birthing centers
Model of childbirth care	Hospital-based model focused on women's needs
Relationship with women and families	Varies depending on the care setting; relationship mediated by institutional protocols
Relationship with cultural and spiritual practices	Selective, in some cases incorporated
Organizational integration	Professional associations and institutional structures
Main demands	Professional recognition within the medical system
Position on NOM-020	In favor, due to the recognition of the autonomous use of medications and the autonomous management of low-risk births at the primary care level
Section in NOM-020 that regulates them	Bachelor's Degree in Nursing and Midwifery: 6.3.1.4 Bachelor's Degree in Nursing and Midwifery / 6.3.1.5 Specialization in Perinatal Nursing

Source: Graciela Freyermuth based on Goodman and Torres 2015; Coronado 2015; Rosenthal 2015; Galante 2015; Freyermuth and Argüello 2015; Sesia and Berrío 2023; Freyermuth 2024; interviews 2025 regarding the NOM-020 draft.

3.3 Contemporary professional midwifery: Between institutional integration and autonomy

This third field is closely linked to the Latin American movement for humanized or respectful childbirth, a term that gained traction at an international conference held in 1985 in Fortaleza, Brazil. By the end of the 20th century, various women—whether trained abroad, through certificate programs, or as self-taught practitioners—began to develop alternative approaches to childbirth care inspired by this movement. Between 1996 and 2011, four schools were established in Mexico that would significantly shape the profile of professional midwifery (Coronado 2015; Galante 2015; Goodman and Torres 2015; Rosenthal 2015).

These schools share several characteristics: they primarily train young women from rural or semi-urban backgrounds, many of whom are Indigenous and low-income, providing them with solid biomedical skills aligned with international standards for "skilled birth attendants." Beyond their differences, professional midwifery is grounded in a shared vision: childbirth is a physiological process that does not require routine medicalization; care must center on the woman and her family as the central actors in a significant life event; empowerment through information, support, and trust is a key condition for the successful progression of labor; and obstetric and patriarchal violence must be denounced and eradicated.

One important activity carried out by technical professional midwives like Beti Flores is providing consultations during a baby's first few months.

Credit: Juan Carlos Martínez

Within this model of professional midwifery, two major subgroups can be distinguished, at least analytically. On the one hand, there are technical professional midwives, trained in officially recognized schools, certified, and working within the public sector. Although they share the principles of humanized childbirth, their daily practice is constrained by the hegemonic medical model and hospital routines, which in many cases makes it difficult for them to provide care in accordance with the "spirit" of humanized childbirth. On the other hand, autonomous professional midwives work in the private and community sectors, assert their separation from the public healthcare system, and, in some cases, practice outside formal certification processes, maintaining a critical stance toward the established system. Their practice is characterized by continuity of care throughout the entire reproductive process, a strong focus on the woman and her family, and the incorporation of elements from other models, such as indigenous medicine and various ritual and spiritual practices, as well as by a clientele differentiated according to ability to pay and by a diversity of working arrangements, supplies, and costs.

Table 1c. Comparative table. Mexico. Contemporary midwifery: professional midwives

Dimension	Professional technical midwives*	Autonomous midwives	Midwives "in the tradition"
Historical origins	Emerged in the late 20th century as part of the humanized childbirth movement	Became established in the late 20th and early 21st centuries	Recent reconfiguration of autonomous career paths with an emphasis on indigenous traditions
Training	Formal training in midwifery schools (CASA, Nueve Lunas, Mujeres Aliadas, Guerrero)	Hybrid paths: biomedical courses, self-directed learning, certificate programs; some with formal degrees	Extended apprenticeship with traditional midwives + formal education (bachelor's degree) or a hybrid path in autonomous midwifery
Predominant type of knowledge	Biomedical knowledge combined with a humanized childbirth approach	Critical biomedical knowledge + physiological and rights-based approach	Indigenous traditional knowledge combined with contemporary critical reflection
Relationship with the health system	Partial integration into the public system (primary care)	Practice outside the public system; critical dialogue with biomedicine	Practice outside the public system; strong community roots
Legal and administrative status	Conditional institutional recognition (certification, registration)	Variable; many without official national recognition or certification	Variable; many without official national recognition or certification
Primary setting of care	Health centers, birthing centers, primary care hospitals	Homes, private birthing centers, non-institutional settings	Homes, private birthing centers, non-institutional settings
Model of childbirth care	Physiological childbirth with biomedical criteria	Humanized childbirth, minimal intervention	Continuity of the indigenous midwifery tradition
Relationship with women and families	Support during pregnancy, childbirth, and the postpartum period	High continuity and centrality of women's autonomy	High continuity and centrality of women's autonomy

Relationship with cultural and spiritual practices	Varies by school	Selective, in some cases incorporated	Central and explicit
Organizational integration	Linked to schools and, in some cases, professional associations	Informal networks, collectives, individual practice, formal associations	Informal networks, collectives, individual practice, formal associations
Main demands	Integration into the public system; professional recognition	Autonomy of practice; no subordination to state control	Autonomy of practice; no subordination to state control; defense of tradition; recognition as a health system
Position regarding NOM-020	Ambivalent: opportunity and restriction	Ambivalent: opportunity and restriction; criticism due to regulation, loss of autonomy, dehumanization of childbirth, and regulatory control	Criticism of regulation, loss of autonomy, dehumanization of childbirth, regulatory control
Section in NOM-020 that regulates them	Technical midwives: 6.3.1 Professional technical midwifery	6.3.1.3 Bachelor's degree in midwifery or 6.3.1.2 Advanced University Technician / 6.3.2 Non-professionals authorized to provide midwifery services	6.3.1.3 Bachelor's degree in midwifery or 6.3.1.2 University-level technical degree / 6.3.2 Non-professionals authorized to provide midwifery services

Source: Graciela Freyermuth based on Goodman and Torres 2015; Coronado 2015; Rosenthal 2015; Galante 2015; Freyermuth and Argüello 2015; Sesia and Berrío 2023; Freyermuth 2024; interviews 2025 regarding the NOM-020 draft.

* The job category of Technical Midwife within the Ministry of Health was formalized in 2011, following the amendment of Articles 61, 64, and 79 of the General Health Law, which established code M02117.

3.4 A heterogeneous field facing a single standard

Tables 1a, 1b, and 1c summarize the main characteristics of these three fields and their subgroups, including their historical origins, type of training, relationship with the health system, and stance regarding NOM-020. This diversity is far from a minor detail: it is the starting point for understanding why a single standard that aims to regulate "midwifery" as a whole inevitably generates tensions, disputes, and demands for differentiated recognition.

In summary, midwifery in Mexico brings together actors with differing interests and agendas: traditional midwives have fought for respect for their practice and for legal recognition of the births they attend, closely linked to indigenous women's movements; obstetric nurses have sought national and international academic recognition, as well as the possibility of being recognized by the health sector for providing primary-level childbirth care; professional midwives, especially autonomous ones, advocate for the possibility of practicing freely, without being subordinate to state control or hospital logic. The draft NOM-020 sought to address this heterogeneity, and it was within this tension that the controversies analyzed in this article unfolded.

4. The Origins of the Midwifery Regulation

To understand how NOM-020 came about, it is necessary to place it within the context of international maternal health policy in the early 2000s, which took two main paths. On the one hand, efforts were made to strengthen primary care so that midwives, community health workers, and family members could manage normal deliveries and promptly refer women with obstetric complications to secondary care. On the other hand, there was a push for so-called "skilled" birth care, a strategy that in practice meant mandatory hospital births. This approach gained ground in Mexico, particularly after 2008, when free childbirth care programs reinforced the idea—and the practice—that the only safe care was hospital-based care.

As a result, the IMSS-Prospera program (formerly IMSS-Progresa and IMSS-Oportunidades) ceased providing childbirth care at the primary-care level, and delivery rooms in many facilities fell into disuse. By 2010, only about 3 percent of births attended by the program were still managed at the primary care level (Freyermuth 2012). Although NOM-007-SSA2-2016 on care during pregnancy, childbirth, and the postpartum period did not explicitly require all births to be referred to hospitals, its provisions regarding health facility licensing—and their institutional interpretation—together with the punitive monitoring of maternal mortality under the Millennium Development Goals, effectively established a de facto ban on attending births outside hospital settings. Medical and managerial staff increasingly maintained that it was "already prohibited" to attend births in primary-care facilities, consolidating a policy that marginalized community midwifery and contributed to the abandonment of primary obstetric care (Freyermuth, 2012).

For comprehensive support, professional midwife Nantzin recommends that both parents are present.

Credit: Juan Carlos Martínez

It was within this context of institutional closure that the first initiatives to create a regulatory space for midwifery began to take shape. In 2019, the Committee for Safe Motherhood in Mexico secured funding from Bayer[5] which, with support from the MacArthur Foundation, enabled the hiring of a consultant specializing in legislative processes.[6] The team identified legislator Martha Tagle, of the Citizens' Movement,[7] as a key ally for introducing the legislative initiative in Congress.

The resulting initiative proposed amending the General Health Law to incorporate the concept of midwifery units: physical spaces independent of or separate from hospitals, designed to care for pregnant women without medical complications, operating under a model that collaborates with the family and respects women's decisions, with the capacity to refer patients to hospitals with more advanced care. The proposal was backed by more than eighty female legislators from different parties and advanced to the Health Committee (Tagle 2019). However, because it entailed spending for a government agency, it was referred to the National Center for Gender Equity and Reproductive Health[8] (CNEGySR), which ruled that the proposal did not align with current regulations. Legislator Tagle pointed out that, due to the hierarchy of regulations, the law should be amended before the regulation, not the other way around; but in practice, the initiative was put on hold.

At the same time, since the beginning of the 2018–2024 presidential term, then-Undersecretary of Health Hugo López-Gatell had identified midwifery as a pending public policy issue. His entry point was a meeting convened by CSOs in which he acknowledged that one of the main barriers to the practice of midwifery was the lack of a legal definition and its unequal treatment within the legal framework.[9] In his meetings with the Committee for Safe Motherhood, organizations of indigenous midwives, and the CASA School of Professional Midwifery,[10] he came to recognize the wide diversity of midwifery practices in Mexico and raised the need for an inclusive regulation that would address regulatory and health gaps, with the aim of equally benefiting all forms of midwifery and the women and families they serve.

To counter the technocratic mindset that equated safe childbirth with hospital-based childbirth, the former undersecretary sought the support of the Pan American Health Organization (PAHO) in Mexico, whose backing helped demystify international recommendations and emphasize that the fundamental goal was to ensure safe and humanized births, without necessarily relying on a hospital setting. PAHO itself warned that, without incorporating all forms of midwifery, Mexico would not have sufficient resources to consolidate robust primary care. Supported also by Nadine Goodman[11] and various midwife networks, López-Gatell promoted a strategic approach: the central focus should not be the "right of midwives" to practice, but rather the fundamental right of women to receive dignified and humanized care—a framework that proved politically more viable and was adopted by the health authorities who continued the process.[12]

However, this proposal encountered two converging forms of resistance: the technocratic inertia inherited from previous policies, which had dismantled primary care capacity, and the failure to recognize structural inequalities, which stemmed from the premise that all women have equal access to health services. The result was the fragmentation of the original project: instead of a single, inclusive regulation, the CNEGySR ended up proposing two distinct instruments: a standard aimed at traditional midwifery, and technical guideline for non-traditional midwifery, entitled "*Technical Guideline for the Implementation and Operation of Labor-Delivery-Recovery (LPR) Rooms in the Service Networks*" (CNEGySR 2022a), published on September 7, 2022. LPR rooms were developed on a very limited scale and primarily benefited a small portion of the urban population.[13]

Between 2021 and 2022, plans began to take shape to develop a specific standard on midwifery, initially focused on professional midwifery. Figure 3 summarizes the key milestones that marked the process from that starting point through to the publication of the final standard in 2025.

Figure 3. Timeline of key aspects in the development process of NOM-020-SSA-2025

2018

Emergence of local spokesperson networks

Women's Meeting at the Center: midwifery is brought to the attention of authorities as a collective practice, and spokespersons and discourses are established.

Midwifery is discussed as a political and discursive issue among key stakeholders (Undersecretary of Health).

2019

Legislative proposal

To reestablish midwifery units as physical spaces that are independent of or clearly distinct from hospitals.

2022–2023

Start of the regulatory process

Announcement of the drafting of the regulation and convening of the first working group.

Traditional midwifery becomes a subject of regulation, sparking controversy over its definition and scope of practice (response on social media). The bill is canceled due to shifts in the 2022 national agenda.

2024

Second working group, preliminary draft, and draft standard

Participation by government officials, midwifery networks, and physicians, and officials specializing in Indigenous affairs.

Provisional categories are established, the range of voices is broadened, the draft standard is revised, and traditional midwives are excluded or opt out.

Public consultation (CONAMER)

August 20 – October 19, 2024

A proliferation of voices and documents: official letters, templates, and social media.

The concept of "traditional midwife" becomes fragmented; its boundaries, representation, and forms of legitimization are contested.

2025

Official responses

February 17, 2025

Technical templates and annotated versions, presence of social media.

Adjustments and reconfigurations: some terms become established, while others exclude certain practices.

Publication of the NOM (final version)

March 4, 2025

Authorities, midwife networks, and officials from the ministries responsible for Indigenous Peoples work together to support midwife groups and state health institutes in preparing for the implementation of the NOM.

Shift in focus: from the midwife's identity to the mechanisms regulating her working conditions.

June 16, 2025

The Secretariat for Indigenous Peoples, Neighborhoods, and Resident Indigenous Communities (SEPI) cancels a presentation of NOM 020 because it cannot be disseminated since no consultation was conducted with Indigenous Peoples.

The NOM comes into force

August 31, 2025

Midwives' activities on social media and through public statements.

August–October 2025

Petition for judicial protection filed by midwives from Nich Ixim, Chiapas; Teo Tepahkalle in Mexico City; and Partería y Medicinas Ancestrales in Tijuana.

October 13, 2025

The deadline for filing amparo petitions against NOM-020-SSA-2025, which is considered a "self-enforcing general standard."

Granting of injunctions to traditional midwives

November 7, 2025

The 18th District Court of Baja California grants amparo to nine traditional midwives belonging to various Indigenous Peoples (Baja California, Chiapas, and Guerrero); the case was handled by the Federal Public Defender's Office.

5. The Dispute Over Regulation: The 2022 Draft and the Response of Traditional Midwives

The NOM was publicly announced while it was still under development. On September 6, 2022, during the presidential morning press conference, Undersecretary López-Gatell noted that the constitutional framework and the General Health Law were insufficient to protect midwifery and announced the development of a specific NOM that would recognize its various forms, provide legal certainty for midwives, and coordinate their work with the health services network (Presidency of the Republic, September 6, 2022). When asked about the presentation of NOM 020 during the morning press briefing, the director of the CNEGySR expressed surprise at what she considered the premature disclosure of a standard still under development.[14]

The draft that began circulating that year, titled "Draft NOM-XXX-SSA2-2022, the practice of traditional midwifery and community midwifery. Criteria for Linking with Sexual, Reproductive, Maternal, and Neonatal Health Services," proposed regulating and supporting this practice as part of the health system. It explicitly defined traditional midwifery as knowledge transmitted across generations, recognized by the community, and practiced without discrimination, and established that it could be carried out at home, in the community, or in primary and secondary health care facilities. It also recognized the service user's right to be accompanied by a midwife and provided for annual training in essential competencies without replacing traditional knowledge, as well as voluntary referral and counter-referral mechanisms with institutional services.

Traditional midwife Doña Petrona carries out a prenatal checkup for a pregnant woman at the first sign of labor.

Credit: Juan Carlos Martínez

However, the proposed framework was based on a biomedical logic, not on the midwives' own worldview. In practice, the draft standard clinical records, centralized information in health departments, made the validation of births contingent on official procedures, and required specific periodic certification for traditional midwifery that was not imposed on other health providers. Although the rhetoric was one of recognition and collaboration, the structure of the bill tended toward the administrative medicalization of traditional midwifery: it recognized it in order to control it.

5.1 Responses from communities and organizations

The reaction was swift. The Osa Mayor Foundation[15] (2022) was the first organization to publicly highlight the dilemma posed by the regulation: would it strengthen or limit the practice? Its message called on midwives and women to remain vigilant and to actively participate in shaping the regulation so that it would effectively benefit the "guardians of dignified childbirth," in order to safeguard their work and avoid restrictions that could undermine their autonomy.

What was at stake was clearly articulated by Apolonia Plácido Valerio, an Indigenous advocate for traditional midwifery in Guerrero. In her testimony, she precisely describes what respect-based care means in practice:

> In a truly respectful health service, a woman in labor is not greeted with an impersonal questionnaire, but with a greeting in her own language—*Tu'un Savi or Me'phaa*—and with a sincere listening to her story: how she feels, where her pain comes from, and whether she is carrying the weight of violence or worries from home. The midwives, recognized as bearers of ancestral knowledge, decide the next step together with the woman. If she wishes, a warm steam bath is prepared. In the kitchen, rosemary, basil, and rue are mixed; the steaming pot is placed under a chair, and the woman in labor, wrapped in a blanket, sits to absorb the heat that eases her contractions. [...] When the baby appears, no one forces her to lie down under cold lights: she can kneel, hug her partner, let gravity help her. When the baby is born, skin-to-skin on the mother's chest, the midwife records the time, weight, and height on the certificate recognized by the health system, without crossings-out or mistrust. Then the placenta is honored [...] Everything takes place in an environment where Earth medicine coexists with science: if a risk arises, the midwife and the doctor decide together. There are no C-sections imposed "by protocol," nor disparaging comments about "magic teas" or "empirical midwives."[16]

That is the fair treatment Apolonia calls for: respecting ancient wisdom—the temazcal,[17] plants, the rebozo,[18] spirituality—and placing it side by side with academic knowledge. Respect means recognizing midwives' records in official registries, allowing them to guide the rites of heat and the placenta, and training doctors and nurses to understand that, among Indigenous Peoples, health is woven together with Mother Earth, the Sun, and the warm words of the herbs.[19]

On September 24 and 25, 2022, the reactions continued. On Facebook, Aura Renata Gallegos Vargas (2022) described the impact that the government's announcement of the NOM had on more than 20,000 traditional midwives, which was perceived as a "jolt" that reignited the fear of being absorbed by a system that has historically rendered them invisible. Within this broader public debate, Valentina Arana, an autonomous midwife whose practice draws on traditional midwifery knowledge, evoked collective memory—ceremonies around the fire, the passing down of seeds, and the blessings of the grandmothers—to express both the uncertainty of the moment and the resistance that emerged from dreams shared with the elders. The grandmothers urged midwives to "unmask" the machinery that seeks to standardize midwifery practice and called for unity without legitimizing a single model of midwifery (Arana 2022).

In November 2022, the National Agenda for the Defense and Promotion of Traditional Midwifery[20] issued its first public statement, rejecting the regulation as unconstitutional and a violation of the rights of Indigenous Peoples. They argued that any regulation must be developed with the direct participation of midwives themselves, denounced the

obstetric violence and racism faced by indigenous women, and demanded the recognition of traditional midwifery as a fundamental part of community health systems (National Agenda 2022). That same month, the director of the CNEGySR announced that NOM-020 would focus on professional midwifery, not traditional midwifery.

5.2 A consultation that wasn't

In January 2023, a call was issued to establish the Working Group that would prepare the preliminary draft, including organizations of traditional midwives and civil society. In February 2023, the National Agenda issued a second public statement arguing that an Official Mexican Standard could not regulate traditional midwifery because traditional midwives belong to Indigenous health systems rather than to the National Health System. The statement further maintained that inviting a small number of traditional midwives to participate in the Working Group could not substitute for the State's obligation to conduct a free, prior, and informed consultation with Indigenous Peoples. It also called for respect for Indigenous self-determination, ancestral knowledge, and Indigenous health systems. The statement was signed by the Action Front for the Defense, Dignification, Non-Discrimination, and Promotion of Traditional Midwifery, bringing together organizations and midwives from the Ayuujk, Ikoots, Maya, Me'phaa-Tlapaneco, Mixe, Mixteco, Nahua, Purépecha, Tének-Huasteco, Tseltal, and Tsotsil peoples across eleven Mexican states. Their position highlighted the tension between the State's regulatory logic and the recognition of the autonomy of Indigenous health systems (National Agenda 2023).

Although the call for the Working Group included organizations of traditional midwives, representatives of the National Agenda argued that this did not fulfill the State's obligation to conduct a free, prior, and informed consultation with Indigenous Peoples, as required under ILO Convention No. 169. In their view, participation in a technical working group was not equivalent to consulting Indigenous Peoples about a regulation that directly affected their knowledge and practices.

The testimonies of those who were invited to participate in the Working Group reveal why that invitation was not perceived as a legitimate consultation. Sebastiana Vázquez, a traditional midwife from Chiapas and a member of the Nich Ixim movement, explained the conditions that discouraged participation:

> They really should have consulted us traditional midwives; in my view, it was a mistake not to do it properly. It's true that they invited us, but the movement decided we shouldn't go, and as an organization, we chose to respect that majority. Had we gone—and we certainly wanted to—we would have faced a list of requirements: signing piles of documents, pledging not to repeat anything we heard… all those obstacles ended up discouraging us.[21]

Apolonia Plácido Valerio was more direct about the state's absence:

> Look, the truth is that nobody consulted us. The INPI [National Institute of Indigenous Peoples] didn't show up, nor did the Ministry of Health; the so-called "consultation" stayed on the desks. That violates the rights of the people: the voice of the communities was never heard.[22]

Ofelia Pérez, a member of CAMATI Mujeres Construyendo desde Abajo A.C.,[23] , pointed out the impossibility of representing her constituents under those conditions:

> They invited us when the scandal [surrounding the withdrawn 2022 draft NOM] had already happened; at first, they didn't even remember the traditional midwives [...] They put up obstacles: they almost wanted us to sign a non-disclosure agreement, with no chance to consult other colleagues. Only those present could decide, but I can't speak on behalf of everyone if they haven't seen the document or said what they think. The information has to be shared with the grassroots so they can contribute, and if something isn't right, we can reject it together.[24]

These voices point to a fundamental legal problem. Consultation with Indigenous Peoples is not an administrative formality, but a state obligation derived from Convention 169 of the International Labour Organization (ILO) and recognized by the Supreme Court of Justice of the Nation: any measure that may directly affect Indigenous Peoples must be subject to a prior, free, informed, good-faith, and culturally appropriate process, carried out through their own representative institutions. The convening of a small group of midwives, under opaque criteria and with confidentiality clauses, did not meet these standards (Government of Mexico 1990, 1991).

5.3 The first draft stalls

The result was resounding: the 2022 draft standard, pushed forward amid these tensions, was not even submitted to CONAMER, the federal regulatory oversight body responsible for reviewing the impact of proposed regulations before they can proceed through the rulemaking process. The Working Group was never established. Pressure from traditional midwives and those who describe themselves as "in the tradition" was decisive in halting the process. In early 2023, the director of the CNEGySR was replaced, and in September of that year, Undersecretary López-Gatell left his position to participate in Morena's internal primary as a candidate for Mayor of Mexico City. The first attempt to regulate midwifery had failed, but the debate it sparked did not end: it carried over into the next regulatory cycle, with new actors and a reformulated proposal.

6. Shift in the Regulatory Focus: From Traditional Midwifery to Healthcare Facilities

The failure of the first draft did not bring the process to a close: it redirected it. With new leadership at the CNEGySR, a second regulatory process was launched. Without the actors who had driven the 2022 proposal, the regulatory draft was reformulated from the ground up. The draft that the CNEGySR presented to the new Working Group on March 6, 2024, marked a substantial change: it was no longer a regulation aimed at directly regulating the practice of traditional midwifery, but rather an instrument focused on regulating maternal and neonatal care in public, private, and social primary-level health facilities.

The change amounted to a 180-degree shift. The regulation ceased to target the "traditional midwife" as the subject of regulation and instead focused on the "health facility" and professional midwifery. Traditional midwifery was relegated to an optional liaison role: the intercultural discourse remained, but the logic of control shifted from individual practice to the institutional framework. The underlying logic was to recognize in order to integrate, but within the system's rules.

The draft was organized into six chapters covering everything from the objectives of the regulation and the scope of its application to infrastructure, human resources, and process requirements for different types of facilities—labor-delivery-recovery rooms, maternity wards, and midwifery homes. It included an expanded glossary with concepts such as abortion, maternal homes, and person-centered care, and listed guiding principles on human rights, gender perspective, and interculturality. It also referenced eighteen existing official regulations, thereby anchoring the new instrument within the existing regulatory framework.

6.1 What the draft said about traditional midwifery

The place the draft assigned to traditional midwifery clearly revealed the logic behind it. Three effects combined to produce systematic subordination.

The first was classification. Section 3.14 defined traditional midwives as "authorized non-professional personnel" and limited that category to women from Indigenous or Afro-Mexican communities trained through intergenerational transmission. This designation introduced an explicit hierarchy relative to professional midwifery and opened the door to administrative restrictions that did not apply to other health care providers.

The second concerned the conditional nature of traditional midwives' participation. Sections 5.1.3 and 5.1.4 required health facilities to engage respectfully with traditional midwives, but the actual exercise of their practice within health services depended on whether the facility considered that "conditions permitted it." In practice, this wording left the decision about who could attend the birth in the hands of the facility rather than the midwife or the woman receiving care.

The third issue was the administrative burden. Maternity homes managed by traditional midwives were required to: maintain operational links with health districts, establish transport routes, and manage biohazardous waste (section 5.2.3); document activities involving the exchange of knowledge, skills, and competencies, as required by the Technical Guidelines for Community Interventions in Maternal and Perinatal Health (section 5.3.5), thereby making these activities subject to formal institutional documentation; maintain birth and transfer records integrated

into official epidemiological surveillance systems; and register with the National Registry of Midwives (ReNaPa) (6.3), with community professionals assigned to "accompany and advise them." The result was a framework in which traditional practice was recognized but heavily supervised by the institutional apparatus (5.5.1.2).

Although the draft retained references to cultural diversity and the importance of traditional midwifery, it portrayed traditional midwives as figures subordinate to the health system, whose participation in care and in the certification of births was conditional on their formal affiliation with state services and compliance with criteria defined by the system itself.

6.2 The Working Group and changes prior to publication

This draft served as the basis for discussion by the Working Group, which met between March 6 and May 23, 2024. Its membership was predominantly institutional, with the participation of representatives from: federal agencies of the Ministry of Health and public institutions in the health sector such as the Mexican Social Security Institute (IMSS), the Institute for Social Security and Services for State Workers, Petróleos Mexicanos, and the Ministry of the Navy; agencies such as the National Institute for Women (INMUJERES) and the INPI; as well as a more limited representation from civil society and academia. Traditional midwives did not participate in this process, and proposals from the INPI and the General Directorate of Health Planning and Development (DGPLADES)[25] to conduct a specific consultation with them were not incorporated (Ministry of Health and CNEGySR 2024).

The working sessions introduced significant changes to the original draft before the bill was sent to CONAMER for evaluation and subsequent publication in the *Official Gazette of the Federatio*n on July 18, 2024. These changes, and the controversies they generated during the public consultation, are the subject of the following sections.

6.3 What changed in the Working Group: Progress, limitations, and ambiguities

The Working Group sessions held between March and May 2024 introduced significant changes to the original draft. Taken together, these changes followed a recognizable direction: they strengthened the symbolic recognition and certain operational rights of traditional midwifery, expanded the scope of professional midwifery, and softened the most obvious control mechanisms, but without altering the central architecture of the instrument or the hierarchy that places traditional midwifery in a subordinate position within the institutional system.

6.3.1 Progress in the Recognition of Traditional Midwifery

The most significant change was the creation of a specific chapter, Chapter 7, dedicated entirely to the relationship with traditional midwifery, rather than scattering those provisions throughout Chapter 6, as was the case in the draft. This chapter introduced several new elements.

First, traditional midwifery was declared part of traditional Mexican medicine and an indigenous and Afro-Mexican identity marker (section 7.1.2), with the right to a relationship free of subordination in accordance with its biocultural knowledge and resources (7.1.4). Health services were required to implement measures aimed at ensuring dignity and the practice of midwifery in accordance with midwives' own methods (7.1.3).

Second, the requirement to register with ReNaPa was eliminated and replaced by voluntary registration in a state registry managed at the local level (7.1.5.2). This change directly addressed concerns that the registry functioned as a coercive mechanism, although access to certain services, such as birth certificates, remains tied to that registry.

Traditional midwife Sebastiana uses a Pinard stethoscope to listen to a baby's heartbeat.

Credit: Juan Carlos Martínez

Third, section 5.1.7 removed the provision that allowed facilities to make the involvement of traditional midwives contingent on "conditions permitting," and instead established the obligation to actively facilitate such involvement throughout the entire continuum of care. Complementarily, section 5.1.10 explicitly recognized the traditional midwife as an authorized companion throughout the entire care process; as a result, this accompaniment became an operational right that health facilities cannot restrict to visiting hours or make contingent on internal conditions.

Specific state obligations were also incorporated: mandatory training for managerial and operational staff in interculturality, intersectionality, and human rights (7.1.5.1); mechanisms for knowledge exchange with an intercultural focus, recognizing that the traditional midwife also teaches (7.1.5.3); the obligation to admit pregnant women accompanied by their midwife without delay (7.1.5.4); the provision of birth certificates and recognition of records issued by midwives (7.1.7); and the declaration that the National Health System will not consider them volunteer staff and will preserve their community autonomy (7.1.9).

6.3.2 Persisting limitations and ambiguities

Alongside these advances, the Working Group's process also introduced restrictions and left ambiguities unresolved.

The most significant was the definition of traditional midwifery: by limiting it to women from Indigenous or Afro-Mexican communities trained through intergenerational transmission, the text potentially excluded mestizo midwives, migrants, or other community practitioners whose practice is also recognized as traditional in their territories, leaving this definition subject to interpretation by state authorities. The recognition expanded its cultural depth but reduced its social scope.

Another significant limitation was the narrowing of the intercultural approach. The draft had developed this in three sections that required health personnel to recognize barriers of language, religion, or geography; learn to interact with different cultures; and design specific programs to eliminate those barriers. In the published version, all of that was condensed into a brief statement indicating that care must be "respectful, clear, with good communication, and recognition of cultural diversity." This phrase allowed for the demand of respectful treatment, but did not require facilities to have interpreters for indigenous languages, trained staff, or culturally adapted infrastructure. The concrete implementation of the intercultural approach was left to local negotiation on a case-by-case basis. In practice, when a midwife needed to enter a delivery room, use her rebozo, or communicate in her language, she could invoke that clause, but she would have to demonstrate in each specific situation how doing so would improve the accessibility of the service and persuade the unit to allow it.

6.3.3 Changes in professional and autonomous midwifery

The Working Group's process also significantly consolidated the place of professional midwifery within the regulatory system. Section 6.2.1 explicitly recognized their clinical autonomy to attend low-risk births under their own responsibility, a formulation that was not clearly established in the draft. Section 6.2.4 authorized the recommendation and administration of basic obstetric and neonatal medications, including in emergencies, which expanded the scope of clinical practice toward international standards. Recognized educational profiles were systematized, and continuing professional development became a regulatory requirement with biennial recertification.

For autonomous and traditional midwives, however, the outcome was less favorable. Chapter 6.4 classified them as "authorized non-professionals," imposed training requirements, state authorization, and biennial renewal, and established that such authorization was not equivalent to the powers of those holding a degree and license (6.4.5). The controversial section 6.4.8 was included, imposing restrictions on the information these individuals could publicly disseminate.

6.3.4 The threshold to public consultation

With these changes incorporated, the draft was submitted to CONAMER. This body authorized its publication on July 18, 2024, in the Official Gazette of the Federation, thereby formally opening a 60-day public comment period. This mechanism, unusual in policy-making processes due to the obligation to publicly respond to every comment received, would become a forum where various stakeholders would debate the final content of the regulation.

7. The Public Debate: Social Media, Formal Consultation, and Reactions to the Published Standard

The publication of PROY-NOM-020-SSA-2024 in the *Official Gazette of the Federation* on July 18, 2024, was not a quiet technical event. During the 60-day public consultation period, as well as in the weeks before and after, an intense debate unfolded on social media and digital platforms, revealing the depth of divisions surrounding the standard. Between July 13 and October 19, 2024, 142 comments were documented in digital media and on social media. The debate revolved around at least 44 *hashtags*, ranging from institutional ones —#NOM020SSA— to those expressing identity and resistance—#LaParteríaSeDefiende, #ParteríaLibre, #NoALaNorma, #SíAlPartoEnCasa—which illustrates how social media platforms functioned not only as spaces for opinion but also as tools for coordination, amplification, and mobilization for formal participation in the consultation.

7.1 Voices in favor: historical recognition and healthcare expectations

Of the 142 documented comments, 35 expressed a favorable view of the bill. Their arguments centered on two main themes.

The first was historical recognition. Those who supported the regulation emphasized that, for the first time, midwifery—in both its professional and traditional forms—was being named, regulated, and integrated into the National Health System. It was argued that providing legal certainty for midwives meant recognizing an ancestral profession and offering a safe and culturally relevant option to Indigenous, Afro-Mexican, rural, and urban communities, in accordance with Articles 1 and 2 of the Constitution and with international conventions on sexual and reproductive rights.

The second was the health-related potential. Health authorities and professionals presented the regulation as a step toward strengthening primary care and reducing hospital overcrowding, unnecessary cesarean sections, obstetric violence, and maternal mortality. It was highlighted that the proposal included mechanisms for coordination between midwives and health facilities to ensure timely referral of high-risk cases, and that it recognized the possibility for traditional midwives to issue birth certificates. Nadine Goodman, founder of CASA A.C., noted that a key advancement was the recognition of childbirth care and obstetric emergencies at the primary care level, which would allow for the stabilization of women before their referral to the secondary care level.

This wave of favorable messages was driven primarily by institutional spokespersons. The Ministry of Health framed the process as a "historic advance" on Facebook and on the X network, a narrative that was amplified by national media outlets such as La Jornada, Milenio, and Latinus, by health-specialized media, and by state media, with particular resonance in the state of Hidalgo. From civil society and academia, the Observatory on Maternal Mortality in Mexico and the Faculty of Nursing and Obstetrics at the National Autonomous University of Mexico reinforced the rights-based approach and the technical relevance of the project.

An analytically relevant fact is that in this first set of favorable messages, the direct voices of traditional midwives and users appeared only marginally. Institutional and media enthusiasm constructed a narrative of triumph that, in reality, was driven primarily by professional and institutional circles, not by those who experience the effects of the regulation on a daily basis.

7.2 Critical voices: Autonomy, criminalization, and absent consultation

The 107 critical messages documented during the same period articulated a radically different narrative, organized around four main themes.

The first was the dispute over the name and place of midwifery. Critical voices argued that the bill "appropriates" the term *midwife* to associate it with a hospital-based role, and that by establishing a distinction between "professional" and "traditional" midwifery, it erases or marginalizes autonomous midwives. From this perspective, if the state seeks to regulate the practice that occurs within the biomedical system, it should use terms such as "*midwife*" or "*obstetric nurse*," which would avoid creating a hierarchy around an activity that existed before and outside of academia.

The second focus was the defense of autonomy. Midwives and their allies denounced the fact that the bill introduced mandatory notifications, registrations, and biannual recertifications, and that it grants bodies such as the Federal Commission for Protection against Health Risks, the CNEGySR, and health jurisdictions the power to define who can be recognized as a midwife and who can open a midwifery practice, without midwives themselves being part of or leading these bodies. The term "*clandestinidad*" (clandestine, or 'underground') appeared repeatedly as the undesirable outcome to which the regulation would lead: the practical disappearance of traditional knowledge and home-based care.

The third issue was the exclusion of home birth. The official definition of "midwifery center" prioritizes facilities and "professional" midwifery, while the text explicitly omits home birth—a setting where many autonomous and traditional midwives practice. For these stakeholders, this omission amounts to a *de facto* exclusion of a way of giving birth and working that families choose for cultural, economic, privacy, and trust-related reasons.

The fourth issue was the complaint regarding the lack of prior consultation. Midwife networks and allied organizations pointed out that the regulation directly affects Indigenous and Afro-descendant peoples without having fulfilled the legal obligation of prior, free, and informed consultation established in ILO Convention 169. They also warned of risks of appropriation of traditional knowledge, such as the use of the rebozo, herbal medicine, or the temazcal, if these are regulated without community participation.

The core group driving these demands consisted mainly of autonomous and traditional midwives, midwifery centers and networks, doulas and birth companions, service users, and feminist collectives. Their slogan summarized a position that was not one of total rejection, but of conditional acceptance: "Regulate, yes, but with midwives at the table and without criminalizing their practices."

To convey this position to decision-makers, they actively promoted the submission of formal comments to CONAMER and the National Advisory Committee on Public Health Standardization (CCNNSP), launched campaigns on change.org, and deployed lobbying strategies before the National Human Rights Commission, the INPI, and UN bodies, and documented cases of transfers, refusals to issue certificates, and obstetric violence as substantive evidence for their technical observations.

This online debate did not run parallel to the formal consultation: it fueled it. The same organizations and midwives who posted on X, Facebook, and Instagram actively called for comments to be submitted on the CONAMER platform, with the aim of transferring their arguments from the digital space to the institutional process.

7.3 The public consultation: Stakeholders, arguments, and proposals

During the consultation period, 331 signatures were recorded on the CONAMER platform, distributed across 284 submissions. After removing 48 duplicates and one instance of a triple entry, the analysis was based on 284 unique submissions, from which it was possible to identify 210 distinct stakeholders. A key finding for understanding the

dynamics of the process is that in many cases, the arguments were substantially similar to one another, suggesting the existence of coordinated collective efforts to present specific viewpoints to health authorities. The formal consultation was not merely an individual channel for expressing opinions, but a space for organized mobilization.

7.3.1 The actors: Who participated and from where?

Table 2 summarizes the profiles of those who participated in the public consultation and their positions regarding the draft. The most striking finding is that rejection of the draft standard—whether outright or nuanced—was overwhelmingly prevalent across nearly all profiles. The sole exception was federal public institutions, which maintained a technical-procedural stance without substantive opposition.

Table 2. Stance on PROY-NOM-020-SSA-2024

Population / Type of actor	Count	Position on the NOM
Midwives and related profiles (autonomous midwives, traditional midwives, professional midwives, doulas, healers)	46	Predominantly opposed. Advocacy for autonomy, elimination of sections 6 and 7, opposition to biomedical subordination and the "unauthorized non-professional" category.
Organizations and groups (civil associations, CSOs/observatories, networks, academic groups)	52	Majority rejection with nuances. Some propose technical adjustments; others outright rejection due to criminalization, state control, and infringement on collective rights.
Professionals	48	Consistent rejection. Criticism of subordination, defense of medical pluralism and constitutional rights; questioning of 6.4 and 7.
Federal public institution	5	Technical/procedural position. Normative justification or regulatory review; no explicit political opposition.
Service users	59	Virtually unanimous rejection. Defense of the right to decide how, where, and with whom to give birth; elimination of 6 and 7; acceptance of birth certificates issued by autonomous midwives.

Source: Based on Freyermuth and Vázquez (2025b and 2025c).

Midwives and related profiles. Of the 46 participants identified as midwives or related profiles, the largest group (64 percent) consisted of autonomous midwives and midwives practicing within the tradition. Qualitatively, these were the actors who had already framed the debate. They initiated public calls for action, encouraged the submission of comments to CONAMER, and developed the argumentative frameworks that were later taken up by doulas, traditional healers, and service users. The core of the critical discourse lay within this autonomous sector.

In contrast, traditional midwives who intervened as individuals (nine cases) and professional midwives (four cases) constituted relative minorities. The former raised objections centered on cultural rights, generational transmission, and community autonomy; the latter developed technical-legal and conceptual critiques. Neither reached the level of collective organization and mobilization capacity of the autonomous midwives.

An analytically important point is the distinction between "autonomous midwives in the tradition" and "traditional midwives," which a superficial reading may confuse. Both claim ancestral knowledge and a traditional worldview,

but their social and educational backgrounds differ. Traditional midwives derive their legitimacy primarily from generational transmission and community recognition; autonomous midwives in the tradition typically come from formal, urban educational backgrounds and adopt traditional practices within the framework of a contemporary autonomous practice. The convergence of discourse in the defense of tradition does not imply structural equivalence in their training modalities, territorial integration, or mechanisms of legitimacy. This distinction is fundamental to avoiding interpretive oversimplifications and to understanding the actual configuration of forces within the contemporary midwifery field.

Organizations and groups. The 52 participating organizations included civil associations (ten), CSOs and citizen observatories (ten), midwife networks or collectives (27), and an academic research and advocacy bloc (four). The general tone was predominantly critical, though with two distinct discursive strategies.

A first strand articulated an approach of "partial recognition of progress combined with proposals for adjustment." The latter included: specific changes to supplies and medications, editorial adjustments or clarifications of provisions, and reconfiguration of the registry to avoid exclusionary effects. A second strand, more prevalent in networks and collectives, maintained a more outright rejection centered on risks of criminalization, subordination to the biomedical system, and the impact on collective rights. The academic community was divided between those who prioritized legal harmonization—collective rights, prior consultation, regulatory consistency—and those who focused on regulatory precision, such as the inclusion of abortion and post-abortion care within the scope of professional midwifery.

Professionals. The 48 individuals identified as professionals—clinicians and academics—expressed a coordinated and consistent rejection, organized around five converging demands: the defense of reproductive autonomy; the challenge to the category of "authorized non-professional personnel" as discriminatory; the demand to eliminate sections 6.4 and 7.1; the defense of traditional and autonomous midwifery as legitimate cultural knowledge; and the demand that the Civil Registry accept birth certificates issued by autonomous midwives. In several cases, especially among academics, physicians, and researchers, these arguments were grounded in explicit constitutional and regulatory references.

Federal institutions. The five interventions by federal public institutions were grounded in a logic of legality and regulatory consistency, without raising political opposition to the bill. Some defended the bill's relevance by highlighting its alignment with international frameworks such as the WHO and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); others, particularly CONAMER, examined regulatory coherence and the new administrative burdens without questioning the substantive content.

Service users. The 59 service users—53 women and six men—expressed nearly unanimous opposition, centered on the defense of reproductive autonomy and the right to decide how, where, and with whom to give birth. Their letters combined personal experiences with references to human rights and provided qualitative evidence on the effects of the regulation from the perspective of those receiving care—a type of evidence that, as will be seen, the institutional process would treat differently.

7.3.2 The arguments: An analysis of a dispute

A total of 1,554 arguments and 1,489 proposals were coded from the 284 submissions received during the public consultation. Read together, these arguments do not constitute a scattered collection of complaints but rather a coherent critique of the draft NOM. Collectively, they argue that the draft frames the relationship between the State and midwifery in terms of biomedical control rather than horizontal coordination. This critique unfolds through four core lines of argument.

The NOM as a device of State-biomedical control. The most voluminous argument in the debate (423 mentions) revolved around the idea that the draft established a state biomedical regime that subordinated midwifery—especially traditional and autonomous midwifery—to the National Health System through registrations, certifications, and administrative procedures that disregarded community self-regulation mechanisms. Most of the interventions did not reject all interaction with the state, but rather the subordinating regulatory design: they proposed collaboration without absorption and respect for community autonomy.

From this broader critique emerged a second, distinct line of argument, which we describe as *conditional freedom* (271 mentions). This concept refers to the way in which women's and families' freedom to decide where, how, and with whom to give birth—and midwives' autonomy to practice—was made contingent upon compliance with administrative requirements that, in practice, excluded out-of-hospital and community-based birth options. The core of these interventions concerned restrictions on freedom of choice (78.6 percent), followed by limitations on midwives' autonomy (17 percent).

Added to this core was criticism of replacing the community recognition of traditional midwives with a state-administered biomedical certification system (75 mentions). In nearly half of these interventions, it was denounced that the regulation ignored indigenous regulatory systems and peer certification; another 22.7 percent noted that it disregarded community endorsement by externally defining who can be a midwife; an additional 18.7 percent documented how the imposition of external registrations and certifications shifted authority and made the practice more expensive or inaccessible. The final argument was explicit: the regulation not only governs but also punishes. The requirement for registration and a mandatory link to the biomedical system, accompanied by penalties for non-compliance, pushes those who cannot or will not submit into the underground, with the consequent loss of recognition and greater exposure to legal proceedings and stigma.

Language as an instrument of delegitimization. The second line of argument (193 mentions, 97.9 percent critical) focused on the terminology used in the draft NOM. The categories "authorized non-professional" and "professional midwifery," anchored in section 6.4, were interpreted not as technical clarifications but as instruments for linguistically reconfiguring midwifery identity: by replacing the social and community-based term "midwife" with biomedical and hierarchical categories, the regulation would delegitimize community recognition, subordinate the practice to external certifications, and pave the way for its exclusion from the healthcare framework. The distinction between "traditional midwives" and "authorized non-professionals," as well as the introduction of "professional midwife" as a category that excludes those without a license, were repeatedly pointed out as mechanisms of hierarchization disguised as technical precision.

Health effects and the risk of the community model's disappearance. The third line of argument (265 mentions) maintained that the regulation would undermine maternal care by dismantling the community model and redirecting it toward a hospital-centric system. More than two-thirds of the mentions (87.9 percent) questioned forced hospitalization and the erosion of community midwifery, outlining practical effects: loss of continuity of care, obstetric violence and adverse clinical outcomes, lack of interculturality, and restrictions on access to essential medications in emergencies.

This critique of immediate effects was complemented by a forward-looking perspective: the risk of the disappearance (127 mentions) of autonomous and traditional midwifery as the cumulative consequence of regulatory subordination, administrative barriers, sanctions, and stigmatization. Almost all of these interventions (96 percent) described a cycle of exclusion with two dimensions: administrative-regulatory, where bureaucratic procedures and renewals act as a structural barrier; and epistemic-cultural, where the invisibilization of knowledge and the appropriation of the term "midwifery" threaten the continuity of a living cultural heritage.

Criminalization of midwifery. This process of exclusion was further reinforced by a recurring argument concerning the criminalization and de facto outlawing of midwifery practice (79 mentions). Participants contended that mandatory registration, certification, and administrative sanctions would create a punitive regulatory regime that would expose autonomous midwifery to legal prosecution, forcing those unwilling or unable to comply with the regulation into clandestine practice and depriving them of legal recognition.

Legal misalignment: international frameworks and the right to identity. The fourth line of argument noted that the NOM was out of step with international standards in two respects: 48.4 percent of the 93 mentions pointed to contradictions with treaties concerning Indigenous Peoples—ILO Convention 169, prior consultation, community autonomy— while 51.6 percent cited a failure to heed the recommendations of the WHO, the ICM, the UNFPA, and CEDAW regarding the role of midwifery in maternal care and in sexual and reproductive health services with an intercultural approach.

In parallel, and although fewer in number, the 28 mentions regarding the right to identity centered on a particularly sensitive and highly politically charged controversy. Eighty-two percent focused on the direct risk to the right to identity of children born with midwives: the fear that they would be left without a birth certificate or face obstacles to their registration if the issuance of certificates were limited to those linked to the system. The remaining 18 percent criticized the administrative burdens—registration and periodic recertification under medical authorities—as mechanisms that condition the validity of the documents and act as an indirect barrier to the right itself. Since 2008, a birth certificate has been required to obtain a birth record, and its issuance has already created systematic barriers when childbirth occurs outside of health facilities: making certificates contingent on formal affiliation with the system would exacerbate a preexisting problem.

7.3.3 The proposals: An advocacy program

The 1,489 proposals can be read not only as an inventory of demands but as a coordinated program of regulatory advocacy (631 mentions). The dominant proposal was to halt the process and rewrite the regulation with prior, free, and informed consultation; effective participation of midwives and users; and limiting the scope to the institutional setting or professional midwifery. Within this thematic cluster, 53.6 percent explicitly called for the elimination of chapters 6.4 and 7, identified as the core of the control mechanism.

A second thematic cluster demanded legal and cultural recognition of midwifery without subordination or hierarchies, based on community self-determination and unconditional coordination with the health system (217 mentions), and included the guarantee that women and families can decide where, how, and with whom to give birth without that decision being nullified by recertifications or registrations (77 percent of this group, with 251 mentions).

A third thematic cluster (229 mentions) articulated the right to identity—through the acceptance of certificates issued by midwives at all Civil Registry offices (70.9 percent of this demand)—with the equal and participatory inclusion of midwives in regulation (96 mentions). This last point called for defining who midwives are, how they should be certified, and how the regulations should be drafted, based on criteria specific to midwifery rather than the biomedical system.

A fourth thematic cluster brought together operational and technical proposals whose internal composition reveals the priorities of this cluster. A first set of support-related proposals (22 mentions) prioritized the provision of essential supplies (50 percent). A second set of proposals focused on clinical safety (22 mentions), emphasizing mandatory and non-discriminatory referral and transfer protocols (68.1 percent), as well as updating the annexes on medicines and supplies and incorporating safe abortion, when provided by professional midwives, in accordance with WHO

At the Second National Midwives' Meeting in 2016, traditional midwives came together to agree on a common agenda for strengthening midwifery in Chiapas.

Credit: Juan Carlos Martínez

guidelines (9 percent). Finally, a further set of proposals emphasized the right to receive timely care in settings free from violence and discrimination (18 mentions). To make this possible, women should be able to choose freely both the type of care they receive and the setting in which it is provided. These two conditions are inseparable: freedom of choice is only meaningful when recognized and accessible options exist, including midwifery homes and autonomous midwifery. Accordingly, several proposals called for the legal recognition of these settings as a prerequisite for women to exercise this right without institutional barriers.

A fifth thematic cluster included proposals aimed at the inclusion of women and midwives in the regulation (99 mentions), focusing mainly on ensuring the effective participation of midwives and users in the drafting of the regulation (46 mentions) and on promoting broad dialogue and consultation processes (23 mentions). To a lesser extent, they raised the recognition of the diversity of forms of midwifery practice, peer certification mechanisms, and other registration and organization modalities that would avoid exclusive subordination to the National Health System.

Taken together, these proposals articulate the position of the critical bloc more clearly than any single argument: "Regulation, yes, but with midwives at the center, participating on an equal footing and without barriers that undermine or erode the community-based model of midwifery."

8. The Official Responses: Who Did the Government Listen to—and Who Did it Ignore?

The public consultation process generated 593 comments, to which the health authority responded individually (see Table 3). These responses were published in the *Official Gazette of the Federation* on February 17, 2025 (Government of Mexico 2025a). The text was returned to the National Advisory Committee on Public Health Standardization (CCNNSP), where it was approved by vote, and NOM-020-SSA-2025 was published on March 4, 2025, entering into force on August 31 of the same year (Government of Mexico 2025b).

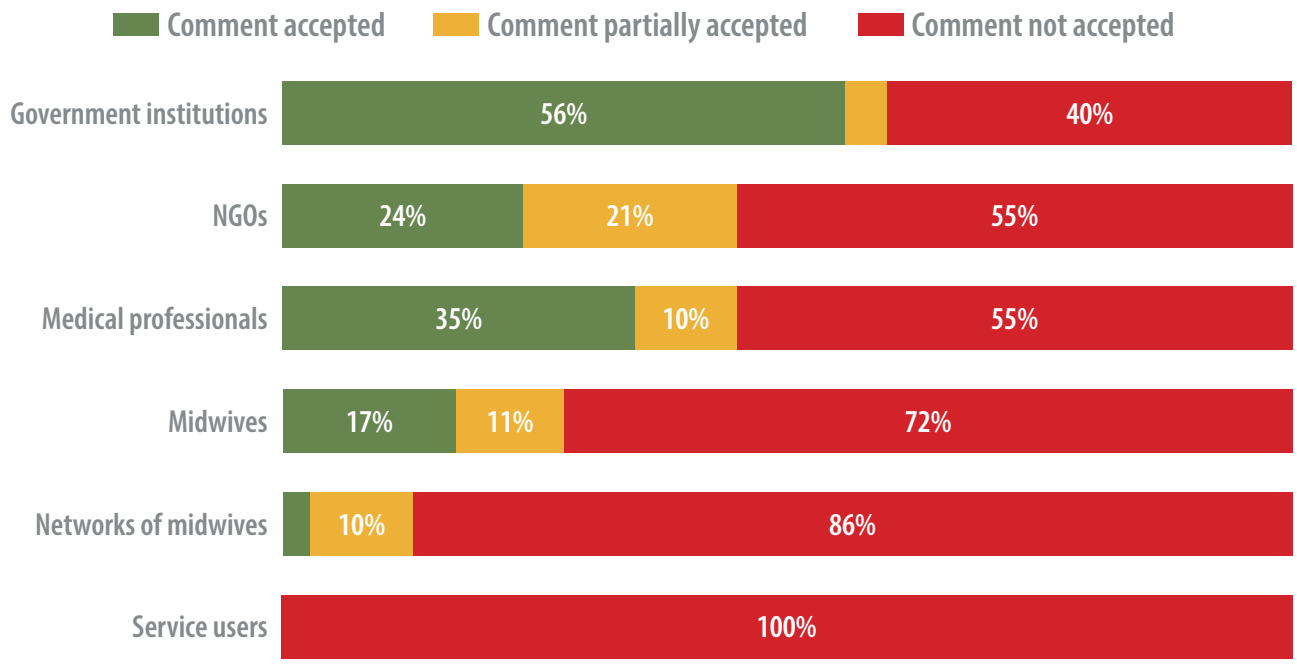
Table 3. Number of comments addressed by the health authority regarding PROY-NOM-020-SSA-2024

Type of stakeholder	Number of comments (percentage)
Total	593 (100%)
Service users	48 (8.1%)
Midwives networks and collectives	29 (4.9%)
Midwives: Autonomous, in the tradition, professional, and traditional	269 (45.4%) Autonomous midwives and midwives in the tradition predominate
Individuals associated with midwifery registered as professionals	40 (6.7%)
Non-governmental organizations	104 (17.5%)
Government officials	103 (17.4%)

Source: Graciela Freyermuth, based on Government of Mexico (2025a). The categorization of actors was performed by Freyermuth and Vázquez (2025a).

Analysis of these responses reveals a pattern that is not random (see Figure 4): only 24 percent of the comments were accepted, 10 percent were partially accepted, and 65 percent were not accepted. But the distribution of these percentages by type of stakeholder clearly reveals the asymmetry: comments from government institutions had an acceptance rate of 56 percent and the lowest rejection rate (40 percent). At the opposite end of the spectrum, all 48 comments from users were rejected, and 72 percent of comments from midwives met the same fate.

Figure 4. Mexico. Resolution of comments on NOM-020 by type of stakeholder, 2025



Source: Graciela Freyermuth, with data from the Government of Mexico (2025a and 2025b).

Professionals and NGOs occupied intermediate positions, with 35 percent total acceptance for the former and 24 percent for the latter, although with a high proportion of partial acceptance (21 percent), suggesting processes of negotiation and adaptation of proposals.

This pattern can be precisely named: institutional alignment bias. Those who are closest to the regulatory framework and technical-normative language achieve greater acceptance of their comments because their proposals align more easily with the process's criteria for legal and operational feasibility. In contrast, contributions from users and midwives tend to propose structural changes—full recognition of their practices, redistribution of responsibilities, incorporation of cultural approaches, effective participation—which are more difficult to incorporate into the technical terms of the regulatory instrument, and therefore have higher rejection rates. Overall, the consultation process reveals power gaps and technical translation gaps: voices with less institutional anchoring require a greater effort to translate their demands into the regulatory format to increase the chances of their being incorporated.

8.1 Female users: Testimonials dismissed as inadmissible

Of the 593 comments analyzed, 48 (8.1 percent) came from users: 44 women and four men. A key structural finding is as follows: the authority responded to these letters as a single unit, even though each letter addressed multiple issues, which underrepresents their weight in the count of accepted or rejected petitions and dilutes the diversity of perspectives contained in the testimonies.

What distinguished these interventions was their testimonial nature. The users recounted direct experiences of pregnancy, childbirth, and the postpartum period attended by midwives, translated those experiences into concrete policy demands, and provided qualitative evidence on the effects of regulation from the perspective of

those receiving care. Their accounts were rooted in the trust built with midwives through continuous support and in contrast to experiences of obstetric violence in medical institutions. For these families, midwifery represented not only a technical alternative or the only accessible resource, but a way to exercise bodily, family, and reproductive autonomy. They recognized the rights-based language of the regulation but believed that subordinating it to medical and bureaucratic criteria could, paradoxically, violate the reproductive autonomy it claimed to protect. They did not reject all regulation, but demanded that it be built on respect and full recognition of midwives as legitimate health agents.

Official responses adopted a predominantly legal and procedural stance. The rejection was justified on four grounds: the impossibility of contravening the General Health Law and its Regulations, which already establish the categories of "professional midwifery" and "authorized non-professional personnel"; the jurisdiction of other authorities—the Ministry of Public Education (SEP) for certification and the Civil Registry for identity; the limited scope of the NOM, confined to health facilities and referral mechanisms; and regulatory technical criteria, as proposals lacking regulatory drafting or explicit legal basis were deemed inadmissible. When comments directly appealed to personal experiences, such as accounts of home births attended by midwives, the authority dismissed them under Article 33 of the Regulations of the Federal Law on Metrology and Standardization, declaring them "not accepted" on the grounds that they were individual experiences. This procedure reveals a technocratic logic that, while legally consistent, excludes community experiences, values, and knowledge from regulatory deliberation.

Regarding birth certificates, the authority noted that the NOM mandates ensuring their provision without discrimination and recognizes the exchange of certificates issued by midwives. However, the formal mandate did not dispel fears regarding persistent administrative obstacles such as: state distribution chains, discretionary verifications, restrictive interpretations, and the absence of deadlines or penalties for refusals. Regional disparities in implementation reinforce these concerns.

8.2 Midwife networks: Demands for autonomy in the face of an unyielding framework

Of the 593 comments, 29 (4.9 percent) were submitted by midwife networks and collectives, which included both formally constituted organizations and like-minded groups organized around common positions. Two points deserve special attention: most traditional midwives participated through these networks rather than in a personal capacity; and two submissions represented the voices of 264 traditional midwives who were not directly included on the CONAMER platform. Eighty-six percent of their proposals were rejected, and only three percent were accepted. This structural exclusion from the formal mechanism is in itself a finding regarding the limits of the consultation.

The demands of these networks were convergent: full recognition of traditional midwifery as part of traditional indigenous medicine; respect for their autonomy and their own forms of knowledge transmission; non-discriminatory access to birth certificates; revision of regulatory language to eliminate hierarchical categories; and the opening of a specific dialogue process to develop a standard on intercultural engagement with traditional midwifery.

The official responses rejected most of these requests on the grounds that they did not warrant substantive changes or did not address the content of the standard. Rhetorical acknowledgments were offered—the NOM is intercultural, certificates must be granted without discrimination, the standard was developed in accordance with constitutional principles—but no structural concessions were made. The request to eliminate sections 6.1.5 and 6.4 was partially addressed, as section 6.1.5 was eliminated and a more precise definition of "authorized non-professionals" was incorporated, without modifying the general regulatory approach. The provision itself was retained, under the justification of the Regulations of the General Health Law. Furthermore, the request to open a new dialogue process was rejected on the grounds that the process already conducted was sufficient.

Working together at the second state meeting of midwives in Chiapas, 2016.

Credit: Juan Carlos Martínez

8.3 Midwives: Language adjustments, rejection of structural changes

Of the 593 comments received, 269 (45.4 percent) were from individuals identified as midwives and one doula. The dominant subgroup was that of autonomous or traditional midwives (237 cases, 88.1 percent of the subset); professional midwives accounted for 30 cases (11.2 percent); and the presence of traditional midwives acting in a personal capacity was marginal (one case).

Among the accepted proposals are relevant, albeit limited, adjustments such as the following: the incorporation into NOM-047-SSA2-2015 of care for the 10- to 19-year-old age group in the chapter on regulatory references; the reformulation of section 5.1.7 to recognize the right of pregnant people to choose a midwife as their care provider, without restricting this to the "traditional" category; the redefinition of "midwifery competencies" as "essential competencies," in order to prevent the concept from being limited exclusively to professional midwives; the expansion of the definition of "maternal health" to include emotional, psychological, and social dimensions; the reformulation of midwifery services toward a broader primary care model; and the elimination of sections 6.4.4.1 (which required Mexican nationality), 6.4.5 (which established hierarchies between professionals and non-professionals), and 6.4.8 (which restricted the public dissemination of health information by unauthorized professionals).

However, most of the structural proposals were rejected. The authority retained the category of "authorized non-professionals" with requirements for formal training, authorization, and biennial renewal, and refused to recognize peer certifications, community endorsements, autonomous regulatory bodies, or the authority of these midwives to attend low-risk births under their own responsibility. Midwifery homes must continue to operate as health facilities subject to NOM-005, with a licensed health professional in charge and professional midwifery staff.

Regarding Chapter 7 on traditional midwifery, although the NOM recognizes its cultural value and mandates that the State guarantee its free practice, proposals to eliminate the chapter, make affiliation voluntary, grant specific clinical-administrative powers to traditional midwives within facilities, or recognize autonomous non-traditional midwifery in that chapter were rejected. The only change incorporated was the addition of voluntary training with an intercultural focus for the care of referred patients, without any enabling effects on clinical functions.

In short, the final version reaffirms professional midwifery as the only modality with full recognition within institutional services, maintains autonomous and traditional midwifery under a regime of conditional state authorization, and recognizes traditional midwifery in cultural terms without translating that recognition into concrete operational processes.

8.4 Professionals: Technical acceptance, rejection of substantive changes

Of the 593 comments, 40 (6.7 percent) came from 19 individuals identified as clinical and academic professionals, with a highly concentrated participation: a single person submitted 15 responses (37.5 percent of the subset).

Proposals aimed at modifying substantive aspects of the regulatory model were systematically dismissed, including: guaranteeing the autonomous practice of traditional midwifery; eliminating licensing and certification requirements as a condition for recognition; updating the language in accordance with human rights standards, for example, by replacing "sexual preferences" with "sexual orientations"; and redefining concepts such as "midwifery home" to incorporate home-based practices. In these cases, the authority reiterated that the NOM regulates health facilities, not models of care—a distinction that, in practice, excludes the recognition of community-based or home-based practices.

This group achieved significant technical advances that did not alter the core structure of the regulation but did expand its content. The most significant of these was the incorporation of the National Commission on Gender and Reproductive Health's *Technical Guidelines for Safe Abortion Care in Mexico* (CNEGySR 2022b)—which was absent from the original draft—in which safe abortion is recognized as an integral part of primary-level sexual and reproductive health services. The definition of midwifery services was also expanded to include the prescription and administration of contraceptives, safe abortion care, stabilization and emergency transport, and comprehensive support throughout the reproductive cycle. Training for health personnel was strengthened in interculturality, gender perspective, sex-gender diversity, and violence, and section 6.4.8, which restricted the public promotion of autonomous midwives, was eliminated.

8.5 NGOs: Partial impact in a framework that remains unchanged

Of the 593 comments, 104 (17.5 percent) came from 14 CSOs, with participation highly concentrated in six organizations that accounted for nearly 90 percent of the responses: the Observatory on Maternal Mortality in Mexico (in partnership with Sakil Nichim Antsetik), the Association for Comprehensive Services for Equity in Society A.C., Education and Training (FOCA), Kinal Antsetik A.C., Midwifery and Natural Health A.C., COEEPEM A.C., and IPAS Mexico/CAM.

Among the accepted changes were: the inclusion of explicit references to Articles 64(IV) and 389 of the General Health Law, which recognize traditional medicine practices and community participation; the inclusion of timely, non-discriminatory referral mechanisms for emergency cases attended by traditional midwives; a drafting revision to avoid imposing the biennial updating requirement exclusively on midwives—the first Mexican health regulation to require such "certification" of service providers, a measure widely criticized as inequitable; recognition that birth records issued by midwives may serve as the basis for the medical certification of births; revisions intended to prevent stigma against traditional midwives within institutional health services; a requirement that health personnel receive training in intercultural approaches and human rights; and a new definition of "authorized non-professionals" to distinguish traditional midwives from other persons without formal academic training.

The proposals that were not incorporated were equally substantive: making a regulatory distinction between autonomous, traditional, and professional midwifery to highlight the diversity of career paths; recognizing traditional midwives as paid staff within the health system; eliminating the requirement to register in the National Registry of Persons Providing Professional Midwifery Services for those practicing autonomously; and establishing financial incentives and specialized training programs in intercultural health and legal abortion. Overall, although the NOM incorporates statements of cultural recognition, it maintains a regulatory structure centered on the biomedical and institutional model, without substantively addressing the demands for autonomy, professional recognition, and structural strengthening of traditional midwifery.

8.6 Civil service: The highest rate of acceptance, but also with limitations

Of the 593 comments, 103 (17.4 percent) came from public officials, primarily from the Mexico City Health Secretariat, with comments from Dr. Oliva López Arellano and Dr. Luis Adrián Mata Manríquez (42 comments) and from IMSS-Bienestar (42 comments), as well as the State Coordination Office for the Prevention and Care of Domestic Violence and Gender Equality in Health (five comments) and the National Council to Prevent Discrimination (14 comments).

The comments of this group had the highest rate of acceptance, and the changes incorporated based on their feedback were the ones that most strengthened the intercultural, human rights, and gender perspectives in the regulation. These are as follows: inclusion of provisions on staff training with an intercultural approach and the use of interpreters; modification of provision 5.2.3 to incorporate recognition of gender expression and the intersectional perspective; inclusion of specific clinical guidelines on abortion, preeclampsia, and hemorrhage; and modifications to the definition of midwifery homes and professional competencies in midwifery.

However, even within the state apparatus, some proposals were rejected. The suggestion to explicitly include professional and traditional midwives in national sexual and reproductive health strategies was dismissed on the grounds that it was already implicit. Proposals to incorporate supplies and techniques applicable to midwifery homes and traditional midwifery into Appendix A were rejected because that annex was declared exclusive to primary-care units. Technical and operational observations for state governments to define their own coordination mechanisms were dismissed without assessing their potential. A particularly illustrative case was that of IMSS-Bienestar, which proposed limiting the regulation exclusively to professional midwifery—a position that, paradoxically, coincided with some demands from the midwives themselves. This proposal was also rejected because the formal purpose of the regulation remained focused on regulating comprehensive maternal and neonatal care facilities as a whole.

Proposals from civil servants were accepted mainly when they helped reinforce the existing institutional framework, improve its internal coherence, or expand on already recognized principles, but without altering the allocation of powers or the core biomedical-administrative control of the regulation.

8.7 A consistent pattern

Taken together, the patterns of acceptance and rejection by type of actor confirm the hypothesis of institutional alignment bias. It is not that the arguments of the users or the midwives were any less sound, as in many cases they were backed by higher-ranking legal frameworks than those invoked by the government. What determined acceptability was not the soundness of the argument, but its compatibility with the narrow scope of the regulation and with the idea of legal-operational feasibility that the authority applied as a filter. Those who managed to translate their demands into that language—drafting adjustments, normative references, conceptual precision—obtained partial acceptance. Those who demanded a redistribution of authority, recognition of trajectories outside the existing legal framework, or structural transformations of the regulatory model were systematically rejected. The consultation functioned less as a deliberation on ends and more as a mechanism for adjusting the text within a previously established framework.

9. The Debate After the Regulation: Continuities and New Interpretations

In the period following the close of the public consultation—from October 19, 2024, to August 31, 2025, the scheduled date of entry into force—205 news articles and comments were documented in digital media and on social media. Their analysis reveals how the debate evolved once the regulation ceased to be a draft and became official text.

9.1 From hope to enshrinement: favorable discourse after publication

The 116 favorable comments from this period no longer present the NOM as a draft with transformative potential, but rather as a regulatory watershed that has already been achieved. This shift is not merely grammatical, reflecting the transition from a draft to a published regulation, but discursive: the NOM is no longer framed as a promise of future change but as a new institutional framework whose legitimacy is taken for granted. Accordingly, the discourse shifts from the future to the present tense: earlier comments stated that the regulation "will allow," "will contribute," or "will open the possibility of"; now it "already recognizes," "establishes," "defines," and "requires." The promises of relative demedicalization and free choice of birthplace remain, but they are now subordinated to the idea of a regulated integration of midwifery within the state apparatus. The discourse thus shifts from justifying the need for the regulation to legitimizing the new regulatory order that it establishes. It is a narrative of institutional consolidation rather than one of hope.

The constellation of actors disseminating this discourse also changed. During the public consultation, communication was dominated by the Ministry of Health's official announcements on the draft NOM, which were widely reproduced by national news media. Following the publication of the final regulation, government institutions continued to disseminate information about the NOM, but professional midwifery associations and networks, feminist collectives, organizations working in sexual and reproductive health, and actors linked to Indigenous Peoples and traditional medicine assumed a more prominent role. These actors appropriated the language of the regulation to legitimize their own practices and claims. This diversification of voices contributed to building broader social legitimacy around the NOM.

Despite this, even in this context of growing public legitimacy for the NOM, autonomous midwives and service users remained only marginally visible. The public legitimization of the regulation continued to be built primarily through institutional and professional channels, not through the experiences and demands of those who face its effects on a daily basis. The asymmetry documented during the consultation was replicated in the subsequent narrative.

9.2 Criticism that persisted: Continuity and intensification

The 86 unfavorable comments recorded after the publication of the final version show a marked discursive continuity with respect to the consultation period: the same lines of criticism, the same signatories, the same profiles. What changed was not the agenda, but its formulation: the arguments became more precise and more politicized, now explicitly articulated as part of a framework of coloniality, institutional racism, and state control over women's bodies and over community-based childbirth care practices. Joining this core with greater visibility were human rights organizations, national indigenous networks, and academic circles that broadened the scope of the initial criticisms.

This is not a new opposition, but rather the consolidation and expansion of an existing coalition that insists on its slogan: "Regulate, yes, but with midwives included and without criminalizing their practices."

9.3 Two interpretations of the same regulation

The coexistence of these two discourses on the same regulatory text reveals more than just a technical dispute. Both sides share a common starting point: they acknowledge the persistence of obstetric violence, inequalities in access to maternal health services, and the need to transform the dominant model of care. They agree that midwifery is a key resource for moving toward more humanized and culturally relevant care, but their interpretations of what the NOM represents in the face of this problem are radically opposed.

For the supportive group, the regulation is a victory: for the first time, midwifery is recognized and integrated into the National Health System, with defined profiles, clinical responsibilities, referral pathways, and its own institutional spaces. For the critical camp, that very integration is co-optation: the NOM establishes a hierarchy between "professionals" and "traditional practitioners," excludes career paths that do not fit the academic mold, and turns registrations and recertifications into surveillance mechanisms that empower the State to decide who is a midwife and under what conditions they may practice.

The differences deepen when considering the relationship between midwifery and the State. Where some see legal certainty and doors opening to formal employment, others see commodification; for example, the requirement for diplomas, periodic recertifications, and infrastructure requirements are interpreted as a shift toward a market-driven training model that ignores territorial conditions and the collective nature of Indigenous and Afro-descendant knowledge.

This tense dialogue does not merely refer to a dispute over a specific regulation. It expresses divergent visions regarding the governance of reproduction and the role that the state and biomedicine should play in the social organization of childbirth. The controversy on social media is, in this sense, a magnified reflection of the structural disagreements that underlie the regulation of midwifery in Mexico.

10. Conclusions

The objective of this article was to analyze how NOM-020 was produced and legitimized as a mechanism for the governance of childbirth and to what extent its final text incorporated the demands of midwives and users regarding their rights. The results reveal a process marked by asymmetries in participation, technical-legal filters that prioritized certain arguments over others, and a persistent gap between the discourse of intercultural recognition and the effective mechanisms for the participation of Indigenous and Afro-descendant peoples and communities.

To understand the scope of these findings, it is necessary to situate them within the historical trajectory reconstructed by the study itself. NOM-020 does not inaugurate a new relationship between the State and midwifery: it updates a recurring pattern that, from the "training" programs of the 1930s to the post-2008 institutionalization of childbirth in hospitals, has included midwives in an instrumental manner—as a useful resource to fill gaps in the system—without recognizing them on their own terms or as subjects with rights and autonomy. The regulation reproduces this logic with a renewed language of rights, gender, and interculturality, but without altering the distribution of authority that underpins it. In this sense, its limitations are not an isolated feature of NOM-020 but the continuation of a long-standing structural pattern of subordinated incorporation of midwifery into the health system.

One of the most significant empirical findings is the shift in the regulatory focus between the 2022 draft standard and the 2024 draft standard. The mobilization of traditional midwives and those who identify themselves as practicing within the tradition contributed to the regulation shifting its focus away from their practice to instead target health facilities and professional midwifery, relegating the connection to traditional midwifery to a non-mandatory status. From the perspective of those who resisted the regulation, this shift constituted a partial victory: the final structure of the NOM does not make them the central regulated subject, which was precisely what they rejected.

10.1 What the consultation process revealed: who was heard and under what conditions

An analysis of the arguments presented during the public consultation and the official responses allows for a precise identification of the mechanism that determined what was incorporated and what was discarded. Beyond the specific amendments incorporated into the final text, the analysis reveals a consistent pattern in how comments were evaluated. Contributions were accepted when they could be accommodated within the legal and operational framework already defined by the authorities, whereas those that challenged the scope of the regulation itself or the distribution of authority between the State and midwifery were systematically excluded.

Users presented far-reaching arguments—that the NOM violates autonomy, free choice, and dignity—supported by direct testimonies of care experiences and obstetric violence. These arguments were systematically rejected on procedural grounds: since they involved individual experiences that could not be translated into a specific regulatory drafting proposal, they did not meet the technical requirements of the regulatory process. The legal and ethical grounding of their arguments was solid, but that was not enough.

Midwives and NGOs managed to partially bypass that filter when they translated their demands into the language of the regulation by pointing to specific sections, formulating alternative wording, or citing regulatory references. When they did so, they secured language adjustments, the removal of restrictive clauses, and conceptual clarifications. But when their proposals called for a redistribution of authority—such as recognizing peer certification, eliminating the "authorized non-professional" framework, or guaranteeing clinical autonomy for autonomous midwives—they

were rejected. The authorities did not refute the data, but rather limited the scope of the guarantee: "Even if it is reasonable, it does not fall within the scope of what this NOM can do."

Proposals put forward by professionals and government officials were more readily accepted, not because their arguments were more compelling, but because their language aligned more easily with the criteria of the regulatory process. However, even these proposals were blocked when they involved expanding the scope of the regulation or redistributing powers.

In short: the public consultation functioned less as a deliberation on goals—rights, autonomy, interculturality—and more as a mechanism for adjusting the text within a pre-established framework. The advances achieved are significant in technical and symbolic terms—training in interculturality, removal of restrictions on dissemination, recognition of midwives' credentials to facilitate the newborn registration process, inclusion of safe abortion—but they did not alter the central architecture of the instrument or the hierarchy that places traditional and autonomous midwifery in a position subordinate to the institutional system.

10.2 The unresolved issue: Indigenous consultation and constitutional recognition

The deepest limitation of the process is not technical, but legal and political. NOM-020 mentions, but does not consult, and partially recognizes, but does not guarantee the binding participation of Indigenous and Afro-descendant communities in the regulatory process. The comments invoking the right to prior consultation, backed by Article 2 of the Constitution and ILO Convention 169, were not refuted on the merits of their arguments but dismissed by declaring the public consultation process that had been carried out to be sufficient. In doing so, the authority closed the door on recognizing indigenous consultation as an autonomous requirement that cannot be replaced by general mechanisms of administrative participation.

This omission takes on greater significance when one considers that, in September 2024, while the NOM consultation was underway, the constitutional reform regarding indigenous and Afro-Mexican peoples and communities was published, explicitly recognizing the right to traditional midwifery and to their own regulatory systems (Government of Mexico 2024b). The temporal coincidence did not translate into regulatory convergence: the NOM proceeded along a technical-administrative path, while the constitutional recognition did not generate a corresponding procedural framework in this process. This dissonance highlights a persistent gap between advances in the realm of recognition and the democratic mechanisms of public policy-making, particularly when it comes to Indigenous Peoples and community knowledge.

10.3 Lessons for advocacy and for authorities

The NOM-020 process offers concrete lessons both for organizations and movements seeking to influence regulatory processes and for the authorities that lead them.

For organizations and midwives, the central lesson is that the asymmetry in advocacy is not explained solely by the strength of the arguments, but also by the timing and procedural arena in which each actor was able to intervene. Professional midwives began advocating in 2018, participated in the Working Group, and succeeded in having their interests incorporated into the initial framework of the standard. That early presence in the technical drafting phase bridged the gap between their demands and the legal language of the instrument, thereby increasing its acceptability.

Traditional midwives, on the other hand, effectively halted the first draft from outside the process, but their decision not to participate in the Working Group limited their ability to influence the phase in which the chapters, definitions, and mechanisms were developed. Subsequent participation through public comments, while providing substantive arguments, took place under procedural conditions less favorable for reshaping the core of the text. Participation "from the outside" can be effective for blocking or raising awareness, but it is often insufficient to modify the regulatory structure unless combined with early presence in technical negotiation forums.

The resulting recommendation is clear: advocacy in standard-setting processes requires multi-level strategies that combine social mobilization to build legitimacy and public pressure, sustained presence in procedural and technical arenas—working groups, proposals with normative drafting, institutional alliances—and the ability to translate demands into the technical-legal language of the instrument.

For authorities, the complementary lesson is equally straightforward: the opening of comment platforms does not, where applicable, replace the obligation of prior, free, and informed consultation with Indigenous and Afro-descendant peoples and communities. Strengthening the intercultural and human rights approach in the regulatory text must be accompanied by participation mechanisms that correct and balance the asymmetries of voice, language, and access that structure these processes. Without such correction, regulatory advances in the area of recognition will remain insufficient to guarantee the democratic legitimacy of regulations that directly affect these peoples and their own health systems.

Notes

1 To the best of our knowledge, only Durán et al. (2022) systematically analyze the comments from a public consultation—the amendment of NOM-051—by identifying stakeholders, expectations, and demands and comparing them with the final text of the standard, though without tracking the reactions and negotiations that occur before and after that stage. The rest of the literature focuses on studying Mexican official standards as instruments of public policy or sectoral regulation, whether by examining their design and legal weaknesses (Zetina Cardona 2022), the need for standards to guarantee specific rights such as accessible tourism (Aguirre Osuna 2024) or the quality of software processes (Flores et al. 2014), or by describing and comparing technical guidelines on accessibility in healthcare (Mayagoitia et al. 1994).

2 Seguro Popular began operations in 2004 with the goal of providing free health insurance and medications to people without social security. The program provided coverage for 294 medical procedures, 633 types of medications, and 37 specific medical supplies.

3 The Houses for Indigenous and Afro-Mexican Women (Casas de las Mujeres Indígenas y Afromexicanas, CAMIs) are community-based centers led by Indigenous and Afro-Mexican women that provide prevention and support services for women experiencing violence. They combine legal assistance in Indigenous languages, traditional and biomedical health services, and community education on sexual and reproductive rights. These centers are funded through federal public resources administered by the National Institute of Indigenous Peoples (INPI) as part of national programs promoting the rights of Indigenous and Afro-Mexican women (see, for example, Vega Gutiérrez, 2020; Hernández Castillo, 2020; Freyermuth, 2024; INPI, 2024).

4 G. Hernández, interview by Graciela Freyermuth and Hilda Argüello, June 9, 2025.

5 Bayer is a multinational pharmaceutical and life sciences company that has supported maternal and reproductive health initiatives through philanthropic and partnership programs. The funding referred to here supported technical assistance for the legislative proposal and did not involve participation in the drafting of the proposed regulation.

6 D. Meléndez Navarro, interview by Graciela Freyermuth Enciso and Hilda Argüello Avendaño, May 26, 2025.

7 Movimiento Ciudadano is a Mexican political party founded in 1999, positioned as a social democratic and progressive party. At the time, legislator Martha Tagle represented this party in the federal Congress.

8 The National Center for Gender Equity and Reproductive Health (CNEGySR) is an agency of the Mexican Ministry of Health responsible for designing and coordinating national public policies on sexual and reproductive health, family planning, gender equity, prevention of gender-based violence, and the reduction of maternal and infant mortality. During the period analyzed in this article, it was the unit responsible for coordinating the development of NOM-020.

9 Hugo López-Gatell, interview by Graciela Freyermuth, June 3, 2025.

10 CASA A.C., an organization that operates a professional midwifery school established in 1997, which has trained 120 professional midwives across 17 graduating classes. A major achievement in 2011 was the inclusion of the Technical Midwife career path in the occupational profile of the sectoral job catalog (CODE: M02117). Since then, there has been a hiring code for professional midwives with technical training.

11 Nadine Goodman was the founder and director of CASA A.C.

12 Hugo López-Gatell, interviewed by Graciela Freyermuth, June 3, 2025.

13 Hugo López-Gatell, interview by Graciela Freyermuth, June 3, 2025.

14 Paola Sesia, personal communication to Graciela Freyermuth Enciso, June 28, 2025.

15 The Osa Mayor Foundation is a private assistance institution and civil organization founded in 2014 in Tulum, Quintana Roo, Mexico. Led by Sabrina Speich, a midwife, and Nancy, an anthropologist, its mission is to support women through processes of change by promoting traditional and autonomous midwifery. To this end, it develops training and certification programs for midwives, promotes the opening of birthing centers, and provides support to low-income women to access free and respectful births, whether at home or in specialized centers. The foundation works, according to its own description, "for equity, dignity, and maternal and child well-being," with a special focus on indigenous health and traditional midwifery through community organizing and an active presence on social media. It also operates a midwifery school.

16 Apolonia Plácido Valerio, interviewed by Graciela Freyermuth and Hilda Argüello, June 18, 2025.

17 A temazcal is a traditional therapeutic practice of Mexican Indigenous medicine. The term derives from the Nahuatl word temazcalli, meaning "house of heat" or "house of steam." It is a type of steam bath conducted in an enclosed structure, which may be built from different materials. Heated stones are sprinkled with water, often together with medicinal plants, producing steam that raises the temperature inside the chamber. Among several Indigenous Peoples in Chiapas, including the Tseltal, the temazcal is used as part of everyday health care and is especially important during the postpartum period, when women use it as a therapeutic practice during puerperal recovery.

18 The rebozo is a traditional Mexican textile garment, rectangular in shape and made primarily of cotton, wool, or silk, which women wear over their shoulders or wrapped around their bodies. In addition to its functions as clothing, protection, or a means of carrying babies and objects, in traditional midwifery it serves as a therapeutic tool used to support pregnancy, labor, childbirth, and the postpartum period. Through various techniques involving support, rocking, compression, and body mobilization, the rebozo is used to promote maternal comfort, facilitate changes in fetal position, and provide physical and emotional support to women during the reproductive process.

19 Apolonia Plácido Valerio, interviewed by Graciela Freyermuth and Hilda Argüello, June 18, 2025.

20 The National Agenda for the Defense and Promotion of Traditional Midwifery in Mexico is composed of indigenous, mestizo, and rural traditional midwives. The organization functions as a political and community network for the defense of traditional midwifery and advocates for the full recognition of midwifery as a legitimate, safe, and culturally respectful health practice, as well as a human and cultural right of Indigenous Peoples. Among its core objectives are the following: ensuring that midwives can practice without threats or harassment; ensuring that their birth certificates are recognized by the civil registry; protecting and transmitting ancestral knowledge; and ensuring intercultural health services that respect women's autonomy to decide how, where, and with whom to give birth. Hereinafter, we will refer to it as the National Agenda.

21 Sebastiana Vázquez Gómez, interviewed by Graciela Freyermuth, June 24, 2025.

22 Apolonia Plácido Valerio, interviewed by Graciela Freyermuth and Hilda Argüello, June 18, 2025.

23 CAMATI Mujeres Construyendo desde Abajo A.C. is a civil society organization in Chiapas formally established in 2016. It is composed mainly of traditional midwives, most of whom are Indigenous and rural; among its members and founders is the spokesperson for the Nich Ixim Movement of Traditional Midwives.

24 Ofelia Pérez Ruiz, interviewed by Graciela Freyermuth and Hilda Argüello, July 1, 2025.

25 The General Directorate of Health Planning and Development is the Mexican federal agency responsible for designing, developing, and implementing care models and policies for the National Health System.

Bibliography

Agenda Nacional para la Defensa y Promoción de la Partería Tradicional. 2022. "Pronunciamiento de la Agenda Nacional para la Defensa y Promoción de la Partería Tradicional". Facebook, 25 November. https://www.facebook.com/share/1BjJ752D4z/.

Agenda Nacional para la Defensa y Promoción de la Partería Tradicional. 2023. "Pronunciamiento de la Agenda Nacional para la Defensa y Promoción de la Partería Tradicional". 10 February. https://anpmi.com.mx/wp-content/uploads/2023/02/pronunciamiento-febrero-2023_Agenda-Nacional-1.pdf.

Aguirre Osuna, Lizzeth. 2024. "El derecho humano al turismo accesible y la NMX-R-050-SCFI-2006: accesibilidad de las personas con discapacidad". *Ciencia Jurídica* 13 (25): 90–111. https://doi.org/10.15174/cj.v13i25.483.

Arana, Valentina. 2022. "Las parteras, una resistencia que encuentra su camino... Vuelven a soplar los vientos, las abuelas nos dijeron que siguiéramos viendo el faro de luz". Facebook, Nakupenda Terra, 24 September. https://www.facebook.com/NakupendaTerra.

CNEGySR. 2022a. *Entornos habilitantes para una experiencia positiva durante la atención integral de la salud materna y perinatal. Lineamiento técnico para la implementación y operación de salas de labor-parto-recuperación en las redes de servicios*. Ciudad de México: Secretaría de Salud / Centro Nacional de Equidad de Género y Salud Reproductiva . https://www.gob.mx/cms/uploads/attachment/file/757963/LINEAMIENTO_SALA_LPR_7-9-2022.pdf

CNEGySR. 2022b. *Lineamiento técnico para la atención del aborto seguro en México. Edición 2022*. Ciudad de México: Secretaría de Salud, Centro Nacional de Equidad de Género y Salud Reproductiva, Instituto Mexicano del Seguro Social e Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado. https://www.gob.mx/cms/uploads/attachment/file/779301/V2-FINAL_Interactivo_22NOV_22-Lineamiento_te_cnico_aborto.pdf.

CONAMER. 2024. *Sistema de Mejora Regulatoria. Proyecto de Norma Oficial Mexicana PROY-NOM-020-SSA-2024*. Comisión Nacional de Mejora Regulatoria. 20 August. https://www.conamer.gob.mx.

Coronado Saldierna, Mari Cruz. 2015. "Escuela de Partería Profesional del Estado de Guerrero". En *25 años de buenas prácticas para disminuir la mortalidad materna en México. Experiencias de organizaciones de la sociedad civil y la academia*, coordinado por Graciela Freyermuth Enciso, 216–219. Ciudad de México: Observatorio de Mortalidad Materna en México / Centro de Investigaciones y Estudios Superiores en Antropología Social.

Durán, Regina, Edalith Asmitia, Juan Rivera, Simón Barquera, and Lizbeth Tolentino-Mayo. 2022. "Effect of Stakeholders' Perspectives on the Front-of-Pack Labeling Regulation in Mexico". Preprint. *Research Square*. https://doi.org/10.21203/rs.3.rs-1527580/v1.

Flores-Ríos, Brenda L., María A. Astorga Vargas, Oscar M. Rodríguez Elías, Jorge E. Ibarra Esquer and María del Carmen Andrade. 2014. "Interpretación de las normas mexicanas para la implantación de procesos de software". *Revista Facultad de Ingeniería Universidad de Antioquia* 71: 85–100. https://doi.org/10.17533/udea.redin.15869.

Freyermuth Enciso, Graciela. 2012. "Capítulo II. Programa de atención materna y perinatal (Arranque Parejo en la vida)". *En Monitoreo de la atención a las mujeres en servicios públicos del Sector Salud*, coordinado por Gabriela Freyermuth Enciso, 51-119. Ciudad de México: INMUJERES / Centro de Investigaciones y Estudios Superiores en Antropología Social, Unidad Sureste.

Freyermuth Enciso, Graciela. 2024. "El devenir de las parteras tradicionales en México desde el siglo XX". En *Medicinas indígenas y afromexicanas. Una aproximación diagnóstica*, coordinado por Roberto Campos Navarro, Carolina Sánchez García y José Antonio Tascón Mendoza, 373–404. Ciudad de México: Universidad Nacional Autónoma de México / Instituto Nacional de los Pueblos Indígenas.

Freyermuth Enciso, Graciela. (Coord.) 2024. *Panorama de la salud de los pueblos indígenas en los albores del siglo XXI: Rezagos y desafíos*. Ciudad de México: Centro de Investigaciones y Estudios Superiores en Antropología Social.

Freyermuth Enciso, Graciela and Hilda Eugenia Argüello Avendaño. 2015. "Viejos y nuevos rumbos de la partería profesional en México". En G. Sánchez Ramírez (ed.), *Imagen instantánea de la partería*, editado por Georgina Sánchez Ramírez, 21–46. San Cristóbal de Las Casas: El Colegio de la Frontera Sur / MacArthur Foundation / Asociación Mexicana de Partería.

Freyermuth Enciso, Graciela and Esther Vázquez Peñate. 2025a. *Base de datos de actores y organizaciones a lo que se les respondió por la consulta pública del PROY-NOM-020-SSA-2024*. Base de datos derivada del DOF, 4 de marzo de 2025, no publicada. Ciudad de México: Observatorio de Mortalidad Materna en México / Centro de Investigaciones y Estudios Superiores en Antropología Social.

Freyermuth Enciso, Graciela and Esther Vázquez Peñate. 2025b. *Base de datos de argumentos y propuestas presentados en la consulta pública del PROY-NOM-020-SSA-2024*. Base de datos derivada de comentarios de la consulta pública oficial, no publicada. Ciudad de México: Observatorio de Mortalidad Materna en México / Centro de Investigaciones y Estudios Superiores en Antropología Social.

Freyermuth Enciso, Graciela and Esther Vázquez Peñate. 2025c. *Base de datos de actores y organizaciones vinculados al debate y los comentarios sobre la partería en México*. Base de datos no publicada. Ciudad de México: Observatorio de Mortalidad Materna en México / Centro de Investigaciones y Estudios Superiores en Antropología Social.

Freyermuth Enciso, Graciela and Fabiola Hernández López. 2025. *Controversias públicas en torno a la NOM-020-SSA sobre partería en México: base de datos de publicaciones y debates en redes sociales y sitios web (2022–2025)*. Data set. Zenodo. https://doi.org/10.5281/zenodo.18892719.

Freyermuth Enciso, Graciela and Sebastiana Vázquez Gómez. En prensa. *Floreciendo desde las raíces: la travesía de una líder tseltal hacia el empoderamiento y su transformación*. Ciudad de México: Centro de Investigaciones y Estudios Superiores en Antropología Social.

Fundación Osa Mayor. 2022. "Regulación de la partería mexicana: ¿fortalecimiento o limitaciones?". Instagram [@ comunidad.osa], 9 September. https://www.instagram.com/p/CiTxcC7DGJ_/.

Galante Di Pace, María Cristina. 2015. "Centro de Iniciación a la Partería en Oaxaca, de la organización Nueve Lunas". En *25 años de buenas prácticas para disminuir la mortalidad materna en México. Experiencias de organizaciones de la sociedad civil y la academia*, coordinado por Graciela Freyermuth Enciso, 225–231. Ciudad de México: Observatorio de Mortalidad Materna en México / Centro de Investigaciones y Estudios Superiores en Antropología Social.

Gallegos Vargas, Aura Renata. 2022. "Las parteras, una resistencia que encuentra su camino…". Facebook, 25 September. https://www.facebook.com/share/p/19kGoV5REx/.

Gobierno de México. 1990. "Decreto por el que se aprueba el Convenio 169 sobre pueblos indígenas y tribales en países independientes". *Diario Oficial de la Federación*, 3 August. https://dof.gob.mx/nota_to_imagen_fs.php?codnota=4670079&fecha=03/08/1990&cod_diario=201211.

Gobierno de México. 1991. "Decreto Promulgatorio del Convenio 169 sobre Pueblos Indígenas y Tribales en Países Independientes". *Diario Oficial de la Federación*, 4 January. https://transparencia.info.jalisco.gob.mx/sites/default/files/Convenio%20sobre%20pueblos%20ind%C3%ADgenas%20y%20tribales%20en%20Pa%C3%ADses%20Independientes%2024%20enero%201991.pdf.

Gobierno de México. 2009. "Decreto por el que se reforma el artículo 13 de la Ley Federal sobre Metrología y Normalización". *Diario Oficial de la Federación*, 30 April. https://www.diputados.gob.mx/LeyesBiblio/abro/lfmn/LFMN_ref05_30abr09.pdf.

Gobierno de México. 2020. "Decreto por el que se expide la Ley de Infraestructura de la Calidad y se abroga la Ley Federal sobre Metrología y Normalización". *Diario Oficial de la Federación*, 1 July. https://www.dof.gob.mx/nota_detalle.php?codigo=5596009&fecha=01/07/2020#gsc.tab=0.

Gobierno de México. 2024a. "Proyecto de Norma Oficial Mexicana PROY-NOM-020-SSA-2024". *Diario Oficial de la Federación*, 20 August. https://www.dof.gob.mx/nota_detalle_popup.php?codigo=5733911.

Gobierno de México. 2024b. "Decreto por el que se reforman y adicionan diversas disposiciones de la Constitución Política de los Estados Unidos Mexicanos, en materia de pueblos y comunidades indígenas y afromexicanas". *Diario Oficial de la Federación*, 30 de septiembre. https://www.dof.gob.mx/nota_detalle.php?codigo=5739986&fecha=30/09/2024#gsc.tab=0.

Gobierno de México. 2025a. "Respuesta a los comentarios recibidos respecto del PROY-NOM-020-SSA-2024". *Diario Oficial de la Federación*, 17 de febrero. https://www.dof.gob.mx/nota_detalle.php?codigo=5749340&fecha=17/02/2025.

Gobierno de México. 2025b. "Norma Oficial Mexicana NOM-020-SSA-2025". *Diario Oficial de la Federación*, 4 de marzo. https://www.dof.gob.mx/normasOficiales/9491/salud/salud.html.

Goodman, Nadine and María Eugenia Torres. 2015. "CASA: escuela de partería profesional". En *25 años de buenas prácticas para disminuir la mortalidad materna en México. Experiencias de organizaciones de la sociedad civil y la academia*, coordinado por Graciela Freyermuth Enciso, 210–215. Ciudad de México: Observatorio de Mortalidad Materna en México / Centro de Investigaciones y Estudios Superiores en Antropología Social.

Hernández Castillo, Rosalva Aída. 2020. *Casas de la Mujer Indígena: recorte a proyectos que salvan vidas*. La dekonstrucción.

INEGI. 2024. *Estadísticas de natalidad: nacimientos registrados, cubos dinámicos de consulta*. Interactive database, Instituto Nacional de Estadística y Geografía. https://www.inegi.org.mx/sistemas/olap/proyectos/bd/continuas/natalidad/nacimientos.asp.

INPI. 2024. *Padrones de apoyo a Casas de la Mujer Indígena y Afromexicana, primer trimestre de 2024*. Ciudad de México: Instituto Nacional de los Pueblos Indígenas.

Latour, Bruno. 2008. *Reensamblar lo social: Una introducción a la teoría del actor-red*. Buenos Aires: Manantial.

MacArthur Foundation. 2011. *Diagnóstico situacional de la partería profesional y la atención del parto en México. Ciudad de Méxic*o: MacArthur Foundation.

Mayagoitia, Ruth E., E. Rivera y A. Olivares. 1994. "Establishing of access standards for people with disabilities". Presentation at the Conference of the Engineering in Medicine and Biology Society, 1994. Engineering Advances: New Opportunities for Biomedical Engineers. Proceedings of the 16th Annual International Conference of the IEEE.

Presidencia de la República. 2022. "Versión estenográfica de la conferencia de prensa matutina del presidente Andrés Manuel López Obrador". 6 de septiembre. https://lopezobrador.org.mx/2022/09/06/version-estenografica-de-la-conferencia-de-prensa-matutina-del-presidente-andres-manuel-lopez-obrador-808/.

Rosenthal Sievers, Ondine. 2015. "Mujeres Aliadas, A. C.". En *25 años de buenas prácticas para disminuir la mortalidad materna en México. Experiencias de organizaciones de la sociedad civil y la academi*a, coordinado por Graciela Freyermuth Enciso, 220–224. Ciudad de México: Observatorio de Mortalidad Materna en México / Centro de Investigaciones y Estudios Superiores en Antropología Social.

Secretaría de Salud. 2024. *Subsistema de Información sobre Nacimientos (SINAC). Sistema Nacional de Información en Salud (SINAIS*). Base de datos. Ciudad de México: Gobierno de México. https://www.gob.mx/salud/documentos/subsistema-de-informacion-sobre-nacimientos-sinac.

Secretaría de Salud and CNEGySR. 2024. "Minuta de instalación del Grupo de Trabajo para la elaboración del Anteproyecto de Norma Oficial Mexicana para establecimientos de salud y para la práctica de la partería en la atención integral materna y neonatal". Documento institucional no publicado. Ciudad de México: Dirección General del Centro Nacional de Equidad de Género y Salud Reproductiva, 6 de marzo.

Sesia Arcozzi Masino, Paola María and Lina Rosa Berrio Palomo. 2023. *Situación actual de la partería indígena en seis estados de México: Informe ejecutivo 2021–2022*. Oaxaca: Centro de Investigaciones y Estudios Superiores en Antropología Social Pacífico Sur, Unidad Pacífico Sur.

Tagle Martínez, Martha A. 2019. *Iniciativa que adiciona el artículo 64 de la Ley General de Salud, a cargo de la diputada Martha Angélica Tagle Martínez, del grupo parlamentario de Movimiento Ciudadano*. Ciudad de México: Cámara de Diputados, 12 December. https://sil.gobernacion.gob.mx/Archivos/Documentos/2019/12/asun_3983702_20191212_1576180705.pdf.

Toulmin, Stephen E. (2003). *Los usos de la argumentación*. Traducido por María Morrás y Victoria Pineda. Barcelona: Ediciones Península.

UNFPA. 2011. *El estado de las parteras en el mundo 2011. Cuidar la salud, salvar vidas*. New York: United Nations Population Fund. https://www.unfpa.org/sites/default/files/pub-pdf/es_SoWMy_Full_1.pdf.

UNFPA. 2012. "*Ofrecer esperanza y salvar vidas: Inversiones en partería". United Nations Population Fund. Hoja informativa*. https://www.unfpa.org/sites/default/files/resource-pdf/SP-SRH%20fact%20sheet-Midwifery.pdf.

Vega Gutiérrez, Verónica. 2020. *Casas de la Mujer Indígena o Afromexicana (CAMIs) en la Península de Yucatán*. Mérida: Escuela Nacional de Estudios Superiores, Unidad Mérida, Universidad Nacional Autónoma de México.

World Health Organization. 1955. "Comité de expertos para la formación profesional de parteras: primer informe". *Organización Mundial de la Salud. Serie de Informes Técnicos 93*. https://iris.who.int/server/api/core/bitstreams/0e908f21-bf35-410f-a7b5-8933246ec681/content.

World Health Organization. 1966. "La partera en la asistencia a la madre: informe de un Comité de Expertos de la OMS". *Organización Mundial de la Salud. Serie de Informes Técnicos* 331. https://iris.who.int/bitstream/handle/10665/38421/WHO_TRS_331.pdf?sequence=1.

Zetina Cardona, Carlos Santiago. (2022). *Un análisis crítico de los principales instrumentos de regulación ambiental en México. Masters' thesis. Ciudad de México*: UAM-Azcapotzalco. https://doi.org/10.24275/uama.8819.8827.

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