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Report to the
Association for Voluntary Surgical Contraception

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REVIEW OF AND NEEDS ASSESSMENT OF
THE
VOLUNTARY STERILIZATION PROGRAMS IN MEXICO

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Section 1

EXECUTIVE SUMMARY AND RECOMMENDATIONS

From April 20, 1986 through May 7, 1986 a team of Dr. Gustavo Argueta, William Bair, Fernando Gomez and Dr. Filiberto Hernandez conducted an impact review and needs assessment of the Association for Voluntary Surgical Contraception (AVSC) program in Mexico. Program documents and Mexican publications were reviewed, interviews were conducted with leaders of Mexican health and population institutions and other international agencies and project sites were visited in Mexico City, Irapuato, Queretaro, Juarez, Monterrey and Tijuana.

Since 1977 AVSC has provided approximately \$5.6 million support to Mexican institutions, 55 per cent in the public sector, 40 per cent to private organizations and 4 per cent to universities. The bulk of this assistance was in the early stages of program development. It consisted largely of equipment, remodelling of surgical facilities and training to support public sector health institutions as they initiated an impressive family planning program including voluntary surgical contraception (VSC). Recently, AVSC assistance has shifted to include a greater emphasis on support for the private sector. Mixed results to date were due in part to AVSC management limitations.

There has been a rapid increase in demand for VSC in Mexico with numbers using this method increasing from 160,000 in 1976 (9 per cent of the contraceptors) to an estimated 2,000,000 in 1985 (or more than 28 per cent of the contraceptors). Most of this increase has been in female methods with vasectomy remaining at less than 1 per cent of all contraception. Of these numbers, those directly attributed to AVSC through reports from projects receiving financial support for service delivery are relatively small in relation to the total (about 30,000). However, there is no doubt that the training, equipment, and facilities provided by AVSC made and continue to make a significant contribution to the overall progress of the Mexican institutions which are providing the bulk of the VSC service.

Review of surgical procedures found that VSC is indeed voluntary and that in general the surgical procedures, while varied in technique, are good to excellent. However, improvement in efficiency and patient convenience and safety could be accomplished by standardizing throughout the system the most positive elements seen in several locations; i.e., outpatient surgery for interval procedures, emphasis on post partum VSC, use of local anesthesia, use of mini-laparotomy for the majority of cases reserving the laparoscope with silastic band for use in the major centers and teaching institutions, careful pre-operative patient evaluation and operative and post operative monitoring and client-screening and counseling to assure voluntarism.

It is concluded that a requirement for continued assistance remains. Despite considerable increase in contraceptive prevalence from 30 per cent of the married women of fertile age (MWFA) in 1976 to 48 per cent in 1982, the growth rate remains high at around 2 percent. The numbers of women in

fertile age will continue to grow for more than a decade in this country of 80 million inhabitants, regardless of reductions in fertility. Major segments of the population (rural, urban marginal and men) are as yet poorly attended.

It is recommended that priority for AVSC assistance be given to the following strategic objectives:

- a. Improving the quality and efficiency of VSC services.
- b. Assuring effective attention to voluntarism.
- c. Extending services to uncovered populations (rural and urban marginal and men) through a balanced public and private sector program.
- d. Emphasizing institutionalization and self-sufficiency.
- e. Improving AVSC management and coordination with other agencies.

Support is recommended for a variety of activities including the following:

- a. Emphasis on quality improvement and voluntarism through technical assistance, seminars and professional and client information publications.
- b. Assistance to meet the needs of under served populations through:
 1. Financial support for service delivery, equipment and expendable supplies for the organized private sector for work in their own clinic systems, in collaboration with the public sector or in work with private doctors.
 2. Selected support to the public sector for equipment, training and expendable supplies (if required) to extend services to rural and urban marginal populations.
 3. Specialized private and public sector vasectomy clinics.
- c. Improved management through consolidation of projects in the FEMAP system, establishment of AVSC representation in Mexico and coordination with other international agencies.

A time-phased strategy of action is recommended focusing on consolidation of projects, implementation and improved management in 1986 with further expansion beginning in 1987.

A program is recommended that will require additional AVSC support of the order of magnitude of \$300,000 in 1986, \$900,000 in 1987 and about \$2,300,000 in 1988 through 1990.

It is recommended that the bulk of AVSC support should go to four major institutions with some priority given to the greater needs of the private sector. The Mexican Federation of Private Family Planning Associations (FEMAP), the International Planned Parenthood Federation affiliate (MEXFAM), the Mexican Ministry of Health (SSA) and the Mexican Social Security Institute (IMSS) would receive the majority of the funds. A focussed project portfolio should be maintained with flexibility for involvement of other institutions if they bring a unique contribution in service delivery, especially to underserved populations.

Section 2

SCOPE OF WORK

As apparent from the scope of work prepared by AVSC (Appendix B), the emphasis of this work was shifted from a concern for evaluation to a much stronger emphasis on needs assessment and strategy recommendations. As the team read Victor Jaramillo's excellent report¹, which went beyond financial management considerations, it seemed even more realistic to focus on the needs assessment/strategy concerns. Additionally, it would be difficult to disaggregate with any precision the impact of the early role of AVSC from that of many others in achieving the remarkable progress to date in the spread of voluntary surgical contraception in Mexico. However, there was the unfortunate appearance that the present project portfolio, while having reasonable potential, is, with a few exceptions, making only a marginal impact on surgical contraception in Mexico. This is due in part to delays and inadequate follow-up. Apparently the AVSC management approach did not change to meet the requirements of a shift to a group of smaller projects largely in the private sector. Thus, the needs assessment component took on more significance.

1 Draft Informe General de la Visita Practicada por Victor M. Jaramillo a la AVSC en Nueva York y a las Entidades Mexicanas Seleccionadas que reciben apoyo de la AVSC. Bogota, Marzo 29, 1986.

Section 3

COMPOSITION OF TEAM AND METHODOLOGY

The needs assessment team was composed of the following members:

- a. Gustavo Argueta MD (medical consultant, previous Director, Asociacion Demografica Salvadorena, with 10 years experience in family planning).
- b. William Bair MS (private consultant, retired from twenty years of A.I.D. service in Latin America and Africa) - Team Leader
- c. Fernando Gomez MS (AVSC Regional Director with 15 years experience in population programs with A.I.D., the Population Council and AVSC).
- d. Filiberto Hernandez MD, MPA (Mexican physician recently appointed AVSC Mexico Program Advisor).

The team convened in Mexico City on April 21 after individual briefings of several team members in AVSC, New York. Based on review of very informative recent AVSC trip reports to Mexico, the Jaramillo report and the previous experience of three of the team members in Mexico, some modification was made to the approach suggested by AVSC. The schedule was changed to allow more time to visit institutions not presently supported by AVSC and to reduce visits to small projects already reviewed by Jaramillo. The schedule was also modified by the May 1 and May 5 public holidays which limited contact with Mexican authorities. Tentative propositions were suggested as future alternatives to be explored in the review; brief objectives for interviews were identified and a guide for review of ongoing AVSC projects was developed (see Appendix C). Medical surveillance used the standard AVSC format as a guide. Interviews with institutions such as USAID, IMSS, DIPLAF, CONAPO, MEXFAM, Pathfinder, Population Council, were largely directed toward the level of support for and use of VSC in Mexico, their assessment of AVSC role in the past and their opinion on ways to extend and improve VSC services in the future. Review of ongoing projects was to confirm impressions of impact, identify problem areas, especially in the medical field, and to review future needs. Of particular interest was review of the tentative conclusion of FEMAP and AVSC to consolidate all the projects of FEMAP affiliates into one project with FEMAP.

Documents reviewed included:

- AVSC project proposals for ongoing activities (only limited implementation documentation was available).
- Informe Estadistico 1985 - IMSS.
- Informe de las Intervenciones Quirurgicas de Planificacion Familiar. Enero--Junio 1985 - SSA.

- Analisis de las Actividades del Programa de Planificacion Familiar (SSA). Enero-Junio 1985 - DIPLAF.
- Datos Estadisticos. Programa de Planificacion Familiar. Mexico 1986 - DIPLAF.
- Plan Maestro. December 1985. FEMAP.
- Unpublished Charts and Graphs. April 1986. FEMAP.
- Proyecciones Demograficas 1980-2010. Nuevo Leon. FEMAP.
- Programa de Actividades 1986. MEXFAM.
- INOPAL Program - March 1986 Proposal and Project Status - Population Council.
- Draft: Informe General de la Visita Practicada por Victor M. Jaramillo a la AVSC en Nueva York y a las Entidades Mexicanas Seleccionadas que Reciben Apoyo de la AVSC. Bogota, Marzo 29, 1986.
- Draft Appendix Q1 and Q4 of FPIA programs in Brazil, Peru and Mexico. Summary, Conclusions and Recommendations and Mexico trip report (FEMAP). William Bair, November 1985
- Programa Nacional de Salud 1984-1988. Poder Ejecutivo Federal. Sintesis - Ejecutiva.
- Estudio de Costo-Beneficio. IMSS. 1985.

Section 4

BACKGROUND

With the 1974 General Law of Population and the 1984 General Law of Health providing the legal bases for family planning, Mexico is the country in Latin America with the strongest population policy and the most well organized public sector programs of family planning. Public sector programs are complemented by an active and growing participation of the private sector. Together these provide the information and service delivery foundation for an impressive program to reduce fertility and improve maternal and child health. Nevertheless, Mexico started late in its efforts at fertility control. The program faces the enormous challenge of a large population (80 million) with substantial numbers of women of fertile age (19 million), a number that will continue to grow for more than a decade, regardless of reductions in fertility.

The birth rate has been reduced remarkably from 40/1000 in 1976 to less than 30/1000 today. However, with a death rate of 7.5/1000, Mexico's present growth rate of 2% or more continues to present major problems for reproductive health, family welfare and socio-economic development.

Receptivity to family planning is good, with the percentage of fertile age women in union using contraception (based on survey data) increasing from 30.2 per cent in 1976 to 47.7 per cent in 1982. Presumably, the percentage is significantly higher in 1986; the results of a new contraceptive prevalence survey to be carried out in 1986 will provide up to date information.

Demand for female sterilization has grown in this same period. It made up 8.9 per cent (approx. 160,000) of the total contraceptive users (approx. 1.8 million) in 1976. By 1982 this percentage had grown to 28.1 per cent (approx. 1.5 million) of the 5.5 million contraceptive users. This demand is apparently increasing as IMSS and SSA report more requests than they can service and with increasing waiting periods. Where private sector programs are well organized, they also are experiencing growing demand.

The picture for growth in demand for vasectomy is not so clear. This remained at a constant 0.6 to 0.7 per cent of the total contraceptive protection from 1976 to 1982. Recently, there has been increased interest in this method but with little growth in numbers, except in major urban centers. In Juarez, FEMAP reports a ratio of 1 vasectomy for 10 tubal ligations. In the IMSS program, vasectomy is reported to be 0.4 per cent of the contraceptors nationwide, but is 1.1 per cent of the contraceptors in the Valle de Mexico (area around Mexico City). Vasectomies were reported to be 1.4% of VSC in the SSA programs in 1985.

Government family planning (F.P.) statistics are based on reports from public and private sector health and family planning service providers and from the Mexican Fertility Survey (1976), the National Contraceptive

Prevalence Survey (1979) and the National Demographic Survey (1982). There is some possibility of double counting in the private sector programs in collaboration with the public sector; surveys will help to sort this out. Reports from different sources are reasonably but not completely consistent. The preponderance of services were provided in the public sector in 1982 by IMSS. However, pharmacies, private doctors and organized family planning programs in the private sector provided a significant level of F.P. (see Table I)

Table I. Distribution of Family Planning Users by Public and Private Sector, 1982

A. <u>Public Sector</u>	<u>53.4%</u>
IMSS	32.3
ISSSTE	4.9
SSA	14.5
Others	1.7
B. <u>Private Sector</u>	<u>46.6%</u>
Pharmacies	31.4
Doctors' office, clinics, hospitals (including FEMAP and MEXFAM 7%)	14.2
Others	1.0
<u>TOTAL</u>	<u>100%</u>

Source: DIPLAF

The survey data in 1982 indicated that by far the largest provider of VSC service up to that point had been IMSS at 52%. However the contribution of the private sector was substantial at 27 per cent. Presumably this was mostly private physicians, since organized programs of VSC were small. (see Table II).

Table II. Distribution of Users of VSC in 1982
According to Source of Service

<u>Institution</u>	<u>Number</u>	<u>Percent</u>
<u>A. Public Sector</u>	<u>1,051,000</u>	<u>73%</u>
IMSS	752,000	52.0
IMSSSTE	117,000	8.0
SSA	139,000	10.0
Other	43,000	3.0
<u>B. Private Sector</u>	<u>391,000</u>	<u>27%</u>
Organized Programs	20,000*	1.5
Private Physicians and Hospitals	371,000*	25.5
<u>TOTAL</u>	<u>1,442,000**</u>	<u>100.0%</u>

* Proportions estimated

** Represents approximately 14% of MWFA

Source: DIPLAF

Using service statistics reports from various institutions, extrapolating from the 1982 report and making some allowance for loss to the 1985 fertile age group of a portion of 1982 VSC users, an estimate was made of the level of VSC in 1985. Approximately 300,000 VSC procedures may have been performed in 1985 bringing the level of VSC users to close to 2,000,000 or approximately 17% of the married women of fertile age (MWFA). (see Table III)

Table III. Estimated VSC Procedures Performed in 1985

<u>Institution</u>	<u>% of Total VSC's</u>	<u>Number of VSC's</u>	<u>Comments</u>
IMSS	54%	166,000	Reported
SSA	8%	23,000	2 x first 6 months report (may be low)
ISSSTE	8%	23,000	Estimated from past % relation to IMSS
FEMAP/MEXFAM	2%	5,000	Reported
Other private	28%	85,000	Estimated from past % relation to IMSS
TOTAL	100%	302,000	

Source: Institutional reports and estimates

It is reasonable to expect that some time in the near future the percentage of the MWFA who wish VSC will reach 25%. If this were to occur by 1990, for example, nearly 3.5 million of the approximately 14 million MWFA at that time would be sterilized. This would require an additional 2.3 million sterilizations or 460,000 per year, an increase of 158,000 over present levels. One might expect some shift in organizations providing service. IMSS is a closed system and may not remain as high as 54 per cent¹. This may also be true of the well-to-do clientele of the private physicians. (see Table IV)

¹ If the IMSS/Coplamar program goes back to IMSS from SSA this shift may not occur.

Table IV. Possible Levels of VSC Procedures 1990

<u>Institution</u>	<u>% of service 1985</u>	<u>Annual service 1985</u>	<u>% of service 1990</u>	<u>Annual Increase over 1985</u>	<u>Annual 1990</u>
IMSS	54%	166,000	50%	79,000	245,000
ISSSTE	8%	23,000	8%	13,000	36,000
SSA	8%	23,000	12%	19,000	42,000
Private physicians	28%	85,000	24%	38,000	123,000
Organized private programs	2%	5,000	6%	9,000	14,000
TOTALS	100%	302,000	100%	158,000	460,000

Source: Assumptions and estimates of AVSC evaluation team

Section 5

PROVIDERS OF FAMILY PLANNING INFORMATION AND SERVICES

There are a number of institutions both in the public and private sectors which are dedicated to family planning or which include family planning as a priority concern in their health or social programs. The following is not an exhaustive list, but those considered most relevant to VSC at this time. (see Appendices E, F, and G for more detail.)

Private Sector

A. FEMAP

FEMAP (the Mexican Federation of Private Family Planning Associations) is a private sector organization which affiliates 23 associations in 34 cities of the Mexican Republic located in 15 states. All but one of these affiliates, which focuses on adolescent programs, have a community based contraceptive distribution program providing family planning and maternal child health information and service. Eleven affiliates have a clinic or cooperate with the public health authorities in the provision of VSC services. FEMAP expects to have 37 affiliates in 22 states in 1988. FEMAP receives international support at the level of about \$1.8 million per year from FPIA, AVSC, Pathfinder, Population Council and others. Locally generated resources total about \$400,000 and the value of volunteer time is estimated at \$8.6 million. In 1985 FEMAP reported 162,002 family planning users, of which 3,900 females and 300 males received VSC service in 1985.

FEMAP has an Executive Secretariat in Juarez with a professional staff of 17 which provides administrative support and technical assistance to its affiliates.

FEMAP's unique contribution is its involvement of influential private sector leadership, its person to person communication and volunteer involvement at the community level, its integration of an all-method family planning program into a concern for maternal and child health and its growing capability to coordinate with the public sector. Flexibility and willingness to experiment with new methodology enables FEMAP to make a significant contribution in developing and providing training in more efficient and higher quality surgical and client management techniques.

B. MEXFAM

MEXFAM (a private sector organization which is an affiliate of IPPF) was the major provider of family planning in Mexico before the Mexican government began to take positive action in service delivery. Since that time, when it had more than 100 clinics throughout Mexico, MEXFAM has reduced its direct service provision to about 20 locations in 15 states. It now identifies its role as complementary to public services, providing services to uncovered populations, especially low income groups, men and

adolescents. Another objective is to assist the public sector through technical assistance, training, supplementary equipment and materials and information and education.

MEXFAM sees itself as an innovator, demonstrator and an organization seeking to improve quality standards and efficiency. MEXFAM places considerable emphasis on selecting those states with continuing high birth rates and weak family planning services or rapidly growing urban areas for its work. They have identified 10 states for priority attention, three large metropolitan areas and 13 cities of over 200,000 with a growth rate exceeding 5 per cent.

MEXFAM supports projects with community based distribution, volunteers, "people's doctors" and family planning clinics. While some projects are carried out independently by MEXFAM, most are done in collaboration with other organizations such as DIF, SSA or educational institutions. In 1985 MEXFAM reported 3,490 female sterilizations and 60 male, essentially all through a system of confirmed referral to other (largely public sector) institutions.

C. PROFAM

The PROFAM Group has both profit and non-profit private sector corporations housed in its headquarters in Queretaro, Queretaro. The production corporation at present produces vaginal contraceptive suppositories and condoms and is considering the production of oral rehydration salts. The sales corporation has representatives in 22 locations in Mexico covering the whole territory with about 45% of the commercial condom market (not especially large at 6 million/year).

PROFAM has been engaged in promotional activities for vasectomy with AVSC assistance supporting the publication of a Supermacho comic book on vasectomy. With help from a British foundation they carried out a small vasectomy project with private doctors in Leon. PROFAM is seeking support for a special vasectomy clinic in the area of Mexico City.

D. PRIVATE CLINICS AND PHYSICIANS

The private sector, according to the National Council of Hospitals, has one thousand private hospitals, representing approximately 20% of all hospital institutions of the country. There are an estimated 40,000 physicians in private practice, 68% of whom are general practitioners and 32% specialists.

PUBLIC SECTOR

A. SECRETARIA DE SALUD (SSA)

The SSA is the part of the federal government responsible for the provision of health services to the poor, both urban and rural.

Family planning, including VSC, is one of the services provided by the SSA. Norms and plans for the programs are established at the national level by the General Direction of Family Planning (DIPLAF), a part of the under-secretary for health services. Funds are handled by DIPLAF. The programs are executed at the state level by the State Secretaries of Health (one for each state and one for Mexico City).

The SSA provides health services including Family Planning in 4057 facilities; 1366 in urban areas, and 2691 in rural areas. VSC services could be delivered in approximately 900 facilities throughout the country, if the SSA had the equipment and the trained personnel available. Limiting factors in the effectiveness of SSA are that there is not the strong program of in-service training for professionals nor the level of salaries that is found in the Social Security Institute (IMSS).

The budget allocated to SSA by the federal government for the provision of family planning for 1986 is \$4,126.2 million pesos (\$8.25 million dollars).

At the end of June 1985, the health system had the following numbers of current users by method: VSC 191,725 (30.9%); IUD, 150,857 (24.4%); orals 224,279 (36.3%); others 52,619 (8.4%). The pill is the first method, and VSC the second. It is expected that in the near future VSC will become the first method within the methods provided by the SSA.

During 1984, the facilities of SSA reported 33,227 female and 522 male procedures. The average age of the women requesting VSC was 32 years, and had an average of 5.4 living children. Sixty two per cent of these cases were performed during the 72 hours after a delivery. The reported cases cover the entire country, and were performed mainly in urban hospitals, but also included people from the rural areas.

The program is voluntary, and people receive information via messages in the media, from community workers, or in the health facilities. Each client has to sign an informed consent form.

The Mexican government has given a lot of emphasis to its population policy, and has assigned to the family planning programs a high level within the structure of the Health Secretariat. It has been given a General Direction of Family Planning with budget, staff, and programmatic independence.

B. INSTITUTO MEXICANO DEL SEGURO SOCIAL (IMSS)

The Mexican Institute of Social Security is a semiautonomous public organization responsible for the provision of health and retirement benefits to employees of the private sector. It is financed with contributions by employees, employers and government.

The health services provided by IMSS constitutes the largest health network in Mexico, and it is responsible for almost 30%* of the population of the country. It has a national coverage, and services are provided in its own facilities by its own medical personnel.

Administratively, the IMSS has a national general direction, and a national subdirector for medical affairs. It is composed of thirty two delegations, one for each state and the city of Mexico.

Family planning programs are under the supervision of the head of the family planning services, a part of the medical services. In each delegation there is a family planning coordinator. Family planning enjoys a high status within the IMSS structure. Its budget in 1984 was \$5,871 million pesos (31.9 million dollars**), or one percent of the total IMSS health budget).

The IMSS is the largest provider of family planning in Mexico. In 1985 the IMSS affiliates were 5,349,876. Of these, 2,123,679 (39.7%), were current users of contraceptive methods. IMSS also provides family planning services to the non-affiliate population. At the end of 1985, IMSS provided family planning services to 748,073 women from the open population (non-affiliate) and the rural areas. In summary, at the end of 1985, IMSS had 2,871,752 current users of contraceptives.

During 1985, a total of 1,098,858 persons were enrolled (new users) in IMSS programs. About 480,400 (43.7%), asked for the pill; 15,487 (1.4%) received injectables; 437,1643 (39.8%) received IUDs; 161,021 (14.7%) had a tubal ligation, and 4,775 (0.4%) a vasectomy.

Most of the VSC procedures were performed in hospitals located in urban areas, and 106,299 (66%) were performed postpartum. Despite these impressive figures of family planning services delivered every year, IMSS officials feel the demand is larger, and that they have had to reject or postpone many requests, particularly for VSC.

IMSS prepares its own educational material, and informs clients in several ways. VSC requestors sign an informed consent form very similar to the AVSC form.

*If IMSS/COPLAMAR is included, this could be as much as 40%

**Using an exchange rate of 184 pesos per dollar, average rate for the year

C. INSTITUTO DE SEGURIDAD Y SERVICIOS SOCIALES DE LOS TRABAJADORES DEL ESTADO. (ISSSTE)

The purpose of the institute is to provide medical and social assistance to the personnel who work for the government. In terms of family planning, ISSSTE has the following objectives: promote demand, inform, and educate the population in relation to the importance of family planning; motivate women in fertile age to use the services; train health personnel; and establish family planning services in all ISSSTE clinics in Mexico, D.F., and in each of the states. ISSSTE has not given family planning the emphasis in its organizational structure and budget that is seen in IMSS and SSA.

ISSSTE has services in the whole country, and in general health terms provides services to 8% of the total population.

D. CONSEJO NACIONAL DE POBLACION (CONAPO)

The National Council of Population consists of eight Secretaries of State. All activities are coordinated by a General Secretary.

The main activity of CONAPO is the establishment of policies and goals in population. CONAPO provides political support for the delivery of family planning services through IMSS, SSA, ISSSTE, DIF and the private sector. Other activities include IEC, delivering family planning messages through T.V. radio and publications. Due to subject sensitivity, information on VSC is not broadcast on T.V. or radio, only by CONAPO printed material.

E. SISTEMA NACIONAL PARA EL DESARROLLO INTEGRAL DE LA FAMILIA. (DIF)

DIF was created in 1977, as a decentralized public institution with the main purpose of promoting social well being in the country. This implies care to the infant population in relation to health, education, and cultural development, within the family and community context.

The activities and functions are divided into five different programs: preventive medicine and nutrition, education, social promotion, community development, and family nutrition.

DIF does not provide family planning services, but it does provide family planning information and education materials throughout the country in each one of its state facilities, and in Mexico City. DIF is chaired by the President's wife in Mexico City, and by each governor's wife in the states. This aids in developing social acceptance for family planning.

F. OTHER PUBLIC INSTITUTIONS

In Mexico City, the General Direction of Medical Services of the DDF (Department of Federal District), serves the population with no social security. It is, in some way, a duplication of services, since the SSA

also serves this population. The DDF has 25 hospitals, out of which 4 are devoted exclusively to gynecological and obstetrical care, including VSC procedures. It provides medical care to 30% of the population in Mexico City.

An estimated 1.3 million people of the total population are covered by other institutions, such as: ISSSFAM, institute of social security services for the Mexican Armed Forces; PEMEX, health services for the Mexican Oil Company; and Marina, health services for the Mexican marines.

Section 6

MEDICAL CONDITIONS AND VOLUNTARISM

For the development of this assessment of VSC in Mexico, the team tried to gather information from different sources on medical practices, volume of activities, techniques, etc. Even though at present AVSC is not supporting services directly with the IMSS and the SSA, the team requested permission to visit hospitals of these two institutions and were granted access to the surgical rooms to observe procedures. These visits gave us the opportunity to assess the condition at each institute and to compare them. The report that follows is based on published information and direct observation. In order to facilitate the presentation, the chapter has been divided into four parts, and at the end of a set of recommendations are made.

FACILITIES, EQUIPMENT AND STAFF

The surgical facilities are, generally speaking, adequate, clean, and with all the necessary equipment for the surgeries and handling of any possible complications.

The space is normally sufficient for the number of patients, and the equipment and furniture are normally kept in good condition. However, the maintenance of laparoscopy equipment is deficient. At all the places visited, there was no repair or maintenance service during the last year.

The quality of the services is good, although it can be improved in terms of training medical doctors, anesthesiologists, and other personnel involved in the provision of services.

In programs conducted at hospitals, there are problems in scheduling VSC procedures because of other surgeries. Hospitals of the IMSS and SSA have very frequently to cancel or postpone VSC procedures because the operating rooms must be used for emergency surgery. The lack of dedicated space is one of the reasons explaining the high percentage of VSC procedures performed during the early post-partum period.

COUNSELING AND VOLUNTARISM

Counseling is provided at all institutions before the surgery. Usually a social worker talks to the patient about the variety of family planning methods, as well as the advantages and disadvantages of them, including the VSC methods according to international standards. Some clinics have support material for the counseling: pamphlets, posters, diagrams, etc; others need all kinds of educational and information materials.

Once counseling is over voluntarism plays a very important role. All women who decide to undergo surgery do so without any pressure and have been told about the permanency of the procedure, the risks involved, the availability

of other temporary methods, and the fact that they can reject the surgery at any time. On a general basis the informed consent forms of the institution fulfilled AVSC requirements, although in some cases clients' signatures were missing.

There is a great need for information, education and communication activities, since most clinics and hospitals lack audiovisual materials related to the dissemination of voluntary surgical contraception.

SURGICAL TECHNIQUES

A. Health Secretariat

In general terms, the institutions visited are providing the following services: minilaparotomy, laparotomy, laparoscopy and vasectomies. Among these, the procedure most frequently performed is the post-partum minilaparotomy followed by interval laparoscopy. Laparotomies are used in the case of complications in one of the above mentioned procedures, although this rarely occurs. At this stage only a small number of vasectomies are performed.

In 1985, SSA reported that 65% of the VSC procedures performed were minilaparotomies and 16.5% laparoscopies; 16% were laparotomies and 1.4% were colpotomies. Almost three fourths of the tubal occlusions were done by tubal ligation and resection, while the second most used procedure was the application of a silastic band (Yoon Band). The third method was tubal fulguration by electrocoagulation.

For every 100 female VSC procedures just one vasectomy is performed. The most common method of vasal occlusion is the vasal division and ligation (93.1%). The others were done by ligation only.

B. Mexican Institute of Social Security

In 1985, the IMSS performed 165,021 VSC procedures in the country of which 90% were minilaparotomies and 10% were laparoscopies with silastic bands. The number of vasectomies reported by this institution in 1985 was 4,779.

C. Private Family Planning Associations

Private family planning associations funded by AVSC use minilaparotomy as the most common method (80%) and laparoscopies (20%). Tijuana, as an exception, uses laparoscopies in 90% of the cases.

Regarding the vasectomies performed by the organized private sector, the number of procedures is not significant as part of the national VSC total. However, in certain affiliates of FEMAP (e.g., Juarez), vasectomy has become an important part of the VSC services of that clinic.

In general, the team observed that post-partum minilaparotomies were done on an in-patient basis and interval laparoscopies and minilaparotomies are generally done on an out-patient basis. However, we saw and heard of locations where interval in-patient procedures are still used. Vasectomies are all performed by surgeons skilled in the particular techniques used; no major problems were observed. The average time taken for both male and female procedures is approximately 20 minutes.

Patient evaluation and monitoring was good at the locations observed. This important area of patient care should continue to receive attention throughout the system.

ANESTHESIA

The most common anesthesia technique is the epidural with xylocaine since most of the procedures are done by minilaparotomy. The local anesthesia with analgesia is used for laparoscopies and vasectomies. In general, the drugs used are xylocaine 1%-2% without epinephrine locally and a combination of valium, phentanyl, ketalar and atropine for mild systemic analgesia.

Some of the main reasons for the use of epidural anesthesia were reported as follows:

- lack of demerol in most of the hospitals due to government restrictions;
- residents in G&O are trained to use epidural anesthesia and are not exposed to the use of local anesthesia;
- surgeon preference for epidural anesthesia, which produces good muscle relaxation and consequently an easier surgery;
- anesthesiologists have a very strong preference for epidural anesthesia to justify their presence in the operating room. They maintain that local anesthesia does not require their assistance.

For female VSC procedures the most common anesthesia used by the SSA is the regional anesthesia (64.2%), followed by general anesthesia (17.8%), and local anesthesia with analgesia (17.8%).

Local anesthesia was the most common technique used for vasectomy (63%). Regional anesthesia was used in 28.5% of the cases and general anesthesia in 6.7%.

At the IMSS, 80% of all tubal ligations are performed under epidural anesthesia; local anesthesia with analgesia, general anesthesia and neuroleptanalgesia were used in the remaining 20% of the procedures. For vasectomies, local anesthesia with analgesia is the standard procedure.

Private institutions use regional anesthesia in 60% of the cases and local anesthesia with analgesia in 40% (these figures were calculated based on the number of cases at the institutions visited).

SUMMARY AND RECOMMENDATIONS

Anesthesia is one of the main future targets for AVSC involvement since it is necessary to provide more information regarding local anesthesia, its advantages, and all positive aspects. One way to do so might be through seminars with both surgeons and anesthesiologists, the distribution of more information and other types of training programs.

There is a great need for information, education and communication activities since most clinics and hospitals lack different materials related to the dissemination of voluntary surgical contraception.

Other important areas for AVSC's future action are:

- Emphasis on maintaining the use of minilaparotomy and the use of laparoscopy with silastic band in major facilities and training centers.
- Medical supervision. During the previous years there has not been an adequate follow-up of service.
- Voluntarism and counseling. It is necessary to assure voluntarism with more emphasis, as well as appropriate counseling with the help of information and education materials.
- Service extension to underserved population since most of the services are provided in urban areas.
- Vasectomy services with emphasis placed on the method as effective, safe and as a low-cost procedure.

Generally speaking, we can conclude that a great number of VSC procedures are being performed in Mexico following standard medical criteria of the country, in safe facilities and with sufficient equipment to handle any emergency situations which may arise, by trained personnel. However, based on the previous section and on the site visits, great improvements could be made regarding the quality of service.

Perhaps the best manner in which to ensure that VSC procedures are performed in accordance with the medical safety and voluntarism norms, would be by promoting the establishment of centers by the IMSS, SSA and private sector which would comply with AVSC's norms and could count on having all the necessary resources. These centers could be used for training and demonstration of the appropriate surgical techniques, local anesthesia and sedation, and client information, assessment and voluntarism.

Section 7

AVSC PROGRAMS AND THEIR IMPACT

Family planning programs in Mexico started, as in the rest of Latin America, in the mid'60s when the private family planning association affiliated to IPPF was created. Programs in the public sector were slow to start because the Mexican government had a pro-natalistic policy. In the mid-'70s, the General Law on Population reversed this policy and authorized the public sector to start providing all types of contraceptive methods. The Administration that took office in 1976 started to implement these new policies and established the services in the Secretaria de Salubridad y Asistencia (SSA), the Mexican Institute of Social Security (IMSS) and other health systems related to the public sector.

This dramatic change, and its more dramatic and quick implementation, required major efforts in training, equipment, technical assistance and building or remodelling of facilities to provide services in health centers and hospitals. AVSC helped to support this official initiative since the beginning.

The first AVSC grant to Mexico was awarded in 1975 to the Universidad de Nuevo Leon, and was followed in 1976 by other small grants to other universities. In 1977, two major programs were awarded to the public sector, one to IMSS and the other to SSA. The grant to IMSS provided only equipment, and the grant to SSA was partially for equipment and partially for renovation of dedicated space to perform VSC procedures. In the same year, AVSC sent the first laparoscopic units to both institutions. Since then, and up to 1982, AVSC's contribution to the program in the public sector was very substantial. Table V shows the budgets AVSC allocated to Mexico since 1975.

The table shows clearly that the years of major AVSC support to Mexico coincide with the initiation of the family planning programs in the public sector.

Table V. AVSC BUDGET ALLOCATION TO MEXICO BY YEAR

<u>Year</u>	<u>Budget</u>	<u>Percentage</u>
1975	\$ 17,400	0.3%
1976	35,700	0.6
1977	1,009,167	18.2
1978	206,242	3.7
1979	1,416,858	25.5
1980	402,800	7.3
1981	550,715	9.9
1982	703,281	12.7
1983	490,512	8.8
1984	524,551	9.4
1985	202,777	3.6
TOTAL	\$ 5,560,007	100.0%

Source: AVSC

The public sector has been the major recipient of AVSC support in Mexico, 54.7%; the private sector has received 41.4%, and universities 3.9%, as seen from Table VI. In the case of the public sector, 50.4% of AVSC support is represented in equipment. In IMSS, equipment represents 99.4% of AVSC support.

In the case of the SSA, the support went in part for equipment and part for the establishment of dedicated space in some health facilities around the country. All of the facilities built in the early years are still in operation, and the equipment is still being used, apart from the two facilities lost in the recent earthquake in Mexico City. See Table VI for an indication of the kinds and amounts of equipment provided.

Table VI: AVSC ALLOCATED BUDGET TO MEXICO BY SECTOR
AND TYPE OF EXPENDITURE, 1975-1985

<u>Sector</u>	<u>Equipment</u>	<u>Other</u>	<u>Total</u>	<u>Percentage</u>
Public				
SSA	\$ 551,520	\$ 1,460,946	\$ 2,012,466	36.2%
IMSS	963,970	5,700	969,670	17.4
ISSSTE	23,495	35,485	58,980	1.1
Universities	40,598	173,533	214,131	3.9
Private				
Associations	243,289	1,338,910	1,582,199	28.4
PIACT	149,286	474,608	623,894	11.2
PROFAM	--	98,667	98,667	1.8
TOTAL	\$ 1,972,158	\$ 3,587,849	\$ 5,560,007	
	35.5%	64.5%		100.0%

Source: AVSC

Section 8

PROJECT POSSIBILITIES SUGGESTED IN REVIEW WITH MEXICAN LEADERS

There are active VSC programs in Mexico which continue to require external assistance to make maximum use of their potential and extend their coverage, to improve the quality and efficiency of their surgical procedures and to ensure that clients are well informed, conveniently treated and satisfied with the service. These requirements apply both in the public and private sectors. External assistance will bear a larger portion of the cost in the private sector and will be expected to catalyze and complement government resources, particularly to achieve quality improvements and extension to uncovered populations. During interviews with leaders of Mexican institutions and visits to projects (see Appendices F & G) a variety of support requirements were suggested.

The following list is not selective or prioritized. It covers roughly five years, and is indicative only of the "possible activities" which program managers in Mexico consider within their priorities. The dollar figures were estimated by the team merely as an indication of what it might cost to carry out a particular activity. It is not an indication that such an action should be funded. Future exploration with these institutions will certainly identify other possibilities and refine costs. Section 9 of this paper will develop a strategy of selection among these and other "possibles".

A. <u>SSA/DIPLAF</u>	<u>U.S. \$</u>
1. Replace equipment damaged by earthquake at Juarez Hospital in Mexico City and others	30,000
2. Mini-lap kits for decentralized health system in 12 states	up to 150,000
3. Expendable supplies \$2/case for 100,000 increase	up to 200,000
4. Vasectomy project in 12 states	up to 120,000
5. Contracted lecturers for training programs in VSC \$5,000/year	25,000
6. Seminars on VSC, patient counseling, anesthesia, surgical procedure, medical safety 5/year x \$3,000	75,000
7. Observation travel for surgical technique, anesthesia, vasectomy 5 each in 2 years	40,000
8. Technical assistance in medical surveillance and evaluation 5 person/month	50,000

<u>A. SSA/DIPLAF (cont'd.)</u>	<u>U.S. \$</u>
9. Demonstration and training centers, e.g., Hospital Juarez in Mexico City, Hospital Civil, Guadalajara, and Metropolitan Hospital in Monterrey, Training, equipment and materials	50,000 each
10. Norplant extension - training, equipment and seminars - 3 years	100,000
11. Repair and maintenance center 5 years spare parts	200,000
<u>B. IMSS</u>	
1. Support for survey of client satisfaction	50,000
2. Mini-lap kits for weekend mobile teams	up to 100,000
3. Surgical centers to replace earthquake damage, to expand service delivery, provide training and carry out research 4 x \$20,000	80,000
4. Norplant extension - training, equipment and seminars - 3 years	20,000
<u>C. CONAPO</u>	
1. Assistance with specific radio or news or printed material in support of VSC	20,000
<u>D. MEXFAM</u>	
1. Equipment and expendable supplies to assist MEXFAM to support referrals for VSC from "peoples doctor" program and to work with State Secretariats of health to develop mobile teams Equipment - 50 VSC centers x \$1,000 Expendables - \$10/case x 20,000	250,000
2. Observation travel 5 x \$4,000	20,000
3. Equipping three hospitals for VSC delivery, demonstration and training 3 x \$20,000	60,000
4. Norplant extension	20,000
5. Seminars, training, and professional literature for private physicians	50,000

<u>E. FEMAP</u>	<u>U.S. \$</u>
1. Support for VSC service delivery \$20/case x 50,000	1,000,000
2. Administrative support for managing consolidated projects: Personnel (1 med. director; 1 Admin. Asst.; 1 Supervisor) \$2,300/month x 60 = 138,0000 Program management travel (105 trips) 80,000	220,000
3. Operating room equipment for FEMAP clinics and to assist public sector (4 operating rooms complete and 20 centers partial)	100,000
4. Training programs, seminars and professional literature for private physicians	100,000
5. IEC materials on VSC - especially vasectomy	40,000
6. Specialized vasectomy clinic	50,000
7. Norplant extension	20,000
8. Observation travel 10 x \$4,000	40,000
<u>F. PROFAM</u>	
1. Vasectomy clinic	50,000
<u>G. OTHER INSTITUTIONS</u> and other actions for all service providers. ISSSTE, DDF, (Sec. of Health), Mexico City Employees SS, other private institutions, Ob/Gyn Assoc., Universities, etc.)	
1. Equipment and training	undetermined
2. Observation travel 10 x \$4,000	40,000
3. AMIDEM Vasectomy Clinic	50,000
4. Information materials for prenatal and other patients	100,000

Section 9

SUMMARY OF PROBLEM, STRATEGIC OBJECTIVES, MEANS, TIMING, AND
MAGNITUDE OF RESOURCES

A. SUMMARY OF PROBLEM

- 1) While there has been much progress in reducing fertility in Mexico, there is still a large and growing number of couples seeking/requiring family planning information and services. Within this group there are segments requiring special additional attention for VSC, i.e.: the rural and urban marginal population and men.
- 2) VSC is increasingly popular and there is widespread receptivity to this service. However, service delivery has not grown as fast as demand, especially for the special groups mentioned in (1). Additionally, the earthquake destroyed several important VSC centers in Mexico City.
- 3) There are important public and private sector institutions providing VSC services, each with their particular advantages and disadvantages. IMSS, the strongest provider, deals with a more limited, higher economic level clientele; SSA, with less capacity and resources, deals with the lower economic, less accessible population; the organized private sector aims at the less advantaged groups with a more person to person approach, but has less resources; private physicians reach many (usually higher economic level) clients, but they are not organized in a way that assistance to them is easy. CONAPO has a wide spread communication program, but is conservative, especially toward VSC.
- 4) VSC services are voluntary and are generally provided in appropriate facilities by well trained surgeons. However, standardized use throughout the system of the best procedures seen would improve efficiency, client convenience, safety and voluntarism.
- 5) AVSC support has made an unmeasurable but undoubtedly positive impact on the impressive growth of VSC in Mexico. However, present project conditions indicate the need for additional AVSC management inputs.

B. STRATEGIC OBJECTIVES

- (1) Improve quality, efficiency and safety of VSC procedures:
 - promotion of outpatient surgery
 - promotion of local anesthesia
 - maintain present emphasis on general use of minilap and use of laparoscope with silastic band in major facilities and training centers

- establishment of systems of medical supervision
 - assure appropriate pre-operative evaluation and monitoring of patient condition during surgery and recovery
 - encourage present growth in emphasis on post-partum delivery of VSC, and in focus on high reproductive risk.
- (2) Assure full attention to voluntarism:
- client assessment and counselling
 - informed consent
- (3) Service extension to selected underserved population:
- male
 - rural and urban marginal population
- (4) Institutionalization and self-sufficiency:
- policy commitment
 - trained leadership
 - generation of income from local public or private sources
- (5) Improved AVSC management:
- increased technical assistance, supervision and evaluation
 - more focussed portfolio with fewer management units and more network relationships
 - increased coordination with other agencies

C. MEANS OF ACHIEVEMENT

- (1) Improved quality, efficiency and safety of VSC procedures.
- (a) Development and dissemination of information by technical assistance, observation travel, seminars and professional publications. AVSC producing some material, funding, some direct dissemination and participation in seminars. Status international and national medical institutions should be involved.
- All service providers will participate and develop standards.
- (b) Support of centers of excellence for comparative studies and demonstration, training and dissemination of information.
- AVSC-design and funding
- IMSS, AMIDEM, SSA, INN, FEMAP-design and implementation.
- (c) Funding of medical supervision in FEMAP, observation travel and informative seminars for public sector leaders on establishing systems of medical supervision.

- (d) Review of all projects funded by AVSC, including FEMAP and MEXFAM sub-project, to maximize potential for achieving a quality improvement, not merely numbers of procedures.
 - (e) Priority to demonstrated needs for minilap kits and assure appropriate laparoscope maintenance capability and silastic band.
 - (f) Informational material for prenatal patients explaining alternatives of post-partum contraception and concepts of high reproductive risk. AVSC-fund production (in consultation with John Hopkins PCS). All service providers use.
 - (g) Coordination with JHPIEGO and Development Associates (DA) to develop common approach to quality concerns within training programs.
 - (h) Coordination with Population Council to support VSC elements of operations research as needed and to secure Population Council support for operations research relevant to VSC.
 - (i) Coordination with Westinghouse to get earliest possible results of CPS.
- (2) Assure full attention to voluntarism:
- (a) Patient educational materials. AVSC fund development and production of materials (consult with John Hopkins PCS). All service providers use.
 - (b) Seminars and training courses for program leadership. AVSC fund in cooperation with universities, ob/gyn society, INN, AMIDEM, other sponsors. All service provider use.
 - (c) Staff training. AVSC fund part of training program. All service providers develop workshops, seminars and include in ongoing in-service training.
 - (d) Inclusion in system of medical supervision.
 - (e) Review of AVSC-supported activities (planned and in implementation); assure adequate attention is given to voluntarism.
 - (f) Coordination with JHPIEGO and DA to assure mutual support.
- (3) Service extension to selected underserved population, with balanced participation of public and private sector.
- (a) Support private sector service delivery expansion:
 - AVSC funding equipment, expendable supplies, and service delivery

- FEMAP implementation in affiliate clinics and in coordination with public sector
- MEXFAM implementation in coordination with public sector especially for mobile teams
- other private sector institutions such as PROFAM or AMIDEM implement activities which reach special groups such as men or factory workers with vasectomy
- AVSC supports training and/or equipment for private doctors through MEXFAM and/or FEMAP
- project review will establish criteria and objectives of quality/voluntarism, attention to special groups or impact on wider private sector network or on public sector institutions; seek to achieve unique private sector contribution in addition to numbers of procedures provided directly
- equipment and training for Norplant extension
- coordination with IPPF, FPIA, Pathfinder, who are major supporters of these institutions

(b) Support public sector for specific objectives, for example:

- equipment (and expendables if essential) to support IMSS/Coplamar in IMSS and SSA to extend mobile teams to rural areas (consult FPIA re expendables)
- equipment for centers of excellence for SSA, INN, IMSS and AMIDEM
- extension of Norplant-equipment and training for IMSS and SSA (consult Population Council and FHI)
- expanding DIPLAF vasectomy program

(4) Institutionalization and self-sufficiency:

- (a) review of all projects to eliminate AVSC support for recurrent costs in public sector and reduce AVSC involvement in recurrent costs in private sector.
- (b) encouragement of patient fees for VSC at least in private sector. (IMSS is already paid by insurance and SSA policy inhibits).

- (c) studies and seminars on internal cost control.
 - (d) seminars on cost recovery through patient and community participation.
 - (e) observation travel and seminars for leadership training and policy commitment; encourage dissemination of IMSS cost/benefit study.
 - (f) review of projects to identify institutional commitment and long range plans for continuation, self-sufficiency and appropriate phase-down of AVSC support over time.
- (5) Improved AVSC management:
- (a) local AVSC representative.
 - (b) additional technical assistance, especially for quality issues and evaluation.
 - (c) management component of FEMAP to consolidate activities, reduce AVSC management load and increase supervision and technical assistance. Experience of FPIA support for a similar management approach suggests the viability of this consolidation.
 - (d) where possible, larger projects with various components or networks of institutions.
 - (e) periodic review and evaluation at least every two years.

D. TIME PHASED IMPLEMENTATION

- (1) Year One:
- (a) establishment of local representation, familiarization with projects and coordination with USAID, JHPIEGO, Development Associates, Johns Hopkins PCS, Pathfinder, FPIA, IPPF and Westinghouse.
 - (b) consolidation of portfolio, especially all FEMAP affiliates except Monterrey. Monterrey to be continued separately for a year to maximize attention to and evaluate model of coordination with public sector.
 - (c) disseminate to cooperating institutions AVSC objectives, norms and standards; continuing discussions on ways of coordination and support.
 - (d) focus on implementation of ongoing projects:

- RAM center
 - Distribution and evaluation of Supermacho
 - Equipment for earthquake recovery
 - Central American and Mexican seminar on counselling
- (e) organize one seminar with representatives of different institutions to review VSC quality concerns; plan concerted action of review and training.
- (f) develop project proposals:
- FEMAP consolidated program including components for surgical centers, affiliate support and management and supervision, stimulus to private doctors and training for quality concerns.
 - equipment needs for IMSS rural extension and "centers of excellence".
 - equipment needs for rural extension and "centers of excellence".
 - equipment, expendables and training for MEXFAM in cooperation with the public sector and in support of private doctors.
 - development of publication of materials on quality issues, voluntarism and for prenatal clients.
- (2) Year Two:
- (a) initiate and implement new projects which were designed in year one.
- (b) expand emphasis on vasectomy program in private sector and with AMIDEM (new project design).
- (c) amend projects with IMSS, DIPLAF, FEMAP, MEXFAM to include Norplant extension.
- (d) observational travel for policy commitment, quality concerns, voluntarism.
- (e) implement follow-on seminars in various institutions for quality concerns and voluntarism.
- (f) at end of second year re-evaluate the needs assessment and strategy for years 3, 4, 5; among other things, review opportunities of expansion to other institutions both public and private.

E. PRIORITIES AND MAGNITUDE OF RESOURCES

Program priorities are not necessarily matched by financial priorities. For example, the high priority quality concerns may require more imagination and technical assistance than financing. Due to the public resources available, the high priority given to catalyzing some substantial public expansion of service to the rural and urban private sector. However, despite its higher cost, AVSC would continue to give high priority to the private sector to achieve its unique contribution in other program concerns. Within the public sector it may be more costly to support the SSA which, due to the structure of its organization and finances, may make less efficient use of AVSC resources than, for example, IMSS. However, as SSA generally deals with the lower economic level population and is more able to cooperate with the private sector, higher priority is given to their support.

Financial priorities suggest this Order of Magnitude for Additional Funding:

	<u>Approximate Level (\$000)</u>		
	<u>1986</u>	<u>1987</u>	<u>'88-90</u>
FEMAP	250	300	900
SSA/DIPLAF	*	200	600
MEXFAM		100	400
IMSS	*	200	100
Others	<u>50</u>	<u>100</u>	<u>300</u>
	<u>300</u>	<u>900</u>	<u>2,300</u>

* There may be some requirements for equipment in late 1986 instead of 1987 if management considerations permit review and agreement.

APPENDIX A

GLOSSARY

GLOSSARY

AMIDEM	Academia Mexicana de Investigación en Demografía Médica. Mexican Academy of Research in Medical Demography.
AQV	Anticoncepción Quirúrgica Voluntaria (VSC).
AVSC	Association for Voluntary Surgical Contraception. Formerly Association for Voluntary Sterilization.
CBD	Community Based Distribution.
CONAPO	Consejo Nacional de Población. National Population Council.
CPS	Contraceptive Prevalence Survey.
DA	Development Associates.
DDF	Departamento de Distrito Federal. Department of the Federal District.
DIF	Sistema Nacional para el Desarrollo Integral de la Familia. National Institution for the Comprehensive Development of the Family.
DIPLAF	Desarrollo e Investigación de la Planificación Familiar. Development and Research of Family Planning.
FEMAP	Federación Mexicana de Asociaciones Privadas de Planificación Familiar. Mexican Federation of Private Family Planning Associations.
FHI	Family Health International.
FP	Family Planning.
FPIA	Family Planning International Assistance.
IEC	Information, Education, and Communication.
IMSS	Instituto Mexicano del Seguro Social. Mexican Institute of Social Security.
IMSS/Coplamar	IMSS/Coordinación General del Plan Nacional de Zonas Deprimidas y Grupos Marginados. General Coordination of the National Plan for Depressed Zones and Marginal Groups.
INN	Instituto Nacional de la Nutrición. National Institute of Nutrition.
IPPF	International Planned Parenthood Federation.

ISSSTE Instituto de Seguridad y Servicios Sociales de los
Trabajadores del Estado.
Institute of Security and Social Services for Government
Workers.

Johns Hopkins
PCS Population Communication Services.

JHPIEGO Johns Hopkins Program for International Education in Gynecology
and Obstetrics.

MEXFAM Fundación Mexicana para la Planificación Familiar A.C.
Mexican Foundation for Family Planning.

MWFA Married Women of Fertile Age.

PROFAM Promotora de Planificación Familiar.
Family Planning Promotion (organization).

PIACT or PIATA Programa para la Introducción de Tecnología Anticonceptiva.
Program for the Introduction of Contraceptive Technology.

RAM Repair and Maintenance.

SSA Secretaria de Salud.
Health Secretariat. (Ministry of Health)

VSC Voluntary Surgical Contraception.

WFA Women of Fertile Age.

APPENDIX B
SCOPE OF WORK



Needs Assessment of Voluntary Surgical Contraception in Mexico

April 21 - May 7, 1986

I. PURPOSE

The major purpose of this assessment of VSC activities in Mexico is to define a strategy for AVSC's program of grants and technical assistance for the next three to five years. The two principal questions to be addressed are:

1. What has been the impact of past and present support provided by AVSC to Mexico?

In other words, has AVSC assistance over the past ten years resulted in improved availability and quality of VSC services in Mexico? Has the status of VSC changed appreciably during this time, and if so, can this change be linked to the recipients of AVSC support? Have AVSC resources been appropriately channeled using criteria of meeting demand, cost-effectiveness, geographic coverage, high impact, and prospects for institutionalization? What are the "lessons learned" and do they point the way to future needs and activities?

2. What should AVSC's strategy be in the future?

Once the current status of VSC is defined (in terms of availability, quality, coverage, cost, responsibility, etc.), what should be the specific goals of AVSC support? What institutions are poised to have the greatest overall impact on these goals? What type of financial and technical support will this strategy require? How much (funds)? For how long? What are the implications for AVSC program and management resources?

Insofar as this is a needs assessment (rather than an evaluation), the purpose of which is to assist in future program planning, the team is advised to focus the majority of its time addressing issues relating to question #2.



Needs Assessment of VSC in Mexico

April 21 - May 7, 1986

II. NEED/BACKGROUND

Mexico, with its large population base, relatively high rate of population increase (79.9 million and 2.6% per annum, respectively for mid-1985), and its strategic importance in the region, has long been a priority for AVSC assistance. Since our involvement began in 1975, 69 programs totalling \$5.5 million have been awarded to a wide variety of public and private sector organizations throughout the country. Unlike other countries where AVSC is extensively involved, this support has been dispersed (as distinctly opposed to disbursed) to a large number of institutions (24 since 1975). This is because health and family planning services in Mexico are very decentralized and are coordinated, if at all, very loosely. Furthermore, there is no USAID bilateral program or large Mission presence to assistance in coordinating among local counterparts and the large number of U.S. cooperating agencies which work in Mexico.

Historically, the vast majority of AVSC programs have been geared toward VSC service delivery. In the early years of involvement (the mid to late 1970's), the bulk of AVSC support was provided to the government sector (the Secretaria de Salud y Asistencia and the Instituto Mexicano del Seguro Social) for large scale facility upgradation projects involving extensive equipping and renovation. In recent years this support has shifted primarily to private family planning associations, many of which are affiliated to FEMAP, for the provision of VSC services through this network. Since 1975 AVSC programs have accounted for approximately 30,000 VSC procedures (as per the AVSC quarterly reporting system). Considering the fact that in 1982 VSC prevalence was estimated to be 13.7 percent of married women of reproductive age, it would seem that the vast majority of VSCs are conducted outside the direct purview of AVSC assistance.

At the present time, AVSC has 14 active subagreements in Mexico totalling \$683,613. AVSC's budget allocation for Mexico in FY 1986 is \$750,000, the second highest after Brazil. (This includes \$500,000 provided by AID as an add-on to AVSC's cooperative agreement in 1985 specifically for Mexico, but is unobligated due to the halt in program development following the earthquake last year.) This budget figure should be considered arbitrary and AVSC will look to this assessment to determine whether it is realistic.



Needs Assessment of VSC in Mexico

April 21 - May 7, 1986

It should be noted that this assessment was originally scheduled to take place in October 1985 but was postponed because of the earthquake. Since that time, several program management developments took place which have an impact on this exercise:

- o The appointment in March 1986 of a country program advisor for Mexico, whose role is to assist in the development and monitoring of AVSC programs. This appointment is accompanied by a shift in responsibility for Mexican programs from AVSC/NY to AVSC's Latin America regional office in Bogota.
- o The joint decision (made in February 1986) by AVSC and FEMAP to consolidate all AVSC financial assistance to FEMAP-affiliates through FEMAP headquarters in Ciudad Juarez.
- o Victor Jaramillo's consultancy in March 1986 to review current AVSC subagreements in Mexico from a financial management perspective.

The above developments put to rest several considerations which were originally part of the scope of work of this assessment. Therefore, the focus can now be more on program development issues rather than program management issues.

III. METHODOLOGY

The expected outcome of this assessment is a report addressing the prospects and strategy for AVSC's role in Mexico. The team has the flexibility to decide how to achieve this outcome. A suggested methodology and itinerary are provided, along with a list of questions which can guide interviews with service providers and individuals; however, the team has the flexibility and freedom to decide how to proceed.



Needs Assessment of VSC in Mexico

April 21 - May 7, 1986

The needs assessment will cover the main institutions funded by AVSC currently, as well as key agencies which have received support in the past or will be considered for future assistance. These institutions should include at a minimum:

Federation Mexicana de Asociaciones Privadas de Planificacion Familiar (FEMAP)
Direccion General de Planificacion Familiar (DIPLAF)
Instituto Mexicano del Seguro Social (IMSS)
Promotora de Planificacion Familiar (PROFAM)
National Institute of Nutrition and the Family Planning Associations of Tijuana, Monterrey, Nogales, Matamoros, Celaya, Irapuato and Leon

In addition, meetings could be scheduled with both international and Mexican family planning agencies, which have not received support by AVSC but which have an important role in this field in Mexico. These will include Consejo Nacional de Poblacion (CONAPO), Fundacion Mexicana Para la Planeacion Familiar AC (MEXFAM), Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado (ISSTE), Departamento de Integracion Familiar (DIF), and representatives of Pathfinder and the Population Council in Mexico. On visits to programs outside of Mexico City, the team is encouraged to speak to groups and individuals not related to AVSC programs, in addition to past/current grantees.

In addition, USAID/ Mexico will participate in the briefing and debriefing for the needs assessment.

Interviews will be held with headquarters, program and medical staff of the above institutions, VSC clients at service sites and VSC trainees. Documentation to be reviewed may include reports, client records (including medical history), statistical data, training curricula, evaluation reports, etc. In addition, an attempt will be made to collect the most recent data from contraceptive prevalence surveys and other national studies germane to the status of VSC in Mexico.

APPENDIX C

ITINERARY

C-1

NEEDS ASSESSMENT (MEXICO)ITINERARY

Date	B. Bair	G. Argueta	F. Gómez	F. Hernández
Tuesday April 22	DIPLAF 10.00 Pathfinder F. 13.00 Pop. Council 16.30	DIPLAF 10.00 INN 17.00	DIPLAF Pathfinder Pop. Council	DIPLAF INN
Wednesday April 23	MEXFAM 9.00 IMSS 13.00 CONAPO 17.15	SSA 10.00 IMSS	MEXFAM IMSS CONAPO To Monterrey	SSA IMSS To Monterrey
Thursday April 24	To Querétaro	To Querétaro	Monterrey	Monterrey
Friday April 25	Irapuato	Irapuato	Saltillo	Saltillo
Saturday April 26	To Mexico	To Mexico	Monterrey (Mobile Team)	Monterrey (Mobile Team)
Sunday April 27	To C. Juárez	To C. Juárez	Monterrey	Monterrey
Monday April 28	C. Juárez	C. Juárez	To Tijuana	To Tijuana
Tuesday April 29	C. Juárez	C. Juárez	Tijuana	Tijuana
Wednesday April 30	To Mexico	To Mexico	To Mexico	To Mexico
Thursday May 1	Discussion at Hotel			
Friday May 2	IMSS SSA/DIPLAF MEXFAM			

Date	B. Bair	G. Argueta	F. Gómez	F. Hernández
Saturday May 3	DRAFT			
Sunday May 4	TYPING			
Monday May 5	WRITE AND TYPE REPORT			
Tuesday May 6	WRITE AND TYPE REPORT			
Wednesday May 7	DEBRIEFING AT AID MISSION			

OBJECTIVES

1. DIPLAF

- (a) visit vasectomy program - medical surveillance (Gustavo - Filiberto)
- (b) initiate discussions re constraints to expansion and improvement of sterilization (public and private)
 - ask for available data on spread of sterilization (Bill - Fernando)

2. INN - (Gustavo - Filiberto)

What can INN do to increase/improve sterilization in general - vasectomy particular - training - seminars - demonstrations - work with universities - schools of medicine - publication for medical professionals.

3. MEXFAM - (Bill - Fernando)

What can private sector do to facilitate and inform?

4. IMSS and SSA - hospitals - (Gustavo - Filiberto)

Medical surveillance - are they using most up to date procedures - outpatient - local anesthesia - mini-lap - are there waiting lists - what are constraints.

Bill & Fernando: initiate discussion on expansion and constraints -

- what has AVSC done
- data on sterilization
- center excellence

5. PATHFINDER and POPULATION COUNCIL - (Bill - Fernando)

Ideas on needs in sterilization.

6. PROFAM - supermachos - survey - other ideas to market (Bill - Gustavo)

7. JUAREZ

FEMAP - consolidation and needs - Bill *how fit with FIPIN*
 - medical surveillance - FEMAP)
 IMSS) Gustavo
 SSA)

8. MONTERREY and SALTILLO

- IMSS - cooperation with SSA - Fernando
- medical surveillance - Filiberto
- mobile team - what is needed to extend?

Coordinate with femap?

9. TIJUANA

- review project - Fernando
- medical surveillance - Filiberto

IMSS or SSA - Filiberto

10. IMSS - SSA - MEXFAM

- exchange ideas (all).

WHEN VISITING PROJECTS

A. What is the perspective in which working (if known)

- population size
- birth rate
- contraceptive prevalence
- effective leadership

in sum, why working here?

B. Project

(1) What has been provided:

- money - \$ 1985 or other period
- training
- technical assistance
- equipment

(2) What has been accomplished (in what period):

- surgical procedures: - female - male
 - doctors
- number of trainees - nurses
 - technicians
- IE&C activities

(3) Compare accomplishments to stated objectives

(4) Quality of Service:

- comment on things particularly good - or bad
- use of local anesthesia
- use of mini-lap
- use of informed consent

(5) Comment on management + report + supervision by AVSC or FEMAP

(6) What unique contribution does this project make, e.g.

(a) number of procedures

(b) techniques - local anesthesia

- mini-lap
- outpatient surgery
- counselling
- IEC

(c) outreach - to geographical area of high birth rate or low service or to lower economic level

- (d) low cost
 - (e) involvement of community
 - (f) client satisfaction
 - (g) training
 - (h) emphasis on male (vasectomy)
- (7) What are signs they have shared this unique contribution?
- (8) What are other service providers doing in area:
- number of procedures
 - ease of access of population to service
 - constraints
 - kind of delivery techniques
- (9) How is this project perceived by others?
- (10) What would have happened without this project?
- (11) What would happen if AVSC support is withdrawn?
- (12) What would happen if more support were given (support for what)?

POSSIBILITIES TO CONSIDER FOR FUTURE

1. Support those things that introduce new techniques or procedures especially into programs of major service providers such as IMSS, ISSTE, SSA.

E.G. objectives:

- (a) expand mini-lap
- (b) local anesthesia
- (c) vasectomy
- (d) improved counselling for voluntarism
- (e) improved medical standards
- (f) methodology for extension to unreached areas (e.g. weekend camps)

methods:

- (a) seminars for surgeons and medical faculties
- (b) publications for professionals
- (c) training for medical
 - nursing
 - social workers
 - program leaders
- (d) operational research - surveys
- (e) focus on reproductive risk (AMIDEM)

2. Fill gaps in equipment requirements (especially mini-lap) for all providers

- replace surgical capacity damaged by earthquake
- provision of kits
- RAM center
- expendable supplies of real problem items

3. Improve client knowledge and access

- I & E campaign - PROFAM - FEMAP - MEXFAM
- MEXFAM facilitators - (pilot)
- equip mobile teams to rural areas

4. Continue effort with private sector through FEMAP as alternative for some people - competition and conscience for public sector. But improve FEMAP management capability and establish criteria for ~~such~~ ^{such} project such as:

- (a) demonstrated capacity for service that includes demand for

Because need more help

such c.u.c.b.

90

sterilization

(b) local support for recurrent costs

(c) bringing unique contribution to area, e.g. vasectomy

local anesthesia

low cost

IEC

unserved population

(d) geographical spread to low prevalence area or to areas where government service is weak.

*getting
distributed
to the unserved*

APPENDIX D

MEXICO SUBGRANT OBLIGATIONS BY YEAR

G4/07/86 MEXICO SUBGPANT OBLIGATIONS BY YEAR
SPECIAL REQUEST: LYNN BAKAMJIAN

CANCEL	PROJECT NUMBER	OTHER NUMBER	AGENCY	DIRECTOR'S NAME	OBLIGATION DATE	EFFECTIVE DATE	TERMINATION DATE	EXTENSION DATE	BUDGET TOTAL
1	064-052-P1	MEX-01-SV-1-P	UNIV AUTONOMA DE NUEVA LEON	GARCIA	0	750101	751231	760630	17400.00
	064-052-P2	MEX-01-SV-2-P	UNIV AUTONOMA DE NUEVA LEON	GARCIA	0	760701	770630	0	18704.00
2	167-098-P1	MEX-02-SV-1-P	INST NACIONAL DE LA NUTRICION	PEREZ	0	761001	770930	771231	16996.00
3	166-115-P1	MEX-03-SV-1-P	ASSOC FOR MATERNAL HEALTH	ALMAZAN	0	770301	780228	781130	33884.00
4	213-126-1	MEX-04-EO-1-A	INTL FERTILITY RESEARCH PROG	KESSEL	0	770601	780531	0	131108.00
	064-052-P3	MEX-01-SV-3-P	UNIV AUTONOMA DE NUEVO LEON	GARCIA	0	770701	780630	781031	16195.00
5	170-137-P1	MEX-05-SV-1-P	JUAREZ UNIVERSITY	RIVERA DAMM	0	771101	781031	791031	12323.00
6	243-138-1	MEX-06-SV-1-A	INST MEXICO DEL SEGURO SOCIAL	AZNAZ	0	771201	781130	0	312160.00
	245-140-1	MEX-07-SV-1-A	SEC DE SALUD Y ASISTENCIA	CORREU	0	771201	781130	790531	444517.00
8	246-141-1	MEX-08-IE-1-A	ISSSTE	TOMMASI	0	771201	781130	790430	58980.00
9	244-139-1	MEX-09-RM-1-A	PIACT OF MEXICO	AZNAZ	0	780201	790131	790228	145016.00
10	248-142-1	MEX-10-SV-1-A	FPA OF CIUDAD JUAREZ	DE LA VEGA	0	780201	790131	0	45030.00
	167-098-2	MEX-02-SV-2-A	INST NACIONAL DE LA NUTRICION	PEREZ	0	780801	790731	0	16200.00
	248-142-2	MEX-10-SV-2-A	FPA OF CIUDAD JUAREZ	DE LA VEGA	0	790201	800131	0	47704.00
	244-139-2	MEX-09-RM-2-A	PIACT OF MEXICO	AZNAZ	0	790301	800229	0	115003.00
	000-090-M13	MEX-11-EO-1-A	INST MEXICO DEL SEGURO SOCIAL	GINER	0	790401	800331	0	381570.00
	245-140-2	MEX-07-EO-2-A	SEC DE SALUD Y ASISTENCIA	CORREU	0	790601	800531	810731	827305.00
	170-137-2	MEX-05-SV-2-A	JUAREZ UNIVERSITY	RIVERA DAMM	0	791101	801031	810331	14720.00
11	322-174-1	MEX-12-SV-1-A	YUCATAN UNIVERSITY	CANTO	0	791201	801130	811231	30256.00
	000-090-M19	MEX-13-EO-1-A	SEC DE SALUD Y ASISTENCIA	CORREU	0	800101	801231	0	14075.00
	248-142-3	MEX-10-SV-3-A	FPA OF CIUDAD JUAREZ	DE LA VEGA	0	800201	810131	0	65855.00
12	000-090-M21	MEX-14-EO-1-A	PRO-SUPERACION FAM. NEOLEONESA	DE GARZA	0	800301	810228	0	13514.00
	244-139-3	MEX-09-RM-3-A	PIACT OF MEXICO	GALLEGOS	0	800301	810228	0	126883.00
	362-182-1	MEX-15-SV-1-A	HOSP UNIVRSITARIO DE TORREON	DEL VALLE	0	800301	810228	0	15920.00
14	363-201-1	MEX-16-SV-1-A	FP PROGRAM OF NO. BAJA CALIF.	DAVIS P.	0	800801	810731	820228	94881.00
	388-203-1	MEX-17-SV-1-A	PRO-SUPERACION FAM. NEOLEONESA	DE GARZA	0	800901	810831	811231	52885.00
	167-098-3	MEX-02-SV-3-A	INST NACIONAL DE LA NUTRICION	PEREZ	0	801201	811130	0	15787.00
	248-142-4	MEX-10-SV-4-A	FPA OF CIUDAD JUAREZ	DE LA VEGA	0	810201	820131	0	64241.00
	244-139-4	MEX-09-RM-4-A	PIACT OF MEXICO	GALLEGOS	0	810301	820228	0	104206.00
	170-137-3	MEX-05-SV-3-A	JUAREZ UNIVERSITY	RIVERA DAMM	0	810401	820330	0	12214.00
15	415-220-1	MEX-18-SV-1-A	HOSPITAL CIVIL DE GUADALAJARA	BAEZA	0	810401	820330	0	35434.00
	245-140-3	MEX-07-SV-3-A	SEC DE SALUD Y ASISTENCIA	MEADE	0	810801	820731	830930	336020.00
	322-174-2	MEX-12-SV-2-A	YUCATAN UNIVERSITY	CANTO	0	820101	821231	0	20695.00
	000-090-M35	MEX-19-EO-1-A	INST MEXICO DEL SEGURO SOCIAL	MARTINEZ	0	820201	830131	0	276240.00
	248-142-5	MEX-10-SV-5-A	FPA OF CIUDAD JUAREZ	DE LA VEGA	0	820201	830131	0	69339.00
	388-203-2	MEX-17-SV-2-A	PRO-SUPERACION FAM. NEOLEONESA	DE GARZA	0	820201	830131	830331	91578.00
	244-139-5	MEX-09-RM-5-A	PIACT OF MEXICO	GALLEGOS	0	820301	830228	831231	132486.00
	363-201-2	MEX-16-SV-2-A	FP PROGRAM OF NO. BAJA CALIF.	GARIBALDI	0	820301	830228	0	48712.00
	170-137-4	MEX-05-SV-4-A	JUAREZ UNIVERSITY	RIVERA DAMM	0	820331	830331	0	20864.00
	415-220-2	MEX-18-SV-2-A	HOSPITAL CIVIL DE GUADALAJARA	BAEZA	0	820331	830331	0	43367.00
	MEX-12-SV-3-A	322-174-3	YUCATAN UNIVERSITY	CANTO	821229	830101	831231	0	14614.00
	MEX-17-SV-3-A	388-203-3	PRO-SUPERACION FAM. NEOLEONESA	DE GARZA	830314	830101	831231	840630	47713.00
16	MEX-20-SV-1-A		SOCIAL COOP. CENTER OF NOGALES	ISLAS	830314	830101	840229	840831	34081.00
	MEX-10-SV-6-A	248-142-6	FPA OF CIUDAD JUAREZ	DE LA VEGA	830314	830201	840131	840831	91879.00
	MEX-16-SV-3-A	363-201-3	FP PROGRAM OF NO. BAJA CALIF.	GARIBALDI	830314	830301	840229	840831	77854.00
17	MEX-21-SV-1-A		FAM. COUN. CENTER OF MATAMOROS	DE LAHOZ	830314	830301	840229	840831	49417.00
	MEX-18-SV-3-A	415-220-3	HOSPITAL CIVIL DE GUADALAJARA	BAEZA	830525	830401	840331	0	42450.00
	MEX-23-SV-1-A		INST NACIONAL DE LA NUTRICION	PEREZ	830525	830601	840531	840831	13350.00
18	MEX-22-SV-1-A		APFAMPRO	PENA	831213	831231	841230	850331	18907.00
19	MEX-25-SV-1-A		ASSOCIATION FOR FAMILY WELFARE	MERCADO	831213	831231	841230	850228	31322.00

\$35,700

\$1009167

\$206246

\$1416858

\$402800

\$550715

\$71895

503

04/07/86 MEXICO SUBGRANT OBLIGATIONS BY YEAR
SPECIAL REQUEST: LYNN BAKAMJIAN

D-2

LANCEL	PROJECT NUMBER	OTHER NUMBER	AGENCY	DIRECTOR'S NAME	OBLIGATION DATE	EFFECTIVE DATE	TERMINATION DATE	EXTENSION DATE	BUDGET TOTAL
20	MEX-27-SV-1-A		HUEJOTZINGO HOSPITAL	VASQUEZ	831213	831231	841230	850331	23620.00
21	MEX-31-SV-1-A-V		DIPLAF	URBINA	A 831213	831231	841230	860331	45305.00
	MEX-17-SV-4-A	328-203-4	PRO-SUPERACION FAM. NEOLEONESA	GARZA	A 840717	840701	850630	860228	90654.00
	MEX-34-SV-1-A-V		YUCATAN UNIVERSITY	CANTO	840807	840701	850630	850930	17216.00
	MEX-36-TR-1-A-V		DIPLAF	URBINA	840807	840801	850731	0	29484.00
22	MEX-32-1E-1-A-V		PROMOTORA DE PLAN FAM, A.C.	DE LA MACORRA	A 840830	840801	850731	860731	98667.00
	MEX-23-SV-2-A		INST. NACIONAL DE LA NUTRICION	PEREZ	840913	840901	850831	0	21150.00
	MEX-21-SV-2-A		FAM. COUN. CENTER OF MATAMOROS	DE LAHOZ	A 840925	840901	850831	860228	29420.00
	MEX-16-SV-4-A	363-201-4	FP PROGRAM OF NO. BAJA, CALIF.	ROMERO	A 840926	840901	850831	860228	55208.00
	MEX-20-SV-2-A		SOCIAL COOP. CENTER OF NOGALES	ISLAS	A 840926	840901	850831	860228	39200.00
	MEX-24-CO-1-A		FEMAP		A 841001	840901	850831	860430	114080.00
23	MEX-37-TR-1-A		DR. RODOLFO QUINONES	QUINONES	850307	850301	850831	0	10080.00
	MEX-25-SV-2-A		ASSOCIATION FOR FAMILY WELFARE	MERCADO	A 850328	850301	860228	860630	25596.00
	MEX-22-SV-2-A		APFAMPRO	PENA	A 850329	850401	860331	0	14150.00
	MEX-27-SV-2-A		HUEJOTZINGO HOSPITAL	VASQUEZ	A 850329	850401	860331	0	12450.00
24	MEX-39-PE-1-A		ACAD MEX DE INVLST EN DEMO MED	GINER	A 850730	850801	860731	0	20316.00
	CAM-02-PE-1-A		INST NACIONAL DE LA NUTRICION	PEREZ	A 851002	850701	851231	860630	17182.00
	MEX-23-SV-3-A		INST NACIONAL DE LA NUTRICION	PEREZ	A 851028	850901	860831	0	15615.00
	MEX-38-SV-1-A		DIPLAF	URBINA	A 851031	850901	860831	0	97370.00
09		5548917.000							
69		5548917.000							

A = Actual

683,613
Ara

IVL 8/12
41 2012

54

Appendix E

INTERVIEWS

INTERVIEWS

1. American Embassy, Sam Taylor, AID Representative

In discussion with Sam Taylor it was apparent he had a great interest in improving the quality of AVSC programming in Mexico as well as seeing it expand.

Some of the salient points discussed were as follows:

- We should be looking to the new things AVSC can do to: reach more people, do it quicker, at lower cost.
- External organizations do not have the time and people to deal with lots of little projects. Such organizations as AMIDEM, FEMAP and MEXFAM are in a better position to handle the management responsibilities. The challenge is to identify 2, 3 or 4 organizations and consolidate efforts with them.
- Governments tend to be inefficient and need the competition and conscience of the private sector to keep them effective.
- Pursue the idea (largely of Jorge Martinez Manantou of IMSS and AMIDEM) of a center of excellence in Mexico City to replace capacity destroyed by earthquake, provide VSC service, serve as training and demonstration center. The problems of land and building finance are the most difficult for AID supported agencies - Population Crisis may help.
- Consider loan guarantee program for private physicians to buy laparoscopes.
- AMIDEM should be encouraged in vasectomy training; identify a few enthusiasts and support them.
- The inability of FPIA and IMSS to agree on a voluntary consent form was a constraint to FPIA forward movement with IMSS.
- Expanded use of local anesthesia is constrained by inability to import Demerol - (IMSS can).
- Urge emphasis on reproductive risk approach of IMSS and AMIDEM.
- Look at the operating procedures; how can the duration be shortened?

In debriefing Taylor expressed general satisfaction with the approach outlined by the team, the consolidation of all of the FEMAP affiliates but Monterrey, the emphasis on quality through seminars and training, the selected support to IMSS and SSA, and the withdrawal of support from "losers". He urged increased emphasis on vasectomy, particularly if a few enthusiastic doctors could be identified to spearhead the effort.

2. DIPLAF/SSA. Dr. Manuel Urbina, Director & Dr. Arturo Vega, Deputy**Salient points:**

- Received published material for national program goals and achievements as well as statistical data for SSA program.
- AVSC assistance to SSA in the past in providing surgical modules was very important in getting the surgical program started as was equipment and training provided to IMSS; many of the 350 laparoscopes in country came from AVSC. Presently AVSC support is largely to the private sector but it is creating awareness in the public sector. AVSC efforts to improve standards have been more successful in the private sector but are influencing the public.
- RAM Center will be useful; have had delay making transition from PIATA but expect to have this resolved in a few weeks - awaiting spare parts from AVSC.
- No real bureaucratic problems working with AVSC. DIPLAF exists to deal with issue of accountability and import; import of equipment and supplies can be handled with 30 days advance notice of shipment required; there is a 2% customs handling fee; they have a complete informed consent procedure and forms.
- **Suggestions for way to work with private physicians include:**
 - (i) There are 10,000 to 30,000 in private practice.
 - (ii) Work with Mexican Federation of Ob/Gyn Physicians.
 - (iii) In pre-service training, family planning is significant component in education of internal medicine, general surgery, ob/gyn, pediatrics.
 - (iv) SSA in-service training programs are open to private doctors.
 - (v) Last administration tried a formal program of supplying private physicians with contraceptives; this failed, largely due to the reporting requirement; private doctors will deliver family planning but will not report.
 - (vi) SSA can provide training but leave most of this work to FEMAP and MEXFAM.
- **Suggestions for future support from AVSC to SSA include:**
 - (i) Equipment requirements, especially to replace that damaged by earthquake. SSA very pleased with rapid response for Hospital General in Mexico City and will request more for Hospital Juarez in Mexico City when construction schedule more advanced.
 - (ii) Equipment and supplies for the 12 States in the decentralized health system. Health services (including IMSS/Coplamar, the

rural health program) will now be under state control and will need help. The three largest States are Nuevo Leon, Jalisco and Mexico. The others are Sonora, Baja California Sur, Guerrero, Colima, Guanajuato, Queretaro, Tlaxcala, Tabasco and Morelos. States will want laparoscopes but many of presently available can be moved. There are 754 rural health centers and 19 hospitals in the IMSS/Coplamar system. There are 23 MOH hospitals and 1100 health centers in these 12 States. Many will have mini-lap kits but they could need as many as 2,000 more (they are meeting with States to find out).

- (iii) Review expendable supplies needs. They can get Demerol. Quality is a problem with local purchases of cat gut - they need for 45,000 cases. They are getting 50,000 silastic rings from FPIA and believe they need more "for the whole system".
- (iv) Would like to develop new vasectomy project based on experience with present small activity. They would like to extend to 12 decentralized States; need equipment, expendable supplies and help with travel costs.
- (v) Are interested in Norplant but want to see results of introductory trials.
- (vi) By Presidential decree they have more responsibility for training in family planning; would like help in contracting lecturers from outside SSA.
- (vii) Interested in seminars on patient counseling for VSC and possible survey on issue of how are norms and standards being applied (surgical, counseling, patient satisfaction).
- (viii) Probably need some research on relative value of local anesthesia (recommended by SSA) as compared to spinal block (used by IMSS) but do not have capacity.
- (ix) Are placing more emphasis on evaluation (service statistics and surveys); have strengthened the surgical module in the soon to be carried out Westinghouse CPS; would appreciate technical assistance for evaluation.

3. IMSS. Dr. Jorge Mart{nez Manantou, Director; Dr. Sergio Correu;
Dr. Ramon Aznar; Dr. Juan Giner

- Received published data on VSC in IMSS system.

- **General issues discussed:**

- (i) Provision of VSC growing in IMSS (165,000 last year of which 5,000 were vasectomies); some of service is outpatient, some in; increasingly VSC related to obstetric event (700,000 ob cases last year with 47% getting contraceptives and 30% of these VSC); know we are not meeting demand; each day the demand is greater and our capability in less (due to earthquake damage and inflation); waiting periods are getting longer.
- (ii) Saturday service (or weekend teams) is important part of extension of service (served 20,000 rural clients last year); personnel are willing to volunteer for this service which is mostly in Sinaloa and Tamaulipas; study of recipients in six states showed access is the limiting factor and the demand is great; there was good response from communities; with decentralization and IMSS/Coplamar under SSA this program was slowed - they expect it to grow again in the future.
- (iii) Relations with AVSC have always been good; Mart{nez says good but should grow and should have person in Mexico to represent AVSC. Correu, who was previously Director of F.P. in SSA, also spoke highly of the contribution to the growth of program of the AVSC supported surgical modules in SSA.
- (iv) IMSS has no import problems and no bureaucratic problems in dealing with AVSC; Mart{nez notes however that such things as their informed consent form, which is approved by a high level ministerial council, are not subject to change; the form used by IMSS does not differ from AVSC requirements in any major substantive way.
- (v) In general their interest in seeking outside assistance lay in the areas of:
 - (a) research (especially for a survey of client satisfaction which has some similarity to the information to be gained by the Westinghouse Surgical Module). Also discussed interest in research on mini-lap compared to laparoscope procedures and local vs. general anesthesia.
 - (b) training ("which will never be sufficient"), especially for vasectomy.
 - (c) ways to replace earthquake damaged capabilities, especially through a center of excellence for service, training, promotion and research.

- **Specific areas where help was requested:**

- (i) Financial support for survey of client satisfaction.
- (ii) Mini-lap kits for their weekend rural program; as many as 1000 kits might be needed.
- (iii) Expendable supplies were not requested (they have 65,000 silastic bands on hand and are using laparoscopes for about 20,000 of the procedures a year; they can buy Demerol locally).
- (iv) Support for surgical center to replace IMSS capacity damaged by earthquake and to increase training; discussed original idea of large center in Mexico City owned and managed by AMIDEM, a private non-profit associate of IMSS; problems were identified:
 - (a) international support for land and building questionable and difficulty of securing local support.
 - (b) difficulty of this private organization handling recurrent costs and problem of IMSS support particularly for non-insured participants.

- Martinez suggested an alternative could be to expand three or four regional training centers within the IMSS system to serve the same purpose of training, research, promotion and VSC service delivery. One could be established in Mexico City and others selected from Coahuila (8000 procedures/year), Jalisco (8000/year), Nuevo Leon (9000/year) and Tamaulipas (6000/year). The IMSS delegation would be expected to make available dedicated operating room space and some equipment; external assistance would be required for equipment (less than that previously provided to SSA for surgical modules).

4. CONAPO. Lic. Geronimo Martfnez, Executive Secretary;
Diana Vidarte, Assistant

- Initial discussion with Assistant showed her enthusiasm for family planning as she had been one of the pioneers in the movement; we were reminded of the importance of the legal basis in Mexico for VSC based on respect for the liberty of the individual; AVSC has had some 60 projects in Mexico - she was most acquainted with the important support to FEMAP.
- Executive Secretary described Council of 8 Secretaries of State and role of General Secretary as technical arm to assist these secretaries in fulfilling their implementing role.
- CONAPO has some role in maintaining information on various family planning activities but does not publish reports on these.
- CONAPO's major implementing role appears to be a general population awareness campaign through TV, radio, newspapers. Twelve percent of TV time is government time and they presently have three spots which are broadcast 40 times/day. These do not have direct family planning information (which sometimes radio and newspapers carry) but do say go to clinic.
- In the last few years they have published 100 titles which talk very seriously about family planning matters.
- Their radio "novelas" carry a serious message.
- **Suggestions for general AVSC support to Mexico:**
 - (i) IMSS the most capacity, most coverage, best organization and the best trained personnel, serves the middle income group.
 - (ii) SSA is second in capacity and deals with lower economic level - those without social security coverage.
 - (iii) ISSSTE has capacity for middle income government employees but has not shown much interest in family planning.
 - (iv) IMSS/Coplamar is a good vehicle for rural extension.
 - (v) Private sector is complementary to public sector and serves those who do not want to use government service (if you have money you try to avoid the bureaucratic delays).
 - (vi) Private sector family planning organizations go to the right people (lower income, outside the reach of IMSS or SSA) but their capacity is limited. MEXFAM is largest and works well with government; second largest is FEMAP - we have good relations but they work more independently.
- Request for AVSC assistance to CONAPO would be for financial support for CONAPO's educational program.

5. MEXFAM. Arturo Lopez, Director & Hector Perez, M.D.

- Received published material on MEXFAM.

- **General issues discussed:**

- (i) MEXFAM, which used to have a large network of clinics, has only 20 at present. As the government has 6-7000 clinics with priority given to family planning, why duplicate? MEXFAM sees role of assisting government where bureaucratic problems have created some constraint in supply or service. They have an interest in developing self-sufficiency in service - also in making agreements with state health authorities to extend service to rural areas.
- (ii) MEXFAM strategy is not to go everywhere - have established priorities by birth rate of region and level of services available and to cities of rapid marginal growth; present priorities: Queretaro, Puebla, Tabasco.
- (iii) MEXFAM experimenting with involving private doctors; have helped 20 unemployed doctors (Mexico produces 5000 M.D.s per year into an overcrowded profession) to set up simple MCH/FP practice in marginal areas of Mexico City, Guadalajara and Tijuana; they do referrals for VSC.
- (iv) Interest in quality and surgical technique issues represented in desire to support three public hospitals to improve service and demonstrate new approaches.
- (v) Information program complements CONAPO, which covers TV with information directed to middle class. MEXFAM uses non-conventional approaches - posters in metro stations, ads (often free) in the foto-novelas which sell 70 million/month, movie ads, etc. They like and have distributed the Supermacho issue on vasectomy.
- (vi) They have had little association with AVSC but would like to start.

- **Specific requests to AVSC:**

- (i) Assist with equipping three hospitals for VSC program.
 - (ii) Other equipment and expendable supplies for work with largely public sector institutions.
- A visit to the "people's doctor" program found a simple but clean and neat dispensary staffed by a female ob/gyn doctor. The simple furnishings, informational materials and equipment provided by MEXFAM cost about \$2000; some was provided by the community. MEXFAM guarantees to pay for a decreasing number of consultations over several months, after which the doctor is self-sufficient. There were seven CBD volunteers in the vicinity.

In the 20 days since it opened the dispensary had 73 family planning consultations and "more" general ob/gyn and MCH consultations - about 8/day. Services are sold at \$3.00/IUD and \$.025/cycle. The doctor is satisfied with the arrangement and says community people will pay that much for satisfactory service. There have been several requests for sterilization, but the nearby hospital is lacking equipment and supplies to expand their service. This dispensary is not a location to do surgery, but assisting the nearby hospital with equipment and supplies could facilitate VSC referrals.

6. FEMAP. Sra Guadalupe de la Vega, Director; Enrique Suarez, Education;
Ernesto Barazza, Executive Secretary; Sra Olga Munez,
Assistant Director

With the FPIA evaluation available, interviews with FEMAP at this time focussed on some specific points related to future plans for VSC.

- Received published material - Master Plan.
- Confirmed importance of AVSC support in their development.
- Discussed strategy of more collaboration with public sector for actual service provision or more emphasis on developing own clinic infrastructure. FEMAP stated interest in remaining flexible and evaluating effectiveness of the two models. The two most productive affiliates are in Juarez, which has its own clinic, and Monterrey, which works in public sector facilities. FEMAP attributes the success of these two differing approaches to the difference in strength of the public sector (Monterrey having a much more developed public sector). FEMAP's opinion is that local conditions and receptivity of public sector health officials will largely dictate the approach. They recognize the cost efficiency to be gained in working with the public sector but also recognize the greater difficulty in achieving quality control outside their own clinics.
- **Response to question: What is FEMAP's unique contribution to VSC?**
 - (i) Information program - in large part based on CBD and other service delivery of temporary methods.
 - (ii) Deal with clients from a more "human point of view". In this regard FEMAP criticized the Supermacho vasectomy issue for maintaining a male dominant attitude.
 - (iii) Have more access to population not served by IMSS and SSA.
 - (iv) Making more progress with vasectomy.
 - (v) Quality of service and reduced patient inconvenience e.g. outpatient, no waiting, service on weekend.
 - (vi) Suarez says actual number of procedures can grow to be significant in national terms.
- **Response to what can be done to improve surgical procedures;**
 - (i) More use of local anesthesia if solve problem of supply of Demerol.
- **Response to what can be done to reduce cost to external donors:**
 - (i) Give priority to FEMAP working with public sector where possible.
 - (ii) Reduce internal costs e.g. use of outpatient procedure and local anesthesia.

- (iii) Begin to charge for procedures (controversial).
- (iv) External cost now \$1.8 million; value of local volunteers estimated at \$8.6 million; value of local financial contributions estimated at \$400,000.
- **Response to what criteria can be used to determine if affiliates are ready for surgical program;**
 - (i) Well established program of temporary methods, usually CBD with response of community.
 - (ii) Good educational program established.
 - (iii) Can provide services which are accessible economically and geographically to population.
 - (iv) Can provide quality VSC services.
 - (v) Be flexible - do not inhibit local initiative!
- **Response to what can be done to support/stimulate private physicians to VSC provision:**
 - (i) FEMAP enthusiasm for this was not great - expressed opinion that those private physicians providing VSC are dealing with well-off clientele and do not need much stimulus or help.
 - (ii) Interest in providing training opportunities especially in expanded Juarez clinic - possibly masters program in Family Planning.
 - (iii) Seminars - especially in use of local anesthesia.
 - (iv) Will give more thought to this.
- **Response to what are requirements from AVSC to manage and support consolidated FEMAP project:**
 - (i) Personnel for management/supervision: full-time medical director, assistant to administrator, possible additional supervisor as they get more involved in recuperation of several problem projects and in expansion; recognize need to work out with FPIA shared responsibilities with staff paid by FPIA.
 - (ii) Financial support for service delivery.
 - (iii) Operating and recovery room and surgical equipment, e.g. two operating rooms Juarez and one Irapuato; equipment for mobile teams

65'

7. PROFAM: Luis de la Macorra, Diretor; Raul Rocha, Assistant

- Visited the spacious installations which house a large staff which manage the production and sales operation of the private, non-profit and for-profit PROFAM Group.
- The largest operation at this time is the condom processing, packaging and sales operation in cooperation with Schmidt Inc. Bulk condoms are imported from the U.S. (with a 40% duty), tested by several processes by PROFAM and packaged and sold through a network of 22 distributors supplying 45% of the commercial condom market with six million units per year. PROFAM also produces (from Mexican raw materials), packages and sells a vaginal suppository contraceptive. Sales are much lower than condoms.
- PROFAM has had two projects with AVSC - they have helped. We are not too well acquainted with what else AVSC did but whoever helped IMSS get equipment and training did a lot of good. IMSS doing a good job in sterilization and SSA has a real problem with young doctors doing rural year staffing lower levels and not having time to handle emergencies, let alone family planning.
- **Projects with AVSC:**
 - (i) AVSC #1: A small experiment with newspaper ads and doctors to do vasectomy in Ciudad Netza Hualcoyotl was not too successful but taught us the need to start with higher economic level target group.
 - (ii) AVSC #2; The publication and distribution of the Supermacho comic book on vasectomy has been frustrated with delays and lack of communication. The book has been published over a year (with some delay required to eliminate two pages). There have been requests from only one Central American country, Guatemala, and few requests from private groups in Mexico. FEMAP in Jauarez does not want it. MEXFAM received 5000 (MEXFAM told team they liked it). SSA received 150,000 copies. (A call to DIPLAF confirmed these had been distributed, well received and they want 150,000 more). PROFAM, wants to sell some but does not yet have AVSC approval. The evaluation protocol has not been agreed with AVSC. Of the 400,000 produced, about 200,000 are still in the warehouse. There are some controversial portions of the comic book but it was produced in the Supermaccho ("Mad magazine") style to appeal to the middle and lower economic level male. (Apparently it does, but at the same time it does not appeal to some classes of the population.)
- PROFAM has had some further experience with vasectomy. With British assistance an experimental project with radio and newspaper advertising was carried out in Leon with private doctors. PROFAM believes the 28 cases performed in six months indicates enough receptivity to warrant development of a specialized vasectomy clinic in the highly populated (20% of Mexico's population) Valle de Mexico area.

- A request for AVSC assistance is pending for a specialized vasectomy clinic. This \$50,000 project expects to be self-sufficient in two years. Raul Roca did not think PROFAM would be interested in a reimbursable support arrangement, but when we saw Luis de la Macorra later he seemed to think this type of financial arrangement would be possible.

8. PAHTFINDER. Lic. Esperanza Delgado

- Received information on the only project Pathfinder still does in VSC (Pathfinder policy is to shift all VSC requests to AVSC). Pathfinder will support a mobile team for VSC with FEMAP affiliate in Juarez to serve six outlying areas in the State of Chihuahua. The team will travel to local hospitals where the procedures will be performed. Other Pathfinder-supported family planning projects make referrals to other institutions for VSC.
- Delgado, who at one time worked in the public sector in the national Office for Family Planning Coordination, stressed the importance of the private sector - the private sector's unique contribution is in providing information, person to person contact, getting change of attitude and going to the individual. She characterized FEMAP as working with many contacts with well-to-do, influential, private citizens, but depending heavily on external assistance. In her opinion, MEXFAM works more closely with local and national public sector officials and is based more on local support with the use of government facilities.
- Recommends giving priority to private sector with MEXFAM and FEMAP, while assisting public sector in order to maintain political support.

9. POPULATION COUNCIL. Thomas Freika

- The Population Council representative is not too aware of what AVSC has done specifically in the past in Mexico, but knows of the good overall progress made in VSC. He states AVSC support will continue to be important.
- **Salient observations of Dr. Freika:**
- A major program of Population Council is contraceptive introduction with Norplant being the biggest issue now. This has been slow to start in Mexico. Population Council has just funded a sizeable effort in SSA with INN coordinating introductory research in seven institutions. This could take two years before decisions are made to expand distribution. (Some countries such as Indonesia, Ecuador and Dominican republic have shortened the process.)
- AVSC support in the Norplant expansion phase should focus on education and training materials, training programs and minimal equipment needs, both for the private and public sector.
- Another major Population Council activity is operations research (INOPAL). **Activities of particular relevance to AVSC are the following;**
 - (i) High reproductive risk with IMSS; AVSC could help with support to strengthen the VSC service in the associated service delivery points.
 - (ii) Research with FEMAP in Juarez to serve the twin-factory (maquiladores) population; can AVSC help to strengthen the clinics where VSC clients will be referred?
 - (iii) INOPAL is a five-year program with enough financing and interest to respond to operations research requests from institutions supported by AVSC.

10. Instituto Nacional de Nutricion (INN)
Dr. Gregorio Perez Palacios, Director of Research

This hospital is a part of the Secretariat of Health, and is Mexico's most important research and post graduate training facility in the health area. Its graduate programs are part of the Mexico Autonomous University, the largest and most prestigious in the country. More than 100 residents and post graduate students receive training in this 250 bed hospital.

The hospital is divided into six programmatic areas, one of them is research that includes the Department of Reproductive Biology. This department has a clinic that offers temporary family planning methods, VSC, and also studies infertility. This program has a three year residency in reproductive biology programs with four students in each year. The department is associated with the World Health Organization and carried out several research projects with WHO support. The department also works as advisor on contraceptive technology to the SSA.

The hospital has assigned one operating room and five recovery beds to the VSC program. It has developed a good minilaparotomy technique with local anesthesia. The INN is very interested in working with other hospitals and/or schools of medicine to expand its technique. Because of the important scientific status of this hospital there is a good possibility that a program with the INN could help to promote minilaparotomy and local anesthesia in Mexico.

11. Visit to Dr. Juan Giner - IMSS
Date: May 6, 1986

We visited Dr. Giner at the F.P. office and we discussed several aspects related to vasectomy.

Dr. Giner related that he with several junior surgeons has performed more than 200 vasectomies with local anesthesia. Since 1984 he has been using electrocautery with the technicator model 80-1777. He has trained more than 30 surgeons with this technique and also published that occurrence of spermatic granuloma and recanalization of vas deferens can be reduced using this technique rather than ligation to occlude the vas. Dr. Giner showed interest in providing the IMSS facilities for a training center in vasectomy, since there is not a program to train physicians now. He stated that the trainer should have done a minimum of 500 vasectomies and the trainee should spend one week observing, assisting and performing a minimum of 10 vasectomies by himself, by rotating in 3 units where IMSS have vasectomy service.

TELEPHONE CONVERSATION BETWEEN JANET HEROUX (JHPIEGO) AND ANA R. KLENIKI
RE: JHPIEGO MEXICO STRATEGY
May 8, 1986

JHPIEGO has a post graduate program in laparoscopic procedures for physicians in Hospital Civil of Guadalajara under Dr. Francisco Alfaro.

It is a specialist training center for physicians with teaching abilities. It is the training of trainers. They work with special laparoscopy projects, and they also have updates for MDs in laparoscopy.

They have a training gynecology update - they function as a continuing medical education center.

They have funded the program already for 1 year, they are reviewing renewal for the 2nd year with the likelihood of a 3rd year.

JHPIEGO also has a program in Tampico with Dr. Juan Vela sponsored by the Asociacion Mexicana de Facultades de Medicina (AMFEM). It is a 3 year program with 34 medical schools. It is aimed at medical students. The program consists of 16 hours of extra curricular teaching in the "how and why" of family planning. The program has recently been evaluated by Jorge Villareal and Alfonso Santamaria. Preliminary fundings are very encouraging. It has been institutionalized in three-quarters of the schools where it was offered.

They anticipate a program with nursing schools.

JHPIEGO does not have a grand plan for major training in the public sector and is very interested in collaborating and coordinating with AVSC for future work in Mexico.

They have just completed a 5 year strategy which they will make available to AVSC within 10 days.



Johns Hopkins Program for International Education in Gynecology and Obstetrics

May 9, 1986

Ms. Anna Klenicki
Association for Voluntary Sterilization
122 E. 42nd. Street
New York, NY 10168

Dear Anna,

When we finally submitted our strategy, it looks like more got shaved off Mexico than I had remembered. So, this attached sheet does not contain much new information other than what I've already given you over the phone.

To fill in some more precise numbers:

AMFEM Nursing School Project: We are starting with 30 nursing schools and are aiming at including up to 50 by the end of a three year project.

Guadalajara Laparoscopy Project: This project aims at five to seven new laparoscopy teams per year, priority targeting from medical faculties, and 10-12 physicians per year will receive the refresher training.

I hope this information is helpful.

I enjoyed speaking with you.

A handwritten signature in cursive script that reads 'Janet Heroux'.

Janet Heroux
Acting Associate Director
Latin America and the Caribbean

JH/11

cc: Dr. Fernando Gomez

from JHPIEGO 5-year
strategy proposal

5-9-86 J. Huron

MEXICO

Through the Mexican Association of Medical Schools (AMFEM), JHPIEGO supported a major program to develop a family planning curriculum to be offered as part of the curricula of the medical faculties. The AMFEM project director conducted meetings for medical school deans and professors from all over Mexico to promote the teaching of a concise, practical and standardized course on contraceptive technology to second year medical students. By the end of the project, approximately 20,000 students at 34 medical schools were exposed to this course, and the course became an official part of the curricula at the majority of the participating medical schools.

Based on experience with the AMFEM model, JHPIEGO will be supporting a program at Mexican nursing schools to develop a family planning curriculum appropriate to nursing students and to institutionalize that curriculum. Nursing school deans and professors will attend advocacy and academic skills meetings where medical school deans and instructors from the successful AMFEM program will facilitate during the early stages of the program.

The government of Mexico has requested JHPIEGO assistance in supporting national and international conferences to improve skills in epidemiology and evaluation design of family planning programs based on reproductive risk. These seminars will be sponsored by AMIDEM, the Mexican Association of Medical Demography.

JHPIEGO is funding the teaching hospital of the University of Guadalajara, in Jalisco, to conduct a laparoscopy team training and laparoscopy refresher program. This project trains a limited number of physician - anesthetist - nurse teams in laparoscopy and updates ob/gyn physicians in laparoscopy. Participants come primarily from underserved areas in south and southwest Mexico. The project also includes annual conferences for high-level and specialist physicians from academia, and the public and private sector on (1) advances in gynecology, and (2) improvements in laparoscopy techniques. Support for this project will continue based on need, to address training needs in relatively underserved regions and provide opportunities for refresher training for ob/gyn physicians who have been working in the field with special emphasis on those from teaching institutions.

APPENDIX F

REPORTS OF VISITS TO VSC ACTIVITIES

REPORTE DE VISITA MEDICA AL CENTRO MATERNO-
INFANTIL Y DE PLANIFICACION FAMILIAR

Ciudad Juarez

FECHA: 28 y 29 de abril de 1986

Durante nuestra visita al Centro, el Dr. Joaquin Merino, médico Gineco-Obstetra hizo la presentación del personal y ademas de las nuevas areas que se estan construyendo (salas de operaciones, sala de expulsión de parto y recuperación).

El centro cuenta con 2 salas de operaciones y 15 camas de recuperación, y ofrece servicios de salud básica, Ginecología y Obstetricia, metodos temporales y permanentes de planificación familiar.

VSC Femeninos ofrecidos por ano:

<u>ANO</u>	<u>No. Casos</u>
1978	812
1979	917
1980	1,038
1981	1,168
1982	976
1983	841
1984	827
1985	907
1986 (hasta marzo)	194
T O T A L	<u>7,680</u>

El 30% de los casos son post-parto (in-patient), y el 70% de intervalo (out patient), de los cuales la gran mayoría son hechos por medio de mini-laparotomías (95%) y laparoscopias con bandas de silastic (5%). No tiene lista de espera y se observo la adecuada información y consejería que reciben los pacientes antes de operarse, ofrecido por medio de material impreso. Ademas se les explica claramente el contenido de la hoja de consentimiento (que esta de acuerdo con los estandares de AVSC). Se revisaron 10 formularios de consentimiento y todos estaban debidamente firmados por la paciente y los mantienen bien archivados. La referencia de los pacientes es por medio del programa de CBD y usuarios satisfechos.

En el pre-operatorio a la paciente se le practica examen general y examen de laboratorio de hemoglobina y hematocrito.

Se observó una Cesarea y luego un caso de mini-laparotomia post-parto en sala de operaciones equipadas con todo lo necesario para atender emergencias, incluyendo medicamentos y narcosis.

La mini-laparotomia se llevo a cabo previa asepsia y anestesia raquídea con una pequena incisión periumbilical, practicándose ligadura de trompas segun técnica de Pomeroy, y luego se cerró por planos y la piel se suturo con seda. La paciente fue monitorizada durante la operación y la duración de la operacion fue de 10 minutos.

El anestesiólogo, Dr. Gomez Badillo, usa lidocaina 2% sin epinefrina 300 - 360 mg. para la anestesia epidural, la cual se usa en el 100% de los casos. La anestesia local no se practica por la dificultad de obtener el Demerol y por las ventajas que les ofrece la anestesia epidural como son la relajación muscular en la paciente y mayor comodidad para el cirujano.

Como pre-anestesia, usan Diazepan mas Atropina 30 minutos antes.

Se practicó revisión del equipo de laparoscopia KLI, donado por JHPIEGO, encontrándose que el trocar no estaba afilado y varios empaques estaban arruinados por mas de un año. Tienen un 80% de seguimiento de los pacientes y reportaron complicaciones menores como hematomas en un 1% y no se reportaron muertes. Se discutió la importancia de informar a AVSC de las complicaciones menores y mayores, ya que en sus informes no tienen complicaciones.

Se observó un caso de vasectomía, por el Dr. Verdugo, medico cirujano, practicando en sus informes no tienen complicaciones.

Se observó un caso de vasectomía, por el Dr. Verdugo, medico cirujano, practicando 2 incisiones pequeñas escrotales, y ligó y corto el conducto deferente con interposición de fascia. La piel fue suturada con seda y se usó anestesia local. El paciente estuvo tranquilo durante la operacion y el Dr. Verdugo hablo con el constantemente durante la operacion que duro 20 minutos.

Tienen indicaciones escritas pre-y post-operatorias para vasectomías y VSC femeninas. Se han practicado 585 casos de vasectomías desde 1978 hasta mayo de 1986, con 2 casos de hematomas y 2 casos de infecciones de herida que evolucionaron sin problemas.

Se discutió la importancia de la supervisión medica en el programa de FEMAP con la Sra. Guadalupe de la Vega para poder promover el servicio de VSC con anestesia local, ofrecen asistencia técnica y servicios de alta calidad para los afiliados a FEMAP. Comentó la Sra. de la Vega que para fines de 1986 tendrán contratado al Supervisor Médico.

Observaciones especiales

- El centro ofrece servicio de VSC de alta calidad por sus instalaciones físicas y el personal adecuado.
- Se le da énfasis en lo relacionado a información y consejería del programa.
- El centro tiene cualidades para ser centro de adiestramiento, para promover servicios innovativos y de alta calidad, y además para ser duplicados entre los afiliados de FEMAP.

El objetivo de la visita al Hospital del IMSS era de observar los procedimientos de VSC. Se hizo contacto telefónico el día anterior con el Dr. Daniel García, director del hospital No. 6; pero desafortunadamente el día de la visita no se pudo observar ningún procedimiento por falta en la coordinación entre la Dirección y el Departamento de Gineco-Obstetricia. Sin embargo se entrevistó al Jefe del Departamento de Gineco-Obstetricia y se obtuvo la siguiente información: tienen un promedio de 100 casos de VSC por mes, de los cuales el 70% son post-parto y el 30% intervalos. Todos los casos se hacen por medio de mini-laparotomía con anestesia epidural (Xilocaina 2%), tienen laparoscopia y únicamente se usa para diagnóstico.

Refiere además que se están insertando DIU en un 35% de los pacientes en el post-parto inmediato (después de la expulsión de la placenta).

No se visitaron salas de operaciones por estar ocupadas.

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INFORME DE LA VISITA AL HOSPITAL GENERAL (SSA)

MEXICO D.F.

FECHA: 23 de Abril de 1986

CONTACTO: Dr. Guillermo Oropeza
Jefe de Servicio de Planificación Familiar y Endoscopia

Debido al reciente terremoto en la Ciudad de Mexico, el Hospital General sufrió muchos danos, tanto materiales como pérdidas humanas; la unidad completa del Departamento de Gineco/obstetricia fue destruida, y como consecuencia, hasta el momento no han podido iniciar sus actividades para atender a las usuarias que solicitan la Anticoncepción. Quirúrgica Voluntaria. El equipo que se usaba para atender los casos de anticoncepción quirúrgica voluntaria, fue destruido con excepción de la fuente de luz del laparoscopio. Actualmente las usuarias que solicitan los servicios de anticoncepción quirúrgica voluntaria, son referidas a otros hospitales pero tampoco las atienden por tener dificultades en ofrecer este servicio.

Se visitó la nueva unidad de Gineco-Obstetricia, que se esta construyendo contigua a la Unidad de Neumología que podra atender 10 casos de anticoncepción quirúrgica voluntaria diarios, y 2 casos de microcirugia semanales. Se espera sea inaugurada a fines de mayo del presente ano.

El Dr. Oropeza, comentó continuar interesado en llevar a cabo un estudio de "doble ciego," comparando dos tipos diferentes de analgésicos (Nubaina y Demerol), con Xilocaina como anestesia local para poder promover el uso de esta en anticoncepción quirúrgica voluntaria en Mexico, ya que se usa poco comparada con el bloqueo epidural.

Se discutió ampliamente las razones en la preferencia del uso de la anestesia epidural en la anticoncepción quirúrgica voluntaria, obteniéndose las siguientes razones:

1. A los médicos residentes desde el inicio de su formación se les ensena a realizar la anticoncepción quirúrgica voluntaria con anestesia epidural, por lo tanto no se les ha enseñado a usar la anestesia local.
2. Comodidad del Cirujano. La anestesia epidural ofrece una relajación muscular en la paciente y hace mas fácil la operación.
3. Por razones económicas, los anestesiólogos tienen mayor inclinación por la anestesia epidural para hacer mas indispensable su presencia en la sala de operaciones.

Se comentó la muerte de una paciente hace varios anos, debido a una anestesia epidural dada por un medico residente sin experiencia.

El Hospital General de Mexico, es un hospital de ensenanza de pre-grado y post-grado, y ademas por el volumen de pacientes que solicitan el servicio de anticoncepción quirúrgica voluntaria sería un lugar adecuado como centro de adiestramiento en técnicas de anticoncepción quifurgica voluntaria. Ademas, por lo menos una vez al ano se realizan conferencias sobre este tema.

VISITA MEDICA AL MODULO "BEATRIZ VALASCO DE ALEMAN
(S S A)
MEXICO, D.F.

CONTACTOS: Dr. Guillermo Avina
Cirujano Gineco-Obstetra, especialista en Laparoscopia y
Vasectomia.

Dr. Ramon Sanchez López
Anestesiólogo

Dr. Pedro Juarez
Dirección General de Planificación Familiar.

DIA DE LA VISITA: 22 de abril de 1986

El módulo "Beatriz Velasco de Aleman," se encuentra instalado dentro de una clínica de los Servicios Medicos Generales de la Secretaria de Salud, a donde normalmente acuden pacientes de status socio-económico medio, existiendo poca afluencia de pacientes de areas rurales, esto tal vez debido a que la clínica se encuentra ubicada en un area urbana de la Ciudad de Mexico.

El módulo se encuentra dotado de espacios funcionales, contando con todos los servicios: agua, electricidad, etc. Cuenta ademas con un area de recepción, orientación, cuarto para examen medico, area quirúrgica y cuarto para recuperación. El cuarto de examen clínico cuenta con todo el equipo necesario. Las condiciones en general, son adecuadas y con buena higiene.

Los servicios con los que cuenta el módulo son exclusivamente de anticoncepción quirúrgica voluntaria. Debe tomarse en cuenta que el módulo comenzó a funcionar en diciembre de 1982, es decir, lleva un poco mas de 3 anos en operación.

Los servicios de seguimiento post-operatorio son tambien llevados a cabo dentro del módulo.

Los procedimientos quirúrgicos que se realizaron en 1985, son la minlaparotomía con la técnica de Pomeroy (10 al ano), la laparoscopia (327 al ano), y la vasectomía local con sedacion (39 al ano).

El módulo cuenta con el equipo indicado para realizar laparotomias en caso necesario.

Los procedimientos son realizados en forma ambulatoria, siendo los pacientes dados de alta en un término de aproximadamente 2 o 3 horas despues de la cirugía.

Los servicios son prestados 5 días a la semana, 6 horas diarias, existiendo una guardia los fines de semana, quien atiende a aquellos pacientes que pudieran presentarse a consecuencia de probables complicaciones.

Los pacientes no tienen que ser colocados en lista de espera, ya que una vez que son entregados sus exámenes de laboratorio, son admitidos el mismo día.

La orientación que recibe el paciente, es tanto pre-operatoria como post-operatoria. En el primero, se le explican los diferentes métodos de anticoncepción, así como las posibles complicaciones y molestias de la operación que en ocasiones pudieran presentarse. En el post-operatorio, se le indican los cuidados que se debe tener posteriores a la cirugía.

La orientación pre-operatoria es iniciada en un principio por la trabajadora social y, posteriormente por el médico al realizar un examen clínico de la paciente, el cual se realiza el día de la cirugía.

Las pruebas de laboratorio solicitadas a la paciente en el pre-operatorio, son la Biometría Hemática, el VDRL, examen general de orina y la espermatobioscopia en forma directa. No se cuenta con laboratorio clínico del módulo, por lo que se envía a la paciente a la clínica adjunta.

Existen formas de consentimiento en cada uno de los expedientes clínicos, las cuales se adaptan en su totalidad a las normas establecidas por AVSC, aunque en ocasiones falta la firma del médico cirujano y del paciente. Se revisaron 10 expedientes clínicos, faltando la firma del paciente en 7 expedientes.

En relación a los records médicos, estos son llevados adecuadamente, contando como se había mencionado anteriormente con hojas de consentimiento.

El control post-operatorio en la vasectomía se realiza a los 7 días y al haberse realizado 25 eyaculaciones, indicando 48 horas de reposo absoluto después de la cirugía. Para las salpingoclasias, se cita a la paciente a los 7 días, en el mismo módulo. No se cuenta con hoja de indicaciones post-operatorias para la paciente.

En caso de alguna emergencia, existen hospitales de la SSA a corta distancia donde las pacientes pueden ser atendidas fácilmente.

El módulo cuenta con el personal necesario para llevar a cabo los procedimientos: cirujano, anestesiólogo, enfermera y trabajadora social, todos trabajando en tiempo parcial.

En relación a complicaciones, se refiere una sola en 3 años, siendo esta una torción de testículo, la cual fue reportada a AVSC. No se ha reportado muerte alguna.

PROCEDIMIENTO QUIRURGICO

La vasectomía se llevó a cabo con 2 incisiones escrotales y los conductos deferentes fueron ligados con interposición de fascia y luego la piel fue suturada con seda. El paciente no experimentó molestias y en forma general el procedimiento fue muy bueno. El tiempo operatorio fue de 20 minutos.

Laparoscopia: Previa asepsia, cateterización de vejiga urinaria, examen ginecológico e inserción de elevador uterino, se hizo incisión periumbilical y la insuflación abdominal con aire ambiental. El método de oclusión tubaria fue fulguración por medio de electrocoagulación. La paciente experimentó ligeras molestias durante el procedimiento y estuvo constantemente monitorizada. El tiempo operatorio fue de 18 minutos.

Anestesia: La anestesia local con Xilocaina simple al 2% con sedación es utilizada para todos los procedimientos de laparoscopia, aunque mas bien, puede ser clasificada como neurolepto analgesia, puesto que los medicamentos utilizados son una mezcla de los siguientes:

- Fentanil - 2 microgramos X Kg. de peso.
- Sulfato de Atropina - 7 a 10 microgramos X Kg. de peso.
- Diazepan - 50 microgramos X Kg. de peso.
- Ketamina - 250 microgramos X Kg. de peso.

Estos son utilizados tanto para vasectomías como para salpingoclasias, aunque en estas ultimas es utilizado el droperidol en lugar del diazepan. Existen medicamentos para emergencias pero no disponen de narcan.

Comentarios Generales:

- Se refiere una falta de promoción y difusión de los padecimientos quirúrgicos, lo que ayudaría grandemente a incrementar el número de procedimientos.
- No existe material de apoyo en relación a folleteria o propaganda, esencialmente para las vasectomía.
- No cuentan con cauterizador para vasectomías, lo que disminuiría el tiempo de operación.
- En general, puede decirse que este programa es realizado de acuerdo a los estandares médicos de AVSC y que existe una muy alta seguridad para el paciente.

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REPORTE DE VISITA A SUPERACION FAMILIAR

IRAPUATO, A.C.

FECHA: 25 de abril de 1986

CONTACTO: Sra. Silvia de Diaz Duran
Directora de Superación Familiar Irapuato.

Dr. Jose Rodolfo Torrero
Jefe de P.F. Hospital General B. Irapuato

Superación Familiar de Irapuato es un afiliado de FEMAP, localizado en el Estado de Guanajuato, considerado con la tasa de crecimiento más alta del país. La ciudad tiene 500,000 habitantes aproximadamente.

Superación Familiar, ofrece servicios de Planificación Familiar temporales, consulta básica de Ginecología y Obstetricia y hace referencia de pacientes para VSC al Hospital General B de la SSA que han sido motivadas por el Programa de Distribución Comunitaria de Anticonceptivos que cuenta con 52 promotoras voluntarias.

Una clínica se esta construyendo con donativos locales y dará servicios de VSC, métodos temporales de P.F., prenatal y atención de partos.

AVSC esta financiando los servicios de VSC desde febrero de 1985, que se utilizan para proveer el material gastable y medicamentos utilizados en cada paciente que son operados en dicho hospital. El número de procedimientos desde febrero de 1985 hasta febrero de 1986 son 294 femeninas y una vasectomia. El 90% de los procedimientos femeninos son post-parto y el 10% de intervalo. La información y consejería de los pacientes se hace por la trabajadora social y por el médico, y para estos propósitos no tienen material informativo.

Se revisaron 10 consentimientos para autorización de la VSC, los cuales estaban debidamente firmados por el solicitante y llenaban los requisitos de AVSC.

Las pacientes reciben una examen físico pre-operatorio y se les practica exámenes de hematocrito y hemoglobina.

Se observó un procedimiento quirúrgico post-parto por el Dr. Torrero, médico general en el Hospital General B, previa anestesia epidural y asepsia se practico incisión subumbilical, identificando las trompas de falopio, las cuales fueron ligadas segun técnica de Pomeroy modificada y luego se cierra los tejidos por planos y la piel con seda. La paciente no fue monitorizada por el anestesiólogo durante la operación ni durante el post-operatorio.

La anestesia epidural se usa en 100% de los casos con Xilocaina simple al 2% (15 cc) mas Xilocaina con epimefrina al 2% (2 cc), mas solución de bicarbonato al 7.5%.

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La anestesia local no se practica en estos casos por desconocimiento de la técnica por el cirujano y la fuerte inclinación del anesthesiólogo hacia la anestesia epidural. El procedimiento quirúrgico duró una hora 5 minutos, las pacientes para ser operadas tienen que ser ingresadas un día antes de la cirugía y se les da el alta un día después, debido a que la minilaparotomía se considera cirugía mayor. Únicamente el 25% de los pacientes operados tienen seguimiento en el hospital y el resto se lleva a cabo por las promotoras del programa de distribución comunitaria. No reportaron complicaciones y se les recomendó la importancia de hacer reporte de complicaciones a AVSC, ya que normalmente existen en todos los programas.

El hospital cuenta con 3 salas de operaciones y 7 camas de recuperación, las instalaciones en general son adecuadas y tienen medicamentos para emergencias. En el hospital no existe narcosis.

Existe un equipo de laparoscopia en buenas condiciones donado por DIPLAF; pero no se usa debido a que el cirujano no ha recibido adiestramiento para su uso.

Observaciones especiales:

- A. La hoja de consentimiento firmada se archiva en las oficinas de Superación Familiar y se recomendó agregar fotocopia del consentimiento firmado al expediente clínico de la paciente que se archiva en el hospital.
- B. Se recomendó hacer un mejor seguimiento de los pacientes que reciben el servicio de VSC.
- C. Se recomienda que el cirujano tenga un adiestramiento formal en técnicas de VSC para reducir el tiempo operatorio y estancia hospitalaria de la paciente.

VISITA AL HOSPITAL DEL INSTITUTO MEXICANO
DEL SEGURO SOCIAL - IRAPUATO

FECHA: 25 de abril de 1985.

CONTACTOS: DR. EZEQUIEL COLIN
Director Médico del IMSS

DR. XAVIER OROSCO VARGAS
Jefe de Gineco-Obstetricia. IMSS

El objetivo de la visita al Hospital del IMSS, es el de obtener información de los servicios de Planificación Familiar ofrecidos y de observar sus instalaciones físicas. Se obtuvo la siguiente información de las personas contactadas:

Durante 1985 se atendieron

VSC femenina: 950
Vasectomías: 51

1986 (1er. trimestre)

VSC femenina: 171
Vasectomías: 2

El procedimiento quirúrgico femenino se lleva a cabo durante el post-parto, post-aborto e intervalo, de los cuales 90% son mini-laparotomías y 10% laparoscopías. La anestesia epidural predomina en el 80% y la anestesia local en el 20% (Xilocaína 1%, más Fentanil).

La vasectomía se hace a través de una incisión escrotal, con corte y fulguración del VASO deferente, se usaba anteriormente la anestesia raquídea y actualmente se usa la anestesia local.

Debido a la saturación de las salas de operaciones tienen demanda insatisfecha y están operando los días sábados, para poder atender la demanda.

La mayoría de los pacientes son referidos por el programa de parteras empíricas, que reciben adiestramiento en el hospital.

Se hizo un recorrido por las 4 salas de operaciones del Hospital, las cuales son muy adecuadas.

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REPORTE DE LA VISITA A PRO-SUPERACION FAMILIAR NEOLONESA, A.C.MONTERREY, NUEVO LEON

El Censo de 1980, reportó para el estado de Nuevo León, una población de 2'513,044 habitantes, esperándose para 1990 y el año 2000: 3'362,000 y 4'499,000 habitantes respectivamente. La tasa bruta de natalidad en 1980 fue de 33.1%, con un crecimiento natural de 2.83%. La tasa global de fecundidad para el estado de Nuevo León, es de 4.36 hijos promedio por mujer. El porcentaje estimado de usuarias es del 33%, siendo necesario aumentarlo al 48.7% si se quiere reducir la fecundidad a 3.57 hijos promedio para 1990.

El programa de Pro-Superación Familiar Neolonesa, no cuenta con servicios propios, siendo éstos otorgados a través de las unidades de la Secretaría de Salud. Pro-Superación Familiar Neolonesa, A.C., cuenta con un grupo de médicos, enfermeras y trabajadoras sociales que se encuentran asignados a la Maternidad "Lolita", al "Centro de Salud No. 4 de Guadalupe", y al "Hospital Metropolitano", todas unidades de la SSA. En ocasiones el personal de médicos, enfermeras y trabajadoras sociales se desplaza a hospitales de localidades vecinas a realizar procedimientos de AQV que es llamado jornadas móviles de anticoncepción quirúrgica voluntaria.

Existe una gran coordinación entre Pro-Superación Familiar Neolonesa y el Director del Programa Materno Infantil de la Secretaría de Salud. Esta coordinación es el punto mas importante de trabajo, ya que significa un buen modelo de cómo los sectores público y privado pueden trabajar conjuntamente para incrementar los objetivos del programa.

Probablemente, una de las debilidades del programa, sea que Pro-Superación Familiar Neolonesa no cuenta con metas claras en cuanto a los resultados de esta coordinación, siendo necesario el establecimiento de técnicas quirúrgicas más sencillas como la minilaparotomía, así como de técnicas de anestesia más seguras para los pacientes.

Por otro lado, es importante el desarrollo de seminarios en cuanto a normas de seguridad para médicos y anesthesiólogos así como demás personal involucrado en la prestación de servicios, con el fin de analizarse más a fondo las ventajas tanto de la mini-laparotomía, así como de la anestesia local con sedación.

La introducción de estas técnicas dentro del personal de la Secretaría de Salud, podrá permitir que en un futuro la relación entre Pro-Superación Neolonesa y la SSA sea cada vez menor, trayendo ésto como consecuencia la autosuficiencia de los médicos de la Secretaría de Salud, su menor dependencia de la asociación privada y a su vez, un mejor desarrollo del programa dentro de la Secretaría de Salud.

Positivamente para el programa, se tiene que, tanto el Hospital Lolita como el Hospital Metropolitano cuentan con residencia de Ginecología y Obstetricia, lo que los coloca como hospitales de enseñanza donde los residentes están siendo entrenados en las técnicas de la anticoncepción quirúrgica.

Contribución de AVSC:

Desde 1980 a octubre de 1986, AVSC ha presupuestado US \$296,344 que han sido utilizados para dotar 2 salas completas para cirugía de los servicios de los hospitales "Lolita" y "Guadalupe", y un laprocator y mesa de cirugía que se asignaron al hospital Metropolitano de la SSA de Monterrey y para cubrir otros gastos del programa.

Logros:

De julio de 1984 a marzo de 1986, se han realizado aproximadamente 3,000 procedimientos, básicamente de anticoncepción femenina. Desde el inicio del proyecto en septiembre de 1980, se han realizado 6,500 procedimientos aproximadamente de AQV.

Este programa no tiene dentro de sus objetivos entrenamiento a personal, sin embargo, un gran número de médicos residentes han sido capacitados en técnicas de anticoncepción quirúrgica en los Hospitales "Lolita" y "Metropolitano".

Durante el último año, puede decirse que el programa ha estado cumpliendo con sus objetivos, sin embargo, no es posible opinar en relación a años anteriores.

El presupuesto aprobado para 20 meses podrá extenderse a 28, y así sobrepasar las metas establecidas dentro del mismo presupuesto.

Desafortunadamente no fue posible observar cirugía en las clínicas, ya que los médicos se encontraban en un Seminario de Vasectomía en la Ciudad de Guadalajara, Jal., financiado por AVSC, y la Academia Mexicana de Demografía Médica (AMIDEM). Sin embargo, puede decirse que la mayoría de los procedimientos realizados en la Maternidad Lolita son de post-parto con anestesia local. En este programa se utiliza para los procedimientos de intervalo, la laparoscopia, utilizando anestesia local con sedación (para ésta, se utiliza una mezcla de Ketamina, Fentanil, Valium y DHBP), considerada en algunos casos como neuroleptoanalgesia.

Desafortunadamente, el uso de mini-laparotomía de intervalo no es considerada como una alternativa, siendo éste uno de los propósitos futuros de trabajo.

En relación a la hoja de consentimiento, ésta se encuentra de acuerdo con las normas establecidas por AVSC. Es firmada por la paciente en forma voluntaria y debe mencionarse la falta de la firma del médico en algunas ocasiones.

En general, puede decirse que las salas de cirugía se encuentran en buenas condiciones, con limpieza adecuada y con el equipo y material suficiente para atender una emergencia en caso de que ésta pudiera presentarse.

Dirección y Supervisión:

La Asociación Pro-Superación Familiar Neolonesa, aún no ha recibido supervisión alguna de FEMAP. La supervisión de AVSC ha sido más que nada de tipo administrativo.

La estructura de la asociación parece ser muy débil, ya que sólo tiene a la Presidenta quien es la principal ejecutora del programa y a cuatro responsables de sus diferentes subprogramas, junto con un administrador para la parte financiera. Cada uno de los programas son independientes, siendo éstos el de adolescentes, educación e información, el quirúrgico y el de distribución comunitaria. Se debe anotar que la parte financiera y de manejo de fondos, cuenta con personal adecuado, encontrándose todo en orden.

AVSC, podría contribuir más en este programa proporcionado ayuda técnica y asesorías en mayor grado.

Contribuciones del Proyecto:

La más importante es la colaboración que éste tiene con la Secretaría de Salud, ya que la Asociación no tiene que contar con instalaciones propias, sino que son utilizadas las del Sector Salud. Esto a su vez, promueve el desarrollo de programas en el Sector Salud y como consecuencia, provee a la comunidad con un mayor campo de acción.

Pro-Superación Familiar Neolonesa, cuenta con 30 pasantes de la Escuela de Medicina que son utilizados para la promoción de la planificación familiar en las áreas más desprotegidas de los servicios. Esto crea a su vez, una mayor conciencia en estos médicos en cuanto a la importancia de la planificación familiar.

Los pacientes que acuden a estos servicios son los más necesitados, ya que en su mayoría carecen de seguridad social.

Al parecer, no se ha hecho algún esfuerzo para expandir este modelo, aunque AVSC debiera utilizarlo probablemente para aumentar la eficiencia de otros programas.

Estadísticas Generales:

El Instituto Mexicano del Seguro Social, realiza la mayoría de los procedimientos. En 1985 se reportaron 9,550 oclusiones tubarias en el Estado de Nuevo León, de las cuales 9,482 fueron realizadas en la población derechohabiente. El número de vasectomías fue de 113, de las cuales 6 se realizaron a la población abierta.

La meta de activas del Instituto para el Programa de P.F. para 1985, fué de 128,907, lográndose una cobertura de 164,128 (45.2% del número de mujeres en edad fértil).

La Secretaría de Salud reportó para 1985, 855 mini-laparotomías post-parto, 56 de intervalo, 336 laparoscopías y 22 vasectomías. El total de usuarias nuevas para el mismo año fué de 743 para los métodos de planificación familiar en general y de 3,762 para las usuarias activas.

Gracias a este proyecto, ha sido posible apreciar la coordinación entre el Sector Salud y la organización privada, lo que nos dá una imagen y perspectiva mayor para acciones futuras.

Es necesario trabajar un poco más con la SSA para lograr la completa institucionalización de los servicios.

Para este proyecto, se ve la necesidad de asignar los recursos en forma diferente, sin tener que aumentar más fondos. Para éstos, es importante la realización de seminarios que promuevan la seguridad y calidad de los servicios, así como el desarrollo de estándares médicos. Asimismo, debiera promoverse por medio de entrenamientos o demostraciones, las técnicas de mini-laparotomías con anestesia local y sedación y la vasectomía.

Otra posibilidad sería el desarrollo de un programa de docencia en anti-concepción quirúrgica para poder ser introducido al curriculum de los médicos de la residencia de Ginecoobstetricia, así como la entrada al Hospital Universitario, tratándose posiblemente de realizar alguna coordinación.

Otra posibilidad de acción, sería la de explorar junto con los médicos pasantes, mejores medios para poder llegar más cerca a la comunidad y así, proporcionar una información más fácilmente aceptable y entendible por la población.

La realización de las jornadas móviles podría permitir por otro lado, no sólo la provisión del servicio, sino además el entrenamiento de los médicos de estos hospitales menores del Estado de Nuevo Leon en las técnicas de anticoncepción quirúrgica. Es así, como estas jornadas pudieran utilizarse como medio de educación y entrenamiento a mayor número de individuos que posteriormente podrían ser utilizados en la prestación de nuevos servicios.

Se recomienda por el momento, el proyecto se continúe manejando directamente y no a través de FEMAP, ya que constituye un modelo muy interesante de colaboración entre el sector privado y el público, con un alto potencial para la institucionalización, lo que significa un nuevo campo de trabajo para el futuro en México.

Por otro lado, la estructura de costos es muy diferente a la de otros programas apoyados por FEMAP, ya que la contribución del Estado y los volúmenes de casos que se logran, permiten que éstos sean de aproximadamente la tercera parte de los que se presentan en otros programas del país.

Por último, este proyecto al carecer de la asistencia técnica necesaria no ha sido explorado más a fondo para poder aprovechar todo su potencial, lo que deberá hacerse en el futuro más cuidadosamente con el fin de servir de modelo a otros programas de México y de la Región.

REPORT ON THE VISIT TO "MATERNIDAD LOLITA" (SSA)
IN MONTERREY, NUEVO LEON

Contacts: Dr. Jesus Gonzales, Hospital Director
Alma Rosa Suarez, Social Worker
Dr. Alma Rosa Lozano, Family Planning M.D.
Blanca Ruth Ramirez, Registered Nurse

"Maternidad Lolita" is located in an urban area in the municipality of San Pedro Graza Garcia. The patients have easy access to the clinic, since it was set up in an area with a high demand for services.

The locative facilities are adequate and with good hygiene conditions. The clinic has 40 beds and several medical offices for consultation and a specific office for family planning consultation. It has an x-ray room and laboratory as well as a surgical area with two operating rooms, which are well equipped and emergency equipment and drugs are available.

The voluntary surgical contraception program is provided mainly on an in-patient basis and it is carried out by third year residents from the G.O. training. The VSC team includes physicians, anesthesiologist, nurses, paramedics and social workers.

The social worker talks with the women pre and post-partum, explaining in detail about the variety of family planning methods, their advantages and disadvantages, including the surgical contraception procedures. She also explains the reproductive function.

When a client voluntarily decides on surgery, an informed consent form is signed. These forms were reviewed and were found in the medical file, according to AVSC standards, although the doctor's signature was missing on some of them.

The medical exam is performed before the surgery, although the gynecological exam is done in the surgery room. The lab tests are performed on the day of surgery.

Minilaparotomy is performed postpartum and laparoscopy is usually interval. These are performed during morning sessions exclusively.

Epidural anesthesia is used for postpartum and local anesthesia with analgesia for laparoscopies. Drugs used for analgesia are: Phentanyl, Valium, DHBP and Ketamina, all microdoses. There was just one complication reported as a result of epidural anesthesia.

The postpartum length of stay is 24 hours. With laparoscopies, discharge occurs the same day. Follow-up consultation takes place seven days afterwards.

It is important to mention that some interval patients are transported to and from the clinic in vehicles provided by the Asociacion Pro-Superacion-Familiar Neolonesa. This is very practical for the patients.

Statistics

	<u>1985</u>	<u>1986 (until March)</u>
Deliveries	1797	603
C. Sections	747	182
Female VSC	578	164
Hysterectomies	65	N.A.

General Comments

"Maternidad Lolita" is a hospital with adequate facilities providing medical care of good quality and with all the necessary equipment to perform surgical contraceptive procedures.

The personnel in general consider that a more active promotion of family planning will increase the demand for the services, and will increase as a consequence the number of surgical contraceptive procedures.

REPORT ON THE VISIT TO THE "HOSPITAL MORONES PRIETO"
(IMSS) IN MONTERREY, NUEVO LEON.

The institution provides gynecological and obstetrical services only.

The locative facilities are in excellent condition, hygienic and well equipped.

There are nine surgery rooms, for all kinds of gynecological operations. The quality and quantity of personnel is good, and there is a very high standard of medical care in general terms.

It was possible to observe a surgical operation during the visit: a laparoscopy using Yoon rings and performed under local anesthesia with analgesia. The drugs used for analgesia were microdoses of valium, phentanyl, ketalar and athropine. At the incision site, xylocaine without opinephrine was used.

Operation time was 15 minutes. It appeared that the surgeon has an excellent practice and manual ability.

Four to six female procedures are reportedly performed every day on an average, and two to three vasectomies per week.

Informed consent forms are always signed, and voluntarism plays an important role in this matter.

The Mexican Institute of Social Security appears to be the health institution performing the greater number of surgical procedures.

The female procedures are mini-laparotomy and laparoscopy. Minilaparotomy is mainly performed postpartum or postabortion under epidural anesthesia. Local anesthesia is never used.

FEMALE SURGICAL PROCEDURES 1985

IMSS Affiliates:

Postpartum	244
Postabortion	6
Interval	484

Non-IMSS Affiliates: 51

Total of procedures: 785

FEMALE SURGICAL PROCEDURES JANUARY - MARCH 1986

Mini-laparotomy	23
Laparoscopy	108
Trans-cesarean	50

Total of procedures: 181

MALE SURGICAL PROCEDURES

1985:	124
1986	43

VISIT TO FAMILY PLANNING ASSOCIATION OF TIJUANA,
BAJA, CALIFORNIA NORTE

This institution was formed in 1979 as a private, non-profit agency. In 1980 it received support from FPIA for a CBD and education program, and from AVSC for a voluntary surgical contraception program. In 1982 FPIA canceled its support, cancelling not only the funds, but also the main source of referrals for the VSC program. In this year AVSC became its only source of support, apart from the small amounts charged to clients.

Tijuana is one of the largest cities in Mexico, with more than 1.3 million inhabitants, and a tremendous lack of VSC services. The IMSS performed in its hospital in Tijuana during 1985 only 700 VSC procedures. The SSA hospitals do not provide this service and used to refer the cases to the FPA. The Association is located in a comfortable building, in the central area of Tijuana and offers services in prenatal care, gynecology, cancer detection and temporary family planning besides VSC. Unfortunately, for reasons not very well established, these services are demanded only by a small number of people.

Since 1980, AVSC has budgeted \$277,155 to support the remodelling of the building to include operating and recovery rooms for VSC, equipment for dedicated space and general support. Also, the main surgeon was trained in vasectomy at Propater in Sao Paulo, Brazil. The result of this effort was less than one could expect. Since its beginning in 1980 up to February 1986, a total of 812 female and 91 vasectomies have been performed. Program officials feel that without the CBD program they did not have a good way to get the message to the people. In the last eighteen months, the program performed 391 VSC procedures, or 50 percent of the service objectives.

The program offers its services in a nice environment; the facilities are very clean and well taken care of. The surgical room has all the necessary equipment. The surgeons and paramedical personnel are well trained, and the procedures are performed according to AVSC Medical Standards. Laparoscopy under local anesthesia and sedation is the normal procedure. For all the patients they have a record that includes the medical history, informed consent and laboratory test results. The informed consent form complies with AVSC guidelines, and the staff take care to write in the medical records.

Management is the main problem with this Association. It was created according to the FEMAP model with a Board of Directors (Patronato), an Administration Director and the staff. In the early stages of this process, there were severe disagreements between the Board and the Director. According to reports given to us for perusal at the clinic, the Board has not met since 1982 and has played no role since then. Community support, a plus in other FEMAP programs, does not exist in this program, and the Association has no plan, sense of direction, objectives, or idea of what its mission should be. Because of the particular situation of this program, FEMAP has played a small part, if anything, during the last years, and for most practical purposes do not consider this Association as part of its system.

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FEMAP did not feel any obligation, or felt that they did not have any authority to monitor or supervise this Association with which they were having problems themselves.

AVSC helped to create a facility that has all that is needed to provide high quality VSC services, but it failed to recognize the administrative and general problems that were making this institution operate at a less than satisfactory level. With technical assistance in I & E and administration, this organization could have performed much better.

It is very difficult to assess the contribution of this organization, other than to perform a few cases. They have good surgical procedures and techniques, but they do not pass their experience on to others in the community. Their impact is limited because of the low caseload and the little knowledge that other health providers have about this facility.

Without AVSC support, this clinic cannot function for a single day, and unless major changes are carried out, there is no reason to commit more funds to this project. It is our recommendation that the present organization be dissolved, the staff compensated and have FEMAP organize a new group that will operate under a difficult structure.

qb

MEDICAL REPORT ON THE VISIT TO THE FAMILY PLANNING
ASSOCIATION OF TIJUANA, BAJA CALIFORNIA, NORTE

This clinic is located in downtown Tijuana, in a two-floor house with an easy access to the public. The first floor has a reception room, two doctors office, laundry room, and a room for equipment sterilization. The second floor has a recovery room with five beds and the dressing and surgery rooms.

The doctors offices are very well equiped. Both have stetosopes, sphigmomanometers, and all the necessary instruments for gynecological exams.

It was possible to observe three VSC procedures: two laparoscopies and a minilaparotomy. Laparotomies were performed under local anesthesia plus analgesia, using a combination of rohipnol (1 amp), nubain (2 amp), ketalar (3 cc), and athropine (0.5). The dosis used were microdosis.

In general terms, the medical standards can be considered high. Surgical techniques are performed appropriately and the surgeon's ability is excellent.

Medical records are in order. They have the patient history, informed consent forms, and lab test results.

Medical personnel are very well qualified, and the provision of services can be considered within a good medical quality.

Unfortunately, and despite the excellent service provided by the institution, the number of patients is still very low. Although the clinic also provides family planning consultation, prenatal care, cancer detection, and gynecological consultation, it has not been possible to increase the number of VSC procedures.

APPENDIX G

EXCERPTS RELATED TO FEMAP
FROM DRAFT REPORT OF EVALUATION
OF FPIA PROGRAM IN LATIN AMERICA
WILLIAM BAIR NOVEMBER 1985

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FPIA PROGRAMS IN BRAZIL, PERU, AND MEXICO:

TRIP REPORT SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

1. Overall Performance

The projects visited in Brazil, Peru and Mexico demonstrate that FPIA is succeeding extremely well in achieving a major objective--to extend family planning information and services to socio-economic classes which have previously had limited access to them. Though often including other maternal and child health services, the predominant health intervention provided in these projects has been family planning. As confirmed by USAID population officers, FPIA has developed projects that fit USAID population strategies and are supportive of U.S. and host country objectives.

Institutions have been selected for FPIA support that have made a policy impact and have extended significant family planning services. The successful experimentation with networking of institutions through The Brazilian Association of Family Planning Agencies (ABEPF) and The Mexican Federation of Private Associations for Family Planning (FEMAP) suggests a good potential for building national institutional capability and multiplying the effectiveness of FPIA support. Five out of the six projects visited were led by women, and women were actively involved at all levels of project implementation.

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2. Community Links

Although most successful in involving community leaders in service delivery in Peru and Mexico, FPIA has also made progress in this direction in Brazil. The conservative policy approach of political, medical and religious leaders in Brazil, however, constrains the organized programs from more expansive, community-based approaches. The widespread availability of contraceptives in the pharmacies at reasonable prices suggests that closer linkages with these channels would be desirable. Unlike many physician-dominated projects, the Center for Research and Studies Clovis Selgado (CEPCS) was doing very well, at least in the initial stages close to Belo Horizonte.

3. Reporting, Monitoring and Evaluating

FPIA has developed a system and a manual of instruction for counting and reporting family planning service clients. The system, however, is not uniformly well understood and compliance is uneven. The system more effectively serves FPIA's reporting purposes than the local project management needs.

FPIA's project development system and monitoring of projects is impressive. Measurable objectives are stated, a time-phased plan of action is developed, and monitoring of progress is accomplished through regular reports and project visits by FPIA personnel.

Calculating impact of projects on contraceptive prevalence, however, is fraught with difficulties, not the least of which is the task of estimating the population of the project catchment

area. Some tentative estimates were made suggesting a range of from two percent to 13 percent prevalence related to these projects. In any event the provision of some 70,000 couple years of protection and service to approximately 100,000 new users in this project period is a significant contribution to expanding the availability of family planning services.

Recommendation: AID and FPIA, together with other organizations, should review the service statistics system and make appropriate modifications. Consideration should be given to including a measure of couple years of protection. Project managers should also be encouraged to make more analysis of the relation between clients reported and the quantities of contraceptives distributed.

4. Cost Factors

4.1 Self-Sufficiency

Projects demonstrate efforts at income generation and encouragement of institutions to work toward self-sufficiency. Attention is paid to seeking low-cost approaches to service delivery--in most instances with considerable success. Three of the projects had costs to FPIA of less than \$9 per new user and \$12 or less per couple year of protection. Two of the higher cost projects, ABEFF and FEMAP, had considerable administrative overhead as new subprojects in the networks continued to be initiated. Future productivity should reduce the costs per client. The higher cost with the Center for Research and Integrated Attention to Mothers and Children (CPAIMC) in Brazil

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appeared related to its higher cost supervisory system and reduced client numbers.

The emphasis on income generation and encouragement for projects to become self-sufficient is positive. In some cases, however, this concern may have been carried to an extreme. For example, several of FEMAP's subprojects express their long-range plans solely in terms of reducing FPIA/FEMAP input and increasing local input.

Recommendation: The emphasis on self-sufficiency and income generation should be continued; realistic expectations should be developed of how much can be expected from client charges without interfering with client use; and plans for self-sufficiency should not divert attention from other elements of long-range planning. Greater linkages with the commercial sector should be explored, especially in Brazil, both as a means to extending services and to developing approaches more likely to be self-sustaining.

4.2 Budgeting

The rapid inflation in Latin America puts in question FPIA's system of budgeting in current value local currency. Staff complained that much time was wasted in repeated readjustments of the budget to bring it in line with new financial situations. The perception in the field was that FPIA was adamant on the issue. The field, however, does not see as a solution that projects should be paid in dollars, although both

AID/W and FPIA headquarters in New York impute this point of view to the field.

Recommendation: AID and FPIA should continue to review the practice of budgeting in current value local currency and initiate increased communication with USAIDs and project directors to develop a mutually satisfactory approach.

5. Program Considerations

5.1 Logistics

By and large, commodity logistics are handled very well; commodities are warehoused carefully and appropriate systems are used to document shipments, receipts and distribution. Problems of shipment delays associated with customs regulations have been encountered in Brazil and Mexico.

5.2 Information, Education and Communication (IEC)

The FEMAP project has a strong emphasis on information, education and communication (IEC), using a combination of media, client informational materials and person-to-person approaches. The other projects, however, especially those in Brazil, could profit from a stronger emphasis on IEC.

Recommendation: Increased attention should be given to IEC.

5.3 Invitational Travel

FPIA has used travel grants for project managers especially in Mexico to provide training opportunities and exposure to project approaches in other countries. More emphasis on invitational travel would also strengthen other projects.

Recommendation: Greater use should be made of invitational travel.

6. Relations with USAID

FPIA has done well in aligning its projects with USAID and host country priorities and strategies. It appears, however, that this has been accomplished with little dialogue with USAID and other institutions.

Recommendation: FPIA representatives should consult more actively with USAIDs and other agencies in developing their plans and strategies.

7. Summary Recommendation

In summary, these effective projects are a good indication of the substantial contribution FPIA makes to extending family planning services. Problems encountered were relatively minor in comparison to the positive results being obtained.

Recommendation: AID should continue a substantial level of support to these activities.

APPENDIX Q4

MEXICO: TRIP REPORT

Project Visited: Mexico-25: Mexican Federation of Private Family Planning Associations (FEMAP)

1. Background

This project with the Mexican Federation of Private Family Planning Associations (FEMAP) is in its second funding period, 1/1/85-4/30/86. The initial period was 10/1/83-12/31/84.

The specific stated objectives of this project period are to initiate seven new CBD projects in various cities in Mexico and to maintain support for the five subprojects begun in the initial period. A combined total of 21,000 - 27,000 new and 6,100 continuing clients is expected.

FEMAP is a non-profit federation which was organized in 1981 largely due to the success of the pioneering efforts of the Program of Maternal and Child Health and Family Planning, initiated in 1973 in Juarez, Mexico and replicated later in several other cities. From six member association, which served 0.5 percent of Mexico's family planning users, FEMAP has grown to include 22 affiliates operating in 32 cities in 14 states and serving six percent of the country's total users.

The Juarez experience and the subsequent FEMAP model are noted for their program of maternal/child health with a strong emphasis on family planning (all methods), community participation, leadership of women and the dependence on volunteers.

2. Broad Issues

1) How and why was this project selected?

This project was selected to support the expansion of the FEMAP model. Although there is a strong government policy and reasonably strong government health institutions providing family planning services in Mexico, a significant percent of the poor population is outside their reach. The contribution of the private sector, particularly as it involves volunteers and community leaders, adds an important qualitative dimension to the service provided. The high level of continuity of users in the program, (said to be up to 85 percent for one year and 65 percent for five years as compared to less than 50 percent for other programs), is an indication of the quality of the program. The results of a recent study of users in the Juarez project, showing that 75 percent of the users had never used contraceptives before, indicates that this model represents a previously unmet need. FEMAP considers the program the highest quality in Mexico in retention of clients, impact on prevalence in the target area, and involvement of volunteers.

2) What are the objectives of this project?

FEMAP's goals are to extend its program to more cities of Mexico. This objective is consistent with its efforts to secure funding from other donors for the same purpose.

3) Are the objectives of this project appropriate to host country needs?

FEMAP's objectives are consistent with the Mexican government's strong policy to reduce the population growth rate and to extend health and family planning services beyond the population reached by the government program.

4) Are the objectives of this project appropriate to AID objectives and strategy?

With its private sector, expansive, service delivery emphasis, and its involvement of volunteers, women's leadership, community participation, and focus on self-sufficiency, the project is consistent with AID strategy. USAID is very supportive of FPIA assistance to this project.

5) Is this project breaking new ground and if so, what are the policy implications?

Both the creation of a network of FPIA-supported projects and the development of an administrative center which uses FPIA procedures represent new approaches in Mexico. The mutually supportive FEMAP-FPIA partnership which has evolved for developing, funding and monitoring subprojects is said to be excellent by both FEMAP and FPIA personnel. Some of the lessons learned in this relationship in Mexico should be examined in Brazil and Peru.

Programatically, the project is demonstrating how a reasonably broad concern for maternal and child health can be maintained while emphasis is placed on family planning. Those who have become doctrinaire on either side of the MCH/FP issue can

learn from this project. The CBD approach backed by medical services providing IUDs and surgical contraception is not particularly new. On the other hand, the organization to coordinate all these elements and the strong emphasis on volunteers and community participation are unique.

6) What plans exist for continuation of the project when FPIA support ceases?

This project has placed considerable emphasis on self-sufficiency and the generation of local support (see question 7 below). Indeed, the clinic in the Juarez project is now self-sufficient, thanks in part to client fees. Nevertheless, it is apparent that expansion to meet the needs of a growing number of WIFA, a higher percentage of whom are seeking family planning, cannot be financed by user fees alone. FEMAP is not at all sanguine about its ability to meet increased demand, and at the same time to become self-sufficient.

7) Does this project include income generation activities and if so what are their nature?

FEMAP is trying a variety of income-generating activities including campaigns, fairs, and bazaars. Initial experimentation with commercial sales of contraceptives indicates some potential in this area. Each subproject document emphasizes the need for local participation in the provision of land and buildings and in the development of a plan for phased down FEMAP support. Client fees are used to defray some of the costs. Information on the

actual funds generated is limited, but it was estimated at about 25 percent of program costs.

3. Issues Relating to Implementation

1) Project Design--is there evidence of long-term advance planning and/or regional coordination?

At the subproject level, the issue of long-range planning is inextricably linked to that of self-sufficiency, and most subproject long-range plans are stated in financial phase down terms, rather than expressions of programmatic interest or strategy. At headquarters level, FEMAP states that its long-range plan is to cover all the major population centers of the country, depending on the availability of resources. Although FEMAP does strategic planning to identify the most critical areas requiring additional services, its expansion is conditioned primarily by leadership interest and organizational capability in particular cities.

FEMAP leaders note a growth in public awareness of FEMAP and the importance of its program. They feel this may eventually result in governmental or industry subsidies but cite economic conditions in the country as making this unlikely in the near future. They cite examples of positive results from their efforts to collaborate with state and city governments or with the Ministry of Health. With continued government in-kind contributions and more frequent clinic referrals to public facilities, FEMAP will be able to expand its operations to some

degree. Only with sustained international support, however, can it hope to achieve significant growth.

2) Number and Quality of Staff

FEMAP has an excellent 19-person staff of enthusiastic, well-qualified personnel, including physicians, economists, psychologists, social scientists, accountants, administration and support personnel. Of these, FPIA supports six professionals and two secretaries. Field staff have been developed with help from both FEMAP and FPIA. FPIA funds are used to pay salaries of 95 field staff: 12 administrative, 15 physicians, four nursing, 18 social worker supervisors of CBD, 20 CBD coordinators and the rest support staff.

Although all subproject directors and most other staff are women, male staff predominate in the central office. The national director, however, is female.

Management style is personal and informal. There is a great deal of interaction and interpersonal communication perfectly suitable for an organization that is growing and developing. As the program becomes more complex, however, it may be necessary to formalize some of the communication and working relationships and to narrow the span of control of top management. Efforts, however, should be made to retain the current level of enthusiasm, spontaneity and initiative in the growing process.

3) Information Services including Outreach Activities

IEC and outreach are hallmarks of the FEMAP approach. Interpersonal communication at the community level through CDE distributors backed by coordinators is combined with printed community and client informational materials provided by FPIA/PPFA, Spanish-language materials, and materials published by FEMAP. FEMAP is convinced that a strong IEC component is essential to its success among clients.

4) Are training and technical assistance needs for administration/management and program delivery being met?

FPIA, Development Associates and other institutions have been effective in assisting FEMAP in this area. FEMAP employs the FPIA style of management-by-objectives in all subprojects, adapted and simplified as appropriate. A noteworthy accomplishment has been the development of a series of procedural manuals, including an adapted project proposal form, a modified report form, a complete manual describing the FEMAP model and the steps required to put it into operation, and an administrative manual providing step-by-step directions for project proposals and administrative procedures. FPIA's assistance, provided mostly through training site visits, is obvious, especially in the administrative manual, proposal and report forms.

A substantial number of the FEMAP staff have had training at Columbia University, JHPIEGO, and in other stateside training programs. Several indicated they profited greatly from observation travel to Brazil, Colombia and India.

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5) Administration and management - are there problems?

Of the organizations examined, FEMAP demonstrated the clearest understanding of the FPIA client-counting procedures. It has a clear and adequate system of internal reports on clients which counts new users, eliminates dropouts and thus measures "active" users. A special review of records will be required to produce the FPIA designated "continuing users," a process FEMAP staff say they are willing and able to accomplish. They see it, however, only as something useful for FPIA with no value for program management purposes.

Perhaps because of a lower rate of inflation, more overall resources and a very capable administrator, FEMAP expressed little of the concern regarding the budget process that was evident in Brazil and Peru. On the other hand, the USAID Population Officer found the currency issue a problem, and also expressed concern regarding turnover of FPIA staff and delays in project documentation. FPIA delegates considerable authority to FEMAP for subproject approval and budget modification. This appears to be a key element in the remarkable progress FEMAP has made in developing its procedures and subprojects.

From a review of subproject proposals, trip reports and the review and feedback made by FEMAP staff on subproject reports, it is apparent that FEMAP staff are handling their responsibilities in a professional and competent fashion. It is not uncommon to see in a subproject quarterly report mention of a much appreciated technical assistance visit from FEMAP personnel.

A significant problem exists in the importation of commodities. The procedure is that each subproject must order contraceptives direct from FPIA New York through the appropriate coordinating office. This is a cumbersome approach and one which leaves FEMAP little control. FPIA, FEMAP and the national (government) coordination officer for family planning (who has the main responsibility) are working to develop alternative approaches.

6) Quality of Services - do staff have up-to-date information on service delivery techniques, contraceptive technology, etc.?

Considerable attention is given to circulating pertinent information by mail and through personal visits. In one subproject visited, there was good evidence of appropriate medical supervision and a knowledgeable coordinator and supervisors. Careful follow-up was provided to clients. In the maternity and MCH clinic visited in Juarez, (not part of this FEMAP project but closely related to it), the attention to appropriate quality care was apparent. The voluntary nature of sterilization is emphasized and the provisions of PD-3 are followed.

7) Evaluation Activities including Use of Service Statistics and Feedback to Implement Needed Improvements.

Appropriate service statistics forms have been developed, and recent modification of the quarterly report form from the subprojects will provide even better information. The need

remains for a way to estimate continuing users. The local coordinator's monthly report provides information on users by method and by promoter but none on contraceptives distributed. The quarterly report to FEMAP does have contraceptive distribution amounts, but there is little indication of analysis of user numbers compared with amounts distributed.

The FEMAP evaluator, with his recently hired assistant, does a careful analysis of user figures and provides feedback to each project. Partially because projects operate on different trimesters, there has been little comparative analysis among projects, and no consolidated reports are issued. Subproject personnel, however, confer on major problems. As the number of subprojects increases, additional analysis and reporting techniques will be needed.

Staff visits to subprojects are an important element in evaluation, and several trip reports reviewed indicate careful analysis and attention to relevant issues including staff and client verification through interviews.

From time to time, FEMAP engages in ad hoc studies of client and staff characteristics and performance. Those that were reviewed, (a profile of Juarez users, characteristics of coordinators and distributors, and a study of adolescents), provide useful information for program guidance.

8) Cost Data including Calculations of Cost per Client Served.

FEMAP has an effective accounting system which can quickly provide current information on central office expenditures and disbursements to subprojects. There has been an attempt in subproject development to predict costs per user and this issue is followed in regular quarterly analyses. The use of different fiscal periods for FPIA and for various subprojects complicates analysis, but FEMAP will be able to do more complex analysis as experience is gained. A preliminary analysis was made as part of this evaluation of total users, new users, contraceptives distributed, couple years of protection and costs (see Table 1)

There is considerable variation in subproject performance, particularly between projects in their first period and those in their second. Start-up time required high overhead (central office) expenditures, with the central office having used 43 percent of the budget in the first fiscal period compared to 32 percent in the second. This reduction was apparently accomplished by increasing efficiency, since the second period was also an expansion period. Cost (central and subproject) of total users went down from about \$30 in the first period to \$18 in the second, with the cost of new users remaining about the same, between \$25 and ~~430~~.

It is too early to draw conclusions about costs per user compared to other projects. FEMAP's high retention rate should be taken into consideration when comparing the cost of new users. Trends appear to be moving in the right direction, and

	Date Started	USER: JANUARY - OCTOBER 1985				CONTRACEPTIVE DISTRIBUTED						COUPLE YEARS PROTECT	
		Total	Cost/User without/with central/central costs / costs	New	Cost/User without/with central/central costs / costs	Pill Cycles	Per User Month	Condom Units	Per User Month	IUD Units	Per New User	Number	Cost without/with
Promex 01 Irapuato 15,625 unprotected MWIFA	second period Feb. 1, 1985	2,356	\$10-\$15	1,198	\$20-\$29	7,897	1.04	3873	1.4	435	1	72	\$14-20
Promex 02 Leon 35,200 unprotected MWIFA	second period Feb. 1, 1985	1,681	\$11-\$16	912	\$20-\$30	4,890	1.2	30,120	4.96	37	1	677	\$28-\$41
Promex 05 Sactillo 23,000 unprotected MWIFA	second period March 1, 1985	1,824	\$10-\$14 actual estimate 8-12 see note below	914	19-28 but 13-20	6,781	1.1	16,029	4.06	116	1	923	(19-28)
Promex 06 Chihuahua (Delicias Sancillo Camargo, Jimenez Mauque - 87244	second period June 1985	2,885	\$11-\$16 \$ figures are for all of 85 so the actual cost about: \$6-\$8	1,359	\$23-\$34 estimate at \$11-\$16	10,500	1.1	11,729	7.9	40	1	989	32-47 estimate at \$15-\$22
Promex 07 Guadalupe 283,500	first period Feb. 1, 1985	847	\$19-\$27	866	\$18-\$26								
Promex 08 Jucapa 40,000	first period Feb. 1, 1985	1,342	\$11-\$17	1,380	\$11-\$16	3,620	.88	5,840	3.1	26	1-3	386	\$40-\$59
Promex 09 Chamapa 80,000	first period thru Feb. 1, 1985	1,824	\$9-\$14	855	\$20-\$29	2,634	.38	17,216	4.2	68	1	493	\$35-51
Promex 10 Cuahatemoc	first period June 1, 1985	701	\$19-\$28	710	18-27	2,251	1.6	6,030	16			215	\$62-\$91

COST DATA FOR FEMAP FPIA SUBPROJECT

Table 1

First period central costs as % of total - 43%
 second period central costs as % of total - 32%

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the Juarez experience suggests that the policy of starting slowly to build capability and quality performance can result in greater productivity. Nevertheless it is apparent that the present level of output is not particularly low cost.

The cost (and quality) issue is also affected by the amount of contraceptives distributed per client. Although the orals per user months and the IUDs per new user are about what are to be expected, the condom levels are significantly low. The cost of new users (at the project level--not including central costs) ranges from \$11 to \$23 and that of total users from \$6 to \$19. The cost of a CYP, however, ranges from \$14 to \$40 without central costs among projects operational for at least six months. (Global project calculation of FPIA investment indicate \$30/new user, \$18/active user and \$45/CYP).

9) Income Generating Components.

Many approaches are being considered to gain community and government support. Significant in-kind contributions have been provided both at the local and central level, but financial contributions have been minimal. There is considerable reluctance to charge clients for service, except for specialized functions like pap smears, pregnancy testing, some medical exams and maternity services. An effort to begin charging clients a nominal (\$0.10/cycle) fee for contraceptives resulted in a dramatic drop in clients in Chihuahua and a strong negative reaction from the community distributors. This is still being

explored as are several retail commercialization of contraceptive schemes.

10) Commodities and Logistics.

The handling of commodities was the only significantly weak administrative spot noted in this otherwise well-supported network. Due to the import requirements of the Mexican government, FPIA supplies can be delayed in Brownsville for eight months or more before arriving in Mexico, under the direction of the National Family Planning Commission, for delivery to the various projects. Delivery is not regular, and fully adequate procedures have not been developed to monitor the process. Nevertheless, with good relations among project directors and with government officials, loans and transfers are worked out and supplies of contraceptives seem to be generally moving in appropriate quantities. Other items on the commodity list are a more critical problem at this time.

11) Contraceptive prevalence--how much results from the project?

In developing its subprojects, FEMAP has used a simple but effective process of identifying the potential size of the target population. Based on census and various survey data, total population of the area is estimated, married WIFA calculated and an estimate made of those women not served by the official programs. These unprotected married WIFA are considered FEMAP's target group. The number totals about 588,000 in the

subproject areas now operating. FEMAP reports 13,463 total users in these areas--a number that probably is closer to being "active" users than in most projects. Thus the contribution to prevalence is about two percent overall, with as much as 15 percent in a smaller target population where the project has operated for two years.

The project is meeting its goals of beginning new sub-projects and developing the management system necessary to service them. Its service delivery goals are lagging somewhat at this stage of the second project period. With 10 months or 62 percent completed, the project has met 25 percent of its 15,500 new user goal from new projects. (Several of the new projects are just now beginning and momentum should pick up.) The project has met 52 percent of its 8,500 new user goal from old projects and has met 86 percent of its 6,100 continuing user goal.

PERSONS CONTACTED

CPAIMC - Rio de Janeiro

Dr. Helio Aguinaga	CPAIMC Director
Mrs. Lia Kropsch	Project Director
Ms. Estela Goncalves	Project Coordinator

Medical, nursing and auxiliary personnel at the central clinic and at community units in Vasco, Prazeres and Parque Union. Warehouseman at central headquarters.

ABEPF - Rio de Janeiro and Belo Horizonte

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Ms. Rosele Paschoalick	Project Coordinator
Dr. Ivo de Oliveira Lopes	Project Director at Sofia Feldman Hospital

Nursing and auxiliary personnel at Sofia Feldman and community leaders at mini-post in Monte Azul.

CEPECS - Belo Horizonte

Dr. Delzio de Moura	President
Dr. Alberto Henrique Rocha	Project Director
Dr. Roberto Lana Peixoto	Project Coordinator
Dr. Anthony D.G. Abranches	Medical Supervisor
Dr. Antonio Alexo Neta	Medical Supervisor

Medical, nursing and auxiliary personnel in community posts at Serra and Betania. Warehouseman at central headquarters.

CAYETANO HEREDIA UNIVERSITY - Lima

Dr. Carlos Munoz	Project Director
Dr. Victor Diaz	Project Coordinator
Dr. Luz Jefferson	Technical Assessor

Social workers, nursing and medical personnel at Hospital Loayza.

COMMUNITY DISTRIBUTION - Carmen de la Legua, Lima

Dr. Cesar Guzman	Project Director
Ms. Tania	IEC Director
Ms. Maria	Community Program Director

Coordinators and distributors in community based distribution areas in the "Pueblos Jovenes"

FEMAP - Juarez

Mrs. Guadalupe de la Vega	President
Dr. Ernesto Barraza	Executive Director
Dr. Enrique Suarez	IEC Coordinator
Lic. Humberto Ortiz	Evaluation Coordinator
Lic. Manuel Castillo	Administrator
Lic. Jesus Servin	Program Development Coordinator
Lic. Mario Reyes Tellez	Project Administrator, Chihuahua
Dr. Manuel Gonzalez Velazquez	Medical Supervisor, Chihuahua
Ms. Sylvia and Rosie	Community Distribution Supervisors

Community coordinators and distributors in marginal communities around Chihuahua.

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The projects visited in Brazil, Peru and Mexico demonstrate that FPIA is succeeding extremely well in achieving a major objective - to extend family planning information and services to socio-economic classes who have previously had limited access to them. Though often including other maternal and child health services, the predominant health intervention provided in these projects has been family planning. As confirmed by the USAID population officers, FPIA has developed projects which fit the USAID population strategies and are supportive of U.S. and host country objectives.

Institutions have been selected for FPIA support which have made a policy impact as well as extending significant family planning services. The successful experimentation with net working of institutions through ABEPF in Brazil and FEMAP in Mexico, suggest a good potential for building national institutional capability and multiplying the effectiveness of FPIA support. Five out of the six projects visited were led by women and women were actively involved at all levels of project implementation.

Calculating impact of these projects on contraceptive prevalence is fraught with difficulties, not the least of which is the task of estimating the population of the project catchment area. Some tentative estimates were made suggesting a range of from 2% to 13% prevalence related to these projects. In any event the provision of some 70,000 couple years of protection and service to approximately 100,000 new users in this project period is a significant contribution to expanding the availability of family planning services.

Projects demonstrate efforts at income generation and encouragement of institutions to work toward self sufficiency. Attention is paid to seeking low cost approaches to service delivery - in most instances with considerable success. Three of the projects had costs to FPIA of less than \$9/new user and \$12 or less per couple year of protection. Two of the higher cost projects, ABEPF and FEMAP, had considerable administrative overhead as they are in a start up phase with sub projects in the net work. Hopefully future productivity will reduce the costs per client. The higher cost with CPAIMC appeared related to its higher cost supervisory system and reduced client numbers.

Although most successful in involving community leaders in service delivery in Peru and Mexico, FPIA's efforts in this direction were also apparent in Brazil. The more conservative policy approach of political, medical and religious leaders in Brazil constrains the organized programs from more expansive, community based approaches. On the other hand, the widespread availability of contraceptives in the pharmacies at reasonable prices suggests closer linkages with these channels would be desirable. To the surprise of the evaluator, the physician dominated, facility based approach in Minas Gerais, Brazil, was doing very well; at least in these initial stages close to Belo Horizonte.

FPIA's project development system and monitoring of projects is impressive. Measurable objectives are stated, a time phased plan of action is developed and monitoring of progress is accomplished through regular reports and project visits by FPIA personnel.

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Dr. Cesar Guzman	Project Director
Ms. Tania	IEC Director
Ms. Maria	Community Program Director

Coordinators and distributors in community based distribution areas in the "Pueblos Jovenes"

FEMAP - Juarez

Mrs. Guadalupe de la Vega	President
Dr. Ernesto Barraza	Executive Director
Dr. Enrique Suarez	IEC Coordinator
Lic. Humberto Ortiz	Evaluation Coordinator
Lic. Manuel Castillo	Administrator
Lic. Jesus Servin	Program Development Coordinator
Lic. Mario Reyes Tellez	Project Administrator, Chihuahua
Dr. Manuel Gonzalez Velazquez	Medical Supervisor, Chihuahua
Ms. Sylvia and Rosie	Community Distribution Supervisors

Community coordinators and distributors in marginal communities around Chihuahua.

Appendix H

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