

**MIDTERM PROGRAM REVIEW OF
THE U.S. - MEXICO PROGRAM
OF COLLABORATION ON POPULATION
AND REPRODUCTIVE HEALTH**

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by
Judith R. Seltzer
Karen Johnson Lassner
S. Ken Yamashita

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Edited and Produced by

Population Technical Assistance Project
1611 North Kent Street, Suite 508
Arlington, VA 22209 USA
Phone: 703/247-8630
Fax: 703/247-8640
E-mail: poptech@bhm.com

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The review team congratulates the Mexican institutions for their appreciation of and response to this report. During the few months in which the draft report was being reviewed by USAID, its CAs, and the Mexican institutions, the five key institutions (CONAPO, IMSS/RO, IMSS/S, ISSSTE, and SSA) had already started to implement a number of the recommendations. This fact bodes well for the likely outcome of this joint review and for the continued strengthening of the Mexican programs in reproductive health and family planning.

LIST OF ABBREVIATIONS

CA	Cooperating Agency
CBD	community-based distributor
CCO	Operations Coordination Committee
COESPO	State Population Council (<i>Consejo Estatal de Población</i>)
CONAPO	National Population Council (<i>Consejo Nacional de Población</i>)
CORA	Center of Orientation for Adolescents (<i>Centro de Orientación para Adolescentes</i>)
CPR	contraceptive prevalence rate
ENADID	1992 National Demographic Dynamics Survey (<i>Encuesta Nacional de la Dinámica Demográfica 1992</i>)
ENPF	1995 National Family Planning Survey (<i>Encuesta Nacional de la Planificación Familiar 1995</i>)
FEMAP	Mexican Federation of Private Health and Community Development Associations (<i>Federación Mexicana de Asociaciones Privadas de Planificación Familiar</i>)
FHI	Family Health International
FPLM	Family Planning Logistics Management (project)
FY	fiscal year
GIRE	Association for Information on Reproductive Choice (<i>Grupo de Información en Reproducción Elegida</i>)
GOM	Government of Mexico
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency virus
IEC	information, education, and communication
IMSS	Mexican Social Security Institute (<i>Instituto Mexicano del Seguro Social</i>)
IMSS/RO	IMSS/ <i>Regimen Ordinario</i>
IMSS/S	IMSS/ <i>Solidaridad</i>
INEGI	National Institute of Statistics, Geography, and Information
INOPAL	Operations Research Project in Family Planning, Maternal-Child Health for Latin America and the Caribbean
IPC	interpersonal communications
IPPF	International Planned Parenthood Federation
ISSSTE	Social Security Institute for Government Workers (<i>Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado</i>)
IUD	intrauterine device
JICA	Japanese International Cooperation Agency
JHU/PCS	The Johns Hopkins University/Population Communication Services project
JSI	John Snow, Inc.
MCH	maternal and child health
MEXFAM	Mexican Family Planning Foundation (<i>Fundación Mexicana para Planificación</i>)

Familiar)

Minilap	minilaparotomy
MOU	memorandum of understanding
NGO	nongovernmental organization
NSV	no-scalpel vasectomy
OB/GYN	obstetrics/gynecology
OC	oral contraceptive
ODA	Overseas Development Administration
OR	operations research
POE	post-obstetrical event
PSC	personal services contract
QOC	quality of care
R4	Results Review and Resource Request
RH	reproductive health
SDES	Service Delivery Expansion Support
SDP	service delivery point
SEP	Ministry of Education (<i>Secretaría de Educación Pública</i>)
SOMARC	Social Marketing for Change (project)
SSA	Ministry of Health (<i>Secretaría de Salud</i>)
TBA	traditional birth attendant
TFR	total fertility rate
TOT	training of trainers
UNAM/SPP	Universidad Nacional Autónoma de México/Secretaría de Programación y Presupuesto
UNFPA	United Nations Population Fund
UNICEF	United Nations Childrens Fund
U.S.	United States
USAID	United States Agency for International Development
USAID/M	United States Agency for International Development/Mexico
USAID/W	United States Agency for International Development/Washington, D.C.
VSC	voluntary surgical contraception
WHO	World Health Organization

EXECUTIVE SUMMARY

Introduction

The midterm program review of the United States Agency for International Development's (USAID) public sector population strategy in Mexico was carried out by a three-person team from September 16 to October 9, 1996. This review of the public sector component of USAID's population strategy was a collaborative effort involving both Government of Mexico (GOM) and USAID officials as well as independent evaluation experts. Its purposes were to assess the progress achieved in the U.S.-Mexican program of cooperation; to identify areas for improvement and/or intensification of effort during the remainder of the program; and to develop the preliminary framework for a long-term collaboration between the parties. The private sector component of the USAID population strategy in Mexico was reviewed in February 1996.

The current U.S.-Mexican assistance program was built on the experience of nearly two decades of collaboration between the GOM and USAID during which time a true partnership has developed. The Mexican program of reproductive health and family planning has become one of the most extensive and successful in the developing world, so much so that Mexico is increasingly playing a leadership role in South-to-South exchanges. Given the program's strengths and its maturity, increasing attention is being devoted to improving the quality of service delivery. Part of the impetus for this focus on quality has come from the GOM's strong endorsement of reproductive health and rights from the 1994 Cairo Plan of Action.

A memorandum of understanding (MOU), signed between the two governments in June 1992, established a five-year (amended to six-year) agreement for 1992-98. This agreement involves the National Population Council (CONAPO), the GOM's population policy, planning, and coordinating body and the three major public health institutions (the Mexican Social Security Institute [IMSS], the Ministry of Health [SSA], and the Social Security Institute for Government Workers [ISSSTE]) which provide health services to the vast majority of the Mexican population. The objectives of the MOU were to increase access to family planning and reproductive health services particularly among the unserved population and to increase the programmatic self-sufficiency of an expanded health care infrastructure. The MOU outlined the following four broad areas of assistance: 1) training to increase access to the most effective methods and to improve quality of services; 2) expanded service delivery capacity in rural areas; 3) information, education, and communication (IEC); and 4) research. Resources have been concentrated in nine priority states which have the most need in terms of social and economic well-being.

This Executive Summary presents the highlights of the public sector program's progress with special attention given to improvements in the quality of the program. The major areas for future improvements in the program are discussed in the Summary of Key Recommendations. The

Summary of Key Recommendations does not include all the recommendations contained in the report; however, for ease of reference, numbering of recommendations is consistent throughout the report.

Highlights of the Program's Progress

The National Family Planning Program of the GOM has made significant progress during the first three years of the MOU. A large and increasing percentage of the Mexican population uses contraception and the total fertility rate (TFR) has fallen—by nearly one child in some states. These are important accomplishments that have been made in a very short period of time.

Access

Access to family planning has expanded due to 1) extensive training of providers (both medical and paramedical with a particular emphasis on those working at rural facilities); 2) different service delivery strategies (such as postpartum procedures and special sessions or *jornadas* for voluntary surgical contraception [VSC]); and 3) increased communication activities designed to reach special groups such as adolescents and rural populations. In addition, use of more effective contraceptive methods (both male and female VSC, intrauterine devices (IUDs), and to a lesser extent injectables) has increased as use of pills and traditional methods has declined.

Quality of Care

The quality of services has also improved due to a variety of interventions supported by the MOU. These interventions have involved all three of the Mexican public health institutions and have addressed all of the components of quality of care (QOC) to varying degrees.¹ The major thrust of the interventions has been to strengthen technical competence, improve information given to clients, and expand the choice of contraceptive methods. Attention has also been given to improving interpersonal skills, ensuring continuity and follow-up, and promoting an appropriate constellation of services.

Improving Technical Competence. The GOM's Official Norm for family planning service delivery (revised in 1993) addresses appropriate service delivery standards, presents a wide range of contraceptive methods, and mandates information and counseling as integral components of family planning care. The norms have been adopted by each of the institutions and provide an excellent basis for improving QOC. The principal interventions supported by the MOU have been 1) developing and disseminating service delivery guidelines, 2) training, 3) providing

¹Bruce, J. 1990. "Fundamental Elements of Quality of Care: A Simple Framework." Studies in Family Planning 21, 2:61-90.

equipment and 4) counseling. Improvement of interpersonal skills has been addressed within the context of counseling curricula development and training.

(1) **Service Delivery Guidelines.** Service delivery guidelines have been developed for minilaparotomy using local anesthesia and sedation and for no-scalpel vasectomy (NSV). They represent years of cumulative experience on the part of USAID Cooperating Agencies (CAs) and the Mexicans and provide solid technical ground on which to build training and quality service delivery programs. The guidelines have been incorporated in the training curricula.

(2) **Training.** Various training activities have been carried out including the development of training curricula and training of trainers (TOT) and providers. Training curricula and manuals have been produced in all public sector institutions for the following: family planning counseling, post-obstetrical IUD insertion, minilaparotomy using local anesthesia, and NSV. SSA has also developed training curricula for interpersonal communications (IPC), postpartum contraception, and for training nurse supervisors in in-service training and supervision of health auxiliaries. The training activities, most of which are competency-based, are based on the standards of the Official Norm and reinforce appropriate quality of care (QOC) standards.

As a result of the training at all three institutions, clinical skills have been improved in minilaparotomy using local anesthesia (interval and post-obstetrical event), NSV, and IUD insertion (interval and post-obstetrical event). Site visits by the review team confirm that post-obstetrical event (POE) contraception is a routinely provided family planning service. More recently, training has improved adolescent reproductive health.

(3) **Equipment and Supplies.** Under the MOU, contributions of large quantities of equipment, instruments, service delivery supplies, and training materials have supported improvements in the technical competence of providers. All institutions have received equipment and materials for training.

(4) **Counseling.** Significant advances have been made in counseling for family planning and voluntary surgical contraception (VSC). A top-level commitment to counseling has been made by all institutions and family planning and VSC counseling curricula are beginning to be institutionalized. Counseling trainers have been trained in all institutions; these counseling trainers have in turn trained thousands of providers. As a result, counseling is becoming a routine component of public-sector family planning service provision, particularly for interval family planning services.

Information Given to Clients. Because of the Official Norm's emphasis on information and counseling as components of family planning care, most women receiving family planning services in the Mexican public sector get the information and counseling they need to make an

informed choice about their contraceptive method. Considerable MOU resources have been directed to the development of IEC materials—videos, large and small flip charts, pamphlets, booklets, and posters. A large number of these materials have been produced with specific reference to each of the institutions. These materials were seen during sites visits; however, their availability is uneven.

Method Choice. The most significant intervention supported by the MOU to expand contraceptive method choice has been the training of rural-based non-physicians in family planning, with an emphasis on IUD insertion. In addition to increasing access, the purpose of these training activities has been to improve the supply of contraceptives by increasing the number of contraceptive methods available at a particular service delivery level.

Appropriate Constellation of Services. The most important achievement in improving the constellation of services by the three Mexican institutions has been the integration of family planning into the broader context of reproductive health services—if not into the mainstream of primary health care. This is particularly true at IMSS/Solidaridad (IMSS/S) and ISSSTE where family health specialists and family doctors have been trained in family planning and are increasingly responsible for provision of temporary methods of contraception.

Monitoring and Evaluation

The GOM has a well-developed system for monitoring and evaluating the National Family Planning Program. With support from the MOU, impressive research and evaluation activities are being carried out. CONAPO's work to evaluate the demand and supply for family planning will provide critical information to guide future program efforts. Research findings and data are used in a multi-level, iterative process involving CONAPO and the three service delivery institutions to develop annual plans for the National Family Planning Program. Service statistics are used by institutions to set future targets and budgets and to assess program performance. IMSS's, SSA's, and ISSSTE's service statistics systems are an important resource for monitoring and improving programs. The extent of the QOC research demonstrates the high level of GOM interest and openness to improving the quality of services and is applauded.

Program Sustainability

The GOM has made significant progress toward achieving goals to strengthen sustainability identified at the beginning of the MOU. The progress is evident both generally, in overall funding for the program, and, more specifically, in funding of contraceptive procurement.

Financing. The GOM's commitment to reproductive health and family planning and to the terms of the MOU is impressive. The government has increased its financial support for family planning every year since the beginning of the MOU. In 1995-96, it is estimated that the GOM funded 90 percent of the program with 5 percent coming from USAID and the remaining 5

percent coming from other donors. The fact that the budget allocations withstood Mexico's severe economic crisis of 1994-95 is evidence of the government's strong commitment to reproductive health and family planning and to the terms of the MOU.

Contraceptive Procurement. The GOM has made significant strides toward self-reliance in purchasing contraceptive commodities. The government has increased its budget allocation for family planning contraceptive commodities each year for the past three years, reaching nearly 100 percent in 1996. Understandably, Mexican officials are extremely proud of this accomplishment. At the same time, they value USAID support in this area because the terms of the MOU were used as leverage with the Ministry of Finance to obtain the necessary funding. Under the MOU, USAID has supported training of public sector officials in contraceptive logistics management. The training appears to have been highly successful and is an important step in the move toward self-reliance in purchasing contraceptive commodities.

Implementation of the MOU

Inter-institutional Coordination. Coordination among the key GOM institutions directly involved in population matters and in implementing the MOU has been very effective. It is attributable largely to the personal commitment of the institutional leaders and is facilitated by the USAID MOU mechanism. While coordination has been especially good at the national level, owing to the Operations Coordination Committee (CCO), examples of programmatic and local-level coordination also exist. The GOM institutions are congratulated on the excellent level of coordination that currently exists; USAID's role in improving the coordination is also commended.

Technical Assistance. Even though technical assistance was not anticipated at the beginning of the MOU, it has been provided along with the financial support. Each of the Mexican institutions associated with the MOU has received varying levels and types of assistance from several CAs including Pathfinder, AVSC International, The Population Council, and the Population Communication Services (PCS) project of The Johns Hopkins University. The GOM institutions have generally found the assistance useful and the programs have clearly benefited from it.

Preliminary Framework for Long-term U.S. and Mexican Collaboration

The accomplishments of the past three years should be viewed in the context of the overall Mexican Reproductive Health and Family Planning Program. The total Mexican population was just over 93 million in 1996 and the number of family planning users is estimated to be over 8.5 million. Bringing about changes in access and improvements in quality at the major public health institutions means reaching thousands of medical units and SDP's and tens of thousands of medical and paramedical personnel. The GOM has provided the resources and has made the

commitment to fulfill its goals and USAID has been an important partner in this process. From the previous discussion, it is obvious that considerable progress has been made in a very short period of time, but that a number of critical improvements are still needed.

The review team is confident that progress in both expanding access and improving quality will continue given the strong commitment from the GOM and the continued, albeit diminishing, support from USAID and other donors. The high level of professionalism, candor, and openness of the Mexican officials with whom the review team collaborated in this review is essential to this continued progress. USAID's role for the remaining years of the MOU should be to build on the work carried out at each of the institutions over the past three years. USAID's CAs should assist the GOM in addressing those areas highlighted in this report, especially those that will bring about even greater improvements in the quality of services. While the recommendations are numerous, they represent a milestone in the further advancement of the Mexican program which is already one of the most mature among programs in developing countries.

The GOM and USAID have forged a special relationship in reproductive health and family planning under the MOU which may be unique among such bilateral programs. An important element of this relationship has been the financial support from USAID, but the critical element has been the nature and level of collaboration between the Mexican and U.S. institutions. It is, therefore, in the long-term interest of both countries to sustain this relationship at some level. A centerpiece of this future relationship between the GOM and USAID should be the growing role of Mexico as one of the leading countries for South-to-South exchanges.

SUMMARY OF KEY RECOMMENDATIONS

The following discussion highlights areas that need improvement or intensification of effort during the remainder of the MOU and beyond. For each topic, relevant recommendations are made. These recommendations represent the majority of those included in the body of the report.

Access

Despite continuing progress, a higher than average unmet need for family planning exists in rural areas in most of the priority states and among certain population subgroups, including less-educated women and young women and couples who are just beginning their reproductive lives. In addition, constraints to access (limited knowledge of contraception and fear of side-effects) continue to exist, although these are limited to particular areas and population subgroups.

Recommendation 7: Consistent with the high priority given to family planning by the GOM, USAID should continue its commitment to the partnership with the GOM by focusing its resources, through the remainder of the MOU, on those areas of lowest prevalence in order to increase access to population subgroups that still have unmet need.

Quality of Care

For the remainder of the MOU, USAID resources should continue to support improvements in QOC with emphasis on strengthening technical competence, consolidating information activities, and assuring a wide choice of contraceptive methods.

Norms. Subsequent to the 1993 revision of the Official Norm, new GOM policies have been issued with stronger emphasis on QOC, particularly from the client's perspective. Service providers continue to have an unmet need for information on the service delivery norms.

Recommendation 14: SSA and other health sector institutions should consider updating the Official Mexican Family Planning Service Norm and the institution-specific guidelines of the IMSS and ISSSTE. USAID resources through the MOU are to complement those of the GOM for this purpose. Among the suggested revisions is the incorporation of a discussion of reproductive health and family planning service delivery with particular emphasis on the client's perspective. Systematic efforts should also be supported to ensure dissemination of the norms (including alternative communication strategies to get key policy and technical information to service providers) and to ensure comprehension and practice of these norms.

Technical Competence. While USAID CAs have provided substantial support to improve technical competence, the following areas need improvement:

- (1) Out-patient female VSC services in rural medical units.

Recommendation 16: An expert surgical contraceptive technical review team should be established to review the recently developed service delivery guidelines and adapt them, if necessary, before resuming USAID funding of these services. (Subsequent to the midterm review a team of experts carried out the recommended review and found the guidelines satisfactory.)

- (2) Training curricula and manuals.

Recommendation 17: Standardized training curricula, training manuals, and course durations should be supported to ensure the same standard of technical competence among institutions and to ensure more efficient use of resources. Printing of training manuals with the logos of all institutions, as has been done with some of the IEC materials, should be encouraged.

- (3) Training in minilaparotomy.

Recommendation 19: The minilaparotomy training strategy should be reviewed and standardized among institutions to improve the effectiveness of the training, to guarantee the safety of services, and to promote greater use of local anesthesia and sedation.

- (4) Post-obstetrical event contraception. Due to the short hospital stay of obstetrical patients, POE is administered primarily trans-caesarean or post-placenta following delivery or immediately postabortion thereby limiting opportunities for providing adequate information and counseling. Despite the GOM leadership's commitment and MOU-supported activities to ensure voluntarism and informed choice for POE contraception (particularly with respect to IUD insertion), this is a continuing problem that must be addressed.

Recommendation 21: The GOM public health institutions should give utmost priority to ensuring that all men and women seeking contraception receive adequate information and counseling. USAID should give the highest priority to using MOU resources to assist these institutions so that all women admitted to obstetrical wards who desire contraception receive information and counseling; that informed consent is obtained for all women requesting POE surgical contraception or IUD insertion; and that condoms are routinely available as a

method of contraception.

Recommendation 22: To maximize access to high-quality POE counseling and services, GOM public sector institutions should develop, implement, and institutionalize new organizational routines. These routines would allow for a combination of providers (including nurses) to have several opportunities to provide POE contraception during a woman's hospital stay. The current practice of providing POE contraception during a cesarean section or immediately following delivery or abortion limits opportunities for counseling and reduces quality of service.

(5) Training of nurses.

Recommendation 23: During the remainder of the MOU, factors contributing to under-utilization of hospital out-patient nurses as first-line family planning service providers (especially contractual issues) should be addressed and measures should be taken to ensure that nurses are competently trained to provide services, including IUD insertion.

(6) Equipment and materials.

Recommendation 24: MOU resources should continue to be used to provide equipment and supplies, with priority given to training-related equipment and materials such as anatomical models and kits for IUD insertion, minilaparotomy, and NSV.

Recommendation 25: In order to guarantee the safety of out-patient VSC procedures performed in rural areas, MOU resources should be used to complement public sector resources to equip rural out-patient units with the emergency equipment necessary to perform VSC procedures in accordance with approved service delivery guidelines.

(7) Supervision. Supervision at all levels of the service delivery system requires increased attention to strengthen the quality of family planning care.

Recommendation 27: Given the chronic shortage of public sector resources for supervision, all GOM institutions should be assisted through MOU resources to develop and institutionalize appropriate supervisory models based on selective supervision, in-service training, and monitoring of QOC.

Information Given to Clients. The production and dissemination of IEC materials has received substantial support, but there are continuing needs in this area, including the need for greater

sharing across institutions and improved distribution of existing materials.

Recommendation 28: Support should continue for production of IEC materials that have been tested using sound communication methodology. The Inter-institutional IEC Subcommittee should help to determine which existing materials should be reproduced, how costs can be lowered, and to develop strategies for seeking private sponsorship. It is critical that if any additional USAID resources are spent on production of materials, they should primarily support reproducing existing materials that can be used by all institutions.

Recommendation 30: IEC materials should be included in the reproductive health supplies logistics system to ensure that service delivery points (SDPs) are well-stocked.

Choice of Methods. The range of methods of contraception offered by public sector institutions is adequate, although it does not meet the needs of all women. For postpartum women who desire to space births or for women who are breastfeeding, the IUD is the only option since condoms are not actively promoted. It should be noted that IMSS added injectables to its basic stock of methods in 1996. Since Mexican citizens can receive free family planning services at any public sector institution and contraceptives are available in the commercial and private sector, the market for family planning services as a whole should be considered in planning for provision of a wide range of affordable contraceptives.

Recommendations 8, 10, and 11: The public health institutions should broaden the choice of contraceptive methods available to comply more fully with the current *Reproductive Health and Family Planning Program, 1995-2000* objectives developed by SSA and to meet the needs of potential users. This does not necessarily mean that all methods need to be provided at all institutions, but that counseling services should inform clients about the availability of other methods at other sources. Market segmentation analysis, taking into account all provider sources, should be conducted in order to assure availability of an appropriate range of affordable contraceptives.

Informed Choice. Use of an appropriate informed consent form for VSC is of utmost priority to Mexican service providers, although the forms themselves are not sufficient to ensure informed choice. The reproductive health leadership at the public sector institutions is strongly committed to full compliance with written informed consent procedures and recognizes the need to review the current informed consent procedures for VSC.

Recommendation 12: Informed consent forms for male and female VSC should be standardized across institutions based on internationally-accepted guidelines for informed consent. These forms should be included in the supply system in the

same manner and with the same priority as other family planning commodities and supplies. Given the importance of written informed consent for VSC, USAID and its CAs should concentrate their initial efforts following this review on supporting the GOM to standardize VSC informed consent forms and to ensure their utilization at all SDPs.

Efforts to improve informed consent procedures should also be accompanied by continued emphasis on information and counseling activities to assure informed and voluntary contraceptive decision making.

Appropriate Constellation of Services. Support from the MOU has contributed to the promotion of an appropriate constellation of services, primarily by supporting norms dissemination and training in family planning together with training in other areas of reproductive health.

Recommendation 32: Activities that include family planning provision within the context of reproductive health or primary health care should continue to be supported under the MOU since successful integration of family planning services will be an important factor in strengthening service sustainability.

The Mexican public health sector has successfully promoted improved quality of and increased access to health care through such initiatives as the sector-wide *Mother-Child Friendly Hospital* program and the SSA "white flag" community program.

Recommendation 33: The Mexican public health sector institutions should consider developing a recognition system, similar to the Mother-Child Friendly Hospital program, that promotes and rewards provision of quality reproductive health care in health centers and out-patient medical units and "adolescent friendly" services. MOU resources should be used to contribute to the development of this system.

Monitoring and Evaluation

Evaluation. CONAPO has the potential to evaluate the impact of the family planning program using data from the national household surveys (both past and future, planned for 1998) and the current study of the service delivery system.

Recommendation 34: In order to evaluate changes over time and program impact in the target areas for the MOU, CONAPO and USAID should consider supporting a second assessment of the service delivery system to be conducted in tandem with the 1998 household survey.

Method-specific Targets. All three public health institutions use targets for planning and funding their programs. The review team is concerned that an over emphasis on targets can contribute to various problems such as high discontinuation rates and over reliance on non-reversible contraception.

Recommendation 36: CONAPO and the three service delivery institutions should ensure that service targets are not over emphasized to the degree that program staff compromise service quality and method choice in order to meet their *metas* or targets. A balance should be maintained between program targets (including method-specific targets) and the needs of clients. An alternative to targets that substitutes service or process goals based on the service provision norms should be considered for SDP-level management.

Linking Service Statistics and Surveys. Given the existence of both the service statistics system and survey data (with state-level estimates for priority states in the 1995 National Family Planning Survey [ENPF-1995]), there is potential for linking the two sources of information in order to improve planning, monitoring, and evaluation.

Recommendation 40: CONAPO and the three health institutions—perhaps through the existing evaluation subcommittee—should explore ways to link the institution-based service statistics with national survey data.

Recommendation 35: CONAPO should also strengthen and encourage the Consejo Estatal de Población (COESPO) to work with the state-level public health institutions in using the available data (service statistics, community-based data, and surveys) for program planning and evaluation.

Monitoring of Training Activities. The MOU has supported training to improve access to POE procedures and increase use of local anesthesia with sedation for minilap procedures. While some monitoring of interval and POE procedures has occurred, monitoring should be systematic to ensure continued access to interval procedures. There apparently has been no tracking of the number of minilap procedures by type of anesthesia despite the extensive training on use of local anesthesia with sedation.

Recommendation 41: USAID, through the MOU, and the three public health institutions should ensure that there is adequate monitoring of certain types of procedures to assess the impact of training activities and access to services.

Research on Quality of Care. Research has been carried out with respect to all elements of QOC; most of the studies examine multiple elements of QOC with attention to the client perspective.

Recommendations 42 and 43: USAID support for QOC research in the final years of the MOU should focus on dissemination of results and lessons learned and institutionalization of results. Keeping in mind the time and budgetary limitations of the MOU, new QOC studies should be supported only if they can be completed before termination of the MOU.

Program Sustainability

Health Sector Decentralization. A priority of President Zedillo's development plan for 1995-2000 is to reform the health sector into a decentralized system.

Recommendation 45: Given the possible impact of decentralization on the GOM's family planning and reproductive health program, USAID and its CAs should support SSA and IMSS/S in whatever ways are deemed appropriate and feasible, given the limited resources, to diminish any detrimental effects on the delivery of services.

Financing. While use of targets for program monitoring has helped to keep the GOM program focused, targets are also used in the budgetary process.

Recommendation 46: With a relatively minor but concerted effort, the GOM could further ensure the quality of services by distinguishing between use of institutional outputs or aggregate-level targets (e.g., state or municipality) for setting budgets and giving overall programmatic direction and use of output measures for site-by-site management. The GOM is urged to ensure that all service providers clearly understand that institutional output objectives are not mandates for targets at the SDP. Alternative measures that assess the quality of services (see recommendation 36) could be used to complement targets and might also provide better management tools.

Cost of Services. The GOM policy to provide family planning as a free service to the entire population has great merit in terms of promoting access. However, with the ever-increasing number of family planning users, the cost to the GOM of providing these services will continue to rise and may, therefore, compromise the long-term sustainability of the program.

Recommendation 47: With support from the MOU, the GOM should conduct market segmentation (as in recommendation 10) and cost-effectiveness analyses

that could be used to develop different strategies to ensure the future sustainability of the program.

Training and Communication Activities. The sustainability of training and communication activities is important in planning priorities for the remainder of the MOU. Enormous effort is still needed in training given the large number of medical and paramedical personnel and turnover of staff. Similarly, in the communication area, considerable effort is needed to build capacity at the national and local levels.

Recommendation 49: Training and IEC strategies, programs, and technical assistance should be reviewed in light of the urgent need to build sustainable systems for 1) training capacity at the institutions based on a well-defined strategy for pre- and in-service training, and 2) IEC capacity particularly in reproductive health communication at the community level. In addition, some effort to evaluate the IEC and training strategies and to identify those that are most cost-effective would be useful since there are financial implications of continued MOU support in both of these program areas.

Contraceptive Procurement. Over the long run, the cost of contraceptive commodities and the ever-increasing need for family planning services will put pressure on the budget and the GOM's ability to finance commodities.

Recommendation 50: The GOM should explore the possibility of a joint procurement for the three public sector institutions by entering into negotiations with commercial providers. At the same time it should pursue, in collaboration with USAID/Mexico and USAID/W's Center for Population, Health and Nutrition (PHN), the possibility of taking part in the United Nations Population Fund (UNFPA) contraceptive procurement fund.

Contraceptive Logistics. Considerable progress has been made in the development of a good logistics system at each of the institutions. The team approach used by the Family Planning Logistics Management (FPLM) project ensured that GOM officials assumed ownership of the logistics system.

Recommendation 51: USAID should continue the technical assistance and training in contraceptive logistics until the system is fully institutionalized since a smooth logistics system is crucial for an efficient program.

Implementation of the MOU

Inter-institutional Coordination. Building on the excellent inter-institutional coordination that

has occurred especially at the national level, there are a number of areas where further coordination could significantly strengthen the national program. These areas include training, IEC, monitoring and evaluation.

Recommendation 53: Both GOM and USAID should consider further actions that would improve and expand on collaborative efforts, since these efforts will be critical in expanding access to and use of quality family planning and reproductive health services.

Operations Coordination Committee. The Operations Coordination Committee (CCO) has played an important policy role and should continue to be a powerful mechanism for policy and coordination. Both the IMSS/RO and IMSS/S operational programs have been represented by the IMSS Coordinacion de Salud Reproductiva y Materno Infantil program. Owing to IMSS leadership, IMSS/S officials have been increasingly involved in planning IMSS/S's annual work plans under the MOU.

Recommendation 54: The CCO's current focus on critical policy matters should be maintained without entering into the specifics of program implementation. The CCO should be expanded to include a representative from IMSS/S so that all key institutions carrying out MOU-supported activities are part of the official policy and planning process.

Technical Assistance. Although technical assistance by USAID and its CAs was not anticipated under the MOU, USAID and its CAs are still technically accountable given the financial support provided to GOM programs. The CAs should, therefore, be capable, individually or in cooperation with each other, of reviewing, monitoring, and providing technical assistance for all funded project activities. In addition, support of other primary health care or reproductive health care activities requires the same technical oversight as family planning.

Recommendation 56: In order to assure high standards of quality in all activities funded by USAID, CAs should support activities that they can technically review and monitor, using their own in-house technical capacity or working in cooperation with other CAs.

Recommendation 55: USAID/Mexico and GOM institutions should carry out a full review of the technical assistance that has been provided to date under the MOU and prepare a technical assistance plan for the remainder of the MOU.

USAID Management. The implementation of the MOU has become more complex especially as the level of assistance from USAID CAs has increased. Given the varying and sometimes overlapping roles of the different CAs in Mexico, the USAID Mission through its PSC program manager, has increasingly played a central role in coordinating technical assistance.

Recommendation 58: The USAID program manager should be tasked to work more directly with the counterparts on technical issues, and proactively define the roles and responsibilities of the various CAs and coordinate their technical assistance.

Completion of the MOU. While impressive progress has been made in both expanding access and improving quality of services, USAID through the MOU should continue to play an important role in bringing about even greater improvements. Given the timing of the next national household survey in 1998, an extension of the MOU would allow more time for completing the analysis and disseminating the results.

Recommendation 59: USAID/Mexico should extend the MOU through the year 2000 as an unfunded extension. Another program review should be conducted in 1998 to determine if there are additional, minimal funding needs for the remaining period. Finally, the GOM and USAID should consider hosting a significant dissemination event to highlight the 1998 survey results and the bilateral relationship.

Donor Coordination. Coordination among the various donors (e.g., UNFPA, the Japanese International Cooperation Agency [JICA], the Overseas Development Administration [ODA], the World Bank, and the United Nations Children's Fund [UNICEF]) in Mexico takes place on a limited scale. Given the maturity of the Mexico program, the level of coordination among the Mexican institutions, and the fact that many donors are phasing down their assistance, donor coordination should be increased and focused for the benefit of the country program. Areas of potential donor coordination include: commodities; South-to-South exchanges; and, replicating the UNICEF-initiative Mother-Child Friendly Hospitals as a strategy for improving services.

Recommendation 60: The GOM and USAID should pursue opportunities for donor coordination especially where donors are supporting similar or complementary programs. In this sense, the GOM should be encouraged to attempt jointly-funded programs where applicable.

1. INTRODUCTION

1.1 Background

For nearly two decades, the Government of Mexico (GOM) and the United States Agency for International Development (USAID) have worked together to address important population and reproductive health issues. This collaboration was established in 1978 following Mexico's adoption in 1974 of the General Population Law (*Ley General de Población*). The policies contained in the law included policies to limit population growth, reduce mortality, improve the status of women, and support family planning.

The GOM implemented the law by developing an extensive system for the delivery of family planning services through public sector agencies and officially endorsing the activities of private family planning organizations. As a result, the level of contraceptive prevalence increased from 30 percent in the mid 1970s to about 58 percent in 1990. This increase in contraceptive prevalence is considered to be an important factor in the decline of Mexico's level of fertility and population growth. Between the early 1970s and 1990, the total fertility rate (TFR) dropped from 6.6 to 3.4 and the population growth rate declined from over 3 percent to 2.3 percent—impressive accomplishments in a short period of time.

Building on its past success, the GOM has presented future challenges in the *National Population Program, 1995-2000*. The program's goals are to achieve a level of contraceptive prevalence of 70 percent, a TFR of 2.4, and a population growth rate of 1.75 percent. The GOM's program also highlights the need to close the gap in differences in access and use between urban and rural areas and to satisfy the unmet demand for family planning among rural and urban poor, adolescents, and indigenous groups (Poder Ejecutivo Federal, 1995).

Until 1991, USAID assistance to Mexico's population program consisted of a wide range of activities: contraceptive supply; information, education, and communication (IEC); operations research (OR); and training. These activities, carried out by nearly 20 Cooperating Agencies (CAs) in the population field, facilitated the expansion of both public and private sector family planning service delivery. They also laid the groundwork for a true partnership between the GOM and USAID. In 1991, USAID developed a five-year population strategy (1992-96) to consolidate and focus the agency's assistance to Mexico. The strategy has two components: a program of support for the public sector as well as continued support for two private sector organizations, the Mexican Family Planning Foundation (MEXFAM) and the Mexican Federation of Private Health and Community Development Associations (FEMAP). A midterm assessment of the private sector component was conducted in February 1996 (Bowers, Cobb, and Wear, 1996).

USAID's strategy formed the basis for a new period of collaboration between the GOM and

USAID that is set forth in a June 1992 memorandum of understanding (MOU). This five-year agreement was subsequently extended by one year to June 1998.

The parties to the MOU include the National Population Council (CONAPO), the GOM's population policy, planning, and coordinating body, and the three major national health sector institutions (Ministry of Health [SSA], the Mexican Social Security Institute [IMSS], and the Social Security Institute for Government Workers [ISSSTE]).

IMSS covers more than 50 million beneficiaries through two operational systems: IMSS Regimen Ordinario (IMSS/RO) in urban areas and IMSS/Solidaridad (IMSS/S) in rural areas. Within IMSS, the overall coordination of the Salud Reproductiva y Materno Infantil program is the responsibility of IMSS/RO which sets policy and establishes norms. Both IMSS/RO and IMSS/S however deliver health services, albeit to different client populations. Throughout this report, references will be made to IMSS in terms of overall coordination and policy and to IMSS/RO and IMSS/S when the operational aspects of the urban and rural programs are considered.

The Operations Coordination Committee (CCO), an inter-institutional committee of CONAPO and the three public health institutions, guides and monitors the plans and activities under the MOU with support from Pathfinder, USAID's lead CA in Mexico. Two inter-institutional subcommittees have also been set up, one in IEC, the other in evaluation.

The objectives of the MOU were principally to contribute to GOM's goal for the National Family Planning Program—increasing access to family planning and reproductive health services particularly among the unserved populations—and to increase program self-sufficiency for Mexico's expanded health care infrastructure. The agreement called for concentrating assistance in priority geographic areas, those areas with the lowest indices of social and economic well-being in the country. Nine states and the peri-urban areas of Mexico City were identified for special emphasis. These nine priority states are located primarily in the central and southern regions of Mexico: Chiapas, Guanajuato, Guerrero, Hidalgo, Estado de México, Michoacán, Oaxaca, Puebla, and Veracruz.² These states represent 54 percent of the total Mexican population, 67 percent of the rural population, and 53 percent of women of reproductive age.

The funding arrangement for the agreement included USAID's commitment to provide technical, financial, and material resources totalling up to US\$50 million. This funding level was linked to the GOM's commitment to increase its own resources for the National Family Planning Program

²Each of the three major health sector institutions has these nine states among their priority states, but each has some additional states: IMSS—San Luis Potosi and Zacatecas; SSA—Jalisco and Zacatecas; and ISSSTE—Zacatecas. In general activities supported under the MOU have been carried out in a phased manner with activities beginning in some states in year 1 and moving into all priority states by year 2. In addition, most of the MOU resources have been used in priority states, but not exclusively. See for example footnote 6 on AVSC International activities.

by the peso equivalent over the period of the agreement. The GOM's goal of increased financial responsibility for program costs—hence greater sustainability—was to be achieved through the gradual increase of GOM contributions as USAID financial and commodity support declined.

An important feature of the MOU was the GOM's commitment to phase in procurement of 100 percent of its contraceptive needs gradually, beginning with a procurement of 25 percent of the needs in 1992, 50 percent in 1993, 75 percent in 1994, and 100 percent in 1995 and thereafter.

To guide the implementation of the MOU, the Mexican institutions developed a program document, Programa de Apoyo para Extender los Servicios de Planificación Familiar y Salud Reproductiva (CONAPO, July 1992), that outlined the activities (lineas de accion) to be supported. The four broad areas in the GOM program document were:

- (1) Family planning services. Increase the capacity to provide services and improve the quality by expanding the range of contraceptive methods and emphasizing access and availability of methods with the greatest effectiveness.
- (2) Service delivery capacity. Increase the reproductive health and family planning service delivery capacity in rural areas and among indigenous groups by incorporating different types of community personnel.
- (3) IEC activities. Increase and intensify reproductive health and family planning IEC activities.
- (4) Research. Conduct research on contraceptive methods to increase the range of methods available. In addition, support demographic studies and operations and psychosocial research.

The following factors influenced the implementation of the MOU during its first four years:

- (1) The 1994 International Conference on Population and Development in Cairo. Both the United States and the Mexican governments reaffirmed their commitment to reproductive health and rights by endorsing the Plan of Action of the Conference as well as the priorities and strategies highlighted at the Women's Conference in Beijing in 1995. With the commitment to the broader scope of services implied by the Cairo agenda has come the challenges of increasing access to quality services.
- (2) The Mexican economic crisis of 1994-95. The worst economic crisis to hit Mexico in 60 years has had a direct impact on the population program. A severe devaluation of the peso (3.5 pesos to the dollar when the crisis broke in late 1994, compared to 7.4 pesos to the dollar in April 1996) and an inflation rate of 52 percent worsened the economy which had already stagnated due to the contraction of the labor

market and declining domestic consumption of goods and services. The GOM's commitment to increase its resource allocation for population activities, especially the procurement of contraceptive commodities, has suffered greatly, as has the client's ability to pay for services in the private sector. Despite these setbacks, the GOM has pushed ahead with its commitment by first maintaining and then increasing its resource allocation to population activities.

(3) USAID's reduced funding for population assistance. In fiscal year (FY) 96, USAID experienced a severe cut to its worldwide population assistance program budget. Owing to USAID/Mexico and the USAID CAS' careful monitoring of funds since the beginning of the MOU, there remains a sufficient funding pipeline to allow the Mexican institutions to continue with their planned program.

(4) The policy of decentralization of the public health system. Decentralization is one component of the overall reform of the health sector. The GOM has made health reform a priority based on its assessment of the shortcomings of the current system that has developed through a casual and segmented process. Health reform more generally incorporates the social security (IMSS and ISSSTE) and private insurance systems. There is a small, nascent, private insurance market that is starting to gain entry in markets in key urban areas.

Decentralization is part of the health reform directed to providing services to all the uninsured population—those with no access to social security. It is estimated that about 10 million Mexicans, those concentrated in rural, dispersed communities, have no health coverage. The decentralization process has two parts: 1) current SSA services will become the responsibility of state-level governments with SSA maintaining responsibility for Official Norms, evaluation, supervision, and support for financial management; and 2) IMSS/S services will be operated by local governments so that a national coordination office, as is currently in charge of the operational program, will not be needed. It is anticipated that the organization of these latter services will vary among the local governments, but eventually the services will come under SSA.

The process of decentralization has been in effect for some time, but the Zedillo administration has made decentralization a priority. It is expected that major implementation of the decentralization process will begin in January 1997. Yet, as discussed subsequently, there are a number of issues and concerns regarding the future of key services, such as family planning, under a decentralized system.

Despite the above factors—and recognizing that major implementation of the decentralization policy has yet to begin—the GOM, with assistance through the MOU, appears to be meeting the challenges of increased access to quality services.

The GOM's commitment to the Cairo agenda is bringing about a shift of emphasis in the public health sector's program. The Mexican family planning program has evolved from a strong overall focus on demographic goals and a programmatic orientation on reproductive risk to a broader approach of reproductive health with two components: family planning and increasing awareness of the client's perspective and reproductive rights. Improving the quality of services has become a major concern of the program. The balance between the need to set and achieve goals and the importance of satisfying clients' needs and preferences has improved. It is increasingly recognized that satisfied family planning users are not only the key to high continuation rates, but are also the most effective promoters of family planning. Quality is an important issue not only for the clients, but also for improving access, strengthening sustainability, and strengthening Mexico's leadership in South-to-South exchanges.

In July 1995, a team representing USAID's Office of Population visited Mexico to confer with USAID/Mexico and GOM officials implementing the MOU. Mexican and U.S. officials agreed that the program of collaboration in the MOU would benefit from joint review. USAID/Mexico's Results Review and Resource Request (R4) for FY 96 to 98 (USAID/Mexico, April 1996) takes into account the continued importance and strength of the U.S.-Mexican partnership. Population assistance remains a central program area for USAID/Mexico. *Strategic Objective No. 3, achieving a sustainable increase in contraceptive prevalence*, fully supports the GOM's 1995-2000 development plan and population program. As the R4 document notes, progress has been achieved across both quantitative indicators (e.g., contraceptive prevalence and number of delivery points and service providers) as well as measures of program quality (e.g., number of providers trained and level of unmet demand).

1.2 Review Methodology

USAID and GOM conducted a joint review from September 16 to October 9, 1996 of the public sector activities under the MOU. (See appendix A for the Scope of Work of the mid-program review.) The purposes of the review were to assess the progress achieved in the U.S.-Mexican program of cooperation; to identify areas for improvement and/or intensification of effort during the remainder of the program; and to develop the preliminary framework for a long-term pattern of collaboration among the parties. USAID's three-person review team included one official from USAID/Washington's (USAID/W) Office of Population and two independent consultants with extensive experience in evaluation and expertise in quality of care. Senior officials from each of the health sector institutions (SSA, IMSS/RO, IMSS/S, and ISSSTE) participated in the field visits. USAID/Mexico's program manager for the population portfolio also participated in the field visits.

The review process began in July 1996 with the preparation of the Scope of Work which took place during a pre-review visit to Mexico by a member of the USAID team. The review process took place in three stages, the first of which was the preparation of the Scope of Work that was

designed to be carried out jointly by staff of USAID/Mexico, population CAs in Mexico, and GOM counterparts. A two-day team planning session was held for the USAID team in Washington, D.C. which included interviews with key staff from USAID/W and several population CAs.

The second stage consisted of three weeks in Mexico during which time the USAID team reviewed program documents and conducted interviews with officials from CONAPO (and also state Consejo Estatal de Población [COESPOs]), the health sector institutions, as well as staff of population CAs located in Mexico. Joint field trips were made to three of the nine priority states—Chiapas, Michoacán, and Veracruz—where a total of 27 health facilities (hospitals, health centers, and rural community health posts) of SSA, IMSS/S, and ISSSTE were visited. Health providers and clients were interviewed to the extent feasible at each facility. (See appendices C and D for the list of contacts and the list of facilities visited.)

The third stage involved a briefing to review preliminary findings and recommendations with the CCO that oversees the MOU and separate briefings with each of the health institutions. The draft report of findings and recommendations was jointly reviewed.

The immediate next steps are to finalize the report based on input from the GOM and USAID/Mexico and to begin implementation of the recommendations.

2. CHANGES IN DEMAND, ACCESS TO AND USE OF FAMILY PLANNING

USAID's assistance through the MOU has provided support for both meeting the demand for services and improving the supply of services. The demand factors include both the demand for children as well as the demand for family planning services. The MOU has supported communications activities designed to affect the demand for children (including birth spacing) and other interventions designed to meet the unmet demand for family planning. The conceptual framework of family planning supply factors (Bertrand, Magnani, and Knowles, 1994) lists the supply operations which are essential for an effective program.³ Of these, the MOU has emphasized training, IEC, equipment, supervision, research, and evaluation. The functional outputs from this assistance (e.g., number of people trained, IEC materials produced and distributed, and number of people exposed to IEC messages) are intended to improve the three service delivery outputs: access to services, quality of care, and program image. The number of new acceptors is used to track the results of these activities on actual use of services at the program level. The intermediate outcome of the improvement in services is then measured at the population level by changes in contraceptive prevalence. Change in the TFR is a longer-term outcome measure.

Following is a review of the current status and recent changes in some of the demand and supply factors. This review summarizes USAID-supported IEC activities and training outputs as well as service utilization data for new acceptors. Wherever possible, changes in contraceptive prevalence between the 1992 and 1995 national surveys in priority and non-priority states are reviewed. The discussion of changes and comparison by state between 1992 and 1995 is limited because the sample size for the 1992 household survey did not permit state-level estimates. The status of MOU interventions and their impact on the quality of services are presented in section 3.

³Bertrand, Magnani, and Rutenberg, 1996, lays out the components and process of monitoring and evaluating impact of programs.

2.1 Changes in Demand

2.1.1 Changes in Demand for Children

In the current review of the GOM program, demand is examined in two ways: the demand for children and the demand for family planning services. Using national survey data, the demand for children, based on the average ideal number of children, has continued to decline for Mexico as a whole, dropping from 4.5 in 1976 to 3.3 in 1987 and, continuing to decline to less than 3.1 in 1995.⁴ As shown in Table 1, all of the priority states except for Hidalgo, Mexico, and Veracruz continue to have demand levels that are higher than the national average, suggesting that there continues to be a need for communication and other development activities that address some of the underlying determinants of the demand for children.

Table 1

Trends in the Mean Ideal Number of Children for Women in Union, ages 15-49, for Priority and Non-Priority States

State	1995
Chiapas	3.34
Guanajuato	3.15
Guerrero	3.14
Hidalgo	3.05
México	2.53
Michoacán	3.38
Oaxaca	3.20
Puebla	3.27
Veracruz	2.61
Non-priority States*	3.18
All Mexico	3.07

⁴Data for 1976 and 1987 are from Table 2, p. 21, Poder Ejecutivo Federal, 1995; and for 1995, from a special CONAPO tabulation (T4), ENPF, 1995.

Source: State-level data for 1995 are based on special CONAPO tabulation (T4) from ENPF-1995.

* This is a summary rate for the non-priority states.

2.1.2 Changes in the Demand for Family Planning

The demand for family planning is measured as satisfied (those using contraception) and unsatisfied demand or unmet need (those who indicate a desire to space or limit future births but are not using contraception). In 1995, levels of satisfied demand (based on the percent of women using contraception) were quite high—an average of 79 percent among the priority states and an even higher average of 85 percent among non-priority states (see table 2). The corollary of this is unmet need. There have been substantial improvements in recent years: between 1987 and 1995 unmet need dropped from 25.1 percent to 14.1 percent for Mexico as a whole (CONAPO, 1996), with estimated rural unmet need at 21.9 percent compared to only 11.3 percent of urban unmet need.

Unmet need in priority states continues to be higher than in non-priority states, 21 percent compared to 14.5 percent, with the highest levels in Oaxaca, Chiapas, and Guerrero. Table 3 shows the levels of unmet need by parity. There continues to be substantial need among lower parity women for spacing methods and among higher parity women (2 or more children) for limiting methods in both priority and non-priority states.

Table 2

Percent of Women* with Satisfied Demand and Unsatisfied Demand (to space and limit) for Priority and Non-priority States, 1995

State	Users	Unsatisfied Demand for Spacing	Unsatisfied Demand for Limiting	Total Unsatisfied Demand
Chiapas	70.9	11.6	17.4	28.0
Guanajuato	80.2	9.0	10.7	19.7
Guerrero	71.3	13.1	15.6	28.7
Hidalgo	76.8	8.2	15.0	23.2
México	86.1	9.0	4.9	13.9
Michoacán	76.8	10.0	13.2	22.2
Oaxaca	67.3	11.6	21.1	32.7
Puebla	74.5	11.3	14.2	25.5
Veracruz	82.8	7.6	9.6	17.2

Total Priority States	79.0	9.6	11.4	21.0
Total Non-priority States	85.4	8.8	5.7	14.5

Source: Special CONAPO Tabulation from ENPF-1995.

*This table excludes women who have no unsatisfied demand for contraception, but are not using a method as well as infecund women.

Table 3

Percent of Women with an Unsatisfied Demand for Contraception (to space and limit) by Parity for Priority and Non-priority States, 1995

Parity	Priority States		Non-priority States	
	Unsatisfied Demand for Spacing	Unsatisfied Demand for Limiting	Unsatisfied Demand for Spacing	Unsatisfied Demand for Limiting
0	41.7	1.3	31.1	-
1	16.8	7.6	42.4	1.0
2	19.8	18.4	9.2	13.2
3	9.3	13.4	7.0	35.8
4+	12.3	59.4	10.3	49.9
Total	100.0	100.0	100.0	100.0

Source: Special CONAPO tabulation from ENPF-1995.

2.1.3 Information, Education, and Communication

The GOM program document presents IEC as a key element for increasing the demand for services and also for providing services. Approximately \$6 million or 36 percent of overall MOU funds have been devoted to IEC activities during the first three years. The objective of the IEC activities has been to develop high-quality, credible materials for use by service providers with specific population groups, complemented by mass media campaigns. The challenge has been to empower clients through use of these materials. The IEC activities that support service delivery are discussed in terms of QOC in section 3.3.2.

IEC activities that address the demand for children and for services are the responsibility of CONAPO. These activities include: 1) support for the state-level COESPOs in IEC, 2) dissemination of information on reproduction and family planning in rural areas and among indigenous groups (e.g., through radio spots), and 3) reaching certain population groups such as adolescents and men through mass media campaigns on television and radio. The team interviewed staff of two state-level COESPOs in Chiapas and Michoacán. These two groups are at very different stages of institutional development: the COESPO in Michoacán has a well-developed structure and program of activities; the COESPO in Chiapas is still a fledgling organization. There is potential for well-designed inter-institutional activities through the COESPO structure (such as training of *maestros* [teachers] to be change agents and adolescents in the area to be family planning and reproductive health promoters). The COESPOs have an important potential role in planning as well as IEC as decentralization of health services proceeds throughout Mexico. (See also section 6.)

CONAPO has also launched a mass media campaign, "Planifica, es cuestión de querer", that appears to have achieved wide dissemination and recognition. JHU/PCS has assisted in the planning, production, monitoring, and evaluation of this campaign. An impact evaluation of the campaign is being developed; the challenge will be to evaluate the impact of the campaign on actual behavior.

Given the levels of continuing unmet need in rural areas and among certain priority states, radio may be an especially important and effective medium to reach the poorest and most rural areas and also to reach indigenous populations in their own languages. Design of such IEC activities should be closely linked to the needs of specific population subgroups.

Enhanced program image is one of the outputs of the program improvements and of the IEC activities. In 1995, more than 80 percent of survey respondents associated family planning with improved family welfare indicating that the vast majority of Mexican women view the program favorably (CONAPO, 1996, p. 17).

Recommendations:

1. Given the continuing differences in the mean ideal number of children, the GOM should continue its communication and other development efforts to help reduce the demand for children.
2. The GOM should continue its emphasis on trying to reach women with an unmet need for family planning by providing information and services. Information should be provided through the most appropriate and effective media to reach women in rural areas and in priority states. This information should be targeted toward lower parity women with a need for spacing and higher parity women with a need for limiting future births.

3. The COESPOs should continue to receive support from CONAPO to strengthen their capabilities. Further, there should be greater coordination and exchange among the COESPOs so that lessons learned by the stronger groups might benefit groups that are at an earlier stage of development.
4. Since the review team did not assess any of CONAPO's IEC activities, we recommend only that the evaluation activities proceed and that they incorporate an effort to look at impact on actual behavior.

2.2 Changes in the Supply of Family Planning Services

2.2.1 Service Delivery Points and Providers

Approximately 70 percent of the users of contraception in Mexico received their services from a public sector institution, while less than 30 percent received their services from private sources (CONAPO, 1996). Given the size of the Mexican population, 93.2 million in 1996, it is not surprising that the magnitude of service delivery by the three major national health institutions is large. In 1990, there were an estimated 13,000 medical units, and over 250,000 medical and paramedical personnel for Mexico as a whole (CONAPO, July 1992). In terms of USAID's assistance to Mexico through the MOU, overall access to services is measured by the number of SDPs in target areas (and the percent in which family planning services are available) and the number of providers of family health services (and the percent who provide family planning services in target areas).

For each year of the MOU, the number of SDPs and providers of family planning services are indicated in the USAID R4 document. By 1995, the actual number of SDPs in MOU target areas was 27,546; the actual number of providers of family health services was 110,805. These numbers combine service delivery for both the public and private sectors. For the public sector, the SDPs include general hospitals, out-patients clinics, and the homes of health auxiliaries and midwives (considered first-level medical units). The only SDPs in the target areas that do not provide family planning services are the third-level hospitals of the public sector (less than 1 percent of all service delivery units). For the public sector, the number of SDPs providing family planning has apparently remained fairly constant over the life of the MOU; however, the number of public sector service delivery providers has apparently increased, perhaps due to the decentralization of health services (USAID, 1996).

The location of services and their proximity to the unserved population groups (rural and urban poor) or special target groups are factors influencing accessibility. The aggregate data described above from the R4 document do not provide sufficient detail to assess this aspect of access. Both the SSA and the IMSS/Solidaridad programs, however, have an impressive network of health posts and auxiliary staff whose reach is quite extensive in rural areas particularly for the

provision of temporary methods.

2.2.2 *Training*

Considerable effort and resources have been invested in training activities under the MOU to improve both access to and quality of services. During the first three years, about \$2.9 million, roughly 17 percent of all MOU funds expended, was spent on training. This section focuses on training activities that were designed to expand access; many of these activities also affect quality and are discussed in section 3.

Included in the GOM program document is the goal of training and updating 100 percent of the service providers in family planning and reproductive health in priority states. Institution-specific training activities are presented in chart 1 in two broad areas:

- 1) increasing access to methods of contraception, especially more effective methods; and
- 2) increasing access to reproductive health and family planning services in rural areas and among indigenous groups.

Training activities have been supported by agreements with AVSC International and Pathfinder. Across the three public health sector institutions, a large number of doctors and nurses have been trained in family planning, counseling, and specific contraceptive methods including IUDs, minilaparotomy, and vasectomy (see tables 4, 5, and 6). Pathfinder resources have been used primarily to train primary health facility staff including nurse auxiliaries, their supervisors, community-based distributors (CBDs), and traditional birth attendants (TBAs). Training activities for these health workers have included family planning and maternal and child health (MCH), counseling, and IUD insertion (among SSA and IMSS/S personnel). Given the importance of reaching adolescents, a training effort has also been started by SSA under the "El Buen Plan" project to train providers of services specifically for adolescents.

In terms of the Mexican program's training objective, SSA has made a good start, but additional work is needed. IMSS has also made a start in reaching this overall objective; it is particularly in the IMSS/Solidaridad rural program where substantial gains have been made in the percentage of staff trained. ISSSTE has made the most impressive gains in the percentage of staff that has received training, especially in family planning and counseling, and has made notable gains in percentage of staff receiving training in IUD insertion.⁵ AVSC International has a number of training targets in their subagreements with specific institutions; these targets have been met or

⁵Although the Mexican program's written objective is training 100 percent of personnel, the institutions have not consistently tracked the percentages of those trained relative to overall needs. Even so, Pathfinder reported that the MOU has probably provided about 80 percent of the training needs in reproductive health and family planning (including minilaparotomy, NSV, and IUD insertion) for IMSS and ISSSTE (see Delgado, 1996).

surpassed in almost all cases.⁶

⁶From 1992-96, AVSC supported training in priority and non-priority states for both IMSS and SSA. Among IMSS staff trained, most were from priority states: 60 percent of those trained in counseling, 65 percent of doctors trained in minilap, but only 38 percent of doctors trained in NSV. Among SSA staff trained, most were also from priority states: 54 percent of those trained in counseling and 100 percent of doctors trained in IUD insertion, minilap and NSV. Only ISSSTE staff from priority states received AVSC-supported training. Most of the clinical training at all three institutions was conducted in 1994-95, whereas most of the training in counseling provided to IMSS staff was carried out in 1996.

Chart 1

MOU-supported Training Activities to Increase Access

I. Increasing access to methods of contraception, especially more effective methods	
<u>SSA</u>	Training for medical and paramedical personnel at primary health units in counseling, provision of contraceptive methods including IUD insertion. Training for medical and paramedical personnel in hospitals in counseling and postpartum IUD insertion and female sterilization.
<u>IMSS</u>	Training of integrated teams (surgeon, anesthesiologist, and nurse) in hospitals to extend the availability of female sterilization. Training of family doctors at 1,000 family health units in no-scalpel vasectomy (NSV). ⁷
<u>ISSSTE</u>	Training of medical personnel in family planning to permit horizontalization of the service delivery program. Training to increase access to postpartum contraception.
II. Increase access to reproductive health and family planning services in rural areas and among indigenous groups	
<u>SSA</u>	Training for health auxiliaries (including TBAs) and supervisors of health auxiliaries in rural areas to expand the availability of methods beyond pills (especially access to IUDs).
<u>IMSS</u>	Training of rural TBAs in reproductive health, family planning and MCH. Training of health staff (nurse auxiliaries and select TBAs) at rural health units in IUD insertion.

Source: CONAPO, July 1992.

⁷An advantage of the NSV procedure in terms of its accessibility is that it can be performed by a trained family doctor and does not require a skilled surgeon.

Overall, the commitment to training under the MOU and the actual training outputs are impressive. The data presented in Tables 4, 5, and 6 indicate that considerable progress has been achieved both in terms of increased access to family planning, particularly more effective methods such as IUD, minilaparotomy, and vasectomy (no-scapel vasectomy), and increased access to contraceptives in rural areas. The emphasis on postpartum procedures has increased access to contraception for women who receive care from trained personnel in hospitals and hospital clinics. Minilaparotomy training using local anesthesia and sedation has occurred fairly recently and, while use of local anesthesia has increased, it is still relatively limited. In addition to training, strategies such as the "Jornadas de Salud Reproductiva" special days or sessions have increased access to particular methods such as minilap, NSV, IUDs, and pills (see section 3.3.1). Recent efforts to increase access to services for adolescents also look promising. The team's observations in the field support these findings. Given the available information, it is difficult to determine if overall access to the indigenous groups has improved, although the field visits would suggest that access has increased due, in part, to recent training efforts.

Recommendations:

5. During the remainder of the MOU, the GOM should continue to train medical and paramedical staff in order to further expand access to family planning. More specific training recommendations follow in section 3.
6. USAID's CAs should work with the GOM service delivery institutions to assess training outputs in terms of overall training needs.

2.2.3 Other Factors Affecting Access

Other access indicators include the actual cost of contraceptives, restrictive program policies that affect contraceptive choice, the percentage of the population who know the source of contraceptive services, and the extent to which psycho-social barriers inhibit use of contraceptives. In terms of the cost of contraception, the GOM's policy is to provide free family planning services to all citizens. Other costs to users include the cost of transportation to get to services and the opportunity cost of time required to obtain services. Although neither of these factors were carefully examined in this review, they were not cited by the institutions as major problems except in cases involving the most remote communities. In addition, program strategies such as postpartum family planning and jornadas have been successful in improving access to certain services such as IUDs and female and male sterilization.

Table 4**Summary of Training Activities at IMSS**

Courses	AVSC¹	Pathfinder²	Total Train	Target³ Staff/RO	Target³ Staff/S	%Total Train
FP/MCH ⁴ doctors		272	272	13,701	3,420	
nurses/mw		6,176	6,176	18,925	4,165	
other ⁵		1,084	1,084		5,067 ⁶	
Counseling doctors	312	751	1,063			
nurses/mw	717	586	1,303			
other	410	1,253	1,663			
IUD doctors		546	546			
nurses/mw		555	555			
other		2,581	2,581			
OTB doctors ⁷	87	136	223	55		
nurses/mw	57	108	165	55		
other	35	80	115	55		
NSV doctors ⁸	108	193	301	108		
nurses/mw	41	76	117			
other	40	69	109			
Injectables doctors		34	34			
nurses/mw		2	2			
other						
Other ⁹ doctors		46	46			
nurses/mw		8	8			
other		15	15			
Total doctors	507	1,978	2,485			
nurses/mw	815	7,511	8,326			

other	485	5,082	5,567			
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¹ AVSC-supported training includes the period from November 1992 to September 1996.

² Pathfinder-supported training includes the period from June 1993 to June 1996.

³ The estimates of the targets are based on the tables 3-5, annex 1 of the proposal for the third period of the Extension of Reproductive Health and Family Planning Services in the IMSS. AVSC has a target of 213 as the total staff to be trained based on their subagreement with IMSS.

⁴ Some of these courses were on family planning and others covered family planning and maternal and child health topics as well.

⁵ This category includes social workers, CBDs, TBAs, and others.

⁶ All but 200 of these are trained midwives.

⁷ Of the 87 doctors, 17 were anesthesiologists.

⁸ For AVSC, 75 percent of the doctors trained were family doctors and another 7 percent were general practitioners. Only 18 percent were gynecological surgeons.

⁹ Other includes the following courses: TOT training of midwives in family planning and training for adolescent programs.

Table 5

Summary of Training Activities at SSA

Courses	AVSC¹	Pathfinder²	Total Train	Target Staff	All	% Total Trained
FP/MCH ³						
doctors		41	41		8,206	
nurses/mw		141	141		13,344	
other ⁴		1,241	1,241		8,454	
Counseling ⁵						
doctors	552		552			
nurses/mw	426		426			
other	340		340			
IUD						
doctors	241	31	272	181		150%
nurses/mw		157	157	9		
other		45	45			
OTB						
doctors	165		165	56		295%
nurses/mw	165		165	56		295%
other	9		9	56		16%
NSV						
doctors	35	394	429	128		335%
nurses/mw		212	212			
other		17	17			
Injectables						
doctors		40	40			
nurses/mw		35	35			
other						
Other ⁶						
doctors		85	85			
nurses/mw		214	214			
other		227	227			
Total						
doctors	958	591	1,549			
nurses/mw	591	759	1,350			
other	349	1,530	1,879			

¹ AVSC-supported training includes the period from November 1992 to September 1996.

² Pathfinder-supported training includes the period from June 1993 to June 1996.

³ Some of these courses were on family planning and others covered family planning and maternal and child health topics as well.

⁴ This category includes social workers, CBDs, TBAs, and others.

⁵ Combined here are various types of counseling courses: family planning, postpartum counseling, and counseling in NSV.

⁶ Courses included are TOT training in family planning, training for adolescent programs, interpersonal communication, reproductive health, supervision, and breastfeeding.

Table 6**Summary of Training Activities at ISSSTE**

Courses	AVSC¹	Pathfinder²	Total Trained	Target³ Staff	% Target Trained
FP					
doctors	962	1,237	2,199	3,912	56%
nurses/mw	609	1,195	1,804	4,294	42%
other ⁴	159	192	351	736	48%
Counseling					
doctors	704	748	1,452		37%
nurses/mw	597	650	1,247		29%
other	238	247	485		66%
IUD					
doctors	378	422	800	470 ⁵	
nurses/mw	183	200	383		
other		3	3		
OTB					
doctors	14	64	78		
nurses/mw	12	27	39		
other	11	20	31		
NSV					
doctors	71	51	122	90	
nurses/mw	12	24	36		
other		7	7		
Total					
doctors	2,129	2,522	4,651		
nurses/mw	1,413	2,096	3,509		
other	408	469	877		

¹ AVSC-supported training includes the period from November 1992 to September 1996.

² Pathfinder-supported training includes the period from June 1993 to June 1996.

³ The number of target personnel is the total number of ISSSTE service providers in the priority states. Source: AVSC training tables.

⁴ For ISSSTE, other refers to social workers.

⁵ The target for AVSC training in IUD insertion did not differentiate by type of service provider.

Restrictive program policies—operational rules and regulations and what have been called medical barriers—can limit contraceptive choice. However, the review found that overall GOM policies and procedures for family planning (based on the Official Norm⁸) do not restrict access by limiting choice. The Official Norm contains eligibility criteria that promote greater access to contraception while protecting client safety: adolescents can receive hormonal contraception on their first visit and postpone the pelvic exam and PAP smear for a follow-up visit and breastfeeding women can use progesterone-only pills and injectables as of the sixth week postpartum. Users of oral contraceptives (OCs) can receive up to four cycles of pills at any one visit, although return visits can be scheduled annually.

The IMSS adaptation of the Official Norm emphasizes a reproductive risk framework that has been important historically for motivating Mexican providers to promote and clients to use family planning. Given the relatively high levels of client contraceptive use, this emphasis may no longer be needed and could, in fact, limit client access to specific methods if eligibility criteria are followed too strictly (see section 3.1.2).

Knowledge of family planning methods and sources of supply is another aspect of accessibility. General awareness of methods is relatively high in Mexico and continues to increase. In 1995, less than 5 percent of the total population could not name a contraceptive method. Between 1987 and 1995, the percent of the rural population that could not name a method declined from over 15 to about 10 percent (CONAPO, *Indicadores Basicos de Salud Reproductiva y Planificación Familiar*, 1996). Knowledge of several methods is high in Guanajuato, México, and Michoacán while there continues to be significant lack of knowledge of any method or knowledge of only one method in Oaxaca and Chiapas (23 and 20 percent respectively). Non-priority states have higher levels of knowledge compared to priority states; however, without comparable 1992 data, it is not possible to assess changes in the priority states over time (see table 7).

Lack of knowledge is of particular concern among women not currently using a method who desire to postpone or limit future births (women with an unmet need). In Mexico as a whole, about 10 percent of such women indicate that they lack knowledge or information about particular methods, the source of methods, or the use of particular methods. Among two priority states, Chiapas and Oaxaca, the lack of knowledge among these women was as high as 25 percent in 1995 (CONAPO, *Encuesta Nacional de Planificación Familiar*, 1995, p.31). Table 8 compares priority and non-priority states in 1995 and shows that the problem of lack of knowledge is much higher in priority states.

USAID's R4 document monitors the percentage of non-use due to lack of knowledge of family planning methods which is a measure of cognitive accessibility. Considerable effort has been given to IEC, particularly activities directed toward improving access. For example, SSA has

⁸GOM norms are discussed more fully in Section 3.1.

posted attractive signs on the outside of health auxiliaries' houses and

Table 7**Percentage of Women* by Number of Contraceptive Methods Known for Priority and Non-priority States, 1995****Number of Methods Known**

State	0	1	2	3+	Total
Chiapas	14.0	5.9	5.9	74.2	100
Guanajuato	2.8	1.7	1.5	94.1	100
Guerrero	6.4	4.2	3.2	86.5	100
Hidalgo	5.6	3.6	3.4	87.4	100
México	1.6	3.5	1.9	92.9	100
Michoacán	4.0	1.2	1.9	92.9	100
Oaxaca	16.2	6.7	4.8	72.3	100
Puebla	7.2	3.5	3.2	86.1	100
Veracruz	5.7	2.9	2.7	88.6	100
Priority States	6.0	3.4	2.9	87.7	100
Non-priority States	3.5	1.8	2.9	91.9	100

Source: Special CONAPO tabulation (T22) from the ENPF-1995.

*For women in union, ages 15-49.

Table 8**Percentage of Women with Unsatisfied Demand for Contraception by Three Main Reasons for Non-use for Priority and Non-priority States, 1995**

State	Opposition*	Lack of Knowledge	Fear of Side Effects#
Priority States	7.8	10.3	10.9
Non-priority States	9.5	4.8	1.6

Source: ENADID-1992 and special CONAPO tabulation from ENPF-1995.

* Either opposition of woman, spouse, or religion.

Either the respondent had side effects or fears side effects.

ISSSTE has posted signs inside its facilities indicating which reproductive health services are provided. Further, SSA has used a large banner outside a hospital announcing special "vasectomy days." Such IEC activities are very visible and appear to have improved awareness of the source of methods. As indicated in section 3.1.2, large quantities of IEC materials have been produced to improve quality of services by providing more information to clients at SDPs. In general, however, it is premature to discuss the impact of many of the IEC materials since their distribution is not complete.

In Mexico, reasons for non-use of contraception among women with unmet need include psycho-social barriers. Table 8 shows that in 1995 nearly 20 percent of women with an unmet need in priority states cited two such factors, fear of side-effects and opposition of the couple to contraception; in non-priority states just over 11 percent cited these factors. In the priority states of Chiapas and Oaxaca, about 25 percent of women cite these factors (CONAPO, 1995). Whatever improvements may have been made, psycho-social factors continue to be an important barrier to accessibility in some places.

Access to family planning may also be affected by availability of contraceptive commodities. While discussed more fully in section 5.4, it is worth noting here that the review team observed no major problems in terms of the supply of contraceptive commodities or logistics management.

The above analysis adds further support to recommendation 2 that continued emphasis on increasing access to information and services is needed given that ongoing problems such as a lack of information and psycho-social barriers restrict access and, therefore, use of contraception among certain population groups.

2.3 Changes in the Use of Family Planning Services

Data on new acceptors and active users of contraception are kept by each of the three public health institutions. These data are, in turn, reported quarterly to Pathfinder and AVSC International for monitoring the progress of the MOU.⁹ Table 9 summarizes data on new acceptors by residence for years 2 and 3 of the MOU¹⁰. This discussion focuses on new acceptor data because the review team considers changes in new acceptors to reflect changes in access to services. Between years 2 and 3, there was a 14 percent increase across institutions in the

⁹The initial procedure of the three GOM institutions providing one monitoring report to both Pathfinder and AVSC was altered at some point. During this review, all institutions (IMSS, SSA, and ISSSTE) requested that reporting again be uniform for greater efficiency. (See recommendation in section 7.2)

¹⁰New acceptor data for year one includes only some of the priority states since MOU activities began in phases. Hence it is not possible to compare changes in all the priority states starting from year 1 (July 1993 to June 1994).

number of new acceptors. The most dramatic increase occurred at ISSSTE, where the absolute number of new acceptors is the smallest, followed by important increases for both IMSS and SSA. Of the two institutions that provide services to both rural and urban area clients, IMSS recorded an impressive increase of over 80 percent in the number of rural new acceptors. Curiously, the number of urban new acceptors appears to have declined for IMSS suggesting that there may be some extenuating circumstances or problems with the new acceptor data.

Table 9

Summary of New Acceptors by Urban and Rural Residence by Institution* for Years 2 and 3 of the MOU

	IMSS	SSA	ISSSTE
July 1994-June 1995			
Urban	276,966	363,390	37,914
Rural	280,556	60,931	-
Total	657,522	424,321	37,914
% of New Acceptors	58.7%	37.9%	3.4%
July 1995-June 1996			
Urban	244,321	398,953	58,673
Rural	509,495	66,637	-
Total	753,816	465,590	58,673
% of New Acceptors	59.0%	36.4%	4.6%
Change from Year 2-3			
% Change for Urban Acceptors	35.2%	9.8%	54.8%
% Change for Rural Acceptors	81.6%	9.4%	-
% Change for Total Acceptors	14.6%	9.7%	54.8%

Source: New acceptors tables for each institution provided to the review team by Pathfinder, November 6, 1996. (See Appendix E, Supplementary Statistical Tables.)

* IMSS: 11 states (9 priority states and San Luis Potosi and Zacatecas)

SSA: 11 states (9 priority states and Jalisco and Zacatecas)

ISSSTE: 10 states (9 priority states and Zacatecas)

More detailed tables on new acceptors by method for each of the three institutions and for all three years of the MOU appear in appendix E, tables E1-E6. These tables confirm that training of health service providers has increased the number of new acceptors of certain methods. For example, there are increases among IMSS new acceptors of minilap and vasectomy from rural areas and increases in vasectomy among urban men (see tables E-1 and E-2). There are also increases among SSA acceptors of injectables, IUDs, minilap, and vasectomy in both urban and rural areas for the first three states to receive support under the MOU (see table E-3). Among the eight states added by SSA in year 2, very impressive increases were also noted in new acceptors of injectables in both urban and rural areas (see table E-4). For ISSSTE, there have been consistent increases for all methods noted—pills, IUDs, minilap, and vasectomy—in urban areas under the MOU (see tables E-5 and E-6). Beside these increases, there are other fluctuations in the data that the review team cannot explain or that may represent reporting problems (e.g., new acceptors of pills and urban new acceptors of minilap at IMSS; and urban new acceptors of pills and rural new acceptors of injectables at SSA in the three initial states).

Each of the institutions compares its number of new acceptors (users) and active users with annual goals. While this review is necessary, it may not be sufficient to assess the service delivery system. Given the fluctuations observed in some of the new acceptor data for IMSS and SSA, trend data for each state and method should be reviewed and, where unusual patterns appear, some effort should be made to determine the cause (see recommendation 38, section 4).

Contraceptive prevalence rates (CPR) based on national survey data indicate changes over the first three years of the MOU in the priority and non-priority states. Table 10 shows that while there was an increase between 1992 and 1995 across Mexico, the change was somewhat greater in the priority states, about 5 percent as compared to 2 percent. Looking at changes in each of the priority states, there were impressive increases in Guanajuato, Guerrero, Puebla, and Veracruz. In general, the greatest increases occurred across the priority states in the rural areas with México, Guanajuato, and Michoacán heading the list. Several declines were observed in urban areas of Chiapas, Hidalgo, and Michoacán. Some of the variations in CPR by state may be related to the extension of services in rural areas (e.g., by IMSS/S) in certain states.

The overall prevalence rates in seven priority states are still below the national average, while the rates for the rural populations in five of the priority states are below the national average for rural areas. These differences suggest the continued need to reach women in most of the priority states.

Table 10**Trends in Contraceptive Prevalence* by Urban and Rural Residence for Priority and All Non-priority States, 1992 and 1995**

States	1992 Urban	1995 Urban	1992 Rural	1995 Rural	1992	1995
Chiapas	65.4	60.0	38.7	44.2	49.9	51.1
Guanajuato	62.1	72.2	32.1	52.2	53.5	66.0
Guerrero	63.1	65.3	31.9	38.9	46.9	54.1
Hidalgo	75.1	63.3	50.5	56.6	60.2	59.7
México	75.0	76.4	42.8	62.8	71.1	74.5
Michoacán	61.9	58.2	45.0	57.8	55.8	58.1
Oaxaca	60.3	61.6	35.9	37.3	46.3	48.3
Puebla	61.5	68.2	32.9	37.2	49.5	57.6
Veracruz	72.7	78.4	45.7	54.4	59.9	68.8
Priority states	69.0	70.7	39.8	49.1	58.2	63.1
Non-priority states	70.8	71.6	52.8	59.5	67.4	69.5
All Mexico	70.1	71.3	44.6	52.7	63.1	66.5

Source: 1992 data are from CONAPO, Situación de la Planificación Familiar en México: Indicadores de Anticoncepción, Table 11, November 1994. 1995 data are from POPTECH summary prepared for the review team and from special CONAPO tabulations from ENPF-1995.

*For women in union ages 15-49.

Schooling is one of the factors which greatly increases contraceptive use. Women who have reached secondary level or higher are most likely to use contraception (73.3 percent), as compared to women without any education (48.4 percent)(CONAPO, Sintesis de resultados, p.9). These differences underline the importance of focusing on the needs of less educated women.

A review of contraceptive prevalence by parity (table 11) shows that for women with no children, there is a higher percentage of contraceptive use in non-priority states than in priority states; although the rates are low in all states, less than 20 percent. Among women with a single child, the prevalence rates in priority and non-priority states are about on par. Among women of parity 2 and 4 or more, non-priority states have prevalence rates that are considerably higher than those of priority states. These differences suggest the need for continued emphasis on reaching higher parity women in the priority states. At the same time, there is an ongoing need to reach women of zero parity.

Among the sources of contraceptive methods, IMSS is the predominant provider in both priority and non-priority states (see table 12). SSA is the second most important provider in the priority states while pharmacies are the second most important source in the non-priority states. Without data from 1992, it is not possible to show whether the role of any of these institutions increased in relative terms between 1992-95 in the priority states, although the extensive training activities and the new acceptor data would support this possibility.

Data collected in 1995 show variations in method mix between priority and non-priority states. Increased use of VSC in priority states (in both urban and rural areas) and IUDs (in urban areas only) may be due to the training in these methods which was supported under the MOU (see table 13). A look at changes in method mix over time among the nine priority states (see table 14) shows that in general use of VSC and IUDs has increased while use of the pill and traditional methods has decreased. Such changes reflect the impact of training activities, especially those emphasizing more effective methods. There are, however, exceptions in several states. In Guanajuato, use of VSC declined slightly, but use of IUDs increased sharply and use of traditional methods also increased. In Puebla, pill use increased greatly, but use of VSC and other modern methods declined. Variations in method mix among states (and also among institutions, although not shown in any table in the report) may reflect service provider preferences or logistical problems affecting specific methods. (See section 4, recommendation 38.)

Table 11**Contraceptive Prevalence Rates by Parity for Priority and Non-priority States, 1995**

Parity*	Priority States	Non-priority States
0	15.9	19.1
1	60.0	58.5
2	70.0	83.5
3	75.6	68.5
4+	63.4	77.2

Source: Special CONAPO tabulation, October 28, 1996.

*Number of live births.

Table 12**Source of Contraceptive Methods* for Priority and Non-priority States, 1995**

Source	1995 Priority States	1995 Non-priority States
IMSS	36.2	45.9
IMSS/S	4.9	0.6
SSA	21.7	12.3
ISSSTE	4.9	2.6
Other public	6.3	7.4
Pharmacies	11.2	19.6
Other private	14.8	11.7
Total	100.0	100.0

Source: Special CONAPO tabulation from the ENPF-1995.

*For women in union ages 15-49.

Table 13**Method Mix by Urban and Rural Residence for Priority and Non-priority States, 1995**

Method	Urban	Rural
Priority States		
VSC	45.6	43.6
Pills	8.0	10.5
IUDs	23.9	21.1
Other Modern	8.9	11.8
Traditional	13.6	13.1
All Methods	100.0	100.0
Non-priority States		
VSC	41.7	29.0
Pills	16.9	12.3
IUDs	19.7	29.1
Other Modern	8.9	8.3
Traditional	12.8	21.3
All Methods	100.0	100.0

Sources: Special CONAPO tabulation (T6) from ENPF-1995 for Priority States and special CONAPO tabulation (T7) from ENPF-1995 for Non-priority States.

As explained, much of the MOU-supported training was carried out in priority states.¹¹ Therefore, the effect of training and other inputs on use of contraception can be assessed by comparing method mix by source in priority and non-priority states. In general, table 15 shows higher percentages using minilap (much higher at IMSS/S) at all three institutions; NSV at IMSS/RO, SSA, and ISSSTE; and IUDs at IMSS/RO and SSA. The exceptions are the higher percentages of IUD use at IMSS/S and ISSSTE in the non-priority states, although again the review team has no explanation for these exceptions.

¹¹The comparison of priority versus non-priority states is confounded somewhat by variation across the three institutions in terms of which and how many states are called priority states. (See footnote 2.)

The impact of increased use of contraception can be seen over time in changes in the level of fertility. For Mexico as a whole, there was a decline of almost half a child (0.41) between the 1992 and 1995 national surveys, representing changes in fertility between the 1987-91 and the 1991-95 periods. In Guerrero and Michoacán the decrease in fertility was closer to one child (see table 16). These are important changes to have occurred in such a short period of time.

Table 14**Trends in Method Mix* by Priority and Non-priority States, 1992 and 1995**

Entity	VSC 1992	VSC 1995	Pills 1992	Pills 1995	IUDs 1992	IUDs 1995	Other Modern 1992	Other Modern 1995	Traditional 1992	Traditional 1995
Chiapas	47.4	49.2	13.6	9.6	7.8	13.4	11.9	10.9	19.3	16.9
Guanajuato	35.8	34.1	15.2	7.0	14.8	25.3	12.7	9.2	21.5	24.5
Guerrero	43.9	48.8	15.3	9.9	14.3	17.0	13.1	14.0	13.4	10.3
Hidalgo	48.8	49.2	6.5	4.9	20.7	19.0	10.3	13.8	14.5	13.2
México	45.3	45.7	9.8	7.0	23.7	32.4	10.9	6.6	10.3	8.3
Michoacán	36.7	39.4	15.8	11.7	15.7	21.6	13.2	9.9	18.6	17.4
Oaxaca	38.0	49.0	7.9	5.4	12.0	20.7	15.9	9.6	26.2	15.1
Puebla	45.6	41.5	6.0	12.4	14.9	16.3	15.0	10.9	18.5	18.9
Veracruz	50.9	50.6	14.4	9.6	15.0	20.6	8.4	10.7	11.3	9.1
Non-priority States		40.0		16.2		21.0		8.9		14.0

Sources: CONAPO, Situación de la planificación familiar en México: indicadores de anticoncepción, November 1994 for 1992 and special CONAPO tabulations for ENPF-1995.

*For women in union ages 15-49.

Table 15**Total Fertility Rates for Women in Union ages 15-49 Priority States and All Non-priority States, 1992 and 1995**

State	1992 (1987-1991)	1995 (1991-1995)
Chiapas	4.60	4.06
Guanajuato	3.89	3.34
Guerrero	4.47	3.48
Hidalgo	3.48	3.22
México	3.41	2.97
Michoacán	4.23	3.36
Oaxaca	4.56	3.76
Puebla	4.33	3.78
Veracruz	3.23	2.92
Priority States		
Non-priority States*		
All Mexico	3.46	3.05

Sources: INEGI, Encuesta Nacional de la dinamica demographica, 1992 (grafica 6.14, p. 78) and Encuesta nacional de planificación familiar, 1995, Sinthesis de Resultados, Anexo, p. 38.

* A summary TFR for the non-priority states.

Overall Findings on Family Planning Access and Use

The National Family Planning Program of the GOM has continued to show significant progress during the short, three-year period of the MOU. The demand for children in Mexico continues to decline, although in some states and among certain population subgroups the level of demand remains at over three children. Large and increasing percentages of the Mexican population use contraception, but unmet need for family planning remains in both priority and non-priority states. While total fertility rates across Mexico have continued to fall, they remain relatively high in some states and for certain population subgroups.

Access to family planning has improved due to a number of factors: extensive training of providers, different service delivery strategies (e.g., jornadas), a revision in the GOM's Official Norms, and IEC activities. Nevertheless, constraints to access (limited knowledge of

contraception; fear of side-effects and opposition to contraception; and certain eligibility criteria for methods of contraception) continue to exist, but are, for the most part, limited to particular areas and population subgroups. Use of more effective methods (both female and male VSC, IUDs, and, to a lesser extent, injectables) has increased as use of pills and traditional methods has declined. Exceptions to these generalizations are noted in institutional data on new acceptors as well as national surveys.

The GOM institutions and the Population Council under the INOPAL III project have proposed that increased funding and more activities to be targeted to the most marginal geographic areas in order to improve access to the most needy population subgroups. In addition, the public health institutions would like more flexibility to direct MOU resources to marginal areas in some non-priority states.

Recommendation:

7. Consistent with the high priority given to family planning by the GOM, USAID should continue its commitment to the partnership with the GOM by focusing its resources, through the remainder of the MOU, on those areas of greatest need—lowest prevalence and most marginal rural areas—in order to increase access to those population subgroups that still have unmet need. The MOU resources should continue to be devoted to the priority states in order to not diminish the amount of funds available to any given state.

3. STATUS AND CHANGES IN QUALITY OF CARE

3.1 Government of Mexico Norms in Quality of Care

3.1.1 Official Family Planning Service Delivery Norm

The current Mexican family planning service delivery norms, referred to as the Norma Oficial Mexicana (NOM-OO5SSA2-1993), were developed by an inter-institutional committee comprised of public and private institutions involved in provision of reproductive health services, including family planning NGOs and women's groups. The Official Norm was published in 1994 (SSA, 1994). Its purpose is

to standardize the principles, operating criteria, policies and strategies for provision of family planning services in Mexico, with a focus on reproductive health, in order to: adequately select, prescribe and provide contraceptive methods, with absolute freedom and respect for individual choice following counseling; and identify, manage and refer cases of infertility and sterility, and therefore contribute to improved individual, family and social well being.

In terms of quality of care, the Official Norm adequately addresses appropriate service delivery standards.¹² Guidelines are presented for provision of a wide range of contraceptive methods including: orals and injectables (combined and progesterone-only, in numerous formulations); subdermal implants; IUDs; tubal ligation; vasectomy; condoms; vaginal spermicides (creams, tablets, and foam); and periodic abstinence (rhythm, basal body temperature, cervical mucus, and combinations thereof). Emphasis is placed on assuring an adequate supply of contraceptives at all SDPs. Information and counseling are required service delivery components and informed consent must be obtained for VSC. The importance of client-provider interpersonal relations is emphasized within the context of counseling. As regards technical competence, services are to be provided by a trained provider, supervision is to be based on assuring that quality of care criteria are met and parallel infection control procedures are followed. Mechanisms to assure continuity and follow-up are specified. An appropriate constellation of services is assured through linkages to other reproductive health services. Up-to-date technical information on each contraceptive method comprises the body of the norms.

¹²The Official Norm is based on the service delivery guidelines and recommendations of WHO and numerous USAID CAs.

3.1.2 *Institution-specific Guidelines on the Official Norm*

SSA. The Official Norm is used by SSA. Both IMSS and ISSSTE prepared and published institution-specific guidelines on the Official Norm (IMSS, November 1994 and ISSSTE, October 1994).

IMSS. The IMSS guidelines include information on fewer methods: orals (combined and progesterone-only), implants, IUDs, condoms, tubal ligation and vasectomy. This narrower range of methods is based on IMSS institutional policy which defines the quality of contraceptive care as the provision of "the safest and most effective methods, with the least undesirable side effects and greatest continuation rates." IMSS guidelines emphasize that a "health and reproductive risk focus are to be applied in promoting and prescribing contraceptive methods." (IMSS, November 1994.) These IMSS guidelines include a scheme for assessing reproductive risk and selecting the most appropriate contraceptive method according to the scheme. The scheme places varying degrees of emphasis on different methods, with primary emphasis on the IUD. The least emphasis is placed on condoms, which are presented as an interim method or for use with other methods.

The IMSS guidelines are somewhat restrictive in terms of method choice because of the eligibility criteria. Women are classified by categories of reproductive risk and pregnancy history and 3-4 contraceptive options are indicated in order of preference (IMSS, November 1994, Anexo I). These eligibility criteria could limit client choice and, consequently, client satisfaction. According to a growing body of research, meeting the initial needs of the client promotes continued use of contraception. Further, clients who receive the method they initially sought—a large number have a preference before they interact with the provider—are significantly more likely to continue using the method than those who do not receive their "preferred method."¹³ Finally, an emphasis on continuation rates should encompass and incorporate method switching since the needs of the client change over time.

In addition to the guidelines, IMSS produced two additional technical manuals on norms and procedures. One (IMSS, February 1995) describes the family planning tasks of each service provider for both out-patient and in-patient services and the other (IMSS, August 1994) sets forth the guidelines for reproductive health education activities.

ISSSTE. ISSSTE produced its institution-specific guidelines on the Official Norm in one operations manual divided into two sections (ISSSTE, October 1994). The first section presents general ISSSTE policies regarding family planning and describes the tasks of all ISSSTE service providers. Similar to IMSS, ISSSTE policy emphasizes provision of contraceptive methods that are most effective and that have the highest continuation rates. The second section of the operations manual replicates the Official Norm in its entirety, including presentation of technical

¹³Murphy, E., July 1996.

information on all contraceptive methods.

3.1.3 *National Programs in Population, Reproductive Health, and Family Planning*

One year after the Official Norm was published, the *National Population Program, 1995-2000* (Poder Ejecutivo Federal, 1995) was developed. This program calls for improving the quality of family planning care by broadening the range of methods; guaranteeing continuous supply and availability of the contraceptive methods recognized in the Official Norm; assuring that information and counseling is provided on all methods including natural methods; and strengthening the technical competence of service providers and adapting the structure and organization of services to meet client priorities and demands.

Inter-institutional groups for coordinating family planning have existed for several decades in Mexico. The Reproductive Health Inter-institutional Group, comprised of representatives from public and private sector population, health, and women's groups, was formed in 1995 under the leadership of SSA. This group produced the *Reproductive Health and Family Planning Program, 1995-2000* (Poder Ejecutivo Federal, May 1995). The program's general objective is to

guarantee the entire population universal access to high quality family planning information, orientation and services within the wide context of reproductive health, with multiple options for safe, effective and acceptable contraceptive methods for all phases of reproductive life, which allow one to freely exercise the right to decide the number and spacing of one's children, based on informed consent....

Of the program's thirteen objectives, six refer to improving the quality of IEC activities and services or specific aspects of quality of care.

In 1996, the public sector health institutions prepared their individual institutional reproductive health programs for 1995-2000. These programs should continue to reflect the growing interest and commitment to improved quality of care in the Mexican public health sector.

Need to Update. Since the Official Norm's preparation in 1993, the GOM has made reproductive health the centerpiece of its population policy. Both the National Population Program and the Reproductive Health and Family Planning Program have much stronger positions than the Official Norm in assuring the quality of family planning care, particularly from the client's perspective. The Official Norm should be updated to reflect general GOM policy and specific health sector reproductive health policies. SSA has already indicated interest in revising the Official Norm and, as the lead health sector institution, should be encouraged to do so.

The Official Norm would also benefit from greater clarification of its policies on informed consent for VSC. The Norm specifically requires that written informed consent be obtained for

male and female surgical contraception; however, it does not clearly define what information—other than the irreversibility of VSC—should be included in an informed consent form. In addition, it lacks an example of an appropriate informed consent form that can be used as a model.

Further, the Official Norm requires strengthening of its discussion of reproductive risk versus reproductive rights and the client perspective. In the Official Norm, reproductive risk assessment and counseling are defined as essential service delivery components; however, the role of reproductive risk assessment in contraceptive counseling vis-à-vis client needs and perceptions should be clearly stated.

3.2 Operationalization of the Official Norm

Dissemination of the Official Norm—and assuring compliance—means reaching over 225,000 providers at over 13,000 public sector SDPs; the magnitude of the task must be recognized. The challenge is foreboding; yet, Mexican public sector institution leadership is highly committed to the endeavor. The review team did not include a clinician; therefore, many operational aspects of compliance with the Official Norm could not be assessed during the site visits. Since the review team visited a small sample of SDPs in three of the nine priority states, its conclusions may not reflect the situation in all priority states or throughout Mexico.

Site visits confirmed that nearly all QOC routines and procedures outlined in the Official Norm are being operationalized at the service delivery level at all institutions. The strengths and weaknesses identified in operationalizing the Official Norm's QOC routine and procedures were observed equally at all institutions; no single institution was identified as currently having significant QOC problems. The strengths observed in operationalizing the Official Norm centered around progress that has been made in the following areas:

- 1) integrating family planning services into reproductive health care and, more specifically, into family health care, thereby reinforcing an appropriate constellation of services;
- 2) incorporating counseling, with an interpersonal communication focus, into the family planning service delivery routine, thereby improving the quality of information given to clients and interpersonal relations; and
- 3) increasing the extent to which services are being provided by recently trained providers, thus bolstering technical competence.

The Mexican public sector institutions are complying with nearly all policies, routines, and procedures set forth in the Official Norm. The following discussion identifies those areas that still need improvement within the context of the GOM's increased commitment to QOC.

3.2.1 Choice of Method

The Official Norm presents a wide range of contraceptive methods for inclusion in the

"menu" of methods offered by Mexican institutions. It does not, however, mandate which

Chart 2

Contraceptive Methods Included in the Mexican Official Service Delivery Norm and Contraceptive Methods Offered Routinely at Public Sector Institutions by Service Delivery Level

Contraceptive Methods Included in Official Norm	Contraceptive Methods Offered at Public Sector Institutions by Service Delivery Level								
	Hospitals			Medical Units/Health Centers			Community		
	IMSS	SSA	ISSSTE	IMSS	SSA	ISSSTE	IMSS	SSA	ISSSTE
Combined Orals	X	X	X	X	X	X	X	X	
Progesterone-only Orals									
Combined Injectables ¹⁴		X			X			X	
Progesterone-only Injectables		X			X			X	
Subdermal Implants ¹⁵									
IUDs	X	X	X	X	X	X	X	X	
Condoms	X	X	X	X	X	X	X	X	
Vaginal Spermicides									
Periodic Abstinence/Natural Methods									

¹⁴IMSS has recently approved use of a combined hormonal injectable that has not been introduced into the service network.

¹⁵SSA provides subdermal implants in several non-priority states.

methods must be offered. Consequently, the range of methods offered varies among institutions as shown in chart 2.

All institutions offer combined oral contraceptives (2-3 formulations); IUDs; condoms; tubal ligation and vasectomy in hospitals (in and out-patient services) and out-patient units (SSA health centers, IMSS & ISSSTE family medical units, and IMSS/S rural medical units). POE contraception is offered by all four institutions, with emphasis on IUDs and tubal ligation. At the community level, all institutions offer oral contraceptives and condoms via community-based rural auxiliaries (IMSS/S); TBAs (IMSS and IMSS/S); and health auxiliaries (SSA). IUDs are available in communities where IMSS and IMSS/S traditional birth attendants (TBAs) and SSA health auxiliary nurse supervisors have been trained to insert them—as a result of training provided under the MOU. SSA provides the broadest range of methods, since it also offers combined and progesterone-only injectables in hospitals, in health centers, and in communities via health auxiliaries.

The variance in contraceptive methods offered is due partly to specific institutional policies and partly to cost. The policy at IMSS (and, therefore, IMSS/S) and ISSSTE, as mentioned earlier, is to provide the safest and most effective methods that have the highest continuation rates. Cost contributed to discontinuation of subdermal implants as a method offered by SSA and IMSS, since it proved to be too expensive to continue purchasing this method after the conclusion of introductory trials. Despite the cost, SSA continues to offer sub-dermal implants in selected non-priority states. Injectables are not offered by ISSSTE due to cost. Injectables were not offered by IMSS and IMSS/S because of previous negative experiences with low continuation rates. IMSS is planning to offer injectables in the near future, however, to meet the high demand for this method among their users.

Need to Broaden Method Mix. The range of contraceptive methods offered by the public sector institutions is adequate, although it does not meet the needs of all women. For women who are breastfeeding and cared for in out-patient units and for postpartum/postabortion women in hospitals who wish to space their next pregnancy, the only options available are condoms and the IUD. However, since condoms are not actively promoted, the choice is essentially limited to the IUD, although, as mentioned, IMSS added injectables to its basic stock of methods in 1996.

Among the methods not included in the Official Norm is emergency contraception: the prevention of pregnancy through use of contraceptive methods after unprotected intercourse. A variety of hormonal methods and the IUD can be used for such emergencies. Although emergency contraception was first used in the 1960s, there is a widespread lack of knowledge among both providers and women about such methods not only in Mexico, but also in other countries (Robinson, Metcalf-Whittaker, and Rivera, 1996). This method would be a useful addition to the range of methods available in Mexico.

Recommendations:

8. In order to comply more fully with the current National Reproductive Health and Family Planning Program objectives and better meet the needs of Mexican men and women, the Mexican public sector institutions should broaden the choice of contraceptive methods available.

Introduction of injectables into the method mix—which has started—should be completed. Further, a progesterone-only contraceptive is needed for women who are breastfeeding and who wish to delay their next pregnancy. Condoms should be included as a routine method of POE contraception and also actively promoted in out-patient units. Increased offering of condoms as a method of POE contraception, together with the inclusion of a progesterone-only contraceptive for women who are breastfeeding (to be provided at six weeks postpartum) would have the dual advantage of providing more contraceptive options to postpartum/postabortion women, particularly those who are breastfeeding; as well as interim contraception to women who are breastfeeding until progesterone-only contraception can be initiated. Emergency contraception should also be included in the norms and provided as a method of contraception.

9. Given that IMSS's adaptation of the Official Norm may serve to restrict client access, IMSS should consider modifying its eligibility criteria to add the element of satisfying user needs and to diminish the emphasis that providers may place on the reproductive risk framework in advising their clients.

Market Segmentation. Broadening the method mix does not necessarily mean that all methods need to be provided at all institutions. Since Mexican citizens can receive free family planning services at any public sector institution and since contraceptives are available in the commercial and private sector, the market for family planning services as a whole should be considered in planning for provision of a wide range of affordable contraceptives.

The cost implications of increasing the range of methods available within each institution are recognized. For this reason, the review team endorses the contraceptive purchase cost-reduction recommendations made in 1995 by the UNFPA contraceptives logistics mission (UNFPA, 1996) as well as purchasing on the international market (see recommendation 51, section 5.4).

Recommendations:

10. The GOM with support from the MOU should undertake market segmentation analysis, taking into account all provider sources, in order to assure availability of an appropriate range of affordable contraceptives (see also section 5.2). At the national level, CONAPO and the public health institutions should be encouraged to take the lead in this kind of analysis. (See section 6 for the role of state-level bodies.)

11. Following a market segmentation analysis, each of the GOM public health institutions should ensure that their counseling service informs clients of the availability of a particular method at another provider, the location of that provider and the cost of the service.

3.2.2 *Informed Choice*

The Official Norm mandates information and counseling as integral components of family planning care. Indeed, most women receiving family planning services in the public sector are receiving the information and counseling they need to make an informed choice regarding their contraceptive method. However, informed consent procedures need to be reviewed and enforced.

Informed Consent Forms Currently Used. With regard to informed consent for VSC, two very different situations were observed. In the case of female VSC, nearly all SDPs use some type of consent form. The content of the form, however, varied greatly among SDPs belonging to the same institution and among institutions. In general terms, four types of female VSC consent forms were found to be in use:

- A standard institutional surgical consent form that authorizes any type of surgery (and thus does not include information specific to female VSC).
- A consent form that authorizes use of contraception in general, containing a blank space to write the name of the method and no method-specific information.
- A consent form specific for female VSC that provides information about the procedure but does not state that the procedure is permanent and that, consequently, the woman will no longer be able to have children.
- A proper consent form developed specifically for female VSC that adheres to all internationally-accepted standards of informed consent for VSC.

The most commonly used form is the standard surgical consent form. One SDP did not use any type of consent form for VSC.

In those institutions where informed consent forms specific for female VSC were not being used, some providers were not aware that a specific form should be used. Others reported that they were aware of the form but had never received it. Providers were not reluctant to use an appropriate informed consent form. When advised that the wrong form was being used, most providers spontaneously commented that use of the proper form was in their professional interest

and requested that it be provided. It is apparent that use or non-use of an appropriate consent form for female VSC is a problem of standardization and logistics, not of provider resistance.

With regards to informed consent procedure for male VSC, a different situation was found. All SDPs offering vasectomy used a standard and appropriate informed consent form.

Standardization of Informed Consent Forms. IMSS and IMSS/S recently standardized the informed consent form for contraception used primarily for IUDs, tubal ligations, and vasectomies. These forms are provided during the *Jornadas de Salud Reproductiva* in rural medical units. A single form is proposed for temporary and permanent methods. This single-purpose form may be confusing when used among low-literate populations. For example, a woman who desires an IUD may become confused when she is asked to sign a form that makes reference to no longer being able to have children (in the case of tubal ligation). For this reason, IMSS and IMSS/S should consider using two forms: one for surgical contraception and one for temporary methods.

Recommendation:

12. Informed consent forms for male and female VSC should be standardized, preferably across institutions, based on internationally-accepted guidelines for informed consent. These forms should be included in the supply system in the same manner and with the same priority as other family planning commodities and supplies.

Utilization of an appropriate informed consent form for VSC is of utmost priority to Mexican service providers. Reproductive health leadership at the public sector institutions is also strongly committed to full compliance with written informed consent procedures for VSC. Given the importance of written informed consent for VSC, USAID and its CAs should concentrate initial efforts following this review on supporting the GOM to standardize VSC informed consent forms and to ensure their utilization at all SDPs.

The Inter-institutional Reproductive Health Group together with the CCO (recognizing that there is overlap but that all key players are in both) are appropriate fora to assume joint responsibility for standardization of informed consent forms for VSC and establishment of appropriate monitoring mechanisms to ensure their utilization. Efforts to improve informed consent procedures should also be accompanied by continued emphasis on information and counseling activities to assure informed and voluntary decision making.

3.2.3 Compliance with Other Service Delivery Policies in the Official Norm

As explained in section 3.2, the review team, lacking a clinician, was limited in its ability to fully assess technical compliance with the Official Norm. Nevertheless, through observation of

service delivery operations the team identified several differences between policies, routines, and procedures set forth in the Official Norm and actual service delivery practices.

OC Supply. One frequently seen difference was the supply of only one cycle of OCs even to longstanding users who present no problems. Some providers were unaware that the Official Norm allows for supply of up to four cycles. Other indicated that only one cycle was provided in order to have "better control" of OC users. "Control" was understood by the review team to mean that providers would have more regular contact with OC users in order to clarify doubts, dismiss rumors, promote correct and consistent use of OCs, as well as count active users.

Recommendation:

13. To avoid unnecessary visits for OC users, the number of cycles to be supplied at the first and subsequent visits should be standardized in accordance with the Official Norm (allowing for up to 4 cycles to be distributed starting with the first visit).

Changing the prevailing OC supply routine to comply with the Official Norm would require that return appointments be scheduled accordingly and that statistical procedures be adjusted in order to count/estimate active users. Counseling from the onset of OC use needs to emphasize that oral contraception, unlike IUDs and surgical contraception, is a client-controlled method that depends on correct and consistent use to be effective.

Duration of IUD Contraceptive Protection. Service providers are not up-to-date regarding the duration of contraceptive protection afforded by the CuT 380A IUD. Among those questioned, most service providers replied that duration of contraceptive protection was 2-5 years. This misconception is compounded by the Official Norm's outdated statement that it lasts eight years; that further conflicts with the IMSS version of the Official Norm, which states "10 years or more." Given the importance of the IUD in public sector services, the lack of correct information on the duration of CuT 380A use represents unnecessary program and client costs. The leadership at the Mexican public sector institutions is well aware of this information gap and, in fact, told the review team in their briefing that this should be a finding.

Use of Local Anesthesia. The Official Norm states that general, regional, or local anesthesia can be indicated for tubal ligation, but recommends use of local anesthesia with sedation. (IMSS's adaptation of the Official Norm does not make this recommendation.) At the SDPs visited, however, the opposite was observed: general and regional anesthesia are the most common anesthesia used for tubal ligation. This was due, in part, to the fact that training in local anesthesia was only introduced recently. Nevertheless, even in those institutions where providers have been trained in use of local anesthesia, use of general and regional anesthesia continues to predominate. Further discussion of this finding and specific recommendations to ensure compliance with the Official Norm are presented in a subsequent subsection (see recommendations 19 and 20).

Overall Findings. To conclude the discussion of GOM norms on quality of care, the need for updating the Official Norm is clear. New GOM policies have been issued with stronger emphases on QOC, particularly from the client's perspective. In operationalizing the Official Norm, several areas need to be addressed such as broadening the range of methods available to meet the needs of more women and to ensure informed consent. New technical information since the writing of the Official Norm also needs to be included.

Recommendation:

14. SSA and other health sector institutions should consider updating the Official Mexican Family Planning Service Norm and the institution-specific guidelines of the IMSS and ISSSTE. USAID resources through the MOU are to complement those of the GOM for this purpose, recognizing that there will be competing demands for these funds.

Revisions should include:

- Addition of concepts and definitions of reproductive health and family planning service delivery as set forth in the Cairo Plan of Action, the *National Population Program, 1995-2000*, and the *Reproductive Health and Family Planning Program, 1995-2000*, with particular emphasis on the client's perspective;
- The inclusion of updated technical information (e.g., duration of CuT 380A contraceptive protection);
- The standardization of selected routines and procedures that require operational clarification (e.g., the number of OC cycles to be provided to users and informed consent procedures for VSC); and
- The inclusion of sample standardized informed consent forms for male and female VSC.

3.3 Quality of Care Interventions

Under the MOU, activities to improve the quality of family planning care provided by the Mexican public sector have centered on strengthening technical competence, improving information given to clients, and expanding the choice of methods. Activities that contribute to improving interpersonal relations, ensuring continuity and follow-up, and promoting an appropriate constellation of services have also been carried out, but with less emphasis. Chart 3 highlights the main interventions supported by the MOU to improve quality of care at Mexican public sector institutions in priority states.

Chart 3

Mexico: USAID Family Planning QOC Interventions in the Public Sector Supported by the MOU, by GOM Institution & CA* Providing Technical &/or Financial Support

QOC Elements	QOC Interventions Supported by MOU	Public Sector Institution			
		IMSS	IMSS/S	SSA	ISSSTE
Choice of Method	Training of Providers in new methods and existing methods to broaden choice	PI AVSC	PI	PI DA	
	Training in contraceptive logistics management	FPLM	FPLM	FPLM	FPLM
Information Given to Clients	Provision of existing IEC materials	AVSC	AVSC	AVSC	AVSC
	Provision of IEC material/validation of existing materials	PI	PCS PI	PCS PI	PCS PI
	Provision of audiovisual equipment	PI	PI	PI	
Technical Competence in Interpersonal Relations	Review & dissemination FP service Norms & development of VSC service delivery guidelines	AVSC PI	AVSC PI	AVSC PI	AVSC
	Development of training curricula & manuals	AVSC PCS	AVSC	AVSC PCS PI	AVSC
	TOT/providers in: <ul style="list-style-type: none"> • counseling (FP/VSC, POE, NSV) • interpersonal communication • FP/RH & FP updates • adolescent RH • IUD insertion (interval & POE) • minilap (interval & POE) & NSV 	AVSC PI	PI	AVSC PI PCS	AVSC
	Provision of Equipment, instruments & supplies for training & service delivery	AVSC PI	AVSC PI	AVSC PI	AVSC PI
	Supervision: visits & systems development	AVSC PI	PI	AVSC PI	AVSC PI
Appropriate Constellation of Services	TOT & providers in FP & other RH services	PI	PI	PI DA	PI

	Development & dissemination of non-FP RH norms	AVSC PI		AVSC PI	
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*For this table, the following abbreviations are:

AVSC	AVSC International	DA	Development Associates
FPLM	Family Planning Logistics Management	PC	The Population Council
PCS	Population Communication Services	PI	Pathfinder International

The review team's approach to assessing these quality of care interventions included a review of GOM and MOU program documents and of training and IEC materials; interviews with USAID CA staff resident in Mexico; and, most importantly, site visits to a small sample of SDPs in three of the nine priority states. As mentioned in section 3.2, the team's observations may not reflect the general situation in Mexico; however, based on discussions with GOM officials during and after the site visits, the team members are confident that these observations are accurate.

3.3.1 *Technical Competence and Interpersonal Relations*

The MOU has supported improved technical competence at all public sector institutions in four areas: development and dissemination of service delivery guidelines, training, provision of equipment, and supervision. Improvement of interpersonal relations has also been addressed within the context of counseling curricula development and training.

Development and Dissemination of Service Delivery Guidelines.

(1) Dissemination of the Official Norm.

The Mexican public sector institutions have dedicated considerable effort to dissemination of the Official Norm. USAID has played a strong role in facilitating this dissemination by providing support for reproduction of the Official Norm and the adapted norms of IMSS and ISSSTE. Meetings have also been sponsored for presentation and discussion of the norms. At ISSSTE, posters containing key information pertaining to the Official Norm have been produced as part of a dissemination strategy to reach service providers. The posters are located throughout ISSSTE SDPs.

To date, 20,000 copies of the IMSS adaptation of the Official Norm and 4,000 copies of the ISSSTE version have been printed for distribution under the MOU.¹⁶ To give a sense of the overall need in just the priority states, IMSS/RO has 648 medical units and 35,000 medical staff; IMSS/S has 2,726 medical units and over 14,000 staff; ISSSTE has 488 medical units and almost 9,000 staff. In spite of the distribution effort, the number of copies distributed has been insufficient to reach significant portions of the public sector delivery system. To cite one example, IMSS norms have not been distributed among IMSS/S rural medical units because there are not enough copies to do so. In these units, the person responsible for unit operation and provision of medical services is a *pasante*¹⁷ who changes annually. In most cases, a copy of the Official Norm is the only technical information on family planning service provision to which a

¹⁶SSA has used GOM resources to print the Official Norm. USAID has supported its dissemination.

¹⁷*Pasantes* are recent graduates of medical school who must complete one year of social service to receive their diplomas.

pasante has access.

The use of further support for dissemination of the current Official Norm and its institutional adaptations requires careful examination to ensure the best use of MOU resources. On one hand, a great need remains for information on prevailing family planning service delivery norms at the service delivery level. On the other hand, if the Official Norm is to be revised, the limited USAID resources for dissemination would be better spent disseminating the new, updated Official Norm. Building upon a similar Pan American Health Organization-supported activity at SSA, consideration should be given to producing "provider-friendly" communication materials such as signs, posters, wall charts, and flowcharts illustrating the delivery of different services in order to give providers key policy and technical information from the Official Norm that is not expected to change with the update. Such information could include the duration of the IUD, the number of supplies that clients should be given, and informed consent procedures. Signs and posters could be placed in provider work areas such as consultation rooms of out-patient units and OB/GYN wards and nursing stations. Other special strategies to disseminate and highlight the norms (e.g., teleconferences) could also be considered. The review team recognizes that these communications activities are costly and, therefore, MOU resources would have to be used selectively. The JHU/PCS project could assist the Mexican institutions in the development of such dissemination strategies.

Recommendation:

15. Programmatic decisions to support further reproduction and dissemination of current norms should be evaluated carefully, taking into consideration: 1) the likelihood that the Official Norm and, consequently, IMSS and ISSSTE norms may be updated; and 2) the continuing unmet need among providers for information on current service delivery norms. Alternative communication strategies should also be considered for reaching service providers with key policy and technical information.
 - (2) Other service delivery guidelines.

MOU resources have also been used to assist with development of service delivery guidelines for providing minilaparotomy services using local anesthesia and sedation and for no-scalpel vasectomy. The guidelines are incorporated within the training curricula. They represent years of cumulative experience on the part of USAID CAs and the Mexicans themselves and provide solid technical ground on which to build training and service programs.

In August 1996, CA representatives participated in the review of service delivery guidelines for providing female VSC services (primarily minilaparotomies) on an out-patient basis during *Jornadas de Salud Reproductiva* in rural medical units. The development of the guidelines is an extremely important initiative, since their use will improve the safety of such procedures. As mentioned in section 2, jornadas are an important strategy for maximizing access to various

methods including VSC services for men and women living in rural areas far from hospital-based services. The safety of the VSC services is paramount, particularly since regional and general anesthesia were being used to perform the procedures in addition to local anesthesia with sedation.

Recommendation:

16. An expert surgical contraceptive technical review team should be established to review the recently developed service delivery guidelines and adapt them, if necessary, before resuming USAID funding of these services. (Subsequent to the midterm review a team of experts carried out the recommended review and found the guidelines satisfactory.)

The technical review team should include expert surgeons in female VSC from both Pathfinder and AVSC International and from each of the three Mexican institutions; inclusion of an anesthesiologist should also be considered. The participation of expert representatives from all Mexican institutions is recommended since out-patient female VSC procedures are being performed in free-standing health centers by both SSA and IMSS/S without specific out-patient female VSC service delivery guidelines. The immediate objective of this team should be to standardize service delivery guidelines for provision of out-patient minilaparotomy procedures (including informed consent) in non-hospital settings among all public sector institutions by adopting existing guidelines in their entirety or developing new guidelines. Time permitting, a secondary objective should be to propose a standardized minilap training curricula for all public sector institutions that addresses both hospital and out-patient procedures. This curricula should focus on all aspects of minilap service provision, with particular emphasis placed on safety; infection prevention and control; post-operative monitoring and timely detection of signs of alarm; and timely referral to the support site.

The team should review the current guidelines for *jornadas* and the minilap training curriculum, as well as conduct on-site observation of minilap procedures performed in hospitals by surgeons generally assigned to *jornadas*. If needed, recommendations should be made regarding changes required in the training curricula to assure competency in performing out-patient minilap procedures.¹⁸

Training. Significant MOU resources have been dedicated to improving technical competence and interpersonal relations through various training activities including the development of training curricula, training of trainers, and training of providers.

- (1) Curricula Development.

¹⁸Subsequent to the midterm review, a technical team from Pathfinder and AVSC reviewed the guidelines and found them to be satisfactory. The new guidelines are now being used in the field.

Training curricula and manuals have been produced in all public sector institutions for the following: family planning counseling, post-obstetrical IUD insertion, minilaparotomy using local anesthesia, and NSV. SSA has also developed training curricula for interpersonal communications (IPC), for postpartum contraception, and for training nurse supervisors in in-service training and supervision of health auxiliaries. In general, training curricula and manuals have been developed by the Mexican institutions utilizing curricula developed internationally and provided by USAID CAs.

Based on a review of most of these curricula, the training activities supported by the MOU reinforce appropriate quality of care standards. Training is based on the Official Norm and most training is competency-based. In the curricula reviewed, infection control procedures are addressed. Interpersonal relations are addressed in the counseling curricula. SSA counseling curricula for trainers and providers has a strong IPC focus, although all of the counseling training curricula includes elements of IPC.

Two areas that require strengthening are curriculum development and use of training materials. First, site visits revealed that providers generally lack training manuals or have very old ones, even though these manuals have been produced under the MOU. This finding suggests that the distribution and use of training manuals merits review. Second, in some cases the curriculum for the same subject varies in key areas among institutions. For example, IMSS and IMSS/S family planning counseling curricula for trainers and providers omits the theme of informed consent (although this is currently being corrected).

Recommendation:

17. MOU resources should be used to support standard training curricula and manuals across institutions for more efficient use of these resources and to ensure the same standard of technical competence among institutions. USAID should support, insofar as possible, a standardized training curricula, training manual, and course structure for training the same provider group in a particular technical skill or skills. Printing of training manuals with the logos of all institutions, as has been done with some of the IEC materials, should be encouraged.

(2) Training in Counseling and Interpersonal Communication.

Significant advances have been made in the area of family planning and VSC counseling as a result of support provided under the MOU. A top-level commitment to counseling has been made by all institutions. Family planning and VSC counseling curricula have been developed and are beginning to be institutionalized. Counseling trainers have been trained in all institutions and have, in turn, trained thousands of providers. Indeed, counseling is becoming a routine component of public sector family planning service provision, particularly for interval family planning services. Review team site visits confirm the impact of counseling training on QOC, particularly at ISSSTE and IMSS/S where most service providers trained in counseling are nurses and social workers who are at the front lines of service delivery.

PCS has assisted SSA with curriculum development specifically in the area of IPC. A curriculum was developed and tested initially for training health auxiliaries in IPC. As a result of lessons learned, the training curricula was modified and tested for training primarily professional staff in IPC.

Recommendation:

18. Emphasis on counseling training as opposed to separate training in IPC should continue. Mexican institutions should continue to include content areas of the IPC curricula in the counseling curricula with the necessary technical assistance.

The counseling and IPC training activities that have been supported under the MOU meet strong program needs. The above recommendation is not intended to diminish the worth of training providers in IPC. Rather, given the downward trend in financial resources throughout the remainder of the MOU, USAID resources should focus on priority activities such as institutionalization of counseling.

(3) Training in Clinical Skills.

In harmony with the curriculum development activities, MOU support for training of trainers and service providers across all institutions has generally emphasized family planning counseling; minilaparotomy using local anesthesia (interval and POE); NSV; IUD insertion (interval and post-obstetrical event); and more recently, adolescent reproductive health. With the exception of training in adolescent reproductive health, AVSC International has been responsible for the training of trainers in clinical skills and Pathfinder or AVSC International for training of providers.

Training of trainers and providers has also been supported for specific provider groups at individual institutions such as TBAs and TBA trainers at IMSS and IMSS/S and health auxiliaries and their nurse supervisors at SSA. This training has generally focused on providing

rural, community-based women's reproductive health care, including family planning. ISSSTE has also received assistance with training of trainers in general family planning refresher training and training of providers, primarily non-physicians.

(4) Training Areas to Be Strengthened.

During the site visits, the review team assessed technical competence as a result of training from a broad perspective, given the team's non-clinical expertise. Numerous successes were identified particularly in regard to family planning counseling and NSV training. However, the following aspects of training need to be strengthened:

- Minilaparotomy training
- POE contraception
- Training of nurses in family planning
- Provision of training equipment and supplies
- Supervision

Minilaparotomy Training Using Local Anesthesia and Sedation. As mentioned earlier in regard to compliance with the Official Norm, the majority of minilap procedures at SDPs with trained providers continue to be performed with regional or general anesthesia instead of local anesthesia with sedation. This finding was observed in the field and confirmed with data provided by IMSS to AVSC International. The reasons that local anesthesia has not been fully adopted following training go beyond the scope of this review, but appear to be associated, in part, with operational difficulties in training providers (e.g., lack of support from senior hospital management); provider bias (e.g., bias of anesthesiologists); and to some extent, insufficient confidence in the provider's technical competence. In the case of the anesthesiologist, depending on the institution, this individual is not necessarily included in the team to be trained.

Recommendations:

19. The minilaparotomy training strategy should be reviewed and standardized among institutions to improve the effectiveness of the training, guarantee the safety of services, and promote greater use of local anesthesia and sedation. An anesthesiologist should be included in team training activities.
20. The review team endorses AVSC International's plan to develop criteria and a process for certifying training centers and physicians trained in VSC. The work planned at IMSS to develop supervision criteria should be extended to all institutions. In addition, operational problems concerning the training of providers, such as trainee selection criteria and lack of institutional support for using local anesthesia with sedation in minilaparotomy, should be identified and resolved.

Post-obstetrical Event Contraception. The MOU has supported significant training in the provision of POE contraception, including IUD insertion and minilaparotomy. Site visits confirmed that POE contraception is routinely available at all institutions—although to a lesser extent at ISSSTE—and is provided trans-cesarean, post-placenta, postabortion, and prior to discharge. POE counseling has also improved; numerous hospitals have incorporated counseling for POE contraception as a result of the USAID-sponsored training.

The Mexican public sector institution leadership and the activities supported by the MOU have targeted considerable effort to improve counseling in POE contraception and increase voluntarism and informed choice, particularly with respect to IUD insertion. For example, JHU/PCS has collaborated with SSA to develop a brochure for women that presents the benefits of POE contraception. This brochure is being used in prenatal care counseling as well as by *paramedicas* to help POE women choose the method of their preference. Nevertheless, problems with voluntarism and informed choice were observed by the review team. During a visit to the obstetrical ward of a large training hospital, postpartum women informed the review team that they had received IUDs at delivery without their consent.¹⁹ This incident demonstrates that lack of information and counseling on informed choice and voluntarism is a continuing, critical issue that must be addressed in the Mexican public sector reproductive health program.

Recommendation:

21. The GOM public health institutions should give utmost priority to ensuring that all men and women seeking contraception receive adequate information and counseling. USAID should give the highest priority to using MOU resources to assist these institutions so that all women admitted to obstetrical wards who desire contraception receive information and counseling; that informed consent is obtained for all women requesting post-obstetrical event IUD insertion or surgical contraception; and that condoms are routinely available as a method of contraception. (See section 3.2.1.)

To implement this recommendation, MOU resources should continue to support the training of trainers and providers in family planning and VSC counseling, with stronger emphasis on the differences in counseling for interval and POE contraception. Counseling and informed consent need to be further strengthened in the curricula for clinical training in POE contraception. Additional activities need to be started or strengthened, including:

- Agreement on and inclusion in the Official Norm of informed consent as a requirement for POE IUD insertion;
- Standardization and inclusion in the Official Norm of separate informed consent

¹⁹This incident occurred in one of the public sector institutions where counseling training (for other than NSV) has been greatly diminished and where 88 percent of all postpartum counseling training participants have been physicians. This latter finding suggests that in this institution, unlike the others, more attention needs to be given to counseling training for nurses and social workers.

forms for post-obstetrical event IUD insertion and for VSC (see previous recommendation on informed consent);

- Inclusion of "100 percent use of informed consent procedures for post-obstetrical event IUD insertion and male and female VSC" as a criteria for certifying Mother-Child Friendly Hospitals; and
- Production of IEC materials such as posters and signs (and dissemination and use of existing materials) containing key information regarding informed choice and voluntarism and informing users and providers of their rights and responsibilities—particularly for use in pre-natal waiting areas, obstetrical wards, labor, delivery and recuperation rooms, and pre- and post-operative areas.

Due to the short hospital stay of most obstetric patients, multiple service delivery channels for POE contraception need to be improved to allow a time for counseling and providing information other than during labor and delivery. A study of client flow may be necessary to identify the most appropriate opportunities for counseling and providing information, signing of the consent form, and providing POE contraception.

Organization of POE contraceptive services should be centered around the short hospital stay and the needs of the clients. A team approach should be utilized, built around providing POE contraception utilizing both providers in hospital out-patient units as well as in-patient OB/GYN and general surgical providers. This approach would necessitate development of revised service routines and procedures and an expanded role and training for nurses as first line providers of POE contraception. For those women delivering in the hospital where they received pre-natal care (the minority in most institutions), counseling and signing of the informed consent form (conditioned on the delivery outcome, if necessary) could be done during the pre-natal visits.

Recommendation:

22. To maximize access to high-quality POE counseling and services, GOM public sector institutions should develop, implement, and institutionalize new service routines using MOU resources. These routines would allow for a combination of providers (including nurses) to have several opportunities to provide POE contraception during a woman's hospital stay. The current practice of providing POE contraception during a cesarean section or immediately following delivery or abortion limits opportunities for counseling and reduces quality of service.

Training of Nurses in Family Planning. Relatively few hospital out-patient nurses are involved in direct delivery of family planning services, particularly IUD insertions. This appears to be due to a combination of factors: IUD insertion is not included in their official union job description, physicians feel it is their responsibility, and/or nurses have not been trained. Indeed, with the

exception of ISSSTE, relatively few hospital-based nurses have been trained in clinical family planning skills under the MOU. Given the heavy workload of hospital physicians, nurses have an extremely important role in expanding access and improving service quality.

Recommendation:

23. During the remainder of the MOU, factors contributing to under-utilization of hospital out-patient nurses as first-line family planning service providers (including contractual issues) should be addressed and measures should be taken to ensure that nurses are competently trained to provide services, including IUD insertion.

Provision of Equipment and Supplies. The MOU has contributed large quantities of equipment, instruments, and supplies for service delivery and training in support of improved technical competence of providers. All institutions have received equipment and materials for training such as videos, video recorders and players, overhead projectors, books, manuals, and anatomical models. The anatomical models are particularly important since they reduce the number of practice IUD insertion procedures that need to be conducted on human beings during training. All institutions have received medical equipment kits for IUD insertion, minilaparotomy, and NSV. General medical equipment and supplies have been received at all institutions for out-patient NSV services. The specific needs of individual institutions have also been met to the extent possible. To improve provider technical competence, ISSSTE has received basic equipment for family medicine consultation rooms. SSA nurse supervisors of rural health auxiliaries as well as the health auxiliaries and IMSS and IMSS/S TBAs have received bags (*maletines*) containing equipment and supplies. Equipment and supplies are also being provided for the implementation of adolescent reproductive health services at SSA and ISSSTE.

In the case of minilaparotomy and vasectomy, all of the equipment provided has been essential to the training process and has included equipment such as uterine elevators for minilaparotomy and forceps for vasectomy, without which newly trained providers can not put into practice newly acquired skills.

Recommendation:

24. MOU resources should continue to be used to provide equipment and supplies, with priority given to training-related equipment and materials such as anatomical models and kits for IUD insertion, minilaparotomy and NSV.

As the new guidelines for performing out-patient VSC procedures are implemented, rural medical units may require additional emergency equipment and supplies. Having an adequate supply of this surgical equipment in rural units is as important as good training in VSC procedures.

Recommendation:

25. In order to guarantee the safety of out-patient VSC procedures performed in rural areas, MOU resources should be used to complement public sector resources to equip rural out-patient units with the emergency equipment necessary to perform VSC procedures in accordance with approved service delivery guidelines.

The bags or maletines for health auxiliaries—and particularly for their nurse supervisors—are important, however, the equipment and supplies contained in the bags must be related to their tasks. The review team did not assess the role of health auxiliaries within the health provision system, although Pathfinder has suggested that there may be larger issues regarding their function that need to be examined.

Recommendations:

26. Additional requests for funding of maletines should be accompanied by a complete analysis of this activity including assessment of the job functions and equipment and supplies necessary to carry out those functions.

Supervision. Supervisory activities supported under the MOU have been limited primarily to covering the costs of central-level staff of each institution supervising staff at the state or delegation level. Limited resources have been used to develop or implement new supervisory models, primarily at SSA. Site visits indicated, however, that the supervisory function is unclear at nearly all levels of the service delivery system at all institutions. About 8 percent or \$1.4 million of MOU funds have been devoted to supervision and follow-up activities during the first three years.

Recommendation:

27. Supervision at all levels of the service delivery system is needed in order to strengthen the quality of family planning care. Given the chronic shortage of public sector resources for supervision, all GOM institutions should develop supervisory models based on selective supervision that focus on in-service training and monitoring of QOC.

3.3.2 *Information Given to Clients*

Development of IEC Materials. Considerable MOU resources have been invested in the development of family planning IEC materials including videos, large and small flip charts, pamphlets, booklets, and posters. The objective of these IEC materials has been to improve information given to clients by developing high-quality, credible, and pertinent materials to be used by service providers for orienting specific population groups and, in effect, empowering

clients vis-a-vis the service providers. The MOU support has been used to develop institution-specific IEC materials (although older IEC materials that carried the logos of many institutions were observed in the field).

Two approaches to development of these materials have been used. One involves audience research and validation of the materials prior to production. This approach, although time-consuming, has resulted in the production of appropriate IEC materials using sound communication techniques. Financial resources have been insufficient, however, to produce the materials in the quantities that are necessary, in part because of the relatively high cost of the materials. The other approach has been to adapt existing materials—some of which have been validated—and reproduce them in massive quantities. While some of these materials have their merit, many represent resources that could have been more appropriately utilized. Opportunities for sharing resources and materials should be encouraged. For example, in order to reduce costs, JHU/PCS is exploring alternatives with SSA that include sharing costs with the private sector (e.g., manufacturers of contraceptives). Furthermore, there is some sharing by public sector institutions of existing, pretested materials such as the AVSC International flipchart on methods and the MEXFAM videos and materials for adolescents.

In its work with SSA, the JHU/PCS project is also planning to develop an impact evaluation model which would include exit interviews with clients to monitor client satisfaction with the information received from the provider. This type of evaluation of IEC strategies is important to ensure that the activities being supported under the MOU are having the intended effect.

Recommendations:

28. Support should continue for production of IEC materials, particularly reproduction of existing materials that have been tested using sound communication methodology. Any additional MOU resources should be spent on reproduction of existing materials that can be used by all institutions. Efforts should also be made to examine alternatives for lowering production costs (without compromising quality) and obtaining sponsorship from private industry. The Inter-institutional IEC Subcommittee would be the appropriate vehicle to determine which existing materials should be produced, how costs can be lowered, and to develop strategies for seeking private sponsorship.
29. In addition, production of additional materials and evaluation of IEC strategies more generally (as opposed to the usefulness of particular IEC materials) should also be considered and, if deemed important by the IEC Subcommittee, supported with MOU resources.

Availability of IEC Materials. The materials developed under the MOU were seen during site visits, but their availability is very uneven. At the present time—slightly more than midway through the period of the MOU—IEC materials are in short supply at all SDPs at all institutions,

particularly at the lowest levels of the delivery system. IEC materials for use by rural health auxiliaries and health promoters are, for the most part, non-existent. Photocopied IEC materials were frequently observed; photocopying of materials, if done regularly, would be very costly. Also, providers often seemed reluctant to give away materials. Since large quantities of IEC materials have been produced, greater attention needs to be paid to the IEC material distribution system.

Recommendation:

30. IEC materials should be included in the reproductive health supplies logistics system to ensure that SDPs are well-stocked.

3.3.3 Choice of Contraceptive Methods

Contraceptive Methods Available in Rural SDPs. The most significant intervention supported by the MOU to expand method choice has been the training of rural-based non-physicians in family planning, with emphasis on IUD insertion. In addition to increasing access to contraceptive methods, the purpose of these training activities has been to increase the number of contraceptive methods available at a specific service delivery level or to assure a reliable supply of contraceptives. IMSS/S medical auxiliaries, for example, have been trained in IUD insertion to assure constant IUD availability in rural medical units, since the physicians working in these units are pasantes who may not be capable of providing IUD services. SSA nurses have also been trained in some states to provide IUDs to clients identified by the volunteer health auxiliaries that they supervise. In addition, a small number of TBAs has been trained in IUD insertion by IMSS/S and IMSS.

Another significant intervention supported to expand method choice and assure that the approved range of methods is available at SDPs has been the technical assistance in the area of contraceptive logistics management provided by the Family Planning Logistics Management (FPLM) project to IMSS (benefiting both Regimen Ordinario and Solidaridad) and SSA. (See section 5.3 on logistics support.) While site visits confirmed that contraceptives were available, stocks of most contraceptives appeared to be low—particularly condoms—at the *consultorio* level of some medical units. This lack of sufficient stock could affect method choice. There was sufficient stock at the warehouse level, however, and health auxiliaries at most rural outputs reported that they had sufficient stock.

Recommendation:

31. Given the importance of condoms in preventing pregnancies and STDs and their appropriateness for adolescents, adequate supplies of condoms should be made available in all SDPs and their distribution encouraged.

New Contraceptive Methods. To date, only one activity has been supported under the MOU to improve QOC by increasing the number of new contraceptive methods. Training in NORPLANT® implant insertion and removal was initiated following introductory clinical trials, but was discontinued due to the high cost to the Mexican public sector institutions of continued purchase of NORPLANT®, as mentioned above.

3.3.4 Mechanisms to Ensure Continuity and Follow-up

Efforts to improve continuity and follow-up have primarily focused on research activities which are described in the next chapter.

3.3.5 Appropriate Constellation of Services

The MOU's most significant achievement in improving the constellation of services has been through its efforts to assist the Mexican institutions to integrate family planning into reproductive health services, if not into the mainstream of primary health care. This is particularly the case at IMSS/S and ISSSTE where family health specialists and family doctors have been trained in family planning and are increasingly responsible for providing temporary methods of contraception.

Support from the MOU has also promoted an appropriate constellation of services, by supporting norms dissemination and training in family planning together with training in other areas of reproductive health. Examples of this include:

- Development and dissemination of STD prevention and management guidelines at IMSS and SSA;
- Training of SSA nurses who supervise health auxiliaries in rural areas to take PAP smears and insert IUDs;
- Training of SSA health auxiliaries to monitor the health and vaccination status of pregnant women and children under 5 and to provide contraception; and
- Training of IMSS and IMSS/S TBAs in pre-natal, safe delivery, postpartum care, and family planning.

The review team fully recognizes that wherever family planning is provided alongside reproductive health, providers need to be trained to screen for the reproductive health needs of their clients. Outreach workers also need to learn when to refer community residents to health

centers for such services. According to the INOPAL III staff, examples of reproductive health service delivery guidelines from other countries are available and could be adapted for use in Mexican institutions.

Support of other primary health care or reproductive health care activities requires the same technical oversight as family planning. During the site visits, TBAs informed the review team that as a result of their training they now require women to lie down to deliver rather than be in a vertical position, as is traditionally done. Since TBA training does not generally include modification of harmless cultural practices, it is important that CAs review and monitor the technical aspects of training prior to approving support and funding for it. (See section 7.2.)

Recommendation:

32. Activities that include family planning provision within the context of reproductive health or primary health care should continue to be supported under the MOU since successful integration of family planning services will be an important factor in strengthening service sustainability.

3.4 Priorities for Improving Quality of Care for the Remainder of the MOU

For the remainder of the MOU, USAID resources should continue to support improvements in quality of care, with emphasis on insuring a choice of contraceptive methods (recommendation 9); strengthening technical competence (recommendations 17, 19 and 20); and consolidating information-giving activities (recommendations 28 and 30). Priority should be given to the following activities:

- (1) Updating and disseminating the Official Norm to reflect the policies set forth in the *Reproductive Health and Family Planning Program, 1995-2000* (recommendations 16 and 17);
- (2) Institutionalizing routine counseling for temporary and permanent contraception (recommendations 19 and 21);
- (3) Institutionalizing informed consent for surgical contraception and post-obstetrical event IUD insertion (recommendations 12 and 21);
- (4) Strengthening POE contraceptive services, with emphasis on broadening the range of methods available, organizing services based on the needs of the clients, and insuring voluntarism and informed choice (recommendations 21 and 22);
- (5) Continuing training of nurses and auxiliaries as first-line providers of reproductive

health care (recommendations 22 and 23); and

- (6) Developing and institutionalizing appropriate supervisory models with emphasis on selective supervision, in-service training, and QOC monitoring (recommendation 27).

The Mexican public health sector has done an impressive job promoting improved quality and increased access to health care through such initiatives as the sector-wide Mother-Child Friendly Hospital program and the SSA white flag community program. Given the success of these programs, a similar sector-wide program for "family-friendly" or "woman- and child-friendly" health centers and medical units might benefit service delivery in reproductive health. In addition, IMSS has apparently proposed a system for recognizing medical units and adolescent service providers that have received special training and are making systematic efforts to serve young people as "adolescent-friendly" service providers.

Recommendation:

33. The Mexican public health sector institutions should consider developing a recognition system, similar to the Mother-Child Friendly Hospital program, that promotes and rewards provision of quality reproductive health care in health centers and out-patient medical units and "adolescent friendly" services. MOU resources should contribute to the development of this system.

4. MONITORING AND EVALUATION

The GOM has a well-developed system for monitoring and evaluating the National Family Planning Program. CONAPO, the lead public institution for overall evaluation, conducted the national household survey on family planning in 1995 that provided information on levels and trends in fertility and contraceptive use. Similar surveys were conducted in 1976 and 1992 by the National Institute of Statistics, Geography and Information (INEGI) and in 1987 by SSA. Each of the three public health institutions (IMSS, SSA, and ISSSTE) have well-established monitoring systems which routinely collect service statistics (new acceptors, continuing users, method mix, and in the cases of SSA and IMSS/S, data from yearly community censuses). Operations research has also been used to improve the effectiveness and quality of the family planning program.

Research and evaluation have been priority activities under the MOU receiving about \$1.9 million or 11 percent of MOU expenditures; 5 percent for CONAPO evaluation work and 6 percent for the research activities of IMSS, SSA, and ISSSTE. These activities included the 1992 National Demographic Dynamics Survey (ENADID). CONAPO used these survey results to prepare the program support document for the MOU which presented the situation at the time and defined future priorities, including priority states. CONAPO is using the 1995 National Family Planning Survey (ENPF-1995) to refine its geographic targeting strategy and identify priority municipalities within priority states. This midterm review has used both the 1992 and 1995 surveys to assess progress made under the MOU.

To complement the ENPF-1995 survey, CONAPO will conduct a facilities survey in 1996-97 to assess and provide baseline information on the service delivery system, including the quality of the services delivered. (In 1995, USAID's EVALUATION Project assisted CONAPO in refining this proposed research project.) The quality of services delivered will be assessed in terms of providers' attitudes, understanding, and capabilities. These data will then be linked with quality measures of clients' attitudes and experiences from the ENPF-1995. Use of the national survey in combination with the study of the service delivery system will provide insight into the supply environment for family planning, the structure of demand, and the link between the two. One additional national household survey is planned in 1998 as an "end-of-MOU" research project. Even if the MOU is extended, as recommended in section 7.5, the national survey should be completed during 1998 so that there is adequate time for analysis and dissemination. Ideally, this survey should be coordinated with a second assessment of the service delivery system in order to evaluate changes over time in both family planning demand and supply and to determine the impact of the program. A review of the experiences of other countries that have conducted Situational Analyses (studies of the service delivery system), such as Peru, might be useful to CONAPO.

Survey data have been used not only at the national level by CONAPO for planning and evaluation, but also by some of the state-level COESPOs: the COESPO in Chiapas has analyzed the survey data to assess future needs and priorities. The COESPO staff hope to use this analysis in their public information and communications activities and in working with the state-level

public health officials at IMSS, SSA, and ISSSTE to review progress in the family planning program. (See also recommendation 53, section 6.)

Recommendations:

34. In order to evaluate changes over time and program impact in the target areas for the MOU, CONAPO and USAID should consider supporting a second assessment of the service delivery system to be conducted in tandem with the 1998 household survey.
35. CONAPO should also strengthen and encourage the COESPOs to work with the state-level public health institutions to use the available data (service statistics, community-based data, and surveys) for program planning and evaluation.

Annual planning for the National Family Planning Program involves CONAPO and the three service delivery institutions in a multi-level, iterative process. Service statistics are used by institutions to set future targets and budgets and to assess program performance. (See section 5.2.) In the course of the midterm review, the review team discussed the use of targets, the quality and use of the service statistics, the community-level data collected by IMSS/S and SSA, and the links between the service statistics and the national surveys. The team found several gaps in monitoring service delivery outputs that could be useful for assessing MOU-supported training. Discussion on methods used for monitoring and evaluation follows.

Method-specific Targets. All three public health institutions use targets for planning and funding their programs. The review team noted several examples of providers and/or SDPs that placed too much emphasis on meeting targets. This focus on targets can contribute to various problems such as high discontinuation rates and reliance on non-reversible contraception. Both the IMSS and ISSSTE programs promote use of more effective methods of contraception with longer continuation rates and method-specific targets, thereby emphasizing particular methods (IUD and sterilization). The emphasis on method-specific targets (and specific methods cited in section 3.1.2) may affect service quality by limiting the choice of methods. As long as the overall choice of methods in the public and private sectors is adequate and the IMSS and ISSSTE providers inform clients of the availability of other methods at other sources, this institutional bias may be acceptable.

Conversely, instead of targets or outcome goals, some programs emphasize service or process goals, such as the percent of women offered services and knowledge of service providers. In these programs, evaluation and monitoring are based on service provision norms that are translated into service standards. Service providers have job instruments that enable them to meet such standards in these programs. Evaluation, supervision, and monitoring systems should be based on these service standards (Brambila and Vernon, 1996 and Buffington, 1995).

Recommendation:

36. CONAPO and the three service delivery institutions should ensure that service targets are not over emphasized to the degree that program staff compromise service quality and method choice in order to meet their *metas* or targets. A balance should be maintained between program targets (including method-specific targets) and the needs of clients. An alternative to targets that substitutes service or process goals based on the service provision norms should be considered for SDP-level management.

Service Statistics. Based on a cursory review of service statistics, there appears to be agreement at the CCO level in the definitions of new and continuing users; but, these common definitions may not have been disseminated throughout the data collection system of the three institutions. Thus, continuing differences in what and how service statistics are collected yield data that are not comparable across institutions. These differences can be seen in the definition of "new acceptors" that, at times, can include different types of new users, such as first-time-ever users of family planning, first-time users of a particular method, and simply first-time users of a given SDP or institution.

Recommendations:

37. Given the importance of service statistics for program planning, budgeting, and monitoring, it would be useful to review the definitions for new and continuing users and to ensure that standardized definitions are being used throughout the monitoring systems particularly at the state and local levels of the three institutions.
38. Some unexpected fluctuations in the new acceptor data (as noted in section 2.3) indicate that IMSS and SSA should review trends and patterns in the number of new acceptors and compare targets and achievements. Further, the fluctuations observed in the CPR from the household survey data (also discussed in section 2.3) suggest that the GOM institutions should analyze and monitor these fluctuations to detect problems and to identify ways to improve service delivery.

Community-based Data. Community-based health workers (e.g., *parteras* at IMSS/S) typically conduct an annual census in their communities to determine the size and composition of the population (age and sex) and its health status and needs. These data are only used at the local level for monitoring health needs and services, even though in 1996 CONAPO provided assistance to IMSS/S in questionnaire design and data analysis. If the quality of the data is reasonable, there are opportunities for greater use of community-based data. For example, such data could be the foundation of a community-based health surveillance system that could be used to improve program planning and monitoring.

Recommendation:

39. CONAPO, the COESPOs, and the two health institutions with rural programs (SSA and IMSS/S) should review the quality and usefulness of the community-based data to determine if they might be the basis of a health and family planning surveillance system. (See also section 6.)

Linking Service Statistics and Surveys. Given the existence of both the service statistics system and survey data (with state-level estimates for priority states in the ENPF-1995), there is potential for linking the two sources of information in order to improve planning, and monitoring and evaluation.

Recommendation:

40. CONAPO and the three health institutions—perhaps through the existing evaluation subcommittee—should explore ways to link the institution-based service statistics with national survey data. This idea could be explored on a pilot basis in one of the priority states with technical assistance from the INOPAL III project.

Monitoring of Training Activities. The MOU has supported training for improved access to POE procedures and for use of local anesthesia with sedation for minilap procedures. While some monitoring (by AVSC International) of the number of interval and POE procedures (both IUD insertions and minilap) has occurred, it should be systematic to ensure continued access to interval procedures. Apparently, there has been no monitoring of the number of minilap procedures by types of anesthesia (local with sedation, regional, and general) despite the extensive training on use of local anesthesia with sedation. Field observations suggest that while use of local anesthesia is limited, physicians use local anesthesia more often for postpartum procedures than interval procedures.

Recommendation:

41. USAID and the three public health institutions should ensure that there is adequate monitoring of certain types of procedures to assess the impact of training activities and access to services. Data that should be collected include: 1) the number of both interval and POE procedures at IMSS (with separate monitoring for IMSS/OR and IMSS/S), SSA, and ISSSTE; 2) the number of minilaps by types of anesthesia; and, if not too cumbersome for the institutions, 3) the number of minilaps by type of anesthesia categorized as interval or POE.

Research on Quality of Care. As illustrated in chart 4, considerable support has been provided for QOC research under the MOU. This research has been carried out with respect to each of the elements of QOC, and most studies have examined multiple elements. The user perspective is a strong component in most of the research. Quantitative methodologies predominate, although

qualitative approaches have been used as well. Most of the studies are in the planning or early implementation phases.

Chart 4

USAID Family Planning QOC Research & Evaluation Efforts Planned²⁰/Implemented in the Public Sector and Supported by the MOU, by GOM Institution and CA Providing Support 1993-1996

QOC Element ²¹	Topic of Research Activity Supported by MOU	Public Sector Institution				
		IMSS	IMSS/S	SSA	ISSTE	Others
Choice of Methods	Research <ul style="list-style-type: none"> • Emergency contraception as an element in the care of rape victims • IUD insertions by nurse supervisors of health auxiliaries²² Evaluation <ul style="list-style-type: none"> • IUD insertions by TBAs 			PI		PC
Information Given to Clients & Interpersonal Relations	Research <ul style="list-style-type: none"> • quality of postpartum counseling • impact of counseling (p) • informed consent for VSC (p) • informed consent among acceptors after an obstetric event (p) Evaluation <ul style="list-style-type: none"> • audience research & pre-testing of existing IEC materials 	AVSC AVSC ²³ PC	PCS	AVSC ²⁴ PCS	PCS	

²⁰(p) indicates activities that are in the planning phase.

²¹Research and evaluation efforts are classified according to the predominant QOC element under study.

²²This study was first developed as an OR project with TA from INOPAL and DA and later transformed into a service delivery project funded by Pathfinder International.

²³WHO will also provide support.

²⁴This effort is a WHO-supporting study of service quality. AVSC is supporting the study component involving evaluation of postpartum counseling.

QOC Element	Topic of Research Activity Supported by MOU	IMSS	IMSS/S	SSA	ISSSTE	Others
Technical Competence	<p>Research</p> <ul style="list-style-type: none"> • safe provision of IUDs in resource poor settings²⁵ • IUD insertions by TBAs compared to facility-based nurses²⁶ • strategy to decrease hospital C-sections and increase birth spacing <p>Evaluation</p> <ul style="list-style-type: none"> • training of service providers in urban & rural areas 	AVSC PI	FHI/PI PI		PC	
Continuity & Follow-up	<p>Reserach</p> <ul style="list-style-type: none"> • f/u study of vasectomized men to determine factors affecting RTC to confirm azoospermia • time to infertility following vasectomy • female sterilization regret • contraceptive continuation in EEC areas 	AVSC AVSC/F HI AVSC		PI		
Appropriate Constellation of Services	<p>Reserach</p> <ul style="list-style-type: none"> • development of a referral system²⁷ • provision of comprehensive RH care (training as a strategy for systematic offering of RH services) - 2 studies • perceptions of health & disease among indigenous populations (planning RH services for indigenous communities) 			PI PI	PC	
All Elements or	Research					

²⁵The Mellon Fund will also provide support. The focus of this study also involves expanding the choice of methods.

²⁶The focus of this study also involves expanding the choice of methods.

²⁷Designed but not carried out.

Multiple Elements	<ul style="list-style-type: none"> linking FP and other RH services (compliance with norms, provision of comprehensive care, costs) <p>Evaluation</p> <ul style="list-style-type: none"> quality of services provided during Jornadas de Salud Reproductiva in rural hospitals and rural medical units 			PI	PC	
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Nearly all CAs with a significant role in the MOU have supported QOC research, particularly AVSC International; Pathfinder; PCS; The Population Council, through the INOPAL III Project; and Family Health International (FHI). Further, several studies receive (or will receive) support from WHO and the Mellon Fund. Some of the study topics originated with the Mexican public sector institutions, others with the CAs. In the case of ISSSTE, INOPAL III supported a call for operations research proposals. Four were selected (three dealing with QOC), and INOPAL III has provided technical assistance. By far the largest QOC research-cum-evaluation effort supported by the MOU is the CONAPO study of the service delivery system cited above.

(1) Choice of methods. Research on choice of methods has focused on the provision of IUDs by non-physicians in rural areas, a strategy to increase the number of contraceptive methods available at the primary health care level in rural areas. The studies are particularly relevant since the MOU has supported considerable training of non-physicians to provide IUD services in rural areas: training of IMSS/S TBAs, IMSS/S medical auxiliaries who work in UMRs, and SSA nurses who supervise rural-based health auxiliaries.

Research is also being done to improve method choice by adding new methods. One study on emergency contraception is being conducted in the public sector at agencies responsible for providing care to victims of rape.

(2) Technical competence. Technical competence is also being addressed primarily through studies on IUD insertion by non-physicians. One of these studies, conducted with technical assistance from FHI, will compare IUD insertions provided by IMSS TBAs with insertions provided by facility-based nurses. Of particular relevance is a study funded by AVSC International and the Mellon Fund, that will examine the safety of IUD provision in resource-poor settings; IMSS is one of several institutions around the world that is participating.

(3) Information given to clients. Information given to clients is the QOC element that has received the most recent focus in terms of QOC research. Two IMSS studies are planned in the area of informed consent. One is a multi-center study to be supported by WHO (pending approval) and AVSC International that will focus on informed consent for VSC. The other, for which The Population Council's INOPAL III Project will provide TA, examines informed consent among acceptors of contraception following an obstetric event. IMSS is to be commended for its commitment to examining the issue of informed consent. Two additional studies involve counseling: one on the impact of counseling at IMSS, the other on the quality of postpartum counseling at SSA.

(4) Continuity and follow-up. Research efforts have also been directed at mechanisms to ensure continuity and follow-up. The areas of study are contraceptive continuation, female sterilization regret, time to infertility following vasectomy, and

factors affecting the return for follow-up among vasectomized men. The research results should contribute significantly to improving the quality of information and counseling.

(5) Appropriateness of the constellation of services. The appropriateness of the constellation of services as a QOC element is also the focal point of several studies. In two separate studies, ISSSTE will examine the provision of comprehensive reproductive health care by testing a strategy to train providers in the systematic offering of reproductive health care. SSA will study the linking of family planning and other reproductive health services. SSA also conducted a study of indigenous populations' perception of health and disease in preparation for planning provision of reproductive health services in indigenous areas. The review team fully supports using operations research to examine ways to link family planning and other reproductive health services.

Two QOC studies were initiated but not completed²⁸, suggesting that greater technical assistance and oversight may be necessary depending on the individual institution and the investigators responsible. Since most of the studies are still in the planning or implementation phase, results are not available.²⁹

Recommendations:

42. In order to ensure that institutions use research results to improve programs, USAID support for QOC research in the final years of the MOU should focus on dissemination of results and lessons learned and institutionalization of results.
43. Keeping in mind the time and budgetary limitations of the MOU, new QOC studies should be supported only if they can be completed before termination of the MOU.

Other Research Efforts. A number of additional research studies have been supported by the MOU to assess needs and to evaluate and improve on-going activities and program strategies:

- SSA conducted diagnostic studies on basic community health services in three states in 1993 (Guerrero, Veracruz, and Guanajuato).
- UNAM has also evaluated ISSSTE's training and services activities in family planning.
- PCS assisted IMSS in conducting audience research among adolescents and

²⁸One was an OR project that was transformed into a service delivery project at which time a small evaluation was conducted.

²⁹Following the review team's visit to Mexico, presentation of some of the results of the studies were scheduled to be presented at the annual IMSS reproductive health meeting.

service providers in urban areas to develop service delivery and communication strategies.

- CONAPO and IMSS/S are carrying out a survey of adolescent sexuality in preparation for the development of a service delivery program for adolescents.
- IMSS is now analyzing data from a study of the role of TBAs in providing family planning and reproductive health.
- IMSS is also conducting a diagnostic study of reproductive health needs and services among its subscriber (*derechohabiente*) population.

In addition to the research at service delivery institutions, the National Institute of Public Health, with support from The Population Council, conducted a study to determine the demand for an in-service degree program in the management of reproductive health. An AVSC International-supported research effort with ISSSTE to assess different strategies to promote vasectomy, including counseling by providers, orientation conducted by those who have had a vasectomy, pamphlets and posters, and videos is proposed.

The review team observed that CONAPO's staff have strong research skills and produce high quality research. Among the service delivery institutions, most of the research studies have been carried out by IMSS which also has the strongest research skills, although there are now only two researchers on staff. SSA and UNAM appear to have more limited research capabilities as evidenced by the lower quality of the two studies they conducted, which were cited above.

Technical assistance provided by CAs such as AVSC International, Pathfinder, The Population Council, and PCS has helped to strengthen the quality of research. For example, the Population Council has worked to institutionalize qualitative research techniques in the Mexican institutions. A number of audience research studies conducted by IMSS, ISSSTE, and SSA were, however, subcontracted to outside research agencies because of the limited capacity of these institutions to conduct formative research. JHU/PCS has also provided assistance to these institutions to design qualitative research on a variety of issues. Because of the cost of subcontracting this type of research, IMSS has begun to train its own staff with help from PCS. This type of training might be extended to the other public health institutions if they have adequate staff to carry out such work. Continued assistance to strengthen research from the CAs will be important for the remainder of the MOU.

The review team is concerned that the research capability of the public health institutions will suffer as the decentralization process proceeds. This need not be the case, however, if central units remain in place and become less involved in direct training and supervision and more involved in research and norms, and the states concentrate on service provision activities. If, on the other hand, as part of the decentralization, the states are expected to conduct research, there will simply not be adequate human or financial resources to support good research in all states.

Recommendation:

44. In light of decentralization, USAID and the GOM should consider ways to strengthen the research capability of the central units in the service delivery institutions perhaps through greater coordination and sharing of research staff. This recommendation is made recognizing the diminishing resources of the MOU.

Overall Finding. Through the MOU, the GOM is supporting an impressive range of research and evaluation activities. CONAPO's work to evaluate the demand and supply for family planning will provide critical information to guide future program efforts. The service statistics systems of IMSS, SSA, and ISSSTE are an important resource for monitoring and improving programs. The extent of the QOC research is applauded because it demonstrates the high level of GOM interest and openness to improving the quality of services. The strength of the research capabilities across the institutions is mixed and decentralization may weaken the existing capabilities. A number of USAID's CAs have provided useful and valued technical assistance for various research and evaluation studies.

5. PROGRAM SUSTAINABILITY

5.1 National Policies

Reproductive Health. For the past 22 years, the Government of Mexico has emphasized population programs. Mexico was the first country in Latin America to establish a National Population Policy. In 1995 over two decades later, the Government of Mexico, under the new Zedillo Administration, established reproductive health as the centerpiece of the population policy. The GOM prepared the *Reproductive Health and Family Planning Program, 1995-2000* to implement this policy. This document, a major collaborative undertaking of public and private institutions including SSA, IMSS, ISSSTE, CONAPO, the Ministry of Education (SEP), MEXFAM, FEMAP, CORA, clearly articulates the concepts of reproductive health and the critical element of a client-oriented service delivery system (see also section 3.1.1).

Health Sector Decentralization. A priority of President Zedillo's development plan for 1995-2000 is the reform of the health sector into a decentralized system. In the new system, SSA and IMSS/S services would devolve to the states. In order to ensure that services are rendered to the poor, a "basic package" of services—required services that all providers must provide including family planning—has been defined. As part of this process, it is envisioned that the federal government will provide block grants to states with proportionately larger amounts going to states that have a larger population at risk. In this process, all IMSS/S staff, equipment, and infrastructure would be handed over to the state SSA program. The national level SSA would basically cease to exist except as the entity responsible for the establishment of national norms and guidelines.

Implementation of the decentralization process has been initiated in a few trial states and is scheduled to go nationwide in January 1997. The experience in the trial states, however, has raised a number of unanswered questions about "how it will work." There is concern that family planning services, especially those of IMSS/S, will weaken in this process. Further, as discussed in section 4 on monitoring and evaluation, there is additional concern that decentralization will weaken the research capacity of the public health institutions.

IMSS/S's situation stems partly from its relationship to IMSS: IMSS/S receives a significant subsidy from IMSS—approximately 30 percent of the IMSS/S budget is a direct subsidy—with the balance of funding coming from the federal treasury. IMSS/S also depends on community and municipal contributions. In Michoacán, for example, it was estimated that the overall community participation in the form of time and materials in development activities reached approximately 36 percent of all costs, while the Municipality contributed 29 percent and IMSS/S, 35 percent. Whether this impressive system of community participation will simply be transferred is questionable—and the potential impact on services such as family planning is worrisome. At a rural community in Veracruz, one IMSS/S worker said, "...there is no way the

decentralization will take place—any attempts will be met by resistance from the community. They will even burn down the clinic before they give it up to the state...."

Recommendations:

45. Given the possible impact of decentralization on the GOM's family planning and reproductive health program, USAID and its CAs should support SSA and IMSS/S in whatever ways are deemed appropriate and feasible, given the limited resources, to diminish any detrimental effects on the delivery of services.

5.2 Financing

National Budgets. The GOM's commitment to reproductive health and family planning and to the terms of the MOU are truly impressive. The government has increased its financial support for family planning every year since the beginning of the MOU. In 1995-96, it is estimated that USAID and other donor funding represented only 5 percent of total government spending on population. The GOM funded 95 percent of the program. This accounting does not include the cost of donated items such as "donated" television air time. The GOM estimates that over US\$200 million in television advertisement air time was devoted to population messages in 1996.

Funding for public sector family planning programs comes from the national budget. Under the category of "preventive health" (Category DJ) there is a line item for "family planning" (Item 05). This family planning line item is broken down into three sub-items: visits (*consultas*), new users, and continuing users. Each sub-item is, in turn, further divided into inputs such as salaries, materials and commodities, and travel and per diem. By law, line-item flexibility can take place only within sub-items (i.e., within the sub-item "new users"). Flexibility beyond this level requires the authorization of the Ministry of Finance. Also by law, items covered in the family planning line item can only be utilized for family planning: costs for general medical equipment (e.g., sterilizers) and salary of non-family planning staff (e.g., surgeons and anesthesiologists) are covered under the "medical services" line item. As the programs of the public sector institutions become more integrated with other reproductive health services, the personnel costs directly funded by the "family planning" line item will decline. Since the overall budget is based on outputs (visits, new users, continuing users), the GOM is confident that the family planning priority will be maintained.

The public health institutions' budgets are established on an annual basis based on institution-specific analysis. Each institution establishes outputs and presents a budget. The programming for each institution begins at the lowest service delivery point and is aggregated first at the local and then at the state level. These are then aggregated at the national level where a combined budget and program proposal is submitted to the Ministry of Finance (Secretaria de Hacienda).

The budget at the output level is reviewed by Hacienda and CONAPO, and then adjustments are made. CONAPO is an especially important player in this process, since it calculates the proposed institutional outputs in relation to the overall program projects and goals that it has established. Understandably, this negotiation process sometimes results in tension between the public sector entities. The negotiated institutional outputs that filter down through the system are sometimes perceived as a "mandate" to reach targets of new users at the service delivery point. This perception has, on occasion, led to lack of attention to client-oriented service delivery and, ultimately, to allegations of lack of informed consent. As discussed in section 4 under method-specific targets, process measures might be introduced for assessing performance at the lower service delivery levels to avoid the perception of targets as mandates.

Overall, the GOM is commended for its commitment and for the resources it has assigned to reproductive health and family planning. The fact that budgetary allocations have withstood the severe economic crisis is evidence of this commitment and the maturity and seriousness of the GOM in ensuring increased access and use of quality family planning services.

Recommendation:

46. With a relatively minor but concerted effort, the GOM could further ensure the quality of services by distinguishing between use of institutional outputs or aggregate-level targets (e.g., state or municipality) for setting budgets and giving overall programmatic direction and use of output measures for site-by-site management. It is strongly recommended that the three public health institutions ensure that all service providers clearly understand that institutional output objectives are not mandates for targets at the SDP. Alternative measures that assess the quality of services delivered could be used to complement targets and might also provide better management tools.

Cost of Services. Through the National Population Law, the GOM requires public institutions to provide free family planning services. The only other public health services that are offered free are immunizations and nutrition supplement programs.

At the social security institutions (IMSS and ISSSTE), family planning services are, in effect, prepaid for beneficiaries. Employers' and employees' fees, representing over 90 percent of the cost of social and medical services, cover reproductive health and other preventive care services, such as vaccines. Family planning is offered free to the public at large (through SSA and to non-beneficiaries or *no-derechohabientes* of IMSS and ISSSTE). These institutions charge for related ancillary services. At ISSSTE, for example, clients who are not part of the beneficiary population are charged the full amount for the cost of an anesthesiologist, if one is needed for a procedure. In contrast, prices in the commercial market vary widely. In a semi-rural community pharmacy in Veracruz, injectables sell for US\$1.10 and oral contraceptives for US\$2.10 a cycle. The typical unskilled day laborer in the same community can expect to make US\$1.40 a day. At the MEXFAM clinic, attending a normal birth costs US\$150.00. The MEXFAM clinic officials

estimated that the comparable price in a commercial clinic would be approximately US\$170.00.

The fact that family planning services are subsidized is commendable and again shows the GOM's commitment to the program. A large part of the population receiving free services is poor and barely has enough money to pay for transport to a clinic; therefore, GOM subsidization is essential to meet these needs. However, with the ever-increasing number of family planning users, the cost to the GOM of providing services will continue to rise. The GOM should examine different strategies to ensure future sustainability of the program.

As background for developing such strategies, the GOM should conduct a market segmentation analysis to determine which segments of the population receive services from which public and private institutions, what prices these groups pay (in the case of private providers) and what prices they could pay for services. (See discussion in section 3.1.2 and recommendation 10.) This analysis should be complemented by an examination of the costs of services—what does it cost to provide services per acceptor, user, or averted (unwanted) pregnancy. A cost-effectiveness analysis had been proposed a few years ago but apparently was never completed. The information obtained from the aforementioned studies could then be used to plan a cost-recovery strategy for the public sector. The objective of such a plan would be to allow GOM resources and subsidies to be targeted to the population groups most in need. A scaled pricing structure, for example, could relieve some of the cost burden to GOM while still ensuring services to key population groups.

With reduced budgetary pressure, the GOM could focus on other areas such as commodities or personnel remunerations. On this last item, the review team found that appropriate recognition of rural auxiliary staff, of whom all are volunteer, is essential to the future success of the program. The rural auxiliary staff of SSA are highly motivated and creative in their outreach efforts. They work under difficult conditions, in remote rural areas. The auxiliaries and "volunteers" are paid MP\$75 per month to cover transportation and food costs. This amount has not changed in the last three years: in 1993, it was equivalent to US\$25.00, today it is worth US\$10.00.

Recommendations:

47. The GOM should conduct market segmentation (as in recommendation 10) and cost-effectiveness analyses that could be used to develop different strategies to ensure the future sustainability of the program. MOU resources should be used to support these studies in combination with technical collaboration from USAID CAs.
48. The SSA should consider monetary and non-monetary incentives for the rural health auxiliaries. To this end, the SSA and other institutions should use MOU resources to examine the feasibility of social marketing of other health products by the auxiliaries and establishing scholarships with schools of nursing and schools of medicine for them.

5.3 Sustainability of Training and Communication Activities

Training and communications activities are supported by a significant percentage of MOU resources. According to SDES data, approximately 53 percent of all MOU funds are used for training and communications and it is likely that while USAID provides less than 5 percent of the total funding for population programs in Mexico, USAID funds comprise a significant percentage of funds available for discretionary spending. In interviews, GOM officials said that MOU resources were critical for training and communication activities, especially during this period of economic crisis (section 1.1 on the economic crisis). Moreover, GOM officials indicated that one of the principal differences between priority and non-priority states was the extent to which training and communication activities and materials were available.

Therefore, given the importance of training and communication, the sustainability of both of these activities must be taken into account in planning priorities for the remainder of the MOU. For communication activities, technical capacity needs to be built at the national and local levels. More attention needs to be given to community-level IEC activities. In the field, there were numerous examples of materials produced by providers and volunteer promoters, particularly at the lowest level of the delivery system and at the community level where "professionally produced" materials were severely lacking. In addition, many examples of community-based communication activities—song, dance, theater—were observed or described. If resources become tighter, the communities themselves will increasingly be a resource for IEC activities. As decentralization proceeds, one approach to strengthening local capacity would be to organize inter-institutional IEC committees in each state and train people at the municipality, health jurisdiction, and delegation levels to produce their own materials based on sound methodologies. Given resource constraints, in addition to an emphasis on developing technical capacity for IEC activities, attention should also be given to the effectiveness of different IEC strategies.

The review team is aware of the enormity of the task of training particularly given the large number of medical and paramedical personnel and the turnover of staff (e.g., the pasantes). In fact, it is unlikely that the task of training will ever be complete. As stated by one official, "training could continue for 20 years, and we would still not be finished." As such, it is imperative that during the final years of the MOU, the institutions focus on establishing sustainable training systems that have a strategic focus. The institutions should also increase their efforts to engage the medical schools and other pre-service training institutions in order to establish sustainable programs.

Recommendation:

49. Training and IEC strategies, programs, and technical assistance should be reviewed in light of the urgent need to build sustainable systems for 1) training capacity at the

institutions based on a well-defined strategy for pre- and in-service training, and 2) IEC capacity particularly in reproductive health communication at the community level. In addition, some MOU resources should be directed toward evaluating and identifying the most effective IEC and training strategies since there are financial implications of continued MOU support in both of these program areas (see also recommendation 29).

5.4 Contraceptive Commodities and Logistics

Contraceptive Procurement. The GOM has made significant strides toward self-reliance in purchasing contraceptive commodities. In a strong show of commitment, the GOM has increased its budgetary allocation to family planning contraceptive commodities every year for the past 3 years. In 1992, it began purchasing 25 percent of the needed commodities and has increased the percent purchased every year, reaching nearly 100 percent in 1995.³⁰ In 1996, it is estimated that the GOM spent a total of US\$11,328,405 on contraceptive commodities. For 1997, it is anticipated that the GOM will cover 100 percent of the needs for IMSS and ISSSTE and 100 percent of the needs of the first six months for SSA. SSA will engage in discussions with other donors to obtain support for the remaining six months. If donors are not forthcoming, SSA will request a supplemental allocation from the GOM.

Once the budget is approved by the Ministry of Finance, procurement of commodities is the responsibility of each institution. The price that each institution pays for each contraceptive differs slightly; institutions may have different suppliers for the same generic contraceptive. On average, the price paid by the institutions for the commodities is US\$1.94 for each IUD, US\$0.68 for one cycle of levonorgesterol, and US\$0.29 for a package of three condoms.

The GOM's contribution to contraceptive procurement has been achieved in spite of the overall economic crisis. Officials are extremely proud of this accomplishment and are, at the same time, appreciative of USAID's support in this area. One official stated that the terms of the MOU were utilized as leverage with the Ministry of Finance in order to obtain the necessary funding levels. However, after the termination of the MOU, the ever-increasing needs for family planning services—especially for contraceptive commodities—will continue to put pressure on the budget. It is quite possible that the GOM could obtain more favorable prices if the institutions could purchase the commodities jointly and enter into international procurement programs. The UNFPA is currently discussing the feasibility of creating such a worldwide revolving fund for contraceptives.

Recommendation:

³⁰One exception is a donation to SSA by the British Overseas Development Agency through UNFPA and by JICA for HIV/AIDS.

50. The GOM should explore the possibility of a joint procurement for the three public sector institutions by entering into negotiations with commercial providers. At the same time it should pursue, in collaboration with USAID/Mexico and USAID/W's PHN Center, the possibility of taking part in the UNFPA contraceptive procurement fund.

Logistics Support. Since 1993, USAID has supported training of public sector officials in contraceptive logistics management. This training seems to have been highly successful. During the review team's visits to the various service delivery points, there was no evidence of stock outs was found and clinic staff interviewed understood the basics of logistics management, including placement of commodities to ensure "first in - first out"; re-stocking procedures; and how to determine approximate levels of needed buffer stock. At the IMSS facilities, most logistics management was computerized; at the SSA, the forms appeared to be up-to-date, although they were processed by hand.

Despite overall excellence in logistics management, the review team found several areas of concern. At virtually all sites, the team noticed that oral contraceptives (Microgynon) lacked expiration dates. At one location, there were USAID-donated IUDs that had expired but were well within the extended shelf life of the IUD; the staff managing the unit however were unaware that the shelf life of the IUD had been extended. (See section 3.2.3.) At another location, IUDs from the Mexican company Laboratorios Alpha had no expiration date. The institutions no longer purchase from this laboratory because of defects in the IUDs, and presumably, all IUDs from this laboratory were destroyed. The review team did not, however, have any indication that these old Alpha IUDs were defective or that they were actually being used.

In late 1995, SSA, with assistance from the FPLM project, carried out an evaluation of the logistics training. The evaluation found that the training, conducted from March 1993 to February 1995, was quite effective. Each level of personnel had a good knowledge of the logistics system for which they were responsible. Further, the SSA, cognizant of the weak areas, has established training updates to ensure an even greater level of knowledge and understanding. Although an evaluation of the IMSS system has not been carried out, routine technical visits by FPLM have found that the system, for the most part, is functioning well with only minor adjustments, such as standardizing forms, necessary.

FPLM is commended for the excellent technical assistance and training that it has provided over the years. Both SSA and IMSS were especially pleased with the team approach used by FPLM in ensuring that GOM officials felt ownership of the logistics system.

Recommendations:

51. USAID's continued support for assistance in strengthening commodity logistics through FPLM should be a priority until the system is fully institutionalized, since a smooth logistics system is crucial to an efficient program.

52. SSA and CONAPO should ensure that all commodities have an expiration date by discussing this issue with the pharmaceutical companies.

6. INTER-INSTITUTIONAL COORDINATION

According to the GOM officials interviewed, coordination between the institutions directly involved in population matters has never been better. This is attributable largely to the personal commitment of the institutional leaders and has been facilitated by the USAID MOU mechanism. Perhaps the most impressive evidence of such coordination is the completion of the two principal policy documents: the *Reproductive Health and Family Planning Program 1995-2000*, and the Mexican Norms for Family Planning. Both documents were prepared by an expanded consultative committee that included the relevant public sector institutions; other public sector institutions such as the Ministry of Education; NGOs working in family planning (FEMAP, MEXFAM), woman's rights (GIRE), and adolescent services (CORA). This coordination has been formalized nationally through the Inter-institutional Group for Reproductive Health, with SSA as the lead agency.

While there are excellent examples of coordination at the local and program levels, they are often isolated. Some examples follow.

- (1) The state SSA and the state COESPO. In Michoacán the state SSA, in coordination with the state COESPO, is very active in calling the population related institutions on a regular basis to discuss and share information: COESPO has engaged secondary school teachers as resources for implementing a program of population education and counseling of couples prior to marriage and, at the same time, has managed to engage the State Civil Registration unit in requiring that couples have a pre-nuptial reproductive health session before their marriage certificate is issued.
- (2) The principal service providers. Collaboration among the principal service providers takes place on a variety of matters, including routine meetings, sharing of information, sharing of IEC materials, sharing of training opportunities, and establishing networks of references.
- (3) The public sector institutions, MEXFAM and FEMAP. Coordination between the public sector institutions, MEXFAM and FEMAP has always been maintained, especially at the local level. These organizations have both helped each other with IEC materials; commodities, on occasion; and client referrals. Agreements between the institutions, FEMAP, and MEXFAM, for specific services have been limited. Recently, however, MEXFAM and IMSS signed an agreement by which IMSS would purchase training services from MEXFAM for IMSS's young adults program that is being carried out in urban marginal neighborhoods.
- (4) The public sector and the commercial sector. Coordination between the public sector and the commercial sector is still in its early stages. A recent initiative will involve a tri-partite agreement between the public sector (CONAPO), the commercial sector

(Schering), and the NGO sector (MEXFAM and FEMAP). CONAPO is examining the policy framework to enable Schering and other commercial sector entities to enter into agreements with NGOs.

Given the excellent nature of coordination at the national level and considering the above examples of programmatic and local-level coordination, there are a number of areas where further coordination could significantly strengthen the national program. Some of the possibilities for further coordination include:

- (1) Monitoring and evaluation. Service providers collect a large amount of data on a routine basis, including data on new and continuing users, baseline/community data, method mix. CONAPO and COESPO also obtain information on state-level contraceptive use through the national survey system. There is, therefore, a possibility of linking up these two information systems. Further, the COESPOs should be encouraged to work with public health institutions to help use data for program planning and evaluation. (See section 4.)
- (2) Training and IEC. A coordinated and strategic approach would achieve economies of scale by reducing redundant and costly overlaps. Such a strategic approach would also improve the institutionalization of both training and IEC activities.
- (3) Improved market segmentation. CONAPO and existing state-level bodies such as the COESPOS and state inter-institutional reproductive health groups could encourage and motivate other providers (especially NGOs and commercial providers) through models, experiments, and policy instruments. For example, CONAPO could further encourage the involvement of the commercial sector by negotiating with the GOM to obtain approval for over-the-counter sales of other types of contraceptives, not just those that have been approved to date. Further, state-level groups should be involved to ensure local participation by public and private institutions in determining market segmentation, based on market strengths and weaknesses within each state.
- (4) Expanded service delivery. The SSA and CONAPO could enter into discussions with the state-level medical schools to arrange for pre-service training in reproductive health and family planning. This is already happening in some states, but could be expanded to the others as well.
- (5) Coordination with NGO providers. Specific areas of coordination with the NGO providers (such as FEMAP and MEXFAM) can be strengthened and expanded. For example, the coordinated IEC strategy could include the NGO organizations, resulting in further economies of scale in production and dissemination of materials. In addition, training activities could combine personnel from NGOs and public sector institutions to reduce the cost of training to the individual. Finally, NGOs are particularly effective in

experimenting with innovative service delivery strategies. The public institutions should take full advantage of such new approaches in order to expand service delivery especially in hard-to-reach areas.

The GOM institutions are congratulated on the excellent level of coordination that currently exists. USAID's role in improving the coordination is also commended.

Recommendation:

53. Both GOM and USAID should consider further actions that would improve and expand on collaborative efforts, since these efforts will be critical in expanding access to and use of quality family planning and reproductive health services.

7. MOU IMPLEMENTATION

7.1 Operations Coordination Committee

Coordination among the public sector institutions involved in the MOU takes place through the Operations Coordination Committee (CCO). As stated in the MOU, the purpose of this committee is to "analyze and approve financial and technical support proposals [and to] undertake the task of monitoring the approved projects to ensure that the activities are carried out as set forth in work plans...." (MOU, p.4). The Committee also has provisions for "technical level members" to meet and review the proposals and make recommendations to the CCO members. In fact, what appears to happen is that Pathfinder, with input from the CA's as needed, discusses and negotiates each project with the implementing agency. Once the proposal is in final form it is presented to the CCO as a formality rather than for review.

While the CCO members may not be actively involved in the details of each project, the Committee does play an important policy role. For example, the CCO reviews issues, such as the concern over allegations that there is a lack of informed consent in IUD insertion and female sterilization, the findings of the recently completed national fertility survey, the comparability of data such as the definition of a new or continuing user, and overall levels and trends in the national budget.

The CCO thus has been and could continue to be a powerful mechanism for policy and coordination. As members of the CCO, IMSS leadership is congratulated for involving officials of the IMSS/S operational program more directly in negotiations for the annual work plans under the MOU. IMSS/S's involvement is entirely appropriate given that the major strategic focus of the USAID program is on rural areas, making IMSS/S a major implementing partner; and, given that approximately 80 percent of USAID funds going to IMSS is, in turn, allocated to IMSS/S, making IMSS/S the single largest public sector recipient of USAID funds. Because of this key role, IMSS/S should become an official member of the CCO.

Recommendation:

54. The CCO serves an important policy function. Its focus on critical policy matters should be maintained without entering into the specifics of program implementation. The CCO should be expanded to include a representative from IMSS/S so that all key institutions carrying out MOU-supported activities are part of the official policy and planning process.

7.2 Technical Assistance

Technical assistance is provided to the Mexican institutions by USAID through several CAs: those in local or regional offices provide more long-term assistance; others, in Mexico and elsewhere, provide short-term assistance. As of September 1995, there were 15 CAs providing technical support, a decrease from the 20 working at the start of the MOU. In FY 96, it is expected that the number of CAs will further decline to approximately 9—the three principal of which are Pathfinder, AVSC International, and JHU/PCS. Of the USAID/Mexico's US\$12.0 million population budget for FY 96, it is estimated that approximately US\$6.0 million, or 50 percent, will go to direct support of GOM institutions, 20 percent to technical assistance and administrative support, and the remaining 30 percent to assistance to the private sector component of the USAID/Mexico Population Strategy.

Pathfinder and AVSC International are the main providers of subgrants to the GOM institutions. The institutions utilize a portion of these subgrants to finance the local costs of technical assistance, while the CAs (not only Pathfinder and AVSC International, but also JHU/PCS, the Population Council/INOPAL III, JSI, and others) provide technical assistance only. A problem with this system in which CAs do not directly provide funds has been the lack of leverage on the part of CAs in the technical assistance process. The CAs who do not provide funding feel that while they are asked to provide technical assistance, their Mexican counterparts do not consult or give attention as readily to their suggestions as occurs with those CAs that do provide funding.

While the GOM institutions are generally pleased with the type, quality, and quantity of the technical assistance received, the following areas require attention:

- (1) The GOM leadership is not always cognizant of the technical assistance that is available. When one official was asked whether he thought additional technical assistance would be useful, he responded that there were a number of "needs" but he didn't know what was "available".
- (2) The public health institutions were, at times, confused about which CA provides which type of TA—perhaps, in part, as a result of the funding mechanism. Pathfinder, through the SDES, provides local costs with technical experts funded directly through the CA.
- (3) There were specific examples where the institutions were not pleased with the quality and timeliness of the assistance. This dissatisfaction can be attributed, in part, to the CA's lack of understanding and awareness of the high level of technical competence of GOM counterparts. Several GOM officials commented that they were not interested in technical assistance in which they assist and teach the consultant more than the consultant teaches them. The service delivery institution did, however, make special note of the contributions of Pathfinder,

AVSC International, and JSI/FPLM for the high caliber and timeliness of assistance.

Recommendation:

55. USAID/Mexico and the GOM institutions should carry out a full review of the technical assistance provided to date under the MOU and prepare a technical assistance plan for the remainder of the MOU. This plan should include the technical areas where further assistance will be required, the type of expertise needed, and the estimated level of effort required. USAID/Mexico, in coordination with USAID/W's Population, Health and Nutrition Center will identify CAs that can provide such assistance. The USAID/Mexico should then discuss the proposed CAs with the GOM institutions and initiate implementation of the technical assistance plan.

Technical Review and Monitoring. One premise of the MOU was that technical assistance was not needed for execution of most project activities because of the maturity of the Mexican public sector family planning program. Over time, however, the MOU has provided both financial and technical support to carry out activities and, even when technical assistance is not provided, USAID and the CAs are still technically accountable. The CAs should be capable, individually or in cooperation with each other, of reviewing, monitoring, and providing technical assistance for all funded project activities. In addition, and as noted in section 3.3.5, support of other primary health care or reproductive health care activities requires the same technical oversight as family planning activities.

Also, as discussed in section 4, data for monitoring certain training activities (post-obstetrical event procedures and use of local anesthesia with sedation for minilap) are not collected systematically. Such data are important to assess the impact of training. (See recommendation 43.)

Recommendations:

56. In order to assure high standards of quality in all activities funded by USAID, CAs should support activities that they can technically review and monitor, using their own in-house technical capacity or working in cooperation with other CAs.
57. As noted in footnote 7, to increase efficiency, monitoring reports for Pathfinder and AVSC International provided by IMSS, SSA, and ISSSTE should again be uniform.

7.3 USAID Management

The USAID Mission staff managing the population program include the USAID representative and a full-time, locally-hired PSC program manager. The program manager is technically competent and well-suited for the position. All counterparts and CAs are very pleased with the program manager's style and approach. USAID's limited staffing is helped by the program's funding mechanism: funding for the Mexico program has been provided under the "SDES Model" since 1993. In this model, the Mission transfers funds to a USAID centrally-funded CA (in this case Pathfinder) that, in turn, enters into subagreements with the local counterparts. At the beginning of the SDES, it was assumed that such transfers of funds would be the only role for Pathfinder (indeed for USAID) and that technical assistance would not be needed; however, it became apparent that there was a need for technical assistance. Pathfinder, therefore, began providing technical assistance in addition to funding the subagreements. A number of other CAs also became active providers of technical assistance in Mexico. The CAs that provide only technical assistance, rely on the Pathfinder-supported subgrants to cover the local costs associated with such assistance. A number of the major CAs have offices in Mexico; a monthly CAs meeting is held at USAID where the CAs discuss their projects, accomplishments to date, problems, and other pertinent issues. These meetings are also opportunities to discuss policy matters (norms, manuals, etc.) and new proposals being submitted by counterpart institutions.

During implementation of the USAID program, a number of issues have become apparent. First, CAs' roles have increasingly overlapped as the provision of technical assistance has expanded. This overlap has resulted in confusion and friction among the CAs and confusion for the counterparts. Moreover, at least two CAs (AVSC International, The Population Council) provide subgrants of their own that further increases the complexity of CAs' roles as providers of assistance and funders of subgrants. Second, recognizing the problem of CA coordination, the USAID Mission decided that it would have the central role in coordinating technical assistance. Yet, daily management duties have kept USAID's program manager from spending time with the counterparts and visiting field operations. Thus, the program manager has had only limited opportunity to focus on technical issues regarding the direction and progress of the programs.

Recommendation:

58. USAID/Mexico should hire a program assistant which will relieve the PSC program manager's daily management burden. USAID's program manager should be tasked to work more directly with the counterparts on technical issues, and proactively define the roles and responsibilities of the various CAs and coordinate their technical assistance.

7.4 USAID Funding

USAID's funding agreement for the MOU included a commitment to provide technical, financial,

and material resources totalling up to \$50 million. After the first three years, almost \$17 million has been provided.

As noted in table 16, most of the funds have supported IEC activities and the delivery of services. Substantial amounts have also been devoted to training, evaluation and research, and the smallest amount to supervision and follow-up.

Table 16

USAID Funding under the MOU, 1993-95

Category	000s of US\$	Percent
Delivery of Services	4,606	28
IEC Activities	6,003	36
Training	2,890	17
Supervision & Follow-up	1,409	8
Evaluation and Research	1,857	11
Total	16,765	100

Source: Pathfinder, Mexico SDES: Funds per Category, 1996.

Funding has varied considerably in each of the first three years of the MOU. In year 1, nearly 75 percent of the \$3.1 million expended went to support activities of SSA and IMSS (See table 17).

In year 2, just over \$9 million was expended of which 40 percent went to IMSS, 25 percent to SSA, 20 percent to CONAPO's communication activities, and the remaining 12 percent was divided between ISSSTE and CONAPO's evaluation work. In year 3, only \$4.5 million was expended because of funding cuts in the overall USAID program; a significant drop from the previous year's funding. The majority of the third year funds, 67 percent, went to IMSS, 20 percent went to CONAPO's communication work, and the remaining funds were divided between ISSSTE and CONAPO's evaluation activities. At the time of the midterm review, no funds had been provided to SSA because the SSA project proposal had not yet been approved.

It is assumed that funding under the MOU will continue to diminish so that total USAID resources will be less than the \$50 million originally proposed.

Table 17

**Mexico SDES: Funds Per Category
First, Second, and Third Period Funding Levels**

Project		1st Period	2nd Period	3rd
		USD	USD	U
IMSS				
Services		106,122.00	1,657,533.00	
IEC		281,932.00	620,708.00	
Training		416,220.00	846,016.00	
Supervision and Follow-up		190,530.00	411,671.00	
Evaluation and Research		23,922.00	64,072.00	
	Total IMSS	1,018,726.00	3,600,000.00	
SSA				
Services		512,432.00	574,124.00	
IEC		287,968.00	998,676.00	
Training		400,600.00	314,197.00	
Supervision and Follow-up		58,972.00	109,731.00	
Evaluation and Research		20,000.00	530,572.00	
	Total SSA	1,279,972.00	2,527,300.00	
ISSSTE				
Services		75,130.00	92,411.00	
IEC		47,475.00	75,413.00	
Training		16,121.00	251,820.00	
Supervision and Follow-up		86,667.00	121,481.00	
Evaluation and Research			23,117.00	
	Total ISSSTE	225,393.00	564,242.00	
CONAPO				
Communication				
IEC		584,590.00	1,858,700.00	
	Total CONAPO - COM	584,590.00	1,858,700.00	
CONAPO				
C.Evaluacion.				
Evaluation and Research		0.00	585,758.00	
	Total CONAPO - EVA. 0.00	0.00	585,758.00	
	TOTAL	3,108,681.00	9,136,000.00	

7.5 Completion of the MOU

The accomplishments of the first three years of the MOU have been impressive especially considering the large scale of the Mexican Reproductive Health and Family Planning Program. The total Mexican population was nearly 95 million in 1996, and the number of family planning users was over 8.5 million. Bringing about changes in access and improvements in quality at the major public health institutions means reaching thousands of medical units (in 1990, over 13,000 for Mexico as a whole) and service delivery points (over 27,000 in MOU target areas for both public and private sectors as of 1995). It also means reaching tens of thousands of medical and paramedical personnel (over 250,000 for Mexico as a whole; over 110,000 family planning providers in target areas). The GOM has provided the resources and has made the commitment to fulfill its goals; USAID has been an important partner in this process.

Improvements in both access and quality of services provided will continue given the strong commitment from the GOM, and the continued, albeit diminishing, support from USAID and other donors. USAID's role for the remaining years of the MOU should be to build on the work that has been completed thus far at each of the public health institutions. USAID's CAs should assist the GOM in addressing those areas highlighted in the recommendations of this report, especially those that will bring about even greater improvements in the quality of services.

Although the MOU is scheduled for completion in June 1998, the review team sees advantages to extending the agreement to the year 2000. The longer time frame would allow analysis of the household survey scheduled for 1998 to be completed as well as the dissemination of survey results. Further, the GOM and USAID should consider jointly hosting a significant dissemination event to publish these survey results and highlight the success of the bilateral relationship. The review team considers that additional funding for the MOU beyond what is now planned is probably not needed; therefore, we recommend at this point that the proposed extension be unfunded. The funding issue should, however, be reviewed by USAID/Mexico to determine if there are additional, minimal funding needs through the year 2000. If, at that time, further technical assistance or funding is recommended, it would, in all likelihood, consist of high-level technical assistance and very limited funding to encourage the Mexican public sector to address priority and needy population groups and continue to improve service quality. The future relationship between the GOM and USAID should also endorse the growing role of Mexico as one of the leading countries for South-to-South exchanges.

Recommendation:

59. USAID/Mexico should extend the MOU through the year 2000 as an unfunded extension. Another program review should be conducted in 1998 to determine if there are additional, minimal funding needs for the remaining period. Finally, the GOM and USAID should consider hosting a significant dissemination event to highlight the 1998 survey results and the bilateral relationship.

8. DONOR COORDINATION

Several other donors are actively supporting reproductive health and family planning initiatives including UNFPA, JICA, ODA, World Bank, and UNICEF. Donor coordination takes place on a limited scale and as needed. Moreover, except for the World Bank, the funding levels associated with the other donors are limited. Most donors are phasing down support to Mexico, but none have explicitly made a decision to phase out of Mexico. Given the maturity of the Mexico program and the level of coordination among the Mexican institutions, the coordination among donors could be increased and focused for the benefit of the country program. Areas of potential coordination, include:

- Commodities. With the GOM procuring its own contraceptives, donor efforts should be intensified to assist the GOM to obtain the best international prices possible and to join a worldwide revolving fund at UNFPA. These commodities should also include condoms for the human immunodeficiency virus/acquired immunodeficiency virus (HIV/AIDS) programs.
- South-to-South exchanges. One of SSA's priorities is to be a central force in South to South activities. Indeed, UNFPA has designated Mexico as the lead country for South-to-South public sector activities in the western hemisphere. Support for South-to-South activities has come primarily from the Rockefeller Foundation and UNFPA. While USAID has not supported this initiative, it should be made clear that all support toward improving the program will, in turn, improve Mexico's status as a South-to-South host.
- Common agenda. JICA has been carrying out a technical cooperation program with SSA, that is scheduled to end in 1997. JICA has also apparently agreed in principle to support the establishment of a regional training center in Veracruz, but finalization of this project will be subject to an assessment. JICA's third area of support in the sector is for HIV/AIDS programs. A JICA team is scheduled for early 1997 to carry out a country assessment to review its overall cooperation package.
- Mother/Baby Friendly Hospital. This UNICEF initiative has gripped the public sector institutions with an unprecedented commitment to improving maternal and child health, reproductive health, and family planning services. All donors should support this initiative to further improve service delivery.

Recommendation:

60. The GOM and USAID should support the above-mentioned initiatives and the many others where donors are supporting similar or complementary programs. In this sense, the GOM should be encouraged to attempt jointly-funded programs where applicable.

APPENDICES

APPENDIX A

Scope of Work

Mid-Program Review: US - Mexico Program of Collaboration on Population & Reproductive Health

Background:

Mexico and the United States share a two-thousand mile border, extensive economic/commercial ties, and substantial overlap in their cultural traditions. This community of interests has greatly benefited the citizens of both countries -- benefits reflected in the critical importance which a succession of US administrations have attached to the preservation and enhancement of bilateral relations with Mexico.

In addition to both countries' interest in expanding mutually-beneficial contacts, the close relationship between the two governments has enabled them to constructively address a wide variety of bilateral and regional issues. These have included the amelioration of environmental risks along the border; joint efforts to reduce the flow of illicit drugs; improved consultation on emigration and labor issues; coordination of policies and practices affecting marine resources; etc.

One such area in which the two countries have worked very productively over the past twenty years has been the field of population and reproductive health.

U.S. and Mexican interests in this area were underscored in June, 1992, when the Government of the United States of America, represented by the U.S. Agency for International Development (USAID), and the Government of the United States of Mexico, represented by the Mexican National Population Council (CONAPO), the Ministry of Health (SSA), and the administrators of the Mexican social security system (IMSS and ISSSTE) executed a Memorandum of Understanding (MOU) by which all parties agreed to undertake a five-year program of collaboration on matters of population and reproductive health. (By subsequent agreement of the parties, the duration of the MOU was extended to June 30, 1998).

The MOU established two broad objectives for that program of collaboration. These were to 1) increase Mexican citizens' access to and use of modern family planning information and services in Mexico's poorest and most densely-populated areas; and 2) facilitate the assumption, by the participating Mexican agencies, of financial responsibility for an expanded program of population and reproductive health. For purposes of the MOU, the geographic areas selected for special emphasis under this program of collaboration were nine states (and peri-urban parts of the Mexico City) which the Mexican Government identified as being characterized by especially low indices of social and economic well-being compared to other regions of the country. The Mexican Government's goal of increased financial responsibility for program costs was to be achieved by the parties' observation of a reciprocal commitment whereby substantial levels of USAID financial and commodity support would gradually decline over the period of the MOU as Government of Mexico contributions for these and related costs increased.

Several factors have affected implementation of the MOU during the four years it has been in force. In September of 1994 both governments reaffirmed their commitment to individuals'

reproductive rights by fully embracing the goals of the Program of Action as approved by the participants at the International Conference on Population and Development in Cairo. That shared commitment has been somewhat overshadowed, however, by fiscal constraints bearing on both governments. These constraints, most notably including the Mexican economic crisis and U.S. reductions in population assistance resources, have tested the ability of the parties to fully comply with all aspects of the MOU.

In July 1995, a team representing the USAID Office of Population visited Mexico for consultations with USAID/Mexico and with the leadership of the Mexican organizations participating in implementation of the MOU. The team and their Mexican counterparts reached a number of conclusions including, *inter alia*, that:

- the program of collaboration could benefit from a jointly-conducted review, to be carried out in the near future; and

- the program could be further refined to enhance its focus on improved quality of care, expanded monitoring and evaluation, strengthened coordination between institutions, increased public/private partnerships, and a more vigorous development of Mexican leadership in providing technical and policy support for population activities elsewhere in the region (i.e., expanded South-South interaction on population matters).

Purpose of the Review:

The purposes of the joint review are to assess the progress achieved to date as a result of the U.S.-Mexican program of cooperation; to identify areas for improvement and/or more intense effort during the remainder of the cooperative program; and to develop the preliminary framework for a long-term pattern of collaboration among the parties, (i.e., after completion of the current MOU), with such collaboration to be characterized by mutual self-reliance and a shared commitment to the provision of sustainable, high quality family planning information and services for all citizens.

Scope of the Review:

The primary areas of inquiry for the review team (described below) will be determined by the objectives set forth in the MOU--as refined/clarified in the annual workplans prepared by the parties pursuant to the MOU--and by the observations/recommendations developed during the July 1995 consultations between USAID and GOM representatives, as noted above. Within that broad framework, it is expected that the review will address the following issues/questions:

1. Access to & Use of Family Planning Services:

- How have access and use patterns changed in project areas?

- How do these changes compare to changes in non-project areas?

- Who/what are the sources of FP information and services in project areas? In non-project areas?

-To what factors can changes in access & use of FP services in project and non-project areas be attributed?

2. Quality of Care:

-How have changes in quality of care affected access and use patterns?

-What specific interventions in quality of care have GOM agencies implemented in project areas? How have these GOM agencies collaborated with USAID to introduce these interventions/innovations? Has this collaboration been successful in meeting its objectives? If yes, what factors contributed to this success; if less than successful, what are the lessons for future improvement in such collaboration?

-How closely are national family planning norms being observed/enforced at family planning service delivery sites/institutions? Are there any shortcomings in the application of these norms, and if so, what more needs to be done to ensure full compliance with those norms?

3. Program Sustainability:

-Have the parties to the MOU successfully observed their assistance and investment commitments?

-What problems, if any, prevented the observation of those commitments?

-Have the participating GOM agencies increased real resource flows into program operations?

-Have the participating GOM agencies introduced cost-savings and cost-recovery measures into their programs?

-Have the participating GOM agencies procured increasing proportions of their contraceptive commodity requirements?

-Was the MOU realistic in its assumptions regarding program sustainability?

-What sustainability issues, if any, need to be re-addressed within the framework of the MOU?

-How will the GOM's health sector reform process (including efforts to promote increased decentralization of authority and responsibility) affect the financing, availability and delivery of family planning services?

4. Program Coordination:

-Have the participating cooperating agencies (CAs) effectively coordinated with GOM agencies? (Sec no 6 below). Have the CAs met all of their commitments?

-Have the participating GOM agencies successfully coordinated in key areas such as program planning, service delivery, IEC campaigns, introduction of program innovations? Have they institutionalized coordination procedures?

- Do the Cas, GOM and USAID coordinate effectively with other donors, including most notably the UNFPA?

5. Public Sector/Private Sector Collaboration:

-What are the policy positions of the participating GOM agencies regarding collaboration with private sector programs and organizations?

-Identify some examples of public-private collaboration. Have they been successful? If yes, what factors contributed to that success; if not successful, what factors impeded success?

-What opportunities do the participating GOM agencies identify for future collaboration with the private sector? Does the planned IMSS/MEXFAM initiative present a model for more extensive cooperation in the future?

6. CA Support:

-Has the Pathfinder International-managed SDES program been an effective modality for provision of USAID program support? What are the strengths of SDES? Its shortcomings?

-Has Pathfinder effectively coordinated its support activities with participating GOM agencies? With other Cas?

-Has Pathfinder effectively represented the plans/activities of the other participating CAs vis-à-vis the GOM agencies?

-What changes, if any, are proposed for SDES over the remainder of the MOU?

7. Monitoring & Evaluation:

-What M&E tools has the program utilized successfully? Do they provide program information having the depth, quality, timeliness and reliability needed by decision-makers?

-What measures, if any, do the participating GOM agencies propose to enhance the quality, depth, timeliness and/or reliability of management-useful data? Do they envision any USAID role (via appropriate CA involvement) in this area?

8. New Directions:

-On the basis of the foregoing analysis, what changes are needed to ensure effective implementation of the MOU through the remainder of its life?

- Have the participating GOM agencies successfully coordinated in key areas such as program planning, service delivery, IEC campaigns, introduction of program innovations? Have they institutionalized coordination procedures?
- Do the Cas, GOM and USAID coordinate effectively with other donors, including most notably the UNFPA?

5. Public Sector/Private Sector Collaboration:

- What are the policy positions of the participating GOM agencies regarding collaboration with private sector programs and organizations?
- Identify some examples of public-private collaboration. Have they been successful? If yes, what factors contributed to that success; if not successful, what factors impeded success?
- What opportunities do the participating GOM agencies identify for future collaboration with the private sector? Does the planned IMSS/MEXFAM initiative present a model for more extensive cooperation in the future?

6. CA Support:

- Has the Pathfinder International-managed SDES program been an effective modality for provision of USAID program support? What are the strengths of SDES? Its shortcomings?
- Has Pathfinder effectively coordinated its support activities with participating GOM agencies? With other Cas?
- Has Pathfinder effectively represented the plans/activities of the other participating CAs vis-a-vis the GOM agencies?
- What changes, if any, are proposed for SDES over the remainder of the MOU?

7. Monitoring & Evaluation:

- What M&E tools has the program utilized successfully? Do they provide program information having the depth, quality, timeliness and reliability needed by decision-makers?
- What measures, if any, do the participating GOM agencies propose to enhance the quality, depth, timeliness and/or reliability of management-useful data? Do they envision any USAID role (via appropriate CA involvement) in this area?

8. New Directions:

- On the basis of the foregoing analysis, what changes are needed to ensure effective implementation of the MOU through the remainder of its life?

-Looking beyond the MOU, what should be the nature of continuing, long-term collaboration on population issues between the governments of Mexico and the United States?

- Do the participating public sector institutions envision an expanded role as sources of technical assistance and/or training for family planning agencies/personnel from developing countries

Procedure:

Preliminary steps: In July, 1996 a representative of the USAID Office of Population will visit Mexico to negotiate the final text of this scope of work with USAID/Mexico and with representatives of the participating GOM agencies. In cooperation with the Mexican Government, he will also collect demographic and program data needed to assess the impact of the collaborative population assistance program. It is anticipated that this phase of the assessment will require approx. 10 days in Mexico City.

Intermediate steps: Upon the return of the Population Office representative, and for a period of four to six weeks thereafter, USAID will analyze and organize the data collected during the July visit. These data, and the results of the analysis thereto, will be provided to the team selected to undertake the in-country review. (See next paragraph). The review team will also be provided with other descriptive, analytic and evaluation materials developed by USAID, participating cooperating agencies, GOM participating agencies, and other sources as deemed appropriate by the parties to the MOU.

The Program Review: USAID, in conjunction with the POPTECH Project, will provide a three person (?) team to represent USAID in the execution of this program review. The participating GOM agencies will be asked to identify at least two persons to serve on the review team, and one person who will serve as the lead contact for the team while the latter carries out the review in Mexico. It is proposed that the review begin on or about September 16, 1996, and continue for a period of approx. three weeks.

The team will address the questions noted above, as well as other issues which are identified in the course of the July discussions with representatives of the GOM implementing agencies. Information will be collected through field visits to project sites, interviews with managers, service providers and support personnel associated with the GOM population program, and with representatives of USAID/Mexico, cooperating agencies, and other persons as deemed appropriate by the review team. USAID/Mexico staff will be asked to arrange a specific agenda and itinerary for the review team in consultation with the staff of the participating GOM agencies and CAs.

Prior to the departure from Mexico of the expatriate members of the review team, the entire team will provide a briefing for USAID/Mexico and GOM personnel, at which time the team will explain its key findings and recommendations for future action. Those recommendations will be relatively few in number, will be practical and actionable, and will seek to the fullest extent possible to reflect the team's consensus regarding mid-course corrections needed to ensure the success of the collaborative program.

APPENDIX B

List of Contacts

NIVEL CENTRAL

IMSS-Coordinación de Salud Reproductiva y Materno Infantil

Dr. Jorge Arturo Cardona Pérez, Titular
Dr. José E. Braulio Otero Flores, Jefe, División de Planificación Familiar
Dra. Aurora Rábago Ordóñez, Jefe, Div. de Informática Médica y Desarrollo
Dr. Vitelio Velasco Murillo, Jefe, División de Salud Materna
Dr. Miguel Camarillo Valencia, Secretario Particular del Titular
Sr. Juan Manuel Martínez, Coordinador del Campo del Proyecto

IMSS-Solidaridad

Dr. Javier Cabral Soto, Coordinador General
Dra. Celia Escandón Romero, Coordinadora Atención Médica
Dr. Juan García Moreno, Jefe, Depto. de Salud Reproductiva
Dr. Eduardo Pérez Cruz, Jefe, Oficina de Salud Reproductiva
Dr. Angel Flores, Coordinador de Acción Comunitaria
Lic. Gilda Nina Montero López Lena, Jefe, Orientación a la Comunidad
Lic. María Concepción Orozco, Asesora Externa

Consejo Nacional de Población

Dr. José Gómez de León Cruces, Secretario General
Lic. Rodolfo Tuirán Gutiérrez, Director General de Programas de Población
Lic. Daniel Hernández Franco, Coordinador de Asesores

ISSSTE

Dr. Javier Domínguez del Olmo, Jefe, Servicios de Salud Rep. y Materno Infantil
Dr. Marco Antonio Olaya Vargas, Jefe, Depto. de Salud Rep.
Dr. Victor Manuel Vega Pineda, Subcoord. Gen. del Prog. de Ext. de Serv. de Salud Reproductiva

SSA-Dirección General de Salud Reproductiva

Dr. Gregorio Pérez Palacios, Director General
Dra. Ana María Goitia, Dir. de Fomento a la Salud Reproductiva
Lic. Elsa Santos, Directora de Sistemas Gerenciales
Dr. Carlos Alvarez Lucas, Dir. Investigación y Formación de Recursos Humanos
Dr. Humberto Vargas Flores, Dir., Normatividad y Asistencia Téc. en Salud Perinatal y de la Mujer
Dr. Hector Higareda de Orta, Subdirector de Supervisión
Dr. Arturo Vega Saldaña, Dir., de Normatividad y Asistencia Técnica en Planificación Familiar

AGENCIAS COOPERANTES

Toni Martin, Johns Hopkins University/Population Communication Services
Esperanza Delgado, Pathfinder International
Ricardo Vernon, The Population Council, INOPAL III
Carlos Brambila, The Population Council, INOPAL III
Consuelo Juárez, AVSC International
Carmen López, SOMARC
Claudia Beristain, SOMARC
Victoria Fuentes, IPPF

CHIAPAS

SSA

Nivel Central

Dr. Hector Higareda de Orta
Dr. Gerardo Vite Patiño, Jefe de Departamento de Supervisión

Nivel Estatal

Dr. Sabel Cornazzani Reyes, Resp. de Plan. Fam. y Salud Rep.
Lic. Milton Hernández Moguel, Resp. de IEC

Hospital Regional "Rafael Pascacio Gamboa"

Dr. Jorge Luis Bermúdez Davila, Director del Hospital
Dr. Juan B. Sentino Díaz, Jefe de Jurisdicción No. 1
Dr. Efraín León Gamboa, Director de Servicios de Salud
Dr. Sergio Montoya Maza, Jefe del Servicio Ginecología
Dra. Roxana Orantes Montes, Coordinadora Salud Reproductiva
Dra. Esperanza Rivera Campos, Coordinadora Salud Reproductiva
T.E. Oscar Colmenares, Jefe de Estadística
Dra. Ma. Catalina Lozano García, Resp. Módulo Adolescentes
Enf. Lidia González González, Resp. del Programa Hospital Amigo
Dr. Jácome Alfredo Pérez, Coord. Méd. Juris., Juris. No. 1
Dra. Emma Antonio Valdivieso, Resp. del Servicio de Plan. Fam.

Centro de Salud Urbano, Tuxtla Gutiérrez

Dra. Martha Flores Moscoso, Resp. Módulo Adolescentes

Comunidad El Pedregal

Sra. Nelly Gómez Arguello, Presidenta, Comité de Salud
Enf. Guadalupe Mota Ocaña, Supervisora de Auxiliares de Salud
Sra. Elodia García Pérez, Auxiliar de Salud
T.S. Ma. Elena Vargas

Comunidad Nueva Zinacantan
Sra. María, Auxiliar de Salud

ISSSTE

Nivel Central

Dr. Javier Domínguez del Olmo

Nivel Estatal

Dr. Eddie E. Alfaro Coutiño, Subdelegado Médico

Dr. José L. Martínez Saavedra, Jefe, Depto. Atn. Méd. Integral y Coord. de Salud Reproductiva

Clinica Hospital "Dr. Belissario Domínguez"

Dr. Hugo César Balboa Parada, Director

Dr. Ohmar González Castillejos, Subdirector Médico

Dr. Rogelio Sánchez Figueroa, Coordinador de Atención Médica

Dr. Enrique Aragón M., Jefe de Servicios de Gineco-obstetricia

Dr. Francisco J. Hernández Martínez, Coord., Serv. Aux. de Diagnóstico

Dra. Dulce María Mohedano, Resp. Programa Salud Reproductiva

Dra. Delia Coello Coello, Jefe de Enseñanza

Enf. B. Nery Orozco Ramírez, Coord. de Enfermería

Enf. Aracely Rios Rodas, Resp. Programa Salud Reproductiva

T.S. Lic. Ma. Isabel Muñoz, Resp. Programa Salud Reproductiva

Unidad de Medicina Familiar, Ocozocuautila

Dr. Sergio Corzo Crespo, Responsable

Srta. Esperanza de Jesús Cruz Astudillo, Auxiliar de Enfermería

COESPO

Dr. Oscar Alfaro Macías, Secretario Técnico

Dr. Hermilo Domínguez Zárate, Jefe, Depto. de Prog. y Evaluación

Lic. Hector G. Guillen García, Jefe, Depto. de IEC en Población

Lic. Horacio Zepeda Espinosa, Jefe, Depto. de Invest. Sociodem.

Lic. Wel Cruz Macías, Encargado del Area de Informática

Lic. Janet Chanona Pérez, Apoyo al Depto. de IEC en Población

LAE Emilio Jiménez Zenteno, Delegado Administrativo

Srta. Lilia Gladys Mijangos Penagos, Secretaría

IMSS

Nivel Central

Sr. Juan Manuel Martínez
Lic. Juan García Moreno
Lic. Gilda Nina Montero López Lena
Lic. María Concepción Orozco

Nivel Estatal

Dr. Sergio Pérez Cordova, Jefe de Prestaciones Médicas
Dra. Virginia Rodas, Coord. Deleg. de Salud Reproductiva
Dr. Clemente Hernández, Sup. de Acción Comunitaria, Región Norte

Unidad de Medicina Rural, Aztlan

Dra. Alma de la Cruz, Encargada
Sr. Francisco Pérez López, Auxiliar de Area Médica
Sra. Ma. Cruz Hernández Rodríguez, Auxiliar de Area Médica
Sra. Celia, Asistente Rural
Srta. Olga Lilia Rodríguez Pérez, Promotora

Hospital Rural, Bochil

Dr. Fernando Arguelles Orozco, Director
Dr. José Hector Fraustro, Coord. Médico Regional
Dra. Rebeca del Carmen Montero Corza, Méd. Gen. en Cons. Externa
Enf. Virginia Valdéz Rodríguez, Jefe de Enfermería
Enf. Martha Lilia Gómez Culebro, Medicina Preventiva
Pas. en Enf. Norma Vázquez Ramírez

MICHOACAN

SSA

Nivel Central

Dr. Hector Higareda de Orta
Dr. Jaime Laguna, Jefe de Departamento de Supervisión

Nivel Estatal

Dr. José Antonio Mata Hernández, Subjefe, Servicios de Salud
Dr. José Bedolla, Jefe del Depto. de Salud Reproductiva

Centro de Salud Urbano "Dr. J. Manuel González M."

Dr. Leonardo Malgarejo Arteaga, Director del Centro
T.S. Lourdes Rodríguez, Encargada del Depto. de T.S.

Hospital General Regional "Dr. Pedro Daniel Martínez", Uruapan

Dr. Sergio Hidalgo Ramírez, Director
Dra. Lourdes Cortéz, Resp. de Ginecoobstetricia
Dr. Alexander Godoy, Resp. de Consulta Externa
Dra. Rosa María Arrellano, Pediatra

Comunidad Coro Grande

Srta. Martha Reyes Torres, Auxiliar de Salud

Comunidad Tzintzimatato Grande

Sra. Angela Palatino, Auxiliar de Salud

ISSSTE

Nivel Central

Dr. Javier Domínguez del Olmo

Nivel Estatal

Dr. Carlos Ramírez Pérez, Subdelegado de los Servicios de Salud
Dra. Ana Rosalía López Miranda, Jefe Depto. Atn. Méd. Integral
Dr. Rafael Morales, Subdelegado Médico

Hospital General "Vasco de Quiroga"

Dr. Salvador Ruiz Cancino, Director
Dra. Arcelia Juárez Espinoza, Coord. del Serv. Gineco-obst.
Dra. Ana Rosa Bobadilla Quintero, Jefe de Sección del Serv. de Ginecología y Obstetricia
Dr. Jorge D. Vega Fraga, Coordinador de Plan. Familiar
Dr. Gustavo Martínez Alcaraz, Médico Gineco-Obstetra
Enf. Bertha Oryco Calderón, Jefe de Enfermería
Enf. Martha Martínez Martínez, Enseñanza
Enf. Eva Tapia Ruiz, Consulta Externa
T.S. Rosa Elvira Santillán Martínez, Jefe de Trabajo Social
T.S. Ma. del Refugio Parra, Puerperio
Enf. Isabel Virrella, Puerperio

Unidad de Medicina Familiar con Hospital, Patzcuaro

Dr. José Cuauhtemoc Reyes González, Responsable
Dra. Silvia Carbajal Martínez, Coord. Serv. de Salud Reproductiva

COESPO

Lic. Asunción Bustos Velasco

IMSS

Nivel Central

Sr. Juan Manuel Martínez
Dr. Juan García Moreno
Lic. Gilda Nina Montero López Lena

Nivel Estatal

Dr. Rosalio Lobato Novarro, Jefe Delegacional de Prestaciones Médicas
Dr. Julio Vega, Coord. de Salud Reproductiva
Dr. José Manuel Chavez Rodríguez, Supervisor Deleg. Médico Región 3
Dr. Cuauhtémoc Vidales Jaimés, Coord. Delegacional
Enf. Hilda Berenice Madrigal Bracamontes, Coord. Delegacional de Enf.
Dr. Efraín Hernández Suárez, Médico Asesor
Enf. Graciela Avila, Supervisora de Enfermería Región 3
TPS Miguel García Gaytan, Supervisor de Acción Comunitaria
Dra. Graciela Rusiles Gracián, Apoyo a Capacitación de Capacitadores del Adolescente
Enf. Rosa Simón Gallardo, Apoyo a Salud Repro. del Adolescente

Hospital Rural IMSS-Solidaridad Paracho

Dr. Jorge Luis Cano Cordova, Director
Enf. Edith Galindo Domínguez, Jefe de Enfermería
Lic. Francisco Martínez, Administrador
Ing. Miguel Abarca Villafan, Jefe de Conservación
Enf. Josefina Vázquez, Puerperio
Pasante en Enf. Patricia Fernández, Puerperio
T.S. Josefina García, Encargada de las Parteras
Sra. Aurora Jasso, Partera

Unidad de Medicina Rural Ajuno, con Centro Obstetrico Comunitario

Dra. Tania Montejano Figueroa, Encargada
Enf. Margarita Martínez Morales
Sra. María Salud Morales Olvera, Partera

VERACRUZ

SSA

Nivel Central

Hector Higareda de Orta
Dr. Gerardo Vite Patiño, Jefe de Departamento de Supervisión

Nivel Estatal

Dra. Edith Rodríguez Romero, Secretaría de Salud

Dra. Rosa María Ortiz Campo, Jefe de Salud Reproductiva
Dra. Adriana Monroy Hernández, Coord. Estatal de Planificación Familiar
Dr. Norberto Rivera Serrano, Coord. Juris. de Salud Reproductiva

Hospital General

Dr. Roberto González Vergara, Jefe de Ginecología
Dr. Vicente Rocha, Encargado del modulo de VSB
Enf. María Elena Amado
T.S. Laura Guille Gallardo Vallejo, T.S. de Enseñanza
Psic. Ma. de Lourdes Lidio Guzmán, Coord., Programa "Buen Plan"
Pasante en Psic. Dinorah García Herrera, Programa "Buen Plan"
Pasante en Psic. Margarita Rojas Ramírez, Programa "Buen Plan"
Enf. Graciela Campechom, Programa "Buen Plan"

Jurisdicción Sanitaria No. 8

Dra. María Eugenia Alemán Ortega, Jefe de la Jurisdicción
Dra. Arcelia Cordova L., Coordinadora de Salud Reproductiva
Dra. Alma D. Ferrera Guerrero, Coord. de Participación Social
Enf. Yolanda Quiróz Tapia, Supervisora de Enfermería Jurisdiccional
Enf. Elizabeth Antunez Jaime, Coord. de Enfermería
Supervisoras de Auxiliares de Salud: Delfina Bolacios Fuentes, Albina Jiménez Domínguez,
Gabriela Andrade Muñoz, Pedro E. Castillo Castañeda, Elva Cortés Hernández, Martina
Castro Jota, Isabel Cortés Hernández, Rosa Ma. Cortés

Centro de Salud 2, Fraccionamiento Los Pinos

Dr. Rafael Rojano Uscanda, Director
Enf. Gral. Silvia Díaz Lara
Enf. Margarita Espejo Barradas, Programa "Buen Plan"
Pasante Herminia Tenorio Velázquez, Programa "Buen Plan"
Pasante en Ing. Jesús Urrutia Sacaola, Programa "Buen Plan"
Dra. María Tenorio Villavazo, Supervisora
Enf. Josefina Pérez Tornero, Supervisora de Enfermería

Centro de Salud Rural Concentrado El Tejar

Dra. Martha Alicia Sosa González, Encargada
Enf. Rosa Murcia Contreras
Dr. Jorge Ramón Bueno Luna, Supervisor Zonal
Enf. María del Socorro Gómez Pineda, Supervisora
Sr. Adrian Martínez, Promotor de Salud

Comunidad Moralillo

Srta. Delia Hernández Tadeo, Auxiliar de Salud

Comunidad La Candelaria

Sra. Sara Moscoso Vázquez, Auxiliar de Salud

ISSSTE

Nivel Central

Dr. Javier Domínguez del Olmo

Nivel Estatal

Dra. Bertha Rebolledo Iñigo, Subdelegada Servicios Médicos

Dr. Jesús Kai Kacho, Subdirector Servicios Médicos

Dr. Pablo Alva Velázquez, Coord. Medicina Preventiva

Hospital General

Dr. Leonardo Ponce Rangel, Director

Dr. Ernesto Hernández Álvarez, Coord. Gineco-obst.

Dr. Santiago González Sánchez, Pediatra

Dra. Luz María del Pilar Loyo Zapata, Resp. de Planificación Familiar

Dra. Lilia Rivera Rodríguez, Depto. de Atención Méd. Integral

Dr. Joel Hernández Pacheco, Consulta Externa Medicina Familiar

Enf. Marisela Pantoja de Berriel, Jefe de Enfermería

T.S. Ena Georgina Cruz Camarero, Consulta Externa Planificación Familiar

Enf. Mercedes Ramírez Cruz, Consulta Externa Planificación Familiar

Enf. Teresa Vergara Solana, Consulta Externa Planificación Familiar

Enf. María Trinidad Chávez García, Jefe de Enseñanza

Unidad de Medicina Familiar, Estatuto Jurídica

Dra. Socorro Muñoz Gómez, Encargada

Aux. Enf. Blasina Montero Bello

Dra. Ana María Olano Cibrián, Odontología

Sra. Angelina Marcial Hernández, Secretaría

Sr. Agustín Reyes Muñoz, Mantenimiento

IMSS

Nivel Central

Sr. Juan Manuel Martínez

Lic. Juan García Moreno

Lic. Gilda Nina Montero López Lena

Lic. María Concepción Orozco

Nivel Estatal

Dr. Gustavo Díaz Pliego, Jefe Delegacional de Prestaciones de Servicios Médicos

Dr. Eugenio Latapí López, Coord. Regional y Delegacional de Salud Reproductiva

Dr. Carlos Javier Yeo Canales, Grupo Multidisciplinario Región II Coatzacoalcos

Dr. Jorge Velázquez Gallegos, Médico Asesor

Enf. Marisela González Ramírez, Supervisora Deleg. de Enfermería

Hospital Rural "S" IMSS-Solidaridad, Jaltipan de Morelos

Dr. José David Orgáz Fernández, Director

Dra. Noehmi Pérez Velez, Médico-Jornada

Dr. Ricardo Luna, Anestesiólogo-Jornada

Enf. Yolanda Reyes Bartón, Jefe de Enfermería

Lic. Gabriela Saenz Luna, Administradora

Dra. Norma Jiménez Velasco, Puerperio

Parteras: Julia Santiago González, Cristina Castillo Gutiérrez, Catalina Mateos Bautista,

Manuela Torres Bautista, Hortensia Cruz Markin, Alejandra Hernández Reyes, Andrea

Espinosa Pérez

Unidad de Medicina Rural con Albergue, Tatahuicapan

Dr. Ismael Galindo Marín, Encargado

Aux. Area Médica Teresa Pérez Hernández

Parteras: Margarita Hernández Ramírez, María González Hernández, Alejandra Ramírez

Hernández, Petra Bautista Hernández

Unidad de Medicina Rural, Chinameca

Dra. María de los Angeles Anell Saldaña

Aux. Area Médica Helasia López Bautista

APPENDIX C

List of GOM Health Facilities Visited During the Midterm Review

CHIAPAS

SSA

Hospital Regional "Rafael Pascacio Gamboa"
Centro de Salud Urbano, Tuxtla Gutiérrez
Comunidad El Pedregal
Comunidad Nueva Zinacantan

ISSSTE

Clinica Hospital "Dr. Belissario Domínguez"
Unidad de Medicina Familiar, Ocozocuaútlá

COESPO

IMSS

Unidad de Medicina Rural, Aztlán
Hospital Rural, Bochil

MICHOACAN

SSA

Centro de Salud Urbano "Dr. J. Manuel González M."
Hospital General Regional "Dr. Pedro Daniel Martínez", Uruapan
Comunidad Coro Grande
Comunidad Tzintzamacato Grande

ISSSTE

Hospital General "Vasco de Quiroga"
Unidad de Medicina Familiar con Hospital, Patzcuaro

COESPO

IMSS

Hospital Rural IMSS-Solidaridad Paracho
Unidad de Medicina Rural Ajuno

VERACRUZ

SSA

Hospital General

Jurisdicción Sanitaria No. 8

Centro de Salud 2, Fraccionamiento Los Pinos

Centro de Salud Rural Concentrado El Tejar

Comunidad Moralillo

Comunidad La Candelaria

ISSSTE

Hospital General

Unidad de Medicina Familiar, Estatuto Juridica

IMSS

Hospital Rural "S" IMSS-Solidaridad, Jaltipan de Morelos

Unidad de Medicina Rural con Albergue, Tatahuicapan

Unidad de Medicina Rural, Chinameca

APPENDIX D

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APPENDIX E

Table E-1

IMSS, Number of new acceptors by method and by urban/rural residence in the states of Hidalgo, Michoacan, San Luis Potosi y Veracruz, July 1993 - June 1996. *

New Acceptors by Method and Area	July '93-June '94	July '94 - June '95	July '95 - June '96
Hormonals			
Urban	63,418	24,967	24,794
Rural	64,901	108,288	68,883
IUD			
Urban	84,483	79,767	78,062
Rural	48,239	91,618	72,938
BTO			
Urban	26,095	23,844	24,133
Rural	10,223	17,413	19,579
Vasectomy			
Urban	1,713	1,911	2,246
Rural	58	113	357
TOTAL			
Urban	175,709	130,489	129,236
Rural	123,421	217,432	161,757

Source: Pathfinder Mexico.

* The new acceptor data does not include the states of Guerrero and Guanajuato. Since July 1993, AVSC has provided training to staff of clinics in urban areas. IMSS/S has no infrastructure in those states in rural areas. Hence, the new acceptor data somewhat underestimates the number of new acceptors from areas that benefited from training under the MOU.

Table E-2

IMSS, number of new acceptors by method and by urban/rural residence in the states of Guanajuato, Guerrero, Oaxaca, Chiapas, Edo de Mexico, Puebla y Zacatecas, July 1994 - June 1996.

New Acceptors by Method and Area	July '94 - June '95	July '95 - June '96
Hormonals		
Urban	33,086	36,329
Rural	43,050	107,333
IUD		
Urban	168,329	159,387
Rural	24,720	82,387
BTO		
Urban	38,692	42,255
Rural	7,116	28,266
Vasectomy		
Urban	6,370	6,350
Rural	89	516
TOTAL		
Urban	246,477	244,321
Rural	63,124	218,502

Source: Pathfinder Mexico.

Table E-3

SSA, number of new acceptors by method and by urban/rural residence in the states of Guanajuato, Guerrero y Veracruz, July 1993 - June 1996.

New Acceptors by Method and Area	July '93 - June '94	July '94 - June '95	July '95 - June '96
Oral hormonals			
Urban	27,737	26,657	27,458
Rural	8,650	8,422	7,962
Injectables			
Urban	6,002	8,072	14,128
Rural	4,492	6,213	3,765
IUD			
Urban	19,242	23,087	28,657
Rural	726	948	1,364
BTO & vasectomy			
Urban	5,133	7,538	9,292
Rural *			
Condom			
Urban	14,749	16,094	18,376
Rural	3,900	3,850	4,355
Others			
Urban	494	476	879
Rural	885	1,042	1,260
TOTAL			
Urban	73,357	81,924	100,154
Rural	18,653	20,475	17,446

Source: Pathfinder Mexico.

* Rural acceptors of BTO and vasectomy are referred to SSA's urban-based facilities for these procedures, hence rural acceptors are combined with the urban count.

Table E-4

SSA, number of new acceptors by method and by urban/rural residence in the states of Hidalgo, Oaxaca, Chiapas, Edo de Mexico, Puebla, Michoacan, Jalisco y Zacatecas, July 1994 - June 1996.

New Acceptors by Method and Area	July '94 - June '95	July '95 - June '96
Oral hormonals		
Urban	63,299	59,132
Rural	14,894	13,116
Injectables		
Urban	32,965	50,350
Rural	12,104	20,199
IUD		
Urban	102,012	107,075
Rural	2,366	1,771
BTO & vasectomy		
Urban	23,188	22,924
Rural		
Condom		
Urban	57,763	58,140
Rural	9,432	11,844
Others		
Urban	2,269	2,542
Rural	1,750	1,001
TOTAL		
Urban	281,466	298,799
Rural	40,546	49,191

Table E-5

ISSSTE, number of new acceptors by method in urban areas in the states of Guanajuato, Guerrero, Oaxaca, Hidalgo y Veracruz, January , 1994 - June 1996.

New Acceptors by Method	Jan. '94 - June '94	July '94 - June '95	July '95 - June '96
Hormonals	4,833	11,999	15,459
IUD	4,066	8,535	10,375
BTO & vasectomy	2,369	4,971	5,833
TOTAL	11,268	25,505	31,667

Source: Pathfinder Mexico.

Table E-6

ISSSTE, new acceptors by method in urban areas in the states of Chiapas, Edo de Mexico, Puebla, Michoacan y Zacatecas, July 1994 - June 1996.

New Acceptors by Method	July '94 - June '95	July '95 - June '96
Hormonals	5,080	11,510
IUD	4,937	10,796
BTO & vasectomy	2,392	4,700
TOTAL	12,409	27,006

Source: Pathfinder Mexico.