USAID-Mexico
Program of Collaboration
in Family Planning and
Reproductive Health, 1992-1999

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SECTION 1
INTRODUCTION

Purpose of the Report

Mexico, the second most populous country in Latin America and the Caribbean, is a major influence in the region. For more than 20 years, Mexico has also been considered an important player in international population policy and is looked to for models of successful interventions in the fields of family planning and reproductive health. Beginning in 1978, the U.S. Agency for International Development (USAID) provided assistance to the Government of Mexico in its efforts to meet the contraceptive needs of the Mexican people. USAID assistance to the Mexican private sector in family planning also began in 1978 and lasted until 1998. Formal collaboration between Mexico and USAID ended in 1999 because Mexico had achieved an impressive level of quality services in the program's priority areas. Additionally, assistance to Mexico ended because of overall limitations on USAID's population budget in the face of great demand from USAID's traditional recipients and other countries such as Russia and many of the newly independent states of the former Soviet Union. Still facing important challenges, Mexican institutions have the skills, potential, and will to meet the growing needs of the population for family planning and reproductive health services, and are contributing to improvements in these programs in other countries.

This report documents the key accomplishments of the Mexican programs in the public and private sectors that benefited from USAID assistance, and highlights the characteristics of the productive collaboration between Mexico and USAID, particularly during the 1990s. The major foci of the Mexican programs in this decade have been improving the access to and quality of services and working toward sustainability. Lessons learned in these areas and in other aspects of the programs are appended to this report.

The Mexican Setting

With more than 98 million inhabitants by mid-1999, Mexico now has a population that is larger than the combined populations of all the countries in Central America and the Caribbean. Just 30 years ago, in 1970, Mexico's population was 50.6 million, or half of its current level. In the intervening years, the annual population growth rate fell to 1.8 percent from nearly 3.5 percent. The Mexican government estimates that the actual growth rate may be closer to 1.5 percent when migration—most of which is to the United States—is taken into account (see Table 1).
Table 1. Demographic Trends in Mexico, 1950-1998

<table>
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<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Population in millions</td>
<td>27.1</td>
<td>50.6</td>
<td>67.0</td>
<td>83.8</td>
<td>98.1</td>
</tr>
<tr>
<td>Rate of population growth</td>
<td>2.7</td>
<td>3.3</td>
<td>2.8</td>
<td>2.3</td>
<td>1.8</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>6.6</td>
<td>6.8</td>
<td>4.7</td>
<td>3.4</td>
<td>2.5</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>126.6</td>
<td>79.0</td>
<td>53.0</td>
<td>36.6</td>
<td>25.9</td>
</tr>
<tr>
<td>Life expectancy</td>
<td>49.6</td>
<td>61.7</td>
<td>67.0</td>
<td>71.4</td>
<td>75.0</td>
</tr>
<tr>
<td>Urbanization (% in urban areas)</td>
<td>50.7</td>
<td>58.7</td>
<td>60.1</td>
<td>71.3</td>
<td>74.5</td>
</tr>
</tbody>
</table>

Source: 1999 estimations by the National Population Council (Consejo Nacional de Población [CONAPO]).

The major factor influencing the decline in the population growth rate has been fertility. The total fertility rate (TFR), a measure of the average number of children a woman bears in her reproductive life, was 6.7 children per woman in 1970. The TFR declined to approximately 3.2 in 1990, fell further to 2.9 in 1995, and was estimated at about 2.5 in 1999. Because of past high fertility levels and declining mortality, Mexico’s population is also relatively young. Today about 36 percent, or some 35 million Mexicans, are under age 15. Another 20 million Mexicans are ages 15 to 24, and the current 15- to 24-year-old population is the size of Mexico’s entire population in 1940. As a result, the proportion of people of or approaching reproductive age is large, and the total numbers added to the country’s population will continue to be significant even though the total fertility rate has declined. Thus, demands on Mexico’s reproductive health and family planning program will continue to grow from this young segment of the population.

On the economic front, the working-age population (15 to 64 years old) grows by 1.4 million each year, which translates into a demand for approximately 1 million new jobs per year, jobs that Mexico cannot yet generate. In rural areas, unemployment and underemployment affect two-thirds of potential workers. These factors, added to economic disparity and the pursuit of improved living standards, fuel migration from rural to urban areas, especially to Mexico City, Monterrey, Guadalajara, and the assembly plant (maquiladora) towns along the U.S.-Mexico border. The state of Mexico and Mexico City have received more than 400,000 migrants annually from rural areas during the last decade.

Further contributing to these migratory flows is the process of desertification of Mexican lands, which results from increased demands on land and other natural resources and an unfavorable climate. Land degradation (combined with the control of better farmlands by large-scale farmers) and rapid population growth push people from their degraded lands to marginal areas that are even less suitable for agriculture. When they can no longer subsist on the land, rural people migrate. About 900,000 people leave arid and semi-arid areas of Mexico every year. Ultimately, these economic and environmental conditions comprise the “push” factors responsible for the migration of approximately 300,000 Mexicans to the United States each year.

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4 Welti, C., 1997 (for 1995 TFR) and Consejo Nacional de Población, 1999 (for 1999 TFR).
6 Consejo Nacional de Población, 1999. [Schwartz and Notini]
SECTION 2
OVERVIEW OF POPULATION AND REPRODUCTIVE HEALTH POLICIES AND PROGRAMS

Evolution of Mexican Policies

Mexico has not always supported a policy to lower rates of population growth and fertility nor has it always affirmed the need for family planning. Mexico’s official policy through the early 1970s was pronatalist. From 1940 to 1970, Mexico enjoyed a period of political stability and economic growth that allowed the country to accommodate a growing population. The government’s most explicit action toward advancing population growth was the General Law of Population of 1947, which empowered the Secretary of the Interior to do whatever was necessary to promote demographic growth, including “measures to encourage marriage and to increase the birth rate.”

In the late 1960s and early 1970s, there was increasing recognition that “the gains of Mexico’s development efforts were being dissipated by rapid population growth.” Advocates for family planning at this time included not just those who saw a need to slow population growth, but also those who wanted to lower the high rates of unsafe abortion and maternal and infant mortality, and who wanted to extend the availability of contraceptives—then available primarily to wealthy women—to all women. In 1972, President Luis Echeverría announced a government-sponsored national family planning program, which he formalized with a General Population Law in 1973 and the establishment of the National Population Council (Consejo Nacional de Población, or CONAPO) in 1974. With the approval of this law, Mexico became the first country in Latin America to establish a national population policy.

The new law called for a campaign of “responsible parenthood” to enable all citizens to decide “in a free, responsible, and informed manner” on the size and spacing of their family. This language was retained in the 1974 revision of Article IV of Mexico’s Constitution of 1917 to guarantee equal rights to women. The President’s legislative package focused on the need to limit population growth and support family planning, and included “efforts to reduce mortality, improve the status of women, achieve better spatial distribution of the population, and promote incorporation of marginal groups into the mainstream of national development.”

Following Echevarría’s presidency, Mexican population policy was implemented by the four successive administrations. In 1977, during the presidency of José López Portillo, CONAPO developed the first Population Program. This program made explicit the basic principles of Mexican demographic policy and its two major objectives: to promote slower population growth through decreased fertility and to foster population distribution consistent with regional development prospects. During the subsequent administration of Miguel de la Madrid, the 1984 to 1988 National Population Program ratified the goals and objectives of the previous program. The new program was incorporated into the National Demographic Planning System established

7 Alba and Potter, 1986.
by the 1983 Planning Law. During the following administration, President Salinas headed the preparation of a National Development Plan, which ratified the objectives of the population policy that had been pursued since 1974. Moreover, the 1989 to 1994 National Population Program was formulated as a "Special Program" within the development plan and, as such, it had a mandatory status for public agencies at the federal level.

During the period 1994 to 1997, the Mexican government's expenditures (in constant Mexican pesos) for family planning programs in the public sector decreased from 671 million pesos to 424 million pesos. The higher level of funding was reached in the same year that the International Conference on Population and Development took place in Cairo (see Table 2).

### Table 2. Expenditures for the Mexican Government's Family Planning Program, 1994-1997

<table>
<thead>
<tr>
<th>Year</th>
<th>Pesos (constant pesos)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>671.3</td>
</tr>
<tr>
<td>1995</td>
<td>445.3</td>
</tr>
<tr>
<td>1996</td>
<td>562.5</td>
</tr>
<tr>
<td>1997</td>
<td>423.7</td>
</tr>
</tbody>
</table>


In the mid-1990s, President Zedillo's administration issued two documents that updated the national population policy and established reproductive health as the centerpiece of the population policy. The former, the "National Program of Population 1995-2000," reaffirmed the development context of the population policy and defined priorities that include slowing population growth, improving women's status, strengthening families, breaking the cycle of poverty, and addressing issues of population distribution. To slow population growth, the national policy called for promoting an integrated approach to family planning and reproductive health, encouraging smaller families, addressing the unmet need for contraception, increasing the range of available family planning methods, and improving the quality of family planning care.\(^\text{12}\)

The second document, "Reproductive Health and Family Planning Program, 1995-2000," was a collaborative undertaking of key public and private institutions and clearly articulated the concepts of reproductive health and a client-oriented service program.\(^\text{13}\) The main objective of this program was to provide services to all the population in order to contribute to a healthy, satisfactory, and safe sexual life for individuals and couples. Goals of contraceptive prevalence were set for each of the 32 states in the country. Mexico was one of the first countries in the world to adopt the holistic perspective of reproductive health from the International Conference on Population and Development 1994 (ICPD). Both of these program documents reflected the goals of the Program of Action of the ICPD, held in Cairo, and the platform of the 1995 Fourth

\(^\text{12}\) Consejo Nacional de Población, 1996.

\(^\text{13}\) Poder Ejecutivo Federal, 1995.
World Conference on Women, held in Beijing. The commitments made at these conferences underscored the importance of increasing access to quality reproductive health services.

Within the broader context of improving reproductive health, there remain important demographic objectives to reduce fertility and slow the population growth rate. Such objectives have been part of the Mexican government’s population policy since the administration of López Portillo (1976 to 1982). During the early 1990s, the government again set out the objectives that it hoped to attain by 1994: a contraceptive prevalence rate (CPR) of 63.8 percent, a TFR of 2.8 children per woman on average, and a reduction of the annual rate of population growth to 1.8 percent. The year 2000 targets, which were set in 1995, called for reducing the annual population growth rate to 1.75 percent, lowering the TFR to 2.4 children per woman and, to this end, achieving a CPR of 70.2 percent.

A priority for the Zedillo Administration’s development plan for the period 1995 to 2000 was reform of the health sector. The Health Sector Reform Program recognized important achievement, but also critical gaps in health care. As of 1995, about 10 million Mexicans did not enjoy access to regular health services. Some segments of the population were living without minimum sanitation and hygiene conditions, and the quality of services was uneven. The provisions in the reform program with relevance for reproductive health services included: 1) strengthening the capacity and quality of the Mexican Social Security Institute (Instituto Mexicano de Seguridad Social, or IMSS); 2) devolving government resources for health to the states; and 3) introducing a basic package of services to cover, among other things, family planning, maternal health (prenatal, delivery, and postpartum care), and cervical cancer.

The Coverage Extension Program (known as PAC, Programa de Ampliación de Cobertura) was the strategy through which the government expected to deliver the basic package of health services to heretofore underserved segments of the population. The program relied on identifying and strengthening community and institutional resources. It was based on two modes of service provision: strengthening the first-level health units, the most basic level of service delivery facilities (for instance, health posts typically staffed by health auxiliaries in rural areas), so they could fully serve population groups that had only partial access to services, and geographic extension through mobile health teams that could deliver services to communities without access to a health post. The PAC was linked to another program with broader objectives, the Program on Education, Health, and Nutrition (Programa de Educación, Salud, y Alimentación, or PROGRESA), which the Zedillo Administration saw as the main strategy for alleviating poverty.

The Government of Mexico made enormous efforts to decentralize health services. The decentralization process was carried out in two stages: The first stage took place during the De la Madrid Administration (1982 to 1988) and the second stage occurred during the Zedillo Administration. The approach to decentralization was different in each phase.

During the first phase, one goal was to integrate services for the non-affiliated population. These services were provided by the Ministry of Health (Secretaría de Salud, or SSA) and IMSS-Solidaridad, the rural program of IMSS that was meant to be dissolved eventually. The second goal was to give more responsibility to state governments. In 1985, the first state, Tlaxcala, was

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15 Consejo Nacional de Población, 1996.
decentralized and, by the end of the De La Madrid Administration, 14 states had been
decentralized. Decentralization was then halted due to lack of agreement, between the two
institutions involved, on the meaning and consequences of the demise of IMSS-Solidaridad.
While the services of both SSA and IMSS-Solidaridad were partially decentralized, the SSA
remained partly in charge of service delivery and thus responsibility had not devolved
completely to the states.

During the Zedillo Administration, starting in 1995, the government began the second phase of
the decentralization process. The initial proposal of integrating the services of SSA and IMSS-
Solidaridad in the remaining 17 states was soon abandoned. The government executed another
agreement to decentralize the SSA with the 31 states and the Federal District. In August 1996,
this national agreement transferred

"...121,000 jobs, 7,370 pieces of real estate, and 8,495 million pesos (over $1.1 billion)
from the central level to the states. The Federal Government retains the authority to set
health standards; regulate services and sanitary control of goods, establishments, and
decentralized services; and control of professional certification and accreditation of
health units, generation of national statistics, and international representations of the
sector. The state and municipal agencies share responsibilities for the organization,
operation, and monitoring of public and private health services; sanitary control of
services to the population; and fulfillment of health promotion and orientation tasks."\(^{16}\)

Now, SSA services are totally in the hands of state officials, with the exception of the Coverage
Extension Program, which the central level of the SSA continues to administer. Decentralization
has also been partial for IMSS-Solidaridad, given that services in 17 states remained the
responsibility of IMSS. In sum, in 2000, 14 states were totally decentralized and in another 17
states the SSA services were decentralized. The devolution of population and health services to
the states implies that program implementation is dependent on local technical capacity. Such
capacity varies among states, but in general it is not particularly high.\(^{17}\)

Another dimension of decentralization relates to the state-level population councils (Consejos
Estatales de Población, or COESPOs). These units of the National Population Council were
decentralized from their inception. The strength of the State Councils depends on the support
they receive from the local governments and on the extent to which they are staffed by skilled
personnel. Therefore, coordination and evaluation activities with other institutions, the main
mandate of COESPOs, is limited in some states.

**Mexican Institutions in Family Planning and Reproductive Health**

The National Population Council (CONAPO) is the government’s key entity for overseeing
population policy. It is responsible for, among other matters, evaluating demographic programs
undertaken by public-sector entities, including family planning and reproductive health
programs, and for proposing corrective measures considered relevant. However, it has been
difficult for CONAPO to strengthen links with the health sector in the various components of
reproductive health other than family planning, now that integration has taken place and a new

\(^{17}\) Palma, Y. and J.L. Palma, 1999.
holistic approach is being implemented. This is an important issue because CONAPO, by its multisector nature, can provide an adequate approach for the proper implementation of these components.

Beginning in 1973, the two largest public health institutions involved in implementing Mexico’s population policy were the SSA and the IMSS. Both the Echeverría and López Portillo administrations invested in the health sector with a resulting increase in the numbers of hospital, clinics, and medical personnel. Over the years, the network of SSA and IMSS health services and hospitals that make family planning services available has expanded substantially. As of 1997, these two institutions, along with the Social Security Institute for State Workers (ISSSTE), provided family planning services to 66 percent of married couples in Mexico. The entire public sector provided services to 72.6 percent of married couples.

Two nongovernmental organizations (NGOs) have provided services in family planning and reproductive health for many years. While their coverage is much more limited given the predominant role of the public sector, they are considered innovators in testing strategies to deliver services to underserved populations. The mission of the Mexican Foundation for Family Planning (MEXFAM), an affiliate of the International Planned Parenthood Federation (IPPF), founded in 1965, is “to provide high quality and innovative services in family planning, reproductive health, and sex education.” With clinics and other services across the country, donations and profits from its operations are used to meet the needs of the poor and youth. Established in 1973, the Mexican Federation of Private Health and Community Development Associations (FEMAP) is a national, decentralized alliance of private organizations whose mission is to “improve the quality of life for Mexico’s underprivileged population” through community-based programs.

The Inter-Institutional Reproductive Health Group is composed of the eight institutions of the National Health System, the CONAPO General Secretariat, the National Indigenous Institute, the Public Education Secretariat, the Mexican Gynecological and Obstetrics Federation, the National Women’s Program, and the six most-important nongovernment institutions in the field. The Inter-Institutional group took charge of outlining the Reproductive Health and Family Program 1995-200, and among its functions are coordination and follow-up of activities to ensure the accomplishment of goals and objectives.

U.S. and Mexican Collaboration in Family Planning and Reproductive Health

USAID was an important partner with Mexican institutions in the evolution of national policies and in planning, implementing, and coordinating efforts that provided the underpinnings of a successful family planning program. USAID provided support to Mexico’s family planning programs for many years: for the private sector from 1978 to 1998 and for the public sector from 1978 to 1999. From the start, population assistance was the most important part of USAID’s program in Mexico. This assistance was considered of global importance and complemented U.S. foreign policy objectives. Furthermore, what happens in Mexico—population growth,

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international migration, the spread of HIV, and environmental degradation—directly affects what happens on the U.S.-Mexico border. How Mexico fares as it tries to resolve these problems clearly affects the quality of life in both countries.20

For years, USAID was the largest foreign donor to the Mexican family planning program. From 1985 to 1995, USAID’s average contribution was US$10 million per year.21 From 1991 through 1995, Mexico ranked sixth in USAID family planning assistance—after Bangladesh, Kenya, the Philippines, Egypt, and India.22 In Fiscal Year 1996, USAID’s population assistance totaled US$13 million, or approximately 10 percent of Mexico’s national family planning budget of US$124 million for the calendar year 1996.23 By Fiscal Year 1998, the assistance had dropped to US$3 million, or approximately 1.3 percent of the Mexican government’s family planning budget of US$239 million for calendar year 1997 (the latest year for which data were available). USAID terminated its support for family planning to the private sector in September 1998 and to the public sector in March 1999.

USAID Population Assistance Prior to 1992

From the beginning, USAID funding was channeled through cooperating agencies (CAs) or U.S. nongovernmental organizations working in population. These in turn provided assistance to governmental institutions and the two key nongovernmental organizations, MEXFAM and FEMAP. Prior to 1992, USAID did not provide assistance directly to the Government of Mexico. USAID’s population assistance was carried out by nearly 20 CAs covering a wide range of activities including contraceptive supply; information, education, and communication (IEC); operations research (OR); and training. The CAs facilitated the expansion of both public- and private-sector family planning services and laid the groundwork for a true partnership between the Government of Mexico and USAID. In 1991, USAID developed a five-year population strategy for the 1992-1997 period to consolidate and focus its population assistance to Mexico.24

The principal source for contraceptives in Mexico until 1992 was USAID. After that date, such support was scaled back slightly, which made it necessary to adjust budgeting, acquisition, and distribution processes for inputs in all of the institutions of the National Health System. Between 1995 and 1999, the Mexican government used federal finances to acquire all of the materials required for family planning services.

Last Phase of USAID Population Assistance, 1992-1999

In 1992, USAID launched the last phase of its population assistance program in Mexico. USAID’s strategy was to help Mexico achieve a sustainable increase in contraceptive prevalence by improving the accessibility and quality of family planning and reproductive health services, primarily in rural areas where unmet demand for these services is highest.25 The strategy was

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20 USAID, 1997a.
21 USAID, 1996.
designed to contribute to the objectives of the national family planning program, which include reducing fertility and lowering the population growth rate.

From 1992 until early 1999, a memorandum of understanding (MOU) governed U.S.-Mexico collaboration on the national population program. The MOU facilitated USAID support of the programmatic components that were considered critical in the development of the national program. While the major implementing agencies under the MOU were public-sector institutions, the action plan stemming from the MOU stipulated that certain nongovernmental organizations would play an important role.26 The public-sector parties to the MOU were CONAPO, SSA, IMSS, and ISSSTE (see Box 1). The nongovernmental organizations working with USAID during this period were MEXFAM and FEMAP.

The principal purpose of the MOU was coordination. The new arrangement helped to crystallize institutional collaboration among the Mexican institutions, particularly between CONAPO, a coordinating body, and the key implementing institutions of the Mexican public health sector. The MOU document represented a working agreement among various powerful but separate groups, an arrangement that was unique among the countries receiving USAID assistance.27

In 1992, USAID also initiated a project with the two NGOs, MEXFAM and FEMAP. The Transition Project, carried out by IPPF’s Western Hemisphere Region office, became the primary vehicle for USAID assistance to these NGOs. The Transition Project was designed to help these two organizations expand and improve family planning and reproductive health services in low-income and underserved populations, while helping the institutions become self-sustaining.

In the public sector, USAID provided assistance through its Cooperating Agencies in Population to CONAPO, IMSS, ISSSTE, and the SSA. These last three institutions together provided 66 percent of family planning services in Mexico in 1997 (INEGI, 1999; ENADID, 1997).

- **CONAPO (Consejo Nacional de Población, or National Population Council)** is a governmental organization with decentralized state councils called COESPOs (Consejos Estatales de Población, or State Population Councils) that are supported by each state. To carry out its technical and administrative functions, CONAPO has a secretariat responsible for implementing agreements and performing the tasks assigned to it by council members. CONAPO is responsible for population and education programs and is involved at every stage of the population planning process (diagnosis, standards definition, objectives, subprograms, and evaluation mechanisms) and in improving coordination among public institutions and with the private sector. CONAPO is also charged with promoting and conducting demographic and social research upon which Mexico’s population activities are based.

- **The IMSS (Instituto Mexicano del Seguro Social, or Mexican Social Security Institute)** provides social services to private-sector employees as well as underserved populations. One part of the IMSS offers services to 44.6 million subscribers (as of 1998) in urban areas. Another part of the institution, IMSS-Solidaridad serves poor, rural, and indigenous populations in 17 states.

- **ISSSTE (Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado, or Social Security Institute for State Workers)** offers services to government employees and teachers, who together numbered 8.2 million in 1998.

- **The SSA (Secretaría de Salud, or Ministry of Health)**, is responsible for providing services to those who are not covered by social security, and it coordinates the national health program. As of 1998, SSA and IMSS-Solidaridad together served 50.9 million persons (the non-covered population), or nearly 53 percent of the population.

CONAPO and USAID collaborated on the USAID-Mexico program with the following three units of the public-sector health institutions:

- **IMSS**: the reproductive health and maternal and child health division (Coordinación de Salud Reproductiva y Salud Materno-Infantil);

- **ISSSTE**: reproductive health and maternal and child health services (Servicios de Salud Reproductiva y Materno-Infantil); and

- **SSA**: the reproductive health directorate (Dirección General de Salud Reproductiva, or DGSR).

Assistance provided by the USAID-Mexico program focused on:

- improving the quality of family planning and reproductive health services;

- expanding the delivery of family planning and reproductive health services;

- building the competencies of health personnel;

- strengthening information, education, and communication programs in population and family planning; and

- conducting demographic research and family planning evaluation studies.

In the private sector, USAID worked with two key nongovernmental organizations to expand and improve family planning services in low-income and underserved populations, while helping the institutions become self-sustaining.

MEXFAM and FEMAP are the largest family planning NGOs in the country.

- **MEXFAM (Fundación Mexicana para la Planeación Familiar, or Mexican Foundation for Family Planning)** is the Mexican affiliate of the International Planned Parenthood Federation. It operates in the slum areas of 32 cities as well as in regions inhabited predominantly by the indigenous peoples.

- **FEMAP (Federación Mexicana de Asociaciones Privadas de Salud y Desarrollo Comunitario, or Mexican Federation of Private Health and Community Development Associations)**, based in Ciudad Juárez, is an alliance of private family planning organizations that operates in the slum areas of 87 cities and thousands of rural communities.

Assistance to the private sector included:

- identifying income-generating activities, such as laboratory services, fee-for-services agreements, and support for testing selected, promising activities; and

- strengthening institutional capacity and efficiency.

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USAID’s strategic approach for the last phase of its population assistance program had four principal components:30

- Targeting assistance to the public sector in nine poor and mostly rural states;
- Consolidating resources on fewer activities;
- Mobilizing Mexican—rather than external—resources for these efforts; and
- Coordinating population assistance and streamlining USAID’s management of population assistance.

Targeting Priority States

The Mexican government, specifically CONAPO, selected priority states for the national family planning program based on the following demographic indicators: high percent rural population, high infant mortality rate, and high total fertility rate. Eight of the nine states have the most adverse indicators. The state of Mexico has a smaller percent rural population and lower infant mortality and fertility, but it was included among the priority states because it has a large total number of rural residents (1.5 million in 1990) and its rural population is similarly marginal to the other priority states. USAID chose to concentrate support to the government institutions in these priority states because it was determined that such assistance would have the greatest impact. This method of identifying the states with the greatest needs was a valuable tool for focusing USAID assistance (see Table 3).

Table 3. Demographic Indicators Used for Selecting Priority States under the Mexican-USAID Agreement, 1990

<table>
<thead>
<tr>
<th>State</th>
<th>Population (thousands)</th>
<th>% Rural</th>
<th>Infant Mortality Rate (IMR)</th>
<th>Total Fertility Rate (TFR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiapas</td>
<td>3,210.4</td>
<td>47.9</td>
<td>51.7</td>
<td>4.60</td>
</tr>
<tr>
<td>Guanajuato</td>
<td>3,982.6</td>
<td>36.6</td>
<td>41.3</td>
<td>3.89</td>
</tr>
<tr>
<td>Guerrero</td>
<td>2,620.6</td>
<td>47.7</td>
<td>46.2</td>
<td>4.47</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>1,888.4</td>
<td>55.2</td>
<td>43.9</td>
<td>3.48</td>
</tr>
<tr>
<td>México</td>
<td>9,815.8</td>
<td>15.6</td>
<td>30.7</td>
<td>3.41</td>
</tr>
<tr>
<td>Michoacán</td>
<td>3,548.2</td>
<td>38.4</td>
<td>39.5</td>
<td>4.23</td>
</tr>
<tr>
<td>Oaxaca</td>
<td>3,019.6</td>
<td>60.5</td>
<td>49.8</td>
<td>4.56</td>
</tr>
<tr>
<td>Puebla</td>
<td>4,126.1</td>
<td>35.7</td>
<td>41.6</td>
<td>4.33</td>
</tr>
<tr>
<td>Veracruz</td>
<td>6,228.2</td>
<td>43.8</td>
<td>41.2</td>
<td>3.23</td>
</tr>
<tr>
<td>Priority States</td>
<td>38,439.9</td>
<td>37.0</td>
<td>40.4*</td>
<td>3.87*</td>
</tr>
<tr>
<td>All Mexico</td>
<td>81,249.6</td>
<td>28.7</td>
<td>34.8</td>
<td>3.46</td>
</tr>
</tbody>
</table>

* These average IMRs and TFRs were estimated by weighting each individual state indicator by the percent of the state population to the total population of the priority states. These numbers do not appear in the source cited above.


Starting in 1992, USAID's technical and financial support to government institutions concentrated in the nine priority states—Chiapas, Guanajuato, Guerrero, Hidalgo, State of Mexico, Michoacán, Oaxaca, Puebla, and Veracruz. Although Mexico is composed of 32 states, 47 percent of the country's total population and 61 percent of its rural population resided in those nine states in 1990. In contrast, USAID's assistance to private-sector organizations was not focused in the priority states. Since MEXFAM and FEMAP serve low-income populations in other underserved states as well, USAID provided support for activities in these other states. However, there was some overlap of target areas between the activities of the public and those of the private sector.

Consolidating Assistance

Starting in 1992, USAID assistance concentrated on fewer—but higher impact—activities. These activities included expanding clinical family planning services, extending commercial distribution systems for temporary contraceptive methods, intensifying information and

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33 Consejo Nacional de Poblacion and USAID, 1992; McLeod M (USAID). Personal communication, 16 February 1998.
communication efforts, and strengthening research and evaluation capabilities.34 Following a midterm program review in 1996, conducted jointly by Mexican and U.S. officials and independent evaluation specialists, USAID further intensified its focus on the quality of care in service delivery.

Part of the consolidation involved reducing the number of organizations providing technical assistance in Mexico. Twenty CAs were providing technical assistance at the time the latest phase of USAID-Mexico population assistance was launched, but by 1998 the number had declined to 14.35 By the end of the last phase of USAID’s population program in 1999, only seven primary CAs were providing technical assistance: Pathfinder, IPPF, the Population Council (INOPAL III project), AVSC, the Futures Group (SOMARC project), Johns Hopkins University/Population Communication Services (PCS), and INTRAH (PRIME project). Several other CAs continued to provide technical assistance to the Mexican partners on a more limited basis.

Mobilizing Mexican Resources

Central to the agreement between USAID and its Mexican partners was the plan to gradually reduce and, by early 1997, to cease population assistance, combined with a commitment from the Mexican government to increase its funding accordingly. In the private sector, USAID resolved to provide technical assistance to help the key family planning organizations become financially sustainable. This new phase ushered in a transitional program of support for MEXFAM and FEMAP (see Section 5). From 1992 through 1999, USAID provided these institutions with technical assistance aimed at making these historically donor-dependent organizations self-sustaining.

Coordinating Assistance

USAID-funded CAs provided technical support in a range of areas, along with limited funds for contraceptives, to public and private institutions to extend and improve their services to underserved areas.36 Although there was some overlap, in general one group of CAs provided assistance to the public sector while another group worked with the NGOs. Box 2 lists the CAs that provided assistance as of 1998. This arrangement, through which the CAs worked with six Mexican institutions, simplified the administration of USAID’s health and population program in Mexico. The USAID office in Mexico assigned a Population Development Advisor to oversee the implementation of population assistance.

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36 USAID, 1997b.
## BOX 2. COOPERATING AGENCIES ASSISTING THE USAID POPULATION PROGRAM IN MEXICO, 1998

<table>
<thead>
<tr>
<th>CA and project</th>
<th>Primary areas of technical assistance</th>
<th>Public sector</th>
<th>Private sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathfinder International</td>
<td>Coordination of disbursement of funds for public-sector assistance; research and evaluation</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>AVSC International</td>
<td>Training (quality of care, access to services)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Carolina Population Center: The Evaluation &amp; Measure Evaluation Projects</td>
<td>Evaluation</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Family Health International (FHI)</td>
<td>Research and evaluation</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Management Sciences for Health (MSH): Family Planning Management Development project (FPMD)</td>
<td>Management, training (quality of care, marketing)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>John Snow, Inc. (JSI): Family Planning Logistics Management project (FPLM)</td>
<td>Logistics and commodities</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>The Population Council: INOPAL* projects</td>
<td>Research and evaluation (operations research)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Johns Hopkins University (JHU): Population Communication Services (PCS)</td>
<td>Information, education &amp; communication</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>The Futures Group International (TFGI): The POLICY project</td>
<td>Policy research and evaluation</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Basic Health Management, Inc. (BHM): Population Technical Services project (POPOTECH)</td>
<td>Evaluation</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>University of North Carolina, INTRAH: Program for International Training in Health (PRIME)</td>
<td>Training (quality of care)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>International Planned Parenthood Federation (IPPF)</td>
<td>Coordination of private-sector assistance &amp; of Transition Project</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>The Futures Group International (TFGI): Social Marketing project (SOMARC)</td>
<td>Management, sustainability (social marketing)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Georgetown University/Institute for Reproductive Health</td>
<td>Access to services (natural family planning)</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

* INOPAL is the acronym for Investigación Operativa en Planificación Familiar y Atención Materno-Infantil para América Latina y el Caribe, or Operations Research in Family Planning and Maternal and Child Health for Latin America and the Caribbean.

Three program issues define the focus of the last phase of USAID’s population assistance program and complement the objectives of the Mexican programs in both the public and private sectors:

- improved access to services;
- improved quality of services; and
- sustainability of programs.

Population-Based Outcomes

The measures or indicators used in this report correspond to the goals and objectives that were articulated in the MOU and relevant national policies of the Mexican government. Together these measures help to tell the story of the last phase of USAID’s population assistance to Mexico. Wherever possible, baseline indicators from 1992 or 1993 are compared to indicators for 1997, or to more recent data if available.

This report presents the program results of the public and private sectors in Sections 4 and 5, respectively. The results are highlighted in terms of three key program issues: access and quality for the public sector and sustainability for the private sector.

The framework used in this report for examining accomplishments is based on a hierarchy of program effects.\(^{37}\) The assessment starts with several population-based outcomes measured by three indicators: population growth and fertility, both of which are considered long-term measures, and contraceptive practice (percent of women currently using a method of contraception), an intermediate-term measure. These indicators are described in Section 3; this section also reviews differences in contraceptive practice by residence (urban versus rural) and by level of education. Section 4 examines the source of methods for modern contraceptives as an introduction to the discussion of accomplishments for the public- and private-sector programs.

Program-Based Results

The next level of assessment concerns program-based outputs or results that have contributed to the population-based outcomes. Two types of outputs are considered here: service utilization and service output. Service utilization is measured by numbers of clients reached or served (e.g., number of new acceptors and continuing users), which influences contraceptive practice. Most programs, whether public or private, track their clients in terms of these measures. “New acceptors by method of contraception” is a more detailed measure of service utilization that can reflect recent program improvements. Since not all clients who accept a family planning method will use it and not all those who start using a method will continue to do so, a difference between service utilization and contraceptive practice is likely. This report compares program-level data on new acceptors to estimates of contraceptive use from the national survey to give a broader (population-based) view of trends and use patterns.

\(^{37}\) This framework for evaluating family planning programs was developed by the USAID-funded EVALUATION Project of the Carolina Population Center. See Bertrand JT, RJ Magnani, JC Knowles, 1994
The second type of program-based result is service output, which is measured in terms of access to services and quality of services. Increased access to services and improved quality of care contribute to higher service utilization. Service outputs include such measures as the number of service delivery points, the number of providers, and the number of providers trained.

**Program Operations**

The final section presents a summary of key activities that constitute program operations in the areas of management, training, commodities and logistics, IEC, and research and evaluation—all of which are called process indicators. These activities form the operational building blocks that USAID supported to improve family planning and reproductive health programs.
SECTION 3
IMPACT OF FAMILY PLANNING IN MEXICO, 1992-1999

Population Growth and Fertility

Improved family planning programs and increased use of contraception are among many social and economic factors that have contributed to changes in Mexico’s demographics. Recent trends show that Mexico is moving toward fulfilling its demographic goals. The annual rate of population growth, not including the effect of emigration, dropped from nearly 2.2 percent in 1992 to 1.8 percent in mid-1999. The goal for 2000 was 1.75 percent. A key factor driving the reduction in population growth is the decline in fertility. The total fertility rate, estimated at approximately 3.2 children per woman in 1990, fell to 2.9 in 1995 and was estimated to have fallen to 2.5 in 1999. (See Table 4.)

At the state level, when the last phase of the USAID-Mexico collaboration began, the priority states registered fertility rates ranging from lows of 3.1 children per woman in Veracruz and 2.9 in the state of Mexico (levels below or equal to the country average of 3.1) to a high of 4.1 in Chiapas and 4.0 in Guerrero, Oaxaca, and Puebla. By 1997, fertility in all the priority states had fallen to levels ranging from 2.4 children per woman in the state of Mexico to 3.4 in Guerrero and 3.3 in Chiapas, Oaxaca, and Puebla. The greatest changes were seen in Chiapas, Oaxaca, Puebla, and Michoacán, where the TFRs dropped on average by 18.23 percent between 1992 and 1997. The smallest changes were observed in Hidalgo and Veracruz, where the percent decline in TFRs was 14.13 on average. During this period, the TFR for Mexico as a whole declined by 16.13 percent.

Women's attitudes and behavior are important factors underlying changes in fertility. As women desire fewer children, typically their control of fertility through contraceptive use increases and fertility declines. According to national surveys, the demand for children among married women (measured as the average ideal number of children) declined in Mexico from 4.5 children per woman in 1976 to 3.1 in 1995, and further to 2.9 in 1997. The trends in contraceptive prevalence shown in the next section suggest that Mexican women are increasingly controlling their fertility and thus are closer to achieving their ideal family size.

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33 Welti, C., 1997 (for 1995); Consejo Nacional de Población, 1999 (for 1999).
34 ENADID, 1997.
Table 4. Total Fertility Rates for Priority States and All Mexico, 1992 and 1997

Average number of children per woman

<table>
<thead>
<tr>
<th>State</th>
<th>1992</th>
<th>1997</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiapas</td>
<td>4.1</td>
<td>3.3</td>
</tr>
<tr>
<td>Guanajuato</td>
<td>3.6</td>
<td>3.1</td>
</tr>
<tr>
<td>Guerrero</td>
<td>4.0</td>
<td>3.4</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>3.3</td>
<td>2.9</td>
</tr>
<tr>
<td>México</td>
<td>2.9</td>
<td>2.4</td>
</tr>
<tr>
<td>Michoacán</td>
<td>3.8</td>
<td>3.1</td>
</tr>
<tr>
<td>Oaxaca</td>
<td>4.0</td>
<td>3.3</td>
</tr>
<tr>
<td>Puebla</td>
<td>4.0</td>
<td>3.3</td>
</tr>
<tr>
<td>Veracruz</td>
<td>3.1</td>
<td>2.6</td>
</tr>
<tr>
<td>All Mexico</td>
<td>3.1</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Source: CONAPO estimations based on ENADID 1992 and 1997 and INEGI.

If the ideal number of children is lower than actual fertility levels, women may have an unmet need for contraception. By 1997, the ideal number of children and the actual fertility rate were equivalent at the national level. The desire for children was somewhat higher than the national average in all the priority states except for Hidalgo, the State of Mexico, Oaxaca, and Veracruz. However, in almost all priority states, the desire for children was lower than actual fertility. Given the government’s goal for a national TFR of 2.4 children per woman by 2000, it appears that “there continues to be a need for communication and other activities that address some of the underlying determinants of the desire for children.”

Since it can take time for a family planning program to have an impact on fertility, the changes in fertility observed in the priority states between 1992 and 1999 may reflect the influence of earlier program improvements. Given that factors outside the program (such as age of marriage, urbanization, or other socioeconomic factors) also contributed to fertility decline, it would be difficult to make a causal link between the USAID-Mexico program and fertility changes in the priority states. Thus, it may be more useful to examine the program’s intermediate outcomes.

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Contraceptive Practice

Contraceptive practice is the single most important proximate determinant of fertility. An increase in the contraceptive prevalence rate (CPR) to 70.2 percent was the Mexican government’s goal for 2000. Achieving a sustainable increase in contraceptive prevalence was also the goal of USAID’s population assistance program in Mexico.

Contraceptive use among married women of reproductive age for all of Mexico increased from 63.1 percent to 68.4 percent between 1992 and 1997 (see Table 5). During this period, the overall CPR in the priority states increased from 58.2 to 64.1 percent. Since the increase in the CPR in the priority states (where USAID assistance was focused) was slightly greater than the increase observed nationally during the same period (10.1 percent versus 8.4 percent), it is quite possible that USAID’s program had real impact.

The CPR increased in all of the priority states from 1992 to 1997; however, the increase was very small in the priority states of Guanajuato and Guerrero. In 1992, all but one of the priority states had a lower CPR than the national average; the exception was the state of Mexico, which registered a CPR of 71 percent. The CPR in the other eight states ranged from a high of 60 percent in Hidalgo to a low of 46 percent in Oaxaca. In 1997, both the state of Mexico and Veracruz surpassed the national average with rates of 75.4 and 70.3 respectively. At a CPR of 47.4 percent in 1997, Guerrero showed the lowest rate of change. The greatest changes were observed in Puebla, Oaxaca, and Veracruz, where the CPR increased by as much as 20 percent.

Table 5. Contraceptive Prevalence Rates for Priority States and All Mexico, 1992 and 1997

<table>
<thead>
<tr>
<th>State</th>
<th>1992</th>
<th>1997</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiapas</td>
<td>49.9</td>
<td>53.5</td>
</tr>
<tr>
<td>Guanajuato</td>
<td>53.5</td>
<td>54.6</td>
</tr>
<tr>
<td>Guerrero</td>
<td>46.9</td>
<td>47.4</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>60.2</td>
<td>63.2</td>
</tr>
<tr>
<td>México</td>
<td>71.1</td>
<td>75.4</td>
</tr>
<tr>
<td>Michoacán</td>
<td>55.8</td>
<td>60.9</td>
</tr>
<tr>
<td>Oaxaca</td>
<td>46.3</td>
<td>55.1</td>
</tr>
<tr>
<td>Puebla</td>
<td>49.5</td>
<td>59.4</td>
</tr>
<tr>
<td>Veracruz</td>
<td>59.9</td>
<td>70.3</td>
</tr>
<tr>
<td>Priority States</td>
<td>58.2</td>
<td>64.1</td>
</tr>
<tr>
<td>All Mexico</td>
<td>63.1</td>
<td>68.4</td>
</tr>
</tbody>
</table>

Source: CONAPO estimations based on ENADID 1992 and 1997 and INEGI.

Great disparities exist in contraceptive practice between urban and rural women, although the differences became less pronounced during the 1990s, as shown in Table 6. At the national level in 1992, 70 percent of urban women in Mexico practiced contraception compared to about 45 percent of rural women, a difference of about 25 percentage points. Among the priority states, the urban-rural gap was even greater—contraception was practiced by 69 percent of urban women compared to 40 percent of rural women, a difference of 29 percentage points. To address this gap, a substantial part of USAID support to family planning programs in Mexico was used to strengthen services in the rural areas of the priority states.

Table 6. Trends in Contraceptive Prevalence Rate by Urban and Rural Residence for Priority States and All Mexico, 1992 and 1997

<table>
<thead>
<tr>
<th>Percent of married women using contraception (all methods)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source: CONAPO estimations based on ENADID 1992 and 1997 and INEGI.</td>
</tr>
</tbody>
</table>

At the national level by 1997, contraceptive use among both urban and rural women increased, although the gain—from 45 percent to 54 percent—was greater among rural women. Similarly, for priority states, the CPR among both urban and rural women increased, but the gain among rural women was even more pronounced—from 40 percent to nearly 50 percent. While the urban-rural gap remains (about 20 percentage points for all of Mexico and 22 percentage points for the priority states), the trend toward smaller differences between urban and rural women was encouraging.

Moreover, in the three priority states of Oaxaca, Puebla, and Veracruz, the rural CPR increased by more than 30 percent between 1992 and 1997. Other states, like Hidalgo and Michoacán, showed less substantial advances. In 1997, the priority states with the lowest levels of contraceptive use in rural areas were Guanajuato and Guerrero, with CPR levels below 40 percent.
Urban trends are more mixed and difficult to explain at the state level. It is possible that some of the fluctuations are due to sampling differences and sampling errors between the two surveys. For example, there is no obvious explanation for the strong decrease in the urban CPR in the state of Guerrero between 1992 and 1997. This decrease contradicts the general trend—a seemingly irreversible process—observed in countries around the world of increasing use of contraception over time once family planning practices are established within a population.

Table 7. Contraceptive Prevalence Rate by Level of Education for Priority States and All Mexico, 1997
Percent of married women using contraception (all methods)

<table>
<thead>
<tr>
<th>State</th>
<th>No education</th>
<th>Incomplete primary</th>
<th>Completed primary</th>
<th>Secondary or higher</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiapas</td>
<td>39.1</td>
<td>53.2</td>
<td>51.0</td>
<td>69.5</td>
</tr>
<tr>
<td>Guanajuato</td>
<td>50.6</td>
<td>51.5</td>
<td>47.6</td>
<td>64.1</td>
</tr>
<tr>
<td>Guerrero</td>
<td>22.6</td>
<td>41.7</td>
<td>53.4</td>
<td>62.6</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>45.0</td>
<td>58.9</td>
<td>65.8</td>
<td>71.4</td>
</tr>
<tr>
<td>México</td>
<td>57.6</td>
<td>67.4</td>
<td>79.0</td>
<td>79.0</td>
</tr>
<tr>
<td>Michoacán</td>
<td>43.6</td>
<td>55.9</td>
<td>62.1</td>
<td>69.9</td>
</tr>
<tr>
<td>Oaxaca</td>
<td>43.8</td>
<td>49.4</td>
<td>57.3</td>
<td>68.7</td>
</tr>
<tr>
<td>Puebla</td>
<td>35.8</td>
<td>50.7</td>
<td>62.5</td>
<td>73.4</td>
</tr>
<tr>
<td>Veracruz</td>
<td>56.7</td>
<td>66.5</td>
<td>72.7</td>
<td>77.1</td>
</tr>
<tr>
<td>Priority States</td>
<td>45.0</td>
<td>57.6</td>
<td>65.9</td>
<td>73.9</td>
</tr>
<tr>
<td>All Mexico</td>
<td>48.0</td>
<td>61.3</td>
<td>69.8</td>
<td>74.8</td>
</tr>
</tbody>
</table>

Source: CONAPO estimations based on ENADID 1997 and INEGI.

A woman's level of education is strongly associated with differences in the rate of contraceptive use. In general, women who are more educated have higher levels of contraceptive use. The difference in contraceptive use between women with secondary education or higher and those with no education was about as pronounced as urban-rural differences. At the national level in 1997, 75 percent of women at the highest educational level used contraception, compared to about 48 percent of women with no education. In the priority states, this difference was slightly greater, 74 percent compared to 45 percent. (See Table 7.)

This disparity can be seen across the priority states. In the two states with the highest overall level of contraceptive use (the state of Mexico and Veracruz), the difference is small or nonexistent between women who completed primary education and those who completed education at the secondary or higher levels. In contrast, Guerrero, the state with the lowest overall level of contraceptive use, had a very large difference in use between women with the highest and lowest levels of education, 62.6 percent and 22.6 percent, respectively. If future priorities include trying to reach women with the lowest levels of use, much effort will need to
be placed on reaching women with the lowest levels of education and women who live in states with lower overall levels of contraceptive use. These women would benefit not only from improved access to reproductive health services but also from educational opportunities such as literacy training.

An important indicator in evaluating the progress of family planning programs is the magnitude of unsatisfied demand (unmet need). In Mexico, the percentage of women in a union who do not want more children or who wish to delay the birth of their next child, and who do not use any type of contraceptive method, decreased from 16.1 percent to 12.1 percent between 1995 and 1997 (see Table 8). In the priority states, with the exceptions of the state of Mexico and Veracruz, the levels of unmet need are higher. The case of Guerrero is conspicuous, where 25 percent of women who do not wish to increase the size of their family (either now or definitively) do nothing to prevent it; in Chiapas, Guanajuato, Oaxaca, and Puebla, the level of this indicator is around 20 percent. Except in Guanajuato and Guerrero, progress in this indicator was seen in the priority states between 1995 and 1997.

When this indicator is analyzed in the priority states by age, a consistent tendency is observed: the older the age group, the smaller the level of unmet need. It is important to highlight the high percent of unmet need observed among younger groups, and particularly worrisome are figures for adolescents in a union, ages 15 to 19, who do not wish to have more children or who wish to postpone their next birth: 44 percent in Guerrero, almost 44 percent in Oaxaca; around 35 percent in Chiapas, Guanajuato, and Hidalgo; around 30 percent in the remainder of the states with the exception of the state of Mexico (see Table 9).

Analysis of the contraceptive prevalence rates in the 15 to 19 year age group in 1997 points to the need to focus additional services and information on adolescents. For all of the priority states, the level of this indicator is much lower for this youngest group than for all women in fertile age (see Table 10).
Table 8. Percentage of Married Women With Unmet Need for Family Planning Services, for Priority States and All Mexico

<table>
<thead>
<tr>
<th>State</th>
<th>1995</th>
<th>1997</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiapas</td>
<td>27.9</td>
<td>21.0</td>
</tr>
<tr>
<td>Guanajuato</td>
<td>17.5</td>
<td>19.0</td>
</tr>
<tr>
<td>Guerrero</td>
<td>25.1</td>
<td>25.8</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>19.9</td>
<td>16.3</td>
</tr>
<tr>
<td>México</td>
<td>10.8</td>
<td>9.7</td>
</tr>
<tr>
<td>Michoacán</td>
<td>22.0</td>
<td>17.4</td>
</tr>
<tr>
<td>Oaxaca</td>
<td>30.6</td>
<td>21.0</td>
</tr>
<tr>
<td>Puebla</td>
<td>23.7</td>
<td>19.3</td>
</tr>
<tr>
<td>Veracruz</td>
<td>14.5</td>
<td>12.6</td>
</tr>
<tr>
<td>Priority States</td>
<td>19.0</td>
<td>15.7</td>
</tr>
<tr>
<td>All Mexico</td>
<td>16.1</td>
<td>12.1</td>
</tr>
</tbody>
</table>


Table 9. Percentage of Married Women With Unmet Need for Family Planning Services By Age Group, 1997 Priority States

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiapas</td>
<td>36.3</td>
<td>33.2</td>
<td>26.9</td>
<td>19.7</td>
<td>13.2</td>
<td>8.6</td>
<td>2.0</td>
<td>21.0</td>
</tr>
<tr>
<td>Guanajuato</td>
<td>35.2</td>
<td>27.4</td>
<td>28.1</td>
<td>15.1</td>
<td>15.9</td>
<td>10.4</td>
<td>6.7</td>
<td>19.0</td>
</tr>
<tr>
<td>Guerrero</td>
<td>44.4</td>
<td>38.8</td>
<td>33.1</td>
<td>23.1</td>
<td>23.3</td>
<td>13.7</td>
<td>2.7</td>
<td>25.8</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>34.2</td>
<td>27.6</td>
<td>18.1</td>
<td>16.8</td>
<td>11.5</td>
<td>7.8</td>
<td>3.9</td>
<td>16.3</td>
</tr>
<tr>
<td>México</td>
<td>15.2</td>
<td>17.8</td>
<td>10.5</td>
<td>9.0</td>
<td>11.0</td>
<td>4.4</td>
<td>2.9</td>
<td>9.7</td>
</tr>
<tr>
<td>Michoacán</td>
<td>29.4</td>
<td>23.5</td>
<td>23.7</td>
<td>19.5</td>
<td>11.2</td>
<td>12.1</td>
<td>2.5</td>
<td>17.4</td>
</tr>
<tr>
<td>Oaxaca</td>
<td>39.2</td>
<td>35.0</td>
<td>19.8</td>
<td>17.4</td>
<td>19.8</td>
<td>14.5</td>
<td>3.9</td>
<td>21.0</td>
</tr>
<tr>
<td>Puebla</td>
<td>28.1</td>
<td>29.4</td>
<td>24.0</td>
<td>16.3</td>
<td>17.6</td>
<td>12.7</td>
<td>5.2</td>
<td>19.3</td>
</tr>
<tr>
<td>Veracruz</td>
<td>29.0</td>
<td>23.3</td>
<td>16.7</td>
<td>9.8</td>
<td>6.5</td>
<td>5.6</td>
<td>3.7</td>
<td>12.6</td>
</tr>
<tr>
<td>Total</td>
<td>29.7</td>
<td>25.8</td>
<td>19.6</td>
<td>14.1</td>
<td>13.1</td>
<td>8.4</td>
<td>3.6</td>
<td>15.7</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>State</th>
<th>15-49</th>
<th>15-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiapas</td>
<td>53.4</td>
<td>27.2</td>
</tr>
<tr>
<td>Guanajuato</td>
<td>54.6</td>
<td>33.6</td>
</tr>
<tr>
<td>Guerrero</td>
<td>47.6</td>
<td>24.1</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>63.3</td>
<td>34.2</td>
</tr>
<tr>
<td>México</td>
<td>75.4</td>
<td>62.1</td>
</tr>
<tr>
<td>Michoacán</td>
<td>61.0</td>
<td>38.6</td>
</tr>
<tr>
<td>Oaxaca</td>
<td>55.2</td>
<td>31.5</td>
</tr>
<tr>
<td>Puebla</td>
<td>59.6</td>
<td>43.1</td>
</tr>
<tr>
<td>Veracruz</td>
<td>70.4</td>
<td>51.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>64.2</strong></td>
<td><strong>42.5</strong></td>
</tr>
</tbody>
</table>

The use of modern contraceptives is a direct result of service use by people who go to one of the available sources of family planning services. The public sector in Mexico is the predominant source of family planning and reproductive health services, while the private sector provides services to a smaller segment of the population. From 1979 to 1992, the public sector's role increased substantially, from serving 51 percent of service users to almost 67 percent. Its influence continued to grow in the 1990s, providing services to nearly 73 percent of family planning users by 1997 (see Table 11).

Table 11. Trends in Contraceptive Use, By Source of Modern Methods, for Priority States and All Mexico, 1992 and 1997

<table>
<thead>
<tr>
<th>Source of Modern Methods</th>
<th>Priority States</th>
<th>All Mexico</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private sector</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacies</td>
<td>15.1</td>
<td>10.0</td>
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<tr>
<td>Other</td>
<td>15.7</td>
<td>14.3</td>
</tr>
<tr>
<td>Total private</td>
<td>30.8</td>
<td>24.3</td>
</tr>
<tr>
<td>Public sector</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMSS</td>
<td>39.0</td>
<td>39.2</td>
</tr>
<tr>
<td>SSA</td>
<td>17.6</td>
<td>23.9</td>
</tr>
<tr>
<td>ISSSTTE</td>
<td>3.7</td>
<td>4.1</td>
</tr>
<tr>
<td>Other</td>
<td>8.9</td>
<td>8.5</td>
</tr>
<tr>
<td>Total public</td>
<td>69.2</td>
<td>75.7</td>
</tr>
</tbody>
</table>

Source: CONAPO estimations based on ENADID 1992 and 1997 and INEGI.

Within the public sector, the Instituto Mexicano del Seguro Social (IMSS) continued to play a key role; in 1997 it was providing contraceptive services to almost 42 percent of contraceptive users nationwide. The Secretaría de Salud (SSA), whose role increased during the 1990s, was a source of supply for 20 percent of users in 1997. Between 1992 and 1997 in the private sector, the role of pharmacies declined, supplying only about 14 percent of contraceptive users in 1997 compared to nearly 19 percent in 1992.

In the priority states, the public sector has been an increasingly important source of family planning, serving nearly 76 percent of couples using modern methods by 1997, up from about 69
percent in 1992. IMSS has continued to be the predominant provider within the public sector, serving 39 percent of users, although SSA’s share increased from about 17 percent to approximately 24 percent from 1992 to 1997. Given that USAID funds were mainly channeled to the public institutions and to priority states during this period, these figures may partly reflect the impact of USAID’s technical and financial support.

Public-Sector Institutions: IMSS, SSA, and ISSSTE

The accomplishments of the programs of three institutions—IMSS, ISSSTE, and SSA—during the 1990s are reviewed here. Each of these institutions maintains data on new acceptors of contraceptives and continuing or active users. Given the focus of this report on improvements in the programs between 1992 and 1999, changes in the numbers of new acceptors probably best reflects recent improvements. Available program records on new family planning acceptors in the Mexican program varied but indicated a general increase in service utilization.

In the public sector during 1993, the three major service delivery institutions served nearly 930,000 new family planning clients in priority states (see Table 12). By 1997, they served more than 980,000, or roughly 5 percent more than in 1993. The largest gains in new acceptors were made in the states of Chiapas, Oaxaca, Hidalgo, and Puebla, and occurred mostly through the two largest providers, IMSS and SSA. Curiously, the numbers of new acceptors actually declined during this period in two states, Mexico and Veracruz, which had the highest overall contraceptive prevalence, and the declines were evident only through the services of IMSS. What is surprising, however, is the variation across the three institutions in the numbers of new acceptors between 1993 and 1997: The number of new acceptors increased at SSA in all states, for an average increase of about 30 percent, and the number of new acceptors increased at ISSSTE in all but two states (Chiapas and Guerrero), for an average increase of about 22 percent. IMSS recorded increases in new acceptors in only four (Chiapas, Hidalgo, Oaxaca, and Puebla) of the nine priority states. The percentage increase in new acceptors was higher for the priority states (5.6 percent increase) than for all Mexico (0.05 percent increase). Given that USAID support was largely focused on the priority states, the outcome likely reflects the benefits of this assistance.

Methodological notes: When contraceptive use reaches high levels in a population, the number of potential new users decreases; therefore, a decrease in the number of new acceptors does not necessarily mean that the program is decaying. Some methodological problems in measuring acceptors make it difficult to compare data among institutions. In recent years, institutions have carried out a strict revision of their information systems, which makes comparisons through time difficult.
Table 12. Trends in New Acceptors of Contraception for the Public Health Institutions (IMSS, SSA, and ISSSTE) in Priority States and All Mexico, 1993 and 1997

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiapas</td>
<td>51,376</td>
<td>72,137</td>
<td>16,220</td>
<td>28,471</td>
<td>2,447</td>
<td>2,216</td>
<td>70,043</td>
<td>102,824</td>
</tr>
<tr>
<td>Guanajuato</td>
<td>55,397</td>
<td>49,778</td>
<td>21,706</td>
<td>27,336</td>
<td>3,306</td>
<td>8,586</td>
<td>80,409</td>
<td>85,700</td>
</tr>
<tr>
<td>Guerrero</td>
<td>21,684</td>
<td>19,645</td>
<td>22,523</td>
<td>31,900</td>
<td>7,628</td>
<td>5,352</td>
<td>51,835</td>
<td>56,897</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>27,794</td>
<td>38,955</td>
<td>14,318</td>
<td>16,491</td>
<td>2,767</td>
<td>2,899</td>
<td>44,879</td>
<td>58,845</td>
</tr>
<tr>
<td>México</td>
<td>162,887</td>
<td>131,081</td>
<td>79,910</td>
<td>86,485</td>
<td>5,001</td>
<td>7,660</td>
<td>247,798</td>
<td>225,226</td>
</tr>
<tr>
<td>Michoacán</td>
<td>61,372</td>
<td>60,729</td>
<td>21,227</td>
<td>30,234</td>
<td>6,051</td>
<td>7,787</td>
<td>88,650</td>
<td>98,750</td>
</tr>
<tr>
<td>Oaxaca</td>
<td>36,268</td>
<td>48,687</td>
<td>14,336</td>
<td>19,483</td>
<td>2,316</td>
<td>2,973</td>
<td>52,920</td>
<td>71,143</td>
</tr>
<tr>
<td>Puebla</td>
<td>61,818</td>
<td>68,607</td>
<td>22,790</td>
<td>39,652</td>
<td>4,063</td>
<td>4,438</td>
<td>88,671</td>
<td>112,697</td>
</tr>
<tr>
<td>Veracruz</td>
<td>167,590</td>
<td>125,955</td>
<td>29,249</td>
<td>35,766</td>
<td>6,835</td>
<td>7,288</td>
<td>203,674</td>
<td>169,009</td>
</tr>
<tr>
<td>Priority States</td>
<td>646,186</td>
<td>615,574</td>
<td>242,279</td>
<td>315,818</td>
<td>40,414</td>
<td>49,199</td>
<td>928,879</td>
<td>980,591</td>
</tr>
<tr>
<td>All Mexico</td>
<td>1,535,199</td>
<td>1,398,880</td>
<td>553,443</td>
<td>669,735</td>
<td>127,998</td>
<td>149,053</td>
<td>2,216,640</td>
<td>2,217,668</td>
</tr>
</tbody>
</table>


Trends in new acceptors by contraceptive method showed some interesting differences across the three institutions (see Table 13). At IMSS, new users most frequently chose the intrauterine device (IUD). From 1993 to 1995, the number of new acceptors of IUDs increased by more than 28,000 (roughly a 9 percent increase) and probably reflects both increased capacity to offer IUDs and promotion of the device by providers. While the number of new IUD acceptors dropped somewhat in 1997, the IUD was still chosen by 53 percent of all new acceptors at IMSS that year. The number of new acceptors of the second most popular method, hormonal contraceptives, declined dramatically during this period; this decline helps to explain the overall drop in new acceptors at IMSS in some states. One explanation for the decline in new acceptors of hormonals is that IMSS stopped providing the minipill in 1993, although it continued to offer other oral contraceptives.

The numbers of Mexicans selecting surgical contraception (including both female and male sterilization) increased dramatically by more than 26,500, or by about 30 percent, from 1993 to 1997. This increase probably reflects the enhanced capacity of providers to offer female sterilization (bilateral tubal occlusion [BTO]) and no-scalpel vasectomy (NSV). It may also have reflected the IMSS strategy to provide these long-term methods at its rural hospitals and medical units. In addition, the increase from 1995 to 1997 could be explained by the interruption of IMSS special "surgical sessions," which probably caused an accumulation of unmet demand that was then met in 1997. In general, IMSS serves a population that is predisposed to use contraceptives; therefore, the numbers of new acceptors cannot be expected to increase greatly.

Method selection at SSA had a different profile. The most popular method continued to be hormonal contraceptives, and the number of new acceptors in 1997 was nearly 50,000 more than...
in 1993. In relative terms, about 60 percent of new acceptors at SSA chose an hormonal method in 1997, a slight increase over 1993. Between 1993 and 1995, numbers of new acceptors of both the IUD and surgical contraception increased sharply at SSA (by more than 36,000 and 9,800, respectively) but then dropped back in 1997. The IUD remained the second ranking method, requested by roughly one-third of new acceptors, and an additional 7 percent of new acceptors chose surgical contraception.

Hormonal contraceptives were the most popular method among new acceptors at ISSSTE, with a modest increase in the proportion of new acceptors selecting hormonals—for a total of about 45 percent in 1997. The IUD was the second most popular method, and while the number of new acceptors increased by about 3,500 between 1993 and 1995 and by somewhat less than that in 1997, this method continued to attract more than one-third of new acceptors. About one in five new acceptors selected surgical contraception, and the actual number of sterilization procedures at ISSSTE in 1997 (slightly more than 9,400) was somewhat less than half of such procedures performed by the much larger provider, SSA. ISSSTE's relative share of new acceptors among all three institutions was small—about 5 percent.


<table>
<thead>
<tr>
<th>Instituto Mexicano del Seguro Social (IMSS)</th>
<th>Surgical*</th>
<th>IUD</th>
<th>Hormonals</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>86,052</td>
<td>301,866</td>
<td>258,268</td>
<td>646,186</td>
</tr>
<tr>
<td>1995</td>
<td>97,648</td>
<td>329,912</td>
<td>192,149</td>
<td>619,709</td>
</tr>
<tr>
<td>1997</td>
<td>112,566</td>
<td>326,351</td>
<td>176,657</td>
<td>615,574</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secretaría de Salud (SSA)</th>
<th>Surgical*</th>
<th>IUD</th>
<th>Hormonals</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>17,714</td>
<td>81,360</td>
<td>143,205</td>
<td>242,279</td>
</tr>
<tr>
<td>1995</td>
<td>27,540</td>
<td>117,453</td>
<td>162,894</td>
<td>307,887</td>
</tr>
<tr>
<td>1997</td>
<td>22,136</td>
<td>103,649</td>
<td>190,033</td>
<td>315,818</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE)</th>
<th>Surgical*</th>
<th>IUD</th>
<th>Hormonals</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>9,257</td>
<td>15,074</td>
<td>16,083</td>
<td>40,414</td>
</tr>
<tr>
<td>1995</td>
<td>10,048</td>
<td>18,556</td>
<td>23,139</td>
<td>51,743</td>
</tr>
<tr>
<td>1997</td>
<td>9,407</td>
<td>17,839</td>
<td>21,953</td>
<td>49,199</td>
</tr>
</tbody>
</table>

* Surgical methods include female sterilization (bilateral tubal occlusion [BTO]) and male sterilization (NSV).

Table 14 presents the breakdown of all contraceptive users by method. As of 1997, female sterilization (BTO) remained the predominant contraceptive method in Mexico. Throughout the period 1992 to 1997, the proportion of users choosing this method did not change, although the absolute numbers of BTO users increased due to an increase in the overall use of contraception during this period. The percent of users grew for the IUD, the second most popular method, and the use of hormonal methods (orals and injectables) declined. As noted in Table 13, new acceptors of hormonals at IMSS in priority states declined between 1993 and 1997, which may have reflected increased promotion, higher acceptance, and higher continuation rates associated with longer-term methods such as the IUD and sterilization. Use of barrier methods, principally the condom, increased slightly, and a small but growing proportion of Mexicans chose vasectomy. Interestingly, the proportion of all modern method users has stayed constant in relation to the proportion of Mexicans using traditional methods such as the rhythm method and withdrawal.

The breakdown of contraceptive use by method did not vary a great deal between the priority states and the country as a whole. However, both the IUD and traditional methods are used to a somewhat greater extent in the priority states; oral contraceptives are used somewhat less frequently. (See Table 14.)

Table 14. Trends in Contraceptive Use by Method for Priority States and All Mexico, 1992 and 1997
Percentage of all users by method

<table>
<thead>
<tr>
<th>Method</th>
<th>Priority States</th>
<th>All Mexico</th>
</tr>
</thead>
<tbody>
<tr>
<td>BTO</td>
<td>44.0</td>
<td>45.6</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>1.3</td>
<td>1.7</td>
</tr>
<tr>
<td>Oral contraceptives</td>
<td>11.8</td>
<td>6.6</td>
</tr>
<tr>
<td>Injectables</td>
<td>5.8</td>
<td>4.8</td>
</tr>
<tr>
<td>IUD</td>
<td>17.4</td>
<td>22.3</td>
</tr>
<tr>
<td>Barrier methods</td>
<td>4.5</td>
<td>5.0</td>
</tr>
<tr>
<td>Traditional</td>
<td>15.1</td>
<td>13.9</td>
</tr>
<tr>
<td>Other</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: CONAPO estimations based on ENADID 1992 and 1997 and INEGI.

Improved Access to Public-Sector Services

One of the key objectives of USAID's population assistance to Mexico was to increase the availability of family planning services in the priority states. Given that more than 70 percent of Mexicans receive their contraceptive services from a public-sector institution and given the size
of the Mexican population (more than 98 million in 1999), the magnitude of the service delivery by IMSS, SSA, and ISSSTE is large.

Overall access to family planning services is partially measured in terms of the number of service delivery points (SDPs) and the number of providers of such services. From 1993 to 1997, the number of SDPs for Mexico as a whole increased from more than 13,500 to more than 15,800, an impressive 17 percent increase in a short period of time (see Table 15). The increases in the SDPs occurred in the 1993 to 1994 timeframe and within the IMSS-Solidaridad Program because, during those years, many Unidades Médicas Rurales (Rural Medical Units) were built in the nondecentralized states. After that period, the increases in SDPs occurred primarily within SSA and were attributable to an increase in the number of rural health units.

Among the priority states, the number of SDPs also grew, from almost 6,800 to more than 7,800. The service delivery points for the public sector included general hospitals, out-patient clinics, and the homes of health auxiliaries and midwives (considered first-level medical units). The only SDPs in the priority states that do not provide family planning services are third-level hospitals. Establishing SDPs in the priority states is a more difficult task than in the rest of Mexico, given their higher proportion of rural communities compared with the nonpriority states. However, MOU strategies were never intended to increase access by establishing service delivery points, but through other strategies, mainly training and IEC activities.

Table 15. Number of Service Delivery Points in Public Health Institutions in Priority States and All Mexico, 1993 and 1997

<table>
<thead>
<tr>
<th>Priority State</th>
<th>1993</th>
<th>1997</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiapas</td>
<td>772</td>
<td>922</td>
</tr>
<tr>
<td>Guanajuato</td>
<td>501</td>
<td>529</td>
</tr>
<tr>
<td>Guerrero</td>
<td>654</td>
<td>831</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>588</td>
<td>675</td>
</tr>
<tr>
<td>México</td>
<td>990</td>
<td>1,062</td>
</tr>
<tr>
<td>Michoacán</td>
<td>697</td>
<td>750</td>
</tr>
<tr>
<td>Oaxaca</td>
<td>779</td>
<td>1,017</td>
</tr>
<tr>
<td>Puebla</td>
<td>687</td>
<td>826</td>
</tr>
<tr>
<td>Veracruz</td>
<td>1,047</td>
<td>1,217</td>
</tr>
<tr>
<td>Priority States</td>
<td>6,765</td>
<td>7,829</td>
</tr>
<tr>
<td>All Mexico</td>
<td>13,519</td>
<td>15,829</td>
</tr>
</tbody>
</table>

Access is influenced by the location of services and their proximity to underserved groups (marginal urban and rural populations). According to the SSA, the increases in the number of SDPs, together with other strategies of the Coverage Extension Program, lowered the number of underserved Mexicans from 10 million in 1995 to 1.5 million in 1999. This dramatic change was the result of the impressive networks of health posts and auxiliary staff of SSA and IMSS-Solidaridad in rural areas.

In addition to the increase in SDPs, during the 1992 to 1997 period the number of providers (physicians and nurses) in governmental institutions for the country as a whole increased from 231,814 to 278,879; the providers in the priority states during the same period increased from 73,769 to 88,343. The increases for all of Mexico and for the priority states were each about 20 percent.

Training service delivery providers was a major undertaking of the USAID-Mexico agreement, and it was an important strategy for increasing access to family planning and reproductive health services. These training endeavors are reviewed later in this report.

Other indicators of access to services include the actual cost of contraceptives to clients, program policies that may affect contraceptive choice, the level of knowledge of methods and source of contraceptive services, and the extent to which psychosocial barriers inhibit use of contraception. Since the policy of the government of Mexico is to provide free family planning services to all its citizens, the cost of contraception is not an obstacle to use. Other costs to users include the cost of transportation to get to service delivery points and the “opportunity cost” of time required to obtain services. Poorer, remote rural, and indigenous communities are most negatively impacted by transportation and time costs.

Accessibility of family planning services can be gauged in terms of knowledge of contraception and knowledge of sources of supply.

---

46 Physicians with patient direct contact increased by more than 28 percent, from 77,740 to 99,743, between 1993 and 1997 for the country and by 24 percent, from 26,928 to 33,399, during this same period in the priority states. Pathfinder and INSAD, 1999.

47 Source: Data from Sistema Nacional de Salud, Pathfinder reports (for public-sector data), and MEXFAM’s and FEMAP’s “information systems” (private-sector data), cited in USAID, 1998a. The increase in the number of public-sector service providers was due, in part, to the decentralization of services.
Knowledge of contraceptive methods was already high when the MOU went into effect. In the priority states, more than 80 percent of women in their reproductive years had heard about methods such as the pill, the IUD, injectables, and the BTO; the least-known methods were locals, as less than half of the interviewed women knew about them. Increase in knowledge was observed for all methods during the period 1992 to 1997; however, these increases are particularly notable for condoms (13 percentage points) and vasectomy (12 percent points). Advances in knowledge of contraceptive methods were of greatest magnitude in the priority states of Chiapas and Puebla. Actions undertaken mainly by public institutions seem to have had a beneficial effect on couples, allowing them to make more informed reproductive decisions, and a gender perspective seems to be permeating such actions (see Table 16).

### Table 16. Percentage of Women at Fertile Age Who Knew of at Least One Contraceptive Method, by Priority State, 1992 and 1997

<table>
<thead>
<tr>
<th>Priority State</th>
<th>Pills</th>
<th>IUD</th>
<th>Injectables</th>
<th>Local</th>
<th>Condoms</th>
<th>BTO</th>
<th>Vasectomy</th>
<th>Traditionals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ENADID 1992</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiapas</td>
<td>77.0</td>
<td>62.1</td>
<td>72.6</td>
<td>27.3</td>
<td>45.0</td>
<td>71.5</td>
<td>39.8</td>
<td>40.1</td>
</tr>
<tr>
<td>Guanajuato</td>
<td>93.3</td>
<td>85.0</td>
<td>82.0</td>
<td>44.7</td>
<td>78.0</td>
<td>84.7</td>
<td>64.1</td>
<td>59.3</td>
</tr>
<tr>
<td>Guerrero</td>
<td>86.8</td>
<td>76.8</td>
<td>83.1</td>
<td>42.1</td>
<td>71.5</td>
<td>79.4</td>
<td>61.1</td>
<td>55.7</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>86.8</td>
<td>84.6</td>
<td>82.8</td>
<td>47.3</td>
<td>69.0</td>
<td>83.5</td>
<td>59.2</td>
<td>55.9</td>
</tr>
<tr>
<td>México</td>
<td>93.3</td>
<td>91.1</td>
<td>88.9</td>
<td>65.5</td>
<td>84.0</td>
<td>89.4</td>
<td>78.1</td>
<td>69.0</td>
</tr>
<tr>
<td>Michoacán</td>
<td>93.5</td>
<td>86.9</td>
<td>87.8</td>
<td>50.9</td>
<td>82.5</td>
<td>91.0</td>
<td>69.4</td>
<td>73.5</td>
</tr>
<tr>
<td>Oaxaca</td>
<td>77.2</td>
<td>67.1</td>
<td>71.4</td>
<td>30.9</td>
<td>70.0</td>
<td>72.4</td>
<td>45.9</td>
<td>48.7</td>
</tr>
<tr>
<td>Puebla</td>
<td>78.7</td>
<td>72.2</td>
<td>73.8</td>
<td>38.8</td>
<td>59.9</td>
<td>75.0</td>
<td>50.2</td>
<td>51.3</td>
</tr>
<tr>
<td>Veracruz</td>
<td>90.2</td>
<td>83.3</td>
<td>86.7</td>
<td>50.5</td>
<td>75.1</td>
<td>88.1</td>
<td>66.7</td>
<td>57.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>88.1</td>
<td>81.6</td>
<td>82.9</td>
<td>48.9</td>
<td>72.2</td>
<td>83.7</td>
<td>63.8</td>
<td>59.5</td>
</tr>
<tr>
<td><strong>ENADID 1997</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiapas</td>
<td>82.9</td>
<td>78.8</td>
<td>81.9</td>
<td>43.7</td>
<td>72.4</td>
<td>81.1</td>
<td>60.1</td>
<td>51.0</td>
</tr>
<tr>
<td>Guanajuato</td>
<td>92.3</td>
<td>87.4</td>
<td>84.6</td>
<td>53.3</td>
<td>91.2</td>
<td>88.7</td>
<td>79.3</td>
<td>73.6</td>
</tr>
<tr>
<td>Guerrero</td>
<td>85.9</td>
<td>78.6</td>
<td>83.4</td>
<td>48.0</td>
<td>77.4</td>
<td>79.8</td>
<td>68.3</td>
<td>59.4</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>88.2</td>
<td>85.6</td>
<td>85.0</td>
<td>50.7</td>
<td>81.6</td>
<td>85.2</td>
<td>72.4</td>
<td>58.3</td>
</tr>
<tr>
<td>México</td>
<td>94.8</td>
<td>92.5</td>
<td>92.6</td>
<td>66.6</td>
<td>93.4</td>
<td>89.9</td>
<td>85.3</td>
<td>75.3</td>
</tr>
<tr>
<td>Michoacán</td>
<td>92.0</td>
<td>88.6</td>
<td>83.6</td>
<td>45.7</td>
<td>85.5</td>
<td>82.0</td>
<td>69.1</td>
<td>63.3</td>
</tr>
<tr>
<td>Oaxaca</td>
<td>78.0</td>
<td>71.3</td>
<td>73.5</td>
<td>36.0</td>
<td>66.8</td>
<td>76.3</td>
<td>61.1</td>
<td>56.9</td>
</tr>
<tr>
<td>Puebla</td>
<td>86.5</td>
<td>83.2</td>
<td>82.6</td>
<td>47.7</td>
<td>79.0</td>
<td>84.9</td>
<td>72.4</td>
<td>64.1</td>
</tr>
<tr>
<td>Veracruz</td>
<td>94.8</td>
<td>89.8</td>
<td>91.2</td>
<td>53.2</td>
<td>87.8</td>
<td>92.3</td>
<td>79.3</td>
<td>67.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>90.5</td>
<td>86.6</td>
<td>86.7</td>
<td>53.6</td>
<td>85.2</td>
<td>86.5</td>
<td>75.8</td>
<td>66.8</td>
</tr>
</tbody>
</table>

Source: CONAPO estimations based on ENADID 1992 and 1997 and INEGI.
In 1992, one-fifth of Mexican women in a union who did not wish to have more children did not use any family planning method because they did not know about the existence of methods, how to use them, or where to obtain them. In 1997, this percentage had decreased to 16 percent. In the priority states, the figures were 25 percent and 20 percent, respectively. By 1997, there were no women in the priority states who did not know of at least one source of contraception. Accordingly, it can be concluded that, in 1997, when a woman knew about the existence of a family planning method, she also knew where to obtain it.\(^4\)

The public sector, partly with support from USAID’s CAs, gave considerable attention to information, education, and communication (IEC) activities designed to improve access to family planning services. It appears, from the knowledge level measured in 1997, that these IEC efforts were successful.

**Improved Quality of Public-Sector Services**

While improving service quality was an objective of USAID-Mexican collaboration from 1992 through 1999, the public-sector institutions waged a truly impressive effort beginning in 1996. In part stemming from a candid recognition that particular aspects of service quality needed attention, the commitment on the part of IMSS, SSA, and ISSSTE was a highlight of this collaboration.\(^4\)

If clients perceive services to be of good quality, they are more likely to accept and continue to use these services. Increases in new users of family planning services in the priority states presumably resulted from efforts not only to increase the accessibility of services but also to improve their quality. Several factors contributed to the increased quality of family planning services offered in the priority states during the USAID-Mexico program:

- improved technical competence of staff;
- improved interpersonal communication skills;
- increased choice of contraceptive methods;
- more substantial information given to clients; and
- greater emphasis on providing an appropriate constellation of services.

**Improved Technical Competence of Staff**

One of the first steps the Mexican government took to improve the quality of services was to produce an up-to-date set of service delivery norms for family planning. This effort was undertaken by an inter-institutional committee composed of public and private institutions that provided reproductive health services, including family planning NGOs and women’s groups. In 1994, the SSA published the Official Norm (Norma Oficial Mexicana de los Servicios de Planificación Familiar). While the norms were the product of an entirely Mexican initiative, USAID’s CAs and the World Health Organization crafted guidelines and recommendations to


support the committee's work. SSA, IMSS, and ISSSTE dedicated considerable effort to disseminating the Official Norm and the USAID agreement helped fund the printing and distribution of these materials. Two key government policy documents prepared subsequently, “National Population Program for 1995-2000” and “Family Planning and Reproductive Health Program, 1995-2000,” were written in accordance with the Official Norm and both documents emphasized quality of care.

In addition to developing and disseminating the service delivery norms, the USAID-Mexican collaboration supported improved technical competence at IMSS, SSA, and ISSSTE in three areas: training, provision of equipment, and supervision.

The Mexican government’s goal was to train and update the skills of 100 percent of service providers in family planning and reproductive health in all the priority states. IMSS, SSA, and ISSSTE carried out a range of training activities to increase access to all contraceptive methods, but particularly the more effective methods (IUDs, female sterilization, and vasectomy). The two institutions with services in rural areas, SSA and IMSS-Solidaridad, conducted training activities to expand access to reproductive health and family planning services in rural areas and among indigenous groups. These training activities were conducted with the assistance of the Cooperating Agencies.

From 1992 to March 1999, the number of public-sector providers trained was 68,624. About 40 percent of those providers received training in counseling and informed consent, and nearly two-thirds of the trainees in this topic were from IMSS. Another nearly 30 percent of those providers received training in topics related to family planning, maternal-child health, and reproductive health. In terms of reaching the Mexican government’s goal of 100 percent of staff trained, ISSSTE and IMSS advanced the farthest toward this goal, with 38 and 42 percent, respectively, of staff trained. However, it is important to take into account that, because individuals could have been trained in more than one topic, these figures are only approximate (see Table 17).
Table 17. Summary of Training Activities at IMSS, SSA, and ISSSTE Supported by the USAID-Mexico Agreement, 1992 to March 1999

<table>
<thead>
<tr>
<th>Topic</th>
<th>IMSS</th>
<th>SSA</th>
<th>ISSSTE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>FP/MCH/RH^2</td>
<td>14,163</td>
<td>2,245</td>
<td>3,499</td>
<td>19,907</td>
</tr>
<tr>
<td>Adolescent RH</td>
<td>8,762</td>
<td>619</td>
<td>214</td>
<td>9,595</td>
</tr>
<tr>
<td>Counseling &amp; Informed Consent</td>
<td>17,446</td>
<td>4,291</td>
<td>4,999</td>
<td>26,736</td>
</tr>
<tr>
<td>IUD</td>
<td>4,478</td>
<td>342</td>
<td>1,337</td>
<td>6,157</td>
</tr>
<tr>
<td>BTO^3</td>
<td>882</td>
<td>---</td>
<td>188</td>
<td>1,070</td>
</tr>
<tr>
<td>NSV</td>
<td>714</td>
<td>643</td>
<td>298</td>
<td>1,655</td>
</tr>
<tr>
<td>Other^4</td>
<td>1,686</td>
<td>336</td>
<td>1,482</td>
<td>3,504</td>
</tr>
<tr>
<td>Total number of service providers^5</td>
<td>114,824</td>
<td>93,800</td>
<td>31,727</td>
<td>240,351</td>
</tr>
<tr>
<td>Total number trained</td>
<td>48,131</td>
<td>8,476</td>
<td>12,017</td>
<td>68,624</td>
</tr>
<tr>
<td>Total percent trained</td>
<td>42 %</td>
<td>9 %</td>
<td>38 %</td>
<td>29 %</td>
</tr>
</tbody>
</table>


Much of the training occurred in the priority states, but providers in other states also were trained. For example, about two-thirds of the total providers trained in mini-laparotomy using local anesthesia and no-scalpel vasectomy by AVSC in Fiscal Year 1997 were from nonpriority states. Training was extended beyond the priority states to ensure that the learned skills would be spread throughout the institutions. Provider training included preparing training curricula and manuals at each of the institutions in the following areas: reproductive health, family planning counseling, IUDs, no-scalpel vasectomy, minilaparotomy using local anesthesia (BTO), counseling, informed consent, and adolescent reproductive health (see Box 3). In general, the training curricula and manuals were prepared using internationally developed materials provided by the USAID CAs.

---

^50 The training statistics included in this table are based on records of AVSC and Pathfinder. They are complete except for one quarter (June 1996 to September 1996) for Pathfinder.

^51 These topics were taught in numerous courses for a variety of service providers including doctors, nurses, midwives, social workers, community-based distributors, traditional birth attendants, peer educators, and others.

^52 This topic includes training in cervical cancer and precursor vaginal diseases, sexually transmitted disease (STD)/HIV prevention, postabortion care, and quality improvement (COPE), among other subjects.

^53 About half of the training counted here includes in-reach for both female and male sterilization.

^54 "Other" includes training in injectables, evaluation, information, education and communication, breastfeeding, STDs/HIV, postabortion care, cervical cancer and prevention of vaginal diseases, inreach for sterilization, and quality improvement (COPE).


^56 Family doctors, Ob/Gyn nurses, and social workers. This number doesn't include 10,784 doctors and nurses from IMSS-Solidaridad.

^57 General practitioners, Ob/Gyn nurses, social workers, community promoters, and general practitioners in social service.

^58 Family doctors, Ob/Gyn nurses, and social workers.
**Box 3.**

**SUMMARY OF TRAINING CURRICULA AND MATERIALS BY PUBLIC-SECTOR INSTITUTION, SUBJECT, AND TYPE OF MATERIAL SUPPORTED BY THE USAID-MEXICO AGREEMENT, 1992 TO 1999**

<table>
<thead>
<tr>
<th>Type of material</th>
<th>RH</th>
<th>FP</th>
<th>IUD</th>
<th>NSV</th>
<th>BTO</th>
<th>Counseling</th>
<th>Informed consent</th>
<th>Adolescents</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMSS</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manuals</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Didactic packages</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Guidelines</td>
<td>7</td>
<td>2</td>
<td>1</td>
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<td>1</td>
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<tr>
<td>Total</td>
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<td>3</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>SSA</td>
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<td>ISSSTE</td>
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<td>Didactic packages</td>
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<td>Guidelines</td>
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In the framework of the USAID-Mexico collaboration strategy, equipment was allocated to institutions with two central objectives:

a) To increase the technical capacity of service providers by the acquisition of teaching equipment, in particular, pelvic models and pregnancy simulators. Institutional and community personnel benefited from this equipment in terms of improved IUD insertion technique and improved pregnancy and partum care. Approximately 2,100 sets of equipment were acquired, and approximately 30 percent of the medical units in priority states benefited.

b) To increase the supply of modern methods and increase the quality of these services by means of the acquisition of equipment for IUD insertion, and for the performance of BTO and NSV. A total of 5,936 IUD insertion kits were purchased, along with 1,465 kits for BTO and 1,600 material items for no-scalpel vasectomy, such as May tables and Li forceps. Approximately 80 percent of all medical units in the priority states received IUD kits, and approximately 20 percent received BTO and no-scalpel vasectomy equipment.59

**Improved Interpersonal Communication Skills**

Efforts to strengthen interpersonal communication skills were carried out through the development of counseling curricula and training. The Official Norm mandated counseling as an integral part of quality care, and a strong commitment to counseling was adopted at all three institutions. A substantial part of the training of doctors, nurses, and midwives that occurred at IMSS, SSA, and ISSSTE addressed counseling and interpersonal communication skills.

**Increased Choice of Contraceptive Methods**

The Official Norm delineated a wide range of contraceptive methods for inclusion in the “menu” of methods offered by public health institutions. The range of methods available at the three institutions included female sterilization (BTO), vasectomy, oral contraceptives, injectables, and condoms. Norplant® was available at a limited number of IMSS and ISSSTE service delivery units.

The range, quality, and accessibility of contraceptive methods improved significantly through the introduction of new technology and training. In part with USAID population assistance, two enhanced methods of voluntary surgical contraception were first introduced in the public sector: no-scalpel vasectomy (in 1989 at IMSS and in 1991 at SSA and ISSSTE) and minilaparotomy under local anesthesia (in 1990 at IMSS).

No-scalpel vasectomy can be offered at the primary-care level because it does not involve a surgical procedure, is more easily provided. NSV is easier to perform, less costly, less painful, and generally more acceptable than traditional vasectomy, which involves incisions with a scalpel. The idea of teaching service providers to perform no-scalpel vasectomy was initially met with resistance because it was believed that Mexican men would not accept this method. Nonetheless, no-scalpel vasectomy is now provided nationally and acceptance is increasing, although the number of acceptors is still relatively small. The newer procedure for female sterilization, minilaparotomy performed with local anesthesia, is also simpler and more easily provided than traditional tubal ligation, since it uses local rather than general anesthesia.

USAID assistance also helped increase access to hormonal methods, the IUD, and post-obstetric contraception by providing technical support to the public-sector institutions to offer these methods. As a result of a successful pilot project supported by USAID and implemented by the SSA to offer post-obstetric services, by 1997 the SSA was offering postpartum and some postabortion family planning services nationally.60

One of the most significant interventions that USAID supported to expand method choice was the training of rural-based nonphysicians in family planning, with an emphasis on IUD insertion. IMSS medical auxiliaries in rural areas and SSA nurses were trained. Table 18 shows the significant increase in the number of women, at IMSS-Solidaridad facilities in rural areas, who elected to use an IUD, an increase from 63,000 in 1992 to 168,000 in 1998.

Table 18. Trends in the Number of New IUD Acceptors from Rural Areas for Selected States,* 1992 to 1998, IMSS-Solidaridad

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of New IUD Acceptors</th>
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<tbody>
<tr>
<td>1992</td>
<td>63,786</td>
</tr>
<tr>
<td>1993</td>
<td>84,930</td>
</tr>
<tr>
<td>1994</td>
<td>102,701</td>
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<tr>
<td>1995</td>
<td>127,490</td>
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<tr>
<td>1996</td>
<td>158,727</td>
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<tr>
<td>1997</td>
<td>154,590</td>
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<tr>
<td>1998</td>
<td>168,353</td>
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* The selected states are Chiapas, Guanajuato, Guerrero, Hidalgo, Mexico, Michoacan, Oaxaca, Puebla, San Luis Potosi, Tamaulipas, Veracruz, and Zacatecas.

Source: IMSS, 1999.

During the 1990s, training in Norplant® insertion and removal was initiated following introductory clinical trials. Beginning in 1997, an effort was undertaken through the private sector to increase information about emergency contraception using different mass and interpersonal media in Mexico.61 This effort demonstrated that emergency contraception was well accepted by clients who needed it and that a variety of communication strategies could be used to disseminate information about emergency contraception to private physicians, pharmacists, and university students.

60 Pérez-Palacios, G., 1997.
Information Given to Clients

The USAID-Mexico agreement focused considerable attention on developing IEC materials on family planning for providers and clients, and especially on supporting counseling of clients. The IEC materials were designed to allow service providers to offer more information to clients in different forms and in a more systematic way. Materials for service providers included teaching manuals, posters, videos, clinical case cards, and clinical guides. For users, there were samples of contraceptive methods, videos, large and small flip charts, pamphlets, booklets, flyers, and posters.

Field visits to a number of service delivery points in the priority states in 1996 and again in 1998 found numerous IEC materials for clients, but concluded that quantities of some materials were insufficient and that the system for disseminating IEC materials needed strengthening. An evaluation of IEC materials in reproductive health at IMSS in 1999 showed that clients viewed the materials favorably and shared them with parents, children, and friends. However, problems persisted in terms of the systematic and continuous distribution of the materials. Insufficient quantities of materials resulted in nurses and social workers designing their own, which is certainly laudatory but takes up valuable time, and also in a tendency by some staff to hoard what materials they had.

One key aspect of improving information involves securing clients' informed consent prior to their acceptance of contraceptive methods, in particular sterilization and IUD. Most women who use public-sector services in Mexico receive the information and counseling needed to make informed choices regarding contraception. Further, there is apparently general understanding among providers and clients that women have the right to a free decision about family planning. However, following allegations of IUD insertions or sterilizations of women without their prior knowledge and consent, concerted efforts were made to examine the extent of the problems and to correct them. Procedures on informed consent were reviewed at all public health institutions, and training for service providers in counseling and informed consent was also carried out.

Based on Mexican standards, information and counseling should be provided by all types of personnel as part of the services provided at all levels and to every person who solicits such services. By means of the USAID-Mexico collaboration, approximately 46,643 service providers were trained in counseling, family planning, and reproductive health. This figure represents one-third of all service providers in the priority states.

- In the SSA, significant efforts were made to inform health service users about their reproductive health rights, for which purpose flipcharts were produced with the help of Pathfinder Mexico. Procedures for obtaining informed consent were made uniform in the case of acceptors of permanent contraceptive methods. The SSA also issued a special publication about permanent contraception and conducted extensive training and supervisory

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63 IMSS, 1999.
64 Seltzer, et. al., 1997.
65 Brenes, V., et. al. 1998. and Potter, J., 1999. Potter also discusses the persistence of an interventionist style among providers in the public sector that undercuts the official norms on freedom of choice and informed consent.
visits on counseling and informed consent. This publication is directed to service providers and program managers and is also useful for decisionmakers, legislators, and organizations concerned about safeguarding reproductive rights.

- IMSS standardized its informed consent procedures for IUDs and female and male sterilization. Informed consent forms are required in all IMSS medical facilities, and more than 1 million revised forms were provided to the states. The form can be used for temporary as well as permanent methods. IMSS produced a guide on informed consent for service providers as well as a multi-media curriculum on informed consent, in January 1999, that was published and distributed to all delegations.

- At ISSSTE, informed consent is a widespread procedure, although different versions of the informed consent form are used across hospitals. A study of users and providers to assess the degree of compliance with informed consent found excellent compliance but recommended training to reinforce such norms.

The USAID-Mexico agreement also focused on the reproductive health IEC needs of underserved population groups. Greater understanding of the attitudes and opinions about reproductive health among adolescents from different indigenous ethnic groups suggested differing ways to conduct IEC programs. Presumably such understanding will have an impact on the future development of IEC efforts and materials for these groups.

**Appropriate Constellation of Services**

During the 1990s, significant progress was made in emphasizing the reproductive health context for family planning while at the same time focusing more attention on other aspects of reproductive health care. The discussion of Mexican population policy describes some key steps in this process that included reaffirmation of both demographic and health goals.

During the implementation period of the USAID-Mexico agreement, a number of norms on several aspects of women’s reproductive health, including the Official Family Planning Standard (SSA, 1993), were developed or reviewed. Standards that provide a legal and technical basis for program operation were also established for the following: Nutrition, Growth, and Development of the Child and Adolescent (SSA, 1993); Service Provision for Women During Pregnancy, Delivery, and the Postpartum Period and for Newborns (SSA, 1993); Sexually Transmitted Diseases (SSA, 1996); and Cervical Cancer (SSA, 1998). Mexico’s public-sector programs also encouraged increasing men’s involvement in family planning (for example, the considerable training of providers in no-scalpel vasectomy). The 1993 norm on the Prevention and Control of STDs and HIV/AIDS was considered obsolete in 1994 and abolished; a new norm was prepared and made public in March 2000.

67 IMSS, 1996.
70 Cabral, J., et. al., 1998.
Examples of training in reproductive health other than family planning included:

- STD prevention and management among providers at IMSS and SSA;
- cervical cancer screening (PAP smears) for SSA nurse supervisors in rural areas;
- monitoring health and pregnancy status of pregnant women and children under five years for SSA health auxiliaries; and
- prenatal, safe delivery, and postpartum care for traditional birth attendants at IMSS.

The Mexican Social Security Institute launched a strategy called “intensive actions” on reproductive health for outlying rural areas, to promote reproductive health services and identify reproductive and obstetric risks in women. During the project, 3,750 communities and 123,750 families were reached. To extend reproductive health actions to marginal urban areas covered by IMSS, a national campaign focused on promotion and service provision activities, with promotion mainly aimed at families through household visits. A reproductive health module was installed to provide counseling, family planning services, and cervical and breast cancer screening.

The SSA implemented a range of strategies to adapt the Reproductive Health Program to indigenous communities, in order to benefit the various ethnic groups in Mexico while respecting cultural and traditional values held by the indigenous populations.

**Strategies aimed at adolescents.** The adolescent population is considered a priority group for attention in Mexico. Its importance is due, in part, to its size (23 percent of the population) but also to the magnitude and implications of the reproductive health problems confronted by this population, such as early and unwanted pregnancy and sexually transmitted diseases including HIV/AIDS. Aware of the importance of such problems, all of the institutions involved in the USAID-Mexico collaboration incorporated the development of activities oriented toward the sexual and reproductive health of adolescents, with the shared objective of preventing unwanted pregnancies and sexually transmitted diseases. The activities conducted by each institution are described below.

The SSA developed the Program for Attention to Adolescent Sexual and Reproductive Health. This program, based on an integrated model that included service provision, IEC, training, and evaluation, established modules for focusing on adolescents in SSA health centers and hospitals. In these modules, counseling, reproductive health and family planning services, and psychological attention were provided. The SSA program included an evaluation study to measure the impact of its model of attention and to gather feedback on programmatic actions.

The IMSS developed three central strategies targeted to adolescents:

1. A strategy aimed at the urban population in general called “To Be Young: A Commitment Forever,” through which providers of reproductive health services for adolescents were trained;
2. A strategy aimed at the urban poor population and developed jointly with MEXFAM, a central component of which was the conduct of IEC activities aimed at encouraging community participation in reproductive health care; and

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71 Seltzer, et. al., 1997.
3. A strategy aimed at the rural and indigenous population, implemented through service units and the network of IMSS-Solidaridad community personnel, in which the central activities within this strategy were personnel training and research on rural adolescents, carried out with the technical support of INOPAL and the Population Council.

The ISSSTE supported the further development of an institutional program that aimed to structure, organize, and provide coherence to actions directed at adolescents. The general objective of the program was to improve the sexual and reproductive health of adolescents by preventing unwanted pregnancies and sexually transmitted diseases. Training of institutional personnel for attention to adolescents was one of the central strategies implemented by the ISSSTE.

CONAPO carried out a series of communication activities aimed at adolescents, with three central objectives: 1) to help raise the age of union and first pregnancy; 2) to increase the adolescent population's access to information related to reproductive health care; and 3) to encourage the development of a positive approach to family planning and reproductive health. With these aims in mind, several activities were undertaken, including the profusion of radio and TV messages designed for adolescents, within the campaign entitled “Plan your family, It’s a matter of wanting to”; and the implementation of an information strategy using the telephone information service “Planificatel.” CONAPO also elaborated eight “cuadernos” (booklets) for adolescents and couples of reproductive age. The topics of this material were: adolescence and life course, population, contraceptive methods, network of services, life project and family planning, citizenship, and family and couple relationships. Within the Inter-Institutional Committee on Family Planning, a flipchart on adolescence was designed among the health sector institutions and under the coordination of CONAPO.

The activities conducted by each institution allowed for significant progress in attending to adolescent reproductive health, the main features of which were:

- Existing institutional programs for adolescents were reinforced, and programs for adolescents were implemented in institutions where they had not existed previously.
- Access to services for adolescents was extended in the main institutions at a national level. For example, in the SSA, service for adolescents increased from 33 modules in 1993 to 259 modules in 1998.
- The quality of services for adolescents was increased as a result of two central strategies: a) the technical competence of service providers and community personnel was increased through training in providing sexual and reproductive health care to adolescents, with approximately 12 percent of all health-care personnel in the priority states receiving training; and b) a wide range of IEC materials aimed at service providers and the adolescent population was produced and distributed.72

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Pathfinder SDES documentation, 1999.
Service Delivery Operations and USAID-Supported Technical Assistance

Service delivery operations are the building blocks of a family planning program, including management, training, commodities and logistics, IEC activities, and research and evaluation. Their strength collectively determines the adequacy of the overall family planning program. Provided below are examples of how USAID-supported technical assistance contributed to the improvement of service delivery operations. The interests and priorities of each public-sector institution are the primary determinant of any technical assistance effort; however, the institution and the CA usually negotiate the best package of assistance, given the needs of the institution and the expertise of the CA. Pathfinder served a unique role: it coordinated the disbursement of funds for public-sector assistance and took part in program monitoring and evaluation. While other CAs provided specialized technical assistance, Pathfinder facilitated the public-sector institutions obtaining the assistance of the CAs in virtually all areas of service delivery operations.

Management

Management is an essential component of service delivery operations. It encompasses a program’s mission, planning including strategic planning, organizational structure, human resources, monitoring and evaluation, and finance, among others. Only a few of these areas are illustrated here since the predominant focus of USAID assistance to the public sector was in aspects of service delivery operations other than management.

Annual evaluation meetings. For a number of years, each of the three public service institutions conducted annual evaluation meetings with the state-level coordinators from each of the priority states. For example, IMSS held its 19th such meeting at the end of 1998; ISSSTE conducted them beginning in 1990, when its Family Planning department was created; similarly, SSA held such meetings from 1985 on. USAID support for these meetings enabled the institutions to broaden their agendas and include more participants. The meetings were useful in highlighting program issues (such as integrating reproductive health and family planning) and updating staff on management matters such as evaluation and logistics. Each institution planned to continue the meetings with internal budget support.73

Continuous improvement program at the SSA. From 1994 to 1998, the Ministry of Health carried out, on a pilot basis, the Continuous Quality Improvement (Programa de Mejora Continua, or CQI) program. The three principles of CQI are 1) focusing on clients’ needs, 2) working in teams, and 3) analyzing processes. The program was introduced with the assistance of the USAID-funded CA, Management Sciences for Health (MSH), under the Family Planning Management Development (FPMD) project. The pilot program created a central-level quality monitoring unit in the SSA’s General Directorate of Reproductive Health (DGSR) and also tested a decentralized intervention at service delivery operating units, including hospitals and health centers in three states. The most successful intervention—at the State Women’s Hospital in Coahuila—transformed the quality of care by engaging medical service staff, local health workers, and service unit administrators in the CQI process. The SSA and MSH jointly prepared an implementation manual for continuous quality improvement in health services. The SSA used

the manual for training and a final version of the manual was completed in March 1999, but the manual had not yet been published when this report went to press. The SSA hoped eventually to use the manual to implement a “quality accreditation strategy” for primary care facilities based on the baby-friendly hospital initiative supported by the United Nations International Children’s Emergency Fund (UNICEF). (A 12-step implementation process is described in the section of this report that discusses lessons learned.)

In the Gonzalez Neighborhood Urban Health Center in Saltillo, Coahuila, waiting time was reduced significantly. In 1996, the maximum waiting time for a health center user was estimated at five hours, but in 1997, one year after implementation of CQI, the maximum waiting time had been reduced by one hour. On the other hand, postobstetric-event contraceptive coverage in the Coahuila State Women’s Hospital in 1996 was 27 percent, and one year later that coverage had increased to 68 percent. These figures indicate the importance of the continuous improvement program at the state level.

**Estimating service delivery costs at the SSA.** The SSA’s Reproductive Health General Directorate launched a study in 1996 with the assistance of Family Health International, the general objective of which was to estimate the direct costs of family planning services offered by the institution. The study compiled figures on productivity by service provider and on unit costs per user, which permitted (a) development of financial optimization strategies for the institution’s medical units, (b) determination of investment requirements under various scenarios to increase service coverage, and (c) forecasting of the implications of possible changes in the distribution of contraceptive methods provided by the SSA. The main results and the methodology of the study were published in 1999 in *Family Planning Perspectives International* magazine, thus providing international dissemination of the study’s results.

**Training**

This report has already described many of the training activities at the three public-sector institutions in the discussion on improving access and quality of services. Below are additional examples of training undertaken with two USAID-supported CAs, AVSC and INTRAH (through the PRIME project), which, along with Pathfinder, were the main agencies supporting technical activities in Mexico.

**Counseling training at IMSS, SSA, and ISSSTE.** From 1993 through 1999, public health institutions implemented training programs of public-sector service providers in counseling to better address the needs of users, to involve couples and men in family planning, and to ensure informed consent of family planning clients. This training was supported by Pathfinder and AVSC.

- From 1993 to 1999, nearly 4,291 SSA staff from the priority states attended training courses on counseling. Included among the SSA staff trained in counseling were providers of postpartum and postabortion family planning and vasectomy services.

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75 Hubacher, D. et. al., 1997.
77 DeMaria, L., 1998.
Among ISSSTE staff, about 4,999 providers (mostly doctors and nurses) were trained in counseling and informed choice and consent from 1993 to 1999.

At IMSS, approximately 17,446 service providers were trained, including family doctors, obstetricians/gynecologists, nurses, social workers, and state-level coordinators in reproductive health. Through the end of 1995, more than half of the trainees were nurses and social workers. However, because family planning clients tended to see physicians for services, from 1996 on more emphasis was placed on training physicians in counseling skills. This counseling training consisted of a 40-hour, five-day course that covered reproductive health, counseling techniques, STDs, and adult education techniques.

In 1998 and with technical and financial support provided under the USAID-Mexico agreement, IMSS conducted a qualitative study to determine the effect of this counseling training on the quality of its reproductive health services. The results showed that women clients generally found the services provided by social workers and physicians to be quite adequate. The study made various suggestions to improve the impact of the training.78

Establishment of training centers at SSA. With USAID assistance, the SSA established 47 centers for training in the no-scalpel vasectomy technique, as well as 104 attention modules; as a result, by the end of 1998, 151 equipped units offered NSV and the number of vasectomies increased from 736 in 1990 to 5,197 in 1998. In addition, post-obstetric-event contraceptive service was extended to practically all the institution’s medical units offering obstetric care. As a result, post-obstetric-event contraception increased from 18.1 percent in 1992 to 42.6 percent in 1998.79

Training models at IMSS. The IMSS carried out provider training physicians, nurses, health auxiliaries, and traditional birth attendants, with the support of AVSC. These activities emphasized establishing a network of trainers (following a cascade training-of-trainers model) charged with replicating and extending counseling training and who could expand capacity building exponentially. This model started training at the top or central level, proceeded to the delegation level, and then provided training to primary-level service providers. By the end of 1997, 249 of the 5,401 IMSS service providers were trained, with technical support from AVSC, as trainers in counseling for reproductive health.80 In an effort to encourage replication of provider training, in 1997 the reproductive health directorate of the SSA planned to offer counseling training to other directorates in the SSA.81

IMSS and the PRIME project provided another approach to improve training among primary-level providers at IMSS. A pilot project started in 1997 used an integrated approach to reproductive health training, referred to as “inverting the pyramid” because the primary providers are trained first, forming the base of a pyramid of service providers. The IMSS-PRIME model used a participatory, client-centered training methodology. As of mid-1999, four training networks had been established in three states: Puebla, Tlaxcala, and Guanajuato. These training networks were both multidisciplinary (with family physicians, nurses, and social workers as participants) and multilevel, with 84 percent of the participants from the primary

79 Data provided by SSA, 2000.
80 Juárez, C., and DeMaria, L., 1998.
81 Pérez-Palacios, G., 1997.
level and 16 percent from the central and delegation (state) levels. IMSS planned to expand use of the training model throughout their entire system of 1,570 Family Medical Units.\textsuperscript{82}

**Commodities and Logistics**

The systems that ensure that SDPs receive adequate quantities of contraceptives and related supplies directly affect the quality and accessibility of family planning services. In the public sector, USAID assistance through the Family Planning Logistics Management (FPLM) project of John Snow, Inc., supported improvement of the system for contraceptive logistics management at IMSS and SSA. The six principles or “rights” of a good logistics system that formed the basis for the assistance are: “the right goods in the right quantities in the right condition to the right place at the right time and at the right cost.”

FPLM’s support to IMSS included direct technical assistance in designing and improving the logistics information systems, forecasting contraceptive requirements, improving warehouse conditions, and assisting the SSA in working with donors and adjusting to changes caused by decentralization. An evaluation of the new logistics system at IMSS found that use of the new information system to manage supplies was appropriate and that the management of contraceptive supplies was now adequate in the majority of IMSS facilities. This finding was reached despite the fact that the training reached staff (administrative, medical, and supply facility managers) in only about 40 percent of IMSS hospitals and family medicine units. The evaluation included numerous specific recommendations to ensure the proper functioning of the new system and to encourage ongoing improvements throughout IMSS.\textsuperscript{83}

FPLM provided logistics training in the priority states so that officials and staff would be prepared to maintain the logistics system in the face of the major changes anticipated with decentralization. Because of the timing, the FPLM-IMSS strategy was significantly different from the FPLM-SSA strategy: SSA-DGSR stopped receiving USAID-donated products in 1992, so the logistics workshops took place between 1990 and 1992 and decentralization began in 1997. On the other hand, while IMSS also stopped receiving USAID-donated products in 1992, FPLM worked with IMSS on training and information system design and implementation in 1996, finishing in 1998. This helped prepare IMSS to face the decentralization process.

In the period 1993 to 1995, the Reproductive Health General Directorate conducted a logistics training program with the technical assistance of John Snow, Inc., aimed at reinforcing the SSA contraceptives logistics system and helping to ensure timely availability of these kinds of inputs in all of the health centers. As a result of this activity, 520 health professionals were trained in 17 courses. Evaluation of this training, conducted in six states, indicated significant progress in the administration of the SSA contraceptives logistical system, mainly in the supply process. In the majority of state and jurisdictional supply centers, maximum and minimum desirable stock quantities were established, storage conditions were improved considerably, and coordination was strengthened among individuals responsible for program implementation and those responsible for supply.

In terms of contraceptive commodities, the public-sector institutions made considerable progress toward achieving self reliance, and the USAID-Mexico agreement may have provided the

\textsuperscript{82} Catotti, D.N., 1999. Family Medical Units are the IMSS first-level facilities in urban areas.

\textsuperscript{83} IMSS and FPLM /JSI, 1999.
leverage for these institutions to obtain the necessary funding from the Ministry of Finance. From 1992 to 1995, the Mexican government increased the share of commodities it purchased for the public sector from 25 percent to nearly 100 percent. By the end of 1999, all public-sector health institutions were purchasing all of their contraceptive commodities on their own.

**Information, Education, and Communication**

IEC was an important component of USAID's population strategy in Mexico. The public-sector institutions carried out IEC activities to empower users to make informed reproductive health choices. These activities were also designed to improve fertility awareness and to increase service use; at the service level, these activities were intended to improve quality of care by enhancing counseling, facilitating more equitable communication between clients and providers, and providing "high-quality, credible materials for use by providers with specific population groups." Some CAs provided technical assistance to the IEC activities carried out under the USAID-Mexico program, specially through Pathfinder and PCSIJHU. For instance, the SSA carried out IEC-related activities to enhance their program image and as a way of marketing their services, thus creating and promoting a new corporate image using IEC. Due to the extent and variety of IEC activities, only key efforts are highlighted below.

**Institutionalization of IEC capabilities.** JHU/PCS took a strategic approach to helping institutionalize IEC capabilities. This approach involved the Mexican public-sector institutions in audience research and materials pretesting, strategic planning, and the transfer of IEC capabilities. For example, CONAPO conducted audience research and field studies in preparation for its mass media campaign and thereafter produced an integrated communication strategy. JHU/PCS provided some technical assistance to ISSSTE to conduct audience research to identify IEC needs, to update existing materials, and to design an IEC plan. The Reproductive Health General Directorate of SSA received technical assistance to develop strategies in IEC that contributed to publicizing and making operational, in a relatively short period of time, the concept, mission, and components of reproductive health. IEC materials for service providers and the population also were developed. These materials were based on focus groups that represented Mexico's cultural and ethnic diversity.

**Mass media campaigns.** CONAPO launched its mass media campaign, "Planifica, es cuestión de querer," ("Plan Your Family; It's a Matter of Wanting to") to increase awareness of informed choice and to encourage communication between partners about reproductive health. Specific messages in the initial phases of the campaign centered on delaying age of marriage and first pregnancy, ensuring adequate birth spacing, and reducing fertility at older ages. JHU/PCS provided technical support to CONAPO during the planning, monitoring, and evaluation stages of this effort. The SSA and JHU/PCS also worked together as the SSA carried out several activities to build awareness of reproductive health among rural populations and adolescent populations through billboards, radio spots, booklets, and posters.

To evaluate the impact of this mass media campaign, CONAPO carried out a survey in 1996 (Encuesta de Comunicación en Planificación Familiar). Based on this survey, a multivariate analysis revealed significant increases in fertility awareness and informed choice.

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86 Pérez-Palacios, G., 1997.
87 SSA, 1997.
analysis exercise was performed controlling for several characteristics of the socioeconomic context, the institutional influence of education and access to health services; life course factors such as age, parity, and marital status; and social interaction networks on family planning. Results showed a significant (30 percent) increase in positive attitudes toward family planning among respondents who remembered the campaign, even when results were controlled for a variety of socioeconomic factors. In addition, respondents who were aware of the campaign were 2.5 times more likely to recognize that family planning health services are cost-free. The degree of recall of the campaign increased between 1995 (when a national Family Planning Survey was carried out by CONAPO, also supported by USAID) and 1996: 58.3 percent of women interviewed had heard about the campaign the first year and 71.5 percent had heard of it one year later.

PLANIFICATEL. As part of its IEC actions, CONAPO designed an information and orientation telephone service on family planning, which was implemented together with IMSS in 1997. This service is called PLANIFICATEL and has as a main objective to facilitate the access of the population on reproductive age to information on family planning and reproductive health through a network of advisors, trained by CONAPO to answer by telephone the population’s inquiries. Within the context of this activity, the following materials were developed: a) The informative “carpeta” “PLANIFICATEL”; b) two radio spots and two TV spots to promote the services of this telephone information service.

Production of IEC materials. IMSS, SSA and ISSSTE collaborated on the production of materials and on information campaigns to ensure the consistency of messages and formats and to enhance the synergy of IEC efforts. Pathfinder played an important role in supporting the reproduction of numerous materials on a variety of topics related to family planning and reproductive health (see Table 19 below). Developed by public health institutions, the IEC materials were designed for clients and service providers in both rural and urban areas and were aimed at a variety of audiences such as service providers, fertile-age women, adolescents, indigenous populations, and men. A wide range of formats were used, including brochures, posters, flipcharts, manuals, clinical guides, and videos, and, between July 1993 and March 1999, more than 14 million IEC items were produced. During this same period, it is estimated that more than 15 million people were informed about family planning and reproductive health, 43 percent of whom were clients of SSA, 37 percent of whom were clients of IMSS, and 20 percent of whom were clients of ISSSTE.88 The public-sector institutions also created an exhaustive inventory of all IEC materials developed—including those developed with USAID assistance—and available at any of the Mexican partner institutions.89

89 Pathfinder, 1999.
Table 19. Topics and Formats of IEC Materials Produced by the Public Health Institutions in Mexico under the USAID-Mexico Agreement, 1992-1999

<table>
<thead>
<tr>
<th>Institution</th>
<th>Topic</th>
<th>Formats</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMSS</td>
<td>Adolescents, Communication, Contraceptive methods, Counseling and informed consent, Family planning, Institutional norms, Midwives, Reproductive health, Reproductive risk, Rural health, Surgical techniques</td>
<td>Brochures, Teaching kits, Clinical guides, Mini-flipcharts</td>
</tr>
<tr>
<td>ISSSTE</td>
<td>Contraceptive methods, Counseling and informed consent, Family planning, Promotion of services, Reproductive rights</td>
<td>Brochures, Clinical guides, Manuals, Posters</td>
</tr>
<tr>
<td>SSA</td>
<td>Adolescents, Contraceptive methods (cyclofem and no-scalpel vasectomy), Norms, Postpartum contraception, Reproductive rights</td>
<td>Brochures, Fliers, Posters, Radio spots</td>
</tr>
</tbody>
</table>

Source: Pathfinder Mexico, 1999.

About 280 different materials were produced, of which more than 14 million copies were distributed. Table 20 shows the distribution of the release by type of material.

Table 20. Number of IEC Materials Distributed, by Type of Material, 1992-1999

<table>
<thead>
<tr>
<th></th>
<th>Videos</th>
<th>Pamphlets and fliers</th>
<th>Posters and flip charts</th>
<th>Manuals</th>
<th>Radio spots</th>
<th>TV spots</th>
<th>Others</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9,368</td>
<td>6,805,087</td>
<td>6,710,826</td>
<td>150,635</td>
<td>61</td>
<td>14</td>
<td>341,097</td>
<td>14,017,088</td>
</tr>
</tbody>
</table>

Counseling for Adolescents. JHU/PCS assisted IMSS in designing a mobile stand for use in schools and public places to provide adolescents with confidential counseling in reproductive health and referrals to clinics. IMSS also received help developing a sex education counseling manual for service providers working with adolescents. An evaluation of the project after the first six months found significant improvements in the knowledge, attitudes, and behaviors of adolescents, including an increase in protected (versus unprotected) sexual intercourse.

IEC activities to improve access to services. To improve access to family planning services through IEC efforts, the SSA posted attractive signs on the outside of health auxiliary houses and the ISSSTE posted signs inside its facilities indicating which reproductive health services were provided. Such activities were very visible and appeared to have improved awareness of the source of services.

Research and Evaluation

In the framework of the USAID-Mexico assistance strategy, particular importance was placed on evaluation and research activities as being crucial for improvement of and feedback on family planning and reproductive health programs. Evaluation and research activities were aimed at gauging the accomplishment of objectives and goals of the assistance strategy as a whole, as well as identifying improvements in the performance of institutional programs, detecting needs, designing new strategies, and identifying potential forms of interinstitutional support.

The assistance strategy encompassed the following general goals:

1. To use elements of follow up, control, and evaluation already existing as part of institutional projects.
2. To use information from existing sociodemographic surveys and other studies.
3. To generate information by means of surveys and other kinds of studies, in order to analyze the results in terms of demographic indicators of health, social wellbeing, and service quality and in terms of identifying or deepening the knowledge of specific program aspects with the aim of improving their quality.

In its role as a standard-setting institution in technical matters related to population activities in Mexico, CONAPO was responsible for designing and implementing overall evaluation of the assistance strategy. For this reason, a specific evaluation project composed of various studies was implemented within CONAPO. In addition, each of the public service institutions incorporated a strong evaluation and research component within its institutional projects.

Results by general goals.

1. To utilize elements of follow up, control, and evaluation already existing as part of institutional projects. Following guidelines established by the Mexican family planning program, the SSA, the IMSS, and the ISSSTE compiled, among other indicators, data on the number of new acceptors disaggregated by area and types of contraceptive methods used by new acceptors; these data are particularly relevant for assessing institutional operations.

90 USAID/Mexico, 1998c.
2. To use information from existing sociodemographic surveys and other studies. The Mexican government conducted two national household surveys (in 1992 and 1997) that provide information on levels of and trends in fertility and contraceptive use. Some CAs prepared reports based on these surveys; for instance, the Population Council prepared a comprehensive analysis of family planning services that included recommendations to improve services.

3. To generate information by means of surveys and other kinds of studies. Production of information through surveys and other studies in each of the participating institutions was the main component of the evaluation and research activities. These efforts were highly supported under the USAID-Mexico strategy. In the following paragraphs, studies conducted in the framework of this strategy will be outlined, describing each overall objective by institution. Due to their variety and extensiveness, the developed studies will be mentioned but not described.

CONAPO. This institution conducted studies to evaluate the development of the USAID-Mexico assistance strategy as a whole. The primary purpose of this evaluation was to identify changes in family planning and reproductive health service coverage and quality in the nine priority states. The evaluation also sought to identify aspects of the programs that required reinforcement and to obtain elements to encourage demand for services. To reach these objectives, the following studies and surveys were undertaken:

- Study on reproductive behavior and communication;
- National Family Planning Survey, 1995;
- National Mexican Family Planning Institutions Survey, 1996;
- Family Planning Communication Survey, 1996;
- Three telephone surveys;
- A study on family planning service quality from the user perspective (in areas served by IMSS-Solidaridad); and
- Making family planning information systems.

IMSS. This institution incorporated an evaluation component into most of its strategies, which contributed to feedback on and improvement of these strategies. Studies focused on the deepening knowledge of the most difficult-to-access groups: adolescents, poor rural and urban populations, and men. The principal studies carried out were:

- Impact of midwife activities on family planning and reproductive health activities;
- Impact and development of reproductive health days;
- Impact and development of strategies in poor urban areas;
- Comparative study of IUD insertion by midwives and institutional personnel;
- Study on the acceptance of vasectomy among men;
- Study on perceptions and practices of adolescents in rural areas;
- Survey on Reproductive Health (ENSARE);
- Operational diagnosis of logistical systems and contraceptive products;
- Evaluation of IEC materials;
- Continuity in use of oral hormones and IUDs; and
- Current indications for performing cesarean operations.
SSA. Evaluation efforts undertaken by this institution were focused on two of its central strategies: the program for adolescents and interpersonal communication. Meanwhile, research efforts were oriented toward improving the understanding of reproductive behavior and service quality and were prioritized to focus on indigenous groups and the state of Chiapas. The SSA’s main studies were:

- Evaluation of the Program for Attention to Adolescent Sexual and Reproductive Health;
- Evaluation of the SSA interpersonal communication strategy;
- Audience studies;
- Study on the perception of the health-sickness process among indigenous communities;
- Survey on service quality in Chiapas;
- Evaluation of family planning activity costs; and
- Priority information on reproductive health.

ISSSTE. Evaluation and research activities within this institution began with an important effort to evaluate the impact of activities included the training of personnel. Significant efforts also were undertaken to encourage operational research at the state level. The most pertinent studies undertaken by ISSSTE were:

- Evaluation of the impact of reproductive health activities;
- Audience studies;
- Study on family planning services and timely detection of pre-eclampsia: strategies to improve services;
- A diagnostic study and programmatic intervention to improve service quality in postabortion care; and
- Use of community strategies to promote and provide family planning services in the state of Mexico.

The role of the Collaborative Agencies. Collaborative agencies played an important role not only by providing financial support but also by offering technical assistance to support evaluation and research activities. In this context, it is important to mention that the following CAs played a role in evaluation and research: the Population Council through the INOPAL and FRONTIERS projects, Pathfinder, Family Health International (FHI), AVSC, JH/PCS, and the Policy Project. Although all of these CAs performed an important role in evaluation and research activities, the efforts of Pathfinder and the Population Council are worth highlighting.

Pathfinder provided intensive technical assistance to evaluation and research studies to all participating institutions. With the aim of evaluating the USAID-Mexico assistance strategy, Pathfinder prepared three reports that present, in summary form, an analysis of the condition of family planning at the national level and in the priority states at three different phases of the assistance strategy’s implementation: the beginning (baseline), the intermediate phase, and the conclusion.

Primarily through the INOPAL project, the Population Council assisted the public-sector institutions through numerous operations research studies. These studies assessed the effectiveness of different pilot interventions, thus helping to identify successful approaches and to find out how to improve interventions prior to replicating and extending them to wider target populations. The studies covered such areas as service integration, assessment of reproductive
rights and informed consent procedures, and different approaches to increase access to and quality of services and information and contraceptive methods (for example, postabortion care and emergency contraception). Box 4 summarizes the main studies undertaken.

Other studies supported under the USAID-Mexico strategy.

**Rapid assessment of contraceptive prevalence at ISSSTE.** This methodology proved efficient in assessing contraceptive prevalence among the institution’s franchised population, identifying missed opportunities for reaching clients, and measuring the strength of family planning activities at service delivery points. The reduced cost of this rapid assessment technique makes it an attractive tool for program assessment, although conducting this assessment requires a significant time commitment by program administrators and substantial supervision.

**Testing the “family-friendly clinic” strategy at IMSS.** IMSS tested a “family-friendly clinic” strategy, based on UNICEF’s Mother and Child Friendly Hospital Certification Program, to improve the quality of reproductive health care at IMSS outpatient clinics. The documentation for this strategy is extensive and includes materials for training, communicating, and implementing the strategy.

**Testing a distance-learning strategy at IMSS’s rural program.** The rural program of IMSS (Solidaridad) carried out a pilot distance-learning project. Elements of the project included TV programs that were broadcast via satellite to dispersed rural and indigenous communities. The purpose of this strategy was to increase knowledge of reproductive health topics among rural and indigenous people. Results of an institutional assessment showed substantial increases in knowledge of contraceptives, STDs, and preventive behaviors.

**Acceptability and use-effectiveness of contraceptive methods.** For more than two decades, Family Health International conducted acceptability and use-effectiveness studies in Mexico. These studies looked at increasing the acceptability and use-effectiveness of male and female condoms and oral contraceptives, making IUD services more efficient and accessible, determining the time when vasectomy becomes fully effective, and improving the acceptability and efficacy of progestin-only contraceptive pills for breastfeeding women.

**Strategies for identifying underserved groups.** A CONAPO research activity supported by the POLICY Project was intended to identify strategies to meet unmet demand for family planning services in underserved areas. A data base created for the nine priority states combined geographic information (location and road systems) with sources of supply and demand for services. This methodology built on CONAPO’s strategy for identifying underserved populations and was intended to enable CONAPO and the public-sector institutions in rural areas, principally IMSS, to direct their service efforts more effectively.

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93 Population Council, 1999. It should be noted that IMSS has been using this assessment technique for a number of years.
96 Family Health International, 1996.
Starting in 1992, operations research using USAID-Mexico funds was conducted with the following objectives:

**ACCESS TO SERVICES**
Strengthen ISSSTE's reproductive health program components to increase the use of family planning and other reproductive health services by screening for the needs of clinic users, decreasing the high rate of cesarean sections, and helping clinics make the necessary changes in order to provide services to adolescents.

**QUALITY OF CARE AND INFORMED CONSENT**
- Assess the extent to which family planning and reproductive health service delivery norms were implemented in SSA health centers, assess the costs of these services, and observe the degree to which the Program of Action of the International Conference on Population and Development was adopted in primary health care services.
- Strengthen the reproductive rights of IMSS and ISSSTE clients and improve counseling and family planning services provided after obstetric events by assessing services during pregnancy, birth, and the postpartum period.
- Strengthen the reproductive rights of Mexican women by studying the legal instances in which women could redress a violation of their rights and making recommendations to improve these redress mechanisms.
- Improve the quality of care after miscarriages and incomplete abortions by testing strategies and medical techniques to provide improved medical care, pain management, counseling, and family planning methods.
- Study the costs involved in providing high-quality postabortion services in a public hospital in Oaxaca.
- Promote the systematic evolution of IMSS primary health clinics into “Family-Friendly Clinics” that met established benchmarks and offered consistently high-quality reproductive health services for different family members at different life stages.
- Introduce emergency contraception as an element in the care of victims of gender-based violence who report a rape to public agencies and feminist organizations, and conduct information campaigns on emergency contraception for service providers (pharmacists, private physicians, staff of health centers and clinics) and potential clients (young adults, women of fertile age, the general public).
- Improve the care of women by helping IMIFAP develop and test training modules to help service providers detect signs of partner violence among their clients, and by helping Afluentes develop training modules for providers on the delivery of client-centered, context-specific, high-quality services.

**SUSTAINABILITY**
- Improve the sustainability of MEXFAM and FEMAP by helping them produce more detailed information on costs, providing training in the analysis of cost information, and developing marketing strategies to meet the needs of wider segments of the public.
- Test the use of touch-screen technology at MEXFAM to increase the number of new users and to help clinic users select the full range of reproductive health services they need.

**IEC CAPABILITIES**
Identify the information needs of indigenous populations and develop effective information, education, and communication strategies with IMSS-Solidaridad to reduce early pregnancies among indigenous adolescents and young adults.

**RESEARCH AND EVALUATION CAPABILITIES**
Beyond helping to strengthen the operations research and evaluation capabilities of the Mexican partners through collaborating, an explicit effort was conducted to build the institutional capacity of ISSSTE to conduct operations research.

Monitoring. In the public sector, the USAID-Mexico agreement also provided assistance for monitoring many of the service delivery and quality of care improvements that were carried out at the three public-sector institutions. For example, AVSC records showed that it supported hundreds of site visits by institutional personnel to supervise service quality and the technical capacity of providers and to review the implementation of strategies and planned activities.\footnote{AVSC International, 1996a, b, and c; Juárez, C. and L. DeMaria, 1998.}

Evaluation and follow-up system of the quality of family planning services. The main objective was for CONAPO and the health institutions to design and implement an evaluation and follow-up system that would measure changes through time of selected service-quality variables. Health personnel can implement the system in the field and data processing was designed to be easy to handle.

Institutionalization of research and evaluation. Assistance from USAID-supported CAs also facilitated the institutionalization of research skills in the Mexican organizations. At the SSA, for example, the reproductive health directorate provided training in operations research to state-level staff and funded several operations research proposals at the state level. The directorate also sponsored state-level workshops on conducting evaluation studies and identifying evaluation indicators.\footnote{Population Council, 1995b.} An IMSS project to test a “family-friendly clinic” strategy included operations research as one of the 10 criteria for certification at its facilities and indicated an institutional commitment to such work.\footnote{Cardona, A. and A. Arreola, 1998.}

Although it is impossible to quantify the impact of the various evaluation and research efforts carried out by each of the participating institutions in the USAID-Mexico assistance strategy, it is possible to highlight the following relevant results:

- The technical capacity of participating institutions to undertake evaluation and research activities was strengthened.
- A useful archive of quantitative and qualitative information relating to various aspects of reproductive health and family planning was formed. The information is available in the final reports and documents prepared for these studies.
- Evaluation instruments and models have been designed in a rigorous manner to facilitate comparisons with other countries or regions.
- The study of priority groups—adolescents, rural and urban populations, and indigenous groups—was deepened.
- An extensive characterization of audiences will assist in the design of future IEC strategies and materials.

Mexican and U.S. officials recognize the considerable value of evaluation and research in bringing about significant improvements in access to and quality of public-sector services in Mexico. Furthermore, these officials generally acknowledge that USAID support and the CAs’ assistance served as a catalyst for innovations in service delivery.
SECTION 5
ACCOMPLISHMENTS IN FAMILY PLANNING AND REPRODUCTIVE HEALTH IN THE PRIVATE SECTOR, 1992-1999

While the public sector is the predominant provider of family planning services in Mexico, the private sector serves almost 30 percent of users. Pharmacies and other private services represent 16 and 13 percent, respectively, of this market. This section of the report concerns the two largest NGOs working in family planning, MEXFAM and FEMAP. Together they provide services to about three percent of the Mexican population. For many years, both have offered services to some of the poorest segments of Mexico’s population through their clinics and networks across the country.

During the 1990s, MEXFAM and FEMAP faced the challenge of how to become more sustainable. The USAID strategy for population assistance of 1992 contained specific objectives for achieving self-sufficiency in the private sector. These objectives included increasing domestic (Mexican) support for MEXFAM and FEMAP in both absolute and proportional terms, improving the organizations' income-generating capacity, and establishing mechanisms to ensure their long-term financial stability. Previously, the two organizations had received funding from USAID through a matching grants program administered by IPPF and technical assistance from other CAs. From 1992 to 1999, USAID’s strategy in the private sector focused on making these historically assistance-dependent organizations more self-sustaining. The NGOs had anticipated a gradual phase-out of assistance, but USAID pledged to provide support to make the transition smooth. The role of IPPF in assisting MEXFAM and FEMAP, both historically and in the last phase of USAID support, was a key component of the help received by each institution.

IPPF’s Transition Project

USAID provided assistance for decades to the private sector in Mexico, principally to MEXFAM and FEMAP. The level of assistance to MEXFAM in the 1988 to 1992 period averaged US$1.3 million per year, exclusive of commodities, and the level of assistance to FEMAP in this pre-transition period was about US$406,000 per year. The Transition Project emerged from USAID’s objective of helping to increase self-sufficiency among nongovernmental organizations in Latin America and the Caribbean. In Mexico, the project was USAID’s principal mechanism for the last phase of its assistance to the private sector, which was initially scheduled to end in June 1997 but was extended to September 1998.

IPPF’s Western Hemisphere region office implemented the Transition Project beginning in 1992 with a five-year budget of US$68.8 million for the entire Latin American region. Part of this funding was available to Mexico in addition to the assistance provided to the two NGOs by USAID-Mexico. During the 1992 to 1998 period, MEXFAM received US$9.1 million and FEMAP received US$5.4 million from USAID under the Transition Project. The average level of support provided to the two organizations was US$2.1 million a year. Both NGOs received additional support from USAID in the form of contraceptive commodities valued at almost US$1.8 million for MEXFAM and US$4.5 million for FEMAP and in the form of technical

102 Bowers, Cobb, and Wear, 1996.
assistance plus some funding from other USAID projects such as FPMD, SOMARC, and INOPAL.

The initial objectives of the Transition Project were broad. They included increasing access to family planning; expanding the range of contraceptive methods in settings where they were limited; strengthening institutional capacity of the NGOs to improve organizational efficiency and increase locally generated revenue, thus building their sustainability; developing strategies to improve and expand services; institutionalizing program and project evaluation; and disseminating results.

The Transition Project defined sustainability as “the ability to recover the cost of family planning services previously funded by USAID with local income and to continue to provide the same volume and quality of services to low-income populations.” Four of the indicators of sustainability used by the Transition Project were both general and ambitious, and only one of these concerned the organizations’ financial status—the ability to replace USAID funds with local income. The other indicators dealt with the volume of services provided, the ability to serve low-income populations, and the quality of services. About 1.5 years into the project, a USAID management review concluded that service expansion was incompatible with sustainability objectives. Even so, both NGOs and USAID continued to track the volume of services in terms of numbers of clients and couple-years of protection (CYP).

Support from the Transition Project enabled MEXFAM and FEMAP to continue their existing programs, although at times at a reduced scale for MEXFAM. At the same time, Transition Project support helped the two organizations develop and implement measures to replace USAID funding as it ended.

**Private-Sector Institutions**

**MEXFAM**

MEXFAM is the Mexican affiliate of the International Planned Parenthood Federation. Founded in 1965, it is devoted to “providing high quality and innovative services in family planning and reproductive health and sex education.” Headquartered in Mexico City, in 1999 MEXFAM had 35 operational centers in 25 states that carried out work in six program areas. Of the 35 centers, 14 offered clinics providing specialized reproductive health services, including laboratory services and eight of the clinics were equipped with operating rooms; MEXFAM’s other facilities were community consulting rooms, or consultorios. In 1999, MEXFAM estimated that its services reached more than 300,000 families and approximately 400,000 adolescents.

The following were MEXFAM’s six main intervention areas, the first five of which were called its “social programs”:

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103 "Couple-years of protection" is the estimated protection provided by contraception during a one-year period, based on the volume of all contraceptives sold or distributed to clients during that period of time.
104 The information in this section was obtained from Lopez-Juaréz, et. al., 1994; Bowers, Cobb, and Wear, 1996; and MEXFAM (no date).
A community physicians program that assisted private doctors in peri-urban communities to open and maintain small consultorios, or practices, in underserved, low-income, urban areas.

A community-based distribution program that used volunteers to promote family planning in their communities and to distribute pills, condoms, and vaginal tablets.

A factory-based program that provided information and contraceptives to workers in urban and peri-urban factories.

A youth program that carried out education activities for youth both in schools and at social and athletic centers and other gathering places for youth who have left school.

Cooperating programs through which MEXFAM collaborated with various government and private institutions by providing IEC materials and contraceptives.

Medical centers or clinic-based programs that provided a variety of medical services including family planning to clientele of middle and lower socioeconomic levels.

**FEMAP**

Founded in 1973, FEMAP’s mission is to “improve the quality of life for Mexico’s underprivileged population.” With headquarters in Ciudad Juarez, FEMAP has grown into a national federation with 44 affiliates active in 87 cities and thousands of rural communities throughout Mexico. The affiliates are administratively and financially independent, and the organization’s decentralized structure is considered one of its key features.

The following were FEMAP’s six main intervention areas in family planning:

- A community program for reproductive health and family planning carried out with more than 7,000 volunteers responsible for informing and educating users; providing oral contraceptive pills, condoms, and vaginal foaming tablets; and referring clients to FEMAP clinics and hospitals for clinical family planning methods.
- A reproductive health program for adolescents called Projuve-FEMAP, implemented through young peer educators in schools, work places, and the community. These young volunteers provided information, education, and some family planning and reproductive health services.
- An industry-based family planning program launched in 1979 and which covered more than 400 factories around the country.
- Community-based STD and HIV/AIDS prevention programs in the “red zones” of several cities and in the industrial sector.
- A contraceptive social marketing program that became the third largest source of income for FEMAP.
- A family planning program in 47 FEMAP clinics and seven FEMAP hospitals, which vary in size from 12 beds to 60 beds.

In addition, in 1999, FEMAP boasted an integrated model of community-based service delivery that included:

- Medical services carried out through its medical infrastructure (FEMAP provided an average of 1.2 million medical services to underserved populations);
- Environmental sanitation;
- Economic development through micro-enterprise activities and the establishment of community banks; and
- Home improvement and progressive housing projects.
Sustainability: Access and Financial Self-Sufficiency

MEXFAM and FEMAP used different approaches to address the challenges faced by the prospect of an end to USAID support of their programs. At the organizational level, financial sustainability is achieved when an organization continues providing services after traditional sources of donor funding have been reduced or withdrawn. Based on the financial objective defined by the Transition Project, the success of MEXFAM and FEMAP in moving toward sustainability is presented here in terms of their ability to replace USAID funds with local income. The results, described below, are based primarily on trends in income and sources of income.

**MEXFAM**

The story of MEXFAM's approach to sustainability is complex. It is based, in part, on the perception held by MEXFAM's leadership that donor support would continue beyond the end of the Transition Project. It was also based on the inherent difficulty of getting an organization that had been subsidized by donors (IPPF as well as USAID) for more than 25 years to alter its predominant social welfare mission and to incorporate goals, policies, and strategies that would lead to greater self-sufficiency. MEXFAM's approach to sustainability, beginning in 1992, was centered on an expansion of its medical centers program.

Key program characteristics of MEXFAM between 1992 and 1998 are presented in Table 21. MEXFAM's medical clinics were the centerpiece of its sustainability efforts. With assistance from the Transition Project, MEXFAM established a number of new medical centers to provide a broad range of health services, of which family planning was a minor part, to middle-class clients. With Transition Project support, the number of medical clinics increased by 12, from two in 1992 to 14 in 1998. The income generated from these clinics subsidized the five “social programs” of MEXFAM.

The number of community doctors associated with MEXFAM fluctuated, reaching 350 in 1995 and then declining to 250 in 1998. In 1996 and 1997, MEXFAM's sustainability strategy for community doctors involved providing equipment for consulting rooms and assistance for rent and other office expenses. After two years of this support, it was expected that community doctors would be self-sufficient. By 1998, MEXFAM stopped supporting community doctors and their numbers declined, because only those physicians reaching self-sufficiency were permitted to remain with MEXFAM. During the same period, community-based rural promoters, who had traditionally been a critical element in MEXFAM's outreach program, more than doubled in number.

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106 Since USAID was a major source of funding for IPPF over the years, some of the direct support from IPPF to MEXFAM was actually provided by USAID. In this discussion, however, the funding that MEXFAM received from IPPF is considered separate from USAID’s support of MEXFAM through the Transition Project.

<table>
<thead>
<tr>
<th></th>
<th>Number in 1992</th>
<th>Number in 1995</th>
<th>Number in 1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical clinics</td>
<td>2</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Community doctors</td>
<td>316</td>
<td>350</td>
<td>250</td>
</tr>
<tr>
<td>Rural, community-based promoters</td>
<td>955</td>
<td>1,200</td>
<td>2,000</td>
</tr>
<tr>
<td>New users of family planning</td>
<td>363,000 (1993)</td>
<td>293,099</td>
<td>383,472</td>
</tr>
<tr>
<td>Persons reached through I&amp;E on reproductive health</td>
<td>357,862</td>
<td>381,740</td>
<td>428,565</td>
</tr>
<tr>
<td>Medical services provided</td>
<td>34,581</td>
<td>361,467</td>
<td>618,343*</td>
</tr>
</tbody>
</table>

* The number of medical services shown in 1998 includes those provided by the new medical clinics established by MEXFAM.


The number of new users of MEXFAM services dropped between 1993 and 1996; this decrease is attributed to the fact that MEXFAM started charging fees for services and contraceptive methods rather than providing them free of cost. MEXFAM's strategy of selling services started gradually in 1992 and was part of an effort to make the institution financially sustainable. The initial charge was for service delivery—in effect a recovery fee—but there was no charge for contraceptives. Starting in 1997, MEXFAM began to charge for contraceptives as well. By 1998, the number of new users of family planning surpassed the 1993 numbers, suggesting that the program was again expanding its family planning clientele. Records on persons reached through the organization's information and education (I&E) efforts in sex education and reproductive health show increases from 1992 to 1998. MEXFAM's medical centers program showed the greatest increase in services provided during this period, achieving a service level of more than 600,000 in 1998. The emphasis on setting up medical centers was probably another reason for the decline in the number of family planning clients through 1996, although this trend began to shift upward in 1997.\textsuperscript{107}

Despite the decline in the number of new family planning clients, by 1997 MEXFAM was operating a number of new urban and rural community-based projects and adolescent reproductive health activities under the Transition Project. With USAID support from 1992 to 1997, MEXFAM established 17 community-based family planning sites in marginal urban areas (plus seven sites established with funds from other donors), 18 such projects in poor rural areas with scant other health services (plus 17 with other funds), and 14 sexual health projects for adolescents (plus 15 with other funds), including indigenous youth, rural teenagers, and street gang members.

\textsuperscript{107} USAID, 1998.
One of the Transition Project's sustainability indicators was the profile of the client population, which was used to gauge whether a low-income population was being served. In 1996, the socioeconomic profile of MEXFAM's clientele was assessed in terms of educational levels of clients at three of its service program sites. The results indicated that MEXFAM's medical services were reaching a much more educated and presumably middle-class population when compared with the clientele of the community doctors and especially that of the community-based workers. Community doctors and community-based workers were reaching a less-educated population and were providing family planning as well as other health services and information, including first aid and preventive health care.108

**MEXFAM's Road to Sustainability**

A midterm evaluation (February 1996) of MEXFAM's progress toward greater self-sufficiency recommended that USAID assistance to MEXFAM be extended from June 1997 to September 1998 to allow more time for the transition to a phase-out of USAID funding.109 Following that evaluation, MEXFAM carried out a series of activities aimed at greater self-sufficiency. First, MEXFAM consolidated its medical centers program by improving the efficiency and effectiveness of those operations through training personnel in administrative issues, cost analysis, and marketing. Second, MEXFAM identified other international donors and successfully diversified its sources of international support. Finally, as USAID support was being phased out, MEXFAM scaled back the scope of activities of the social programs, although it did not terminate any of them.

During the period of transition to greater self-sufficiency, MEXFAM also made a number of changes in their social programs, including:

- Consolidating work in underserved areas and focusing greater attention on using staff and transportation efficiently in serving different geographic areas.
- Emphasizing more collaboration with public institutions to better serve those communities most in need.
- Initiating user fees, even at symbolic levels, to establish the principle and practice of charging for contraceptives, counseling, and medical services.
- Consolidating the community doctors program by assisting doctors in reaching economic self-sufficiency.

MEXFAM's income fluctuated during the last phase of USAID assistance, as shown in Tables 22, 23, and 24. The organization's income peaked in 1998 at more than US$6.3 million. During the 1992 to 1998 period, sources of income changed dramatically, with almost 94 percent coming from donations at the beginning of this period and dropping to less than 53 percent by 1998. At the same time, the proportion of income from locally generated sources—the sale of health services and products through its medical centers and pharmacies, and through social marketing and community-based distribution programs—increased to more than 47 percent in 1998. This transition was impressive. In 1998, the locally generated income represented about twice the average annual contribution from USAID of US$1.5 million (which included the value of commodities) during the entire 1992 to 1998 period. Thus MEXFAM had more than replaced USAID funds.

---

108 Bowers, Cobb, and Wear, 1996, Table 2.
In 1995, the cost of running all 13 MEXFAM clinics was about US$1.1 million, and the income derived from the clinics was about US$400,000. In the startup phase of clinic operations, costs were much greater than in subsequent phases; by 1998, the cost of running 14 clinics was about US$656,000, a substantial reduction. The income derived from these clinics was more than US$1 million, so the locally generated income produced US$360,000 in profits that year. By 1999, all 14 medical centers were self-sufficient.

Profits from the medical centers were applied to the cost of MEXFAM’s social programs in their respective catchment areas. While all medical centers were self-sufficient by 1999, not all the social programs were supported by locally generated income. In fact, MEXFAM recognized that the nature of these programs—given the client population they serve—meant that they could not become self-supporting. Despite this realization, MEXFAM stated its commitment to maintain the social focus of its mission.

The total cost of the social programs in 1998 was slightly less than US$1 million; thus, profits covered a little more than one-third of costs. The remainder of costs for the social programs was covered by support from other donors that MEXFAM succeeded in obtaining, thus replacing the remainder of USAID assistance for these programs. MEXFAM was actually able to expand its social programs in 1999 because of the combination of successful fundraising efforts with other donors and the locally generated resources.

In terms of contraceptive commodities, MEXFAM was purchasing all its commodity needs with local resources, which eliminated its dependency on USAID-donated products. Other commodities (mainly equipment) were funded by donors as part of specific projects.
Table 22. MEXFAM's Income and Expenditures, 1992 to 1998 (in U.S. dollars)

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<tr>
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<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
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<tr>
<td>Donations</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>USAID funds</td>
<td>1,209,742</td>
<td>1,672,630</td>
<td>2,011,781</td>
<td>1,506,710</td>
<td>987,696</td>
<td>1,077,498</td>
<td>655,677</td>
</tr>
<tr>
<td>USAID - value of commodities</td>
<td>336,707</td>
<td>313,483</td>
<td>223,388</td>
<td>77,905</td>
<td>200,948</td>
<td>117,611</td>
<td>383,026</td>
</tr>
<tr>
<td>Other international donors</td>
<td>3,192,277</td>
<td>2,366,140</td>
<td>2,485,473</td>
<td>2,100,585</td>
<td>2,262,393</td>
<td>2,326,872</td>
<td>2,289,705</td>
</tr>
<tr>
<td>Local donors</td>
<td>381,794</td>
<td>199,064</td>
<td>143,702</td>
<td>264,256</td>
<td>153,002</td>
<td>219,330</td>
<td>192,840</td>
</tr>
<tr>
<td>Sales (social marketing, CBD, pharmacies, etc.)</td>
<td>312,356</td>
<td>528,283</td>
<td>594,765</td>
<td>409,996</td>
<td>493,673</td>
<td>1,689,599</td>
<td>2,154,689</td>
</tr>
<tr>
<td>Medical services (clinics, laboratories, etc.)</td>
<td>31,416</td>
<td>66,014</td>
<td>271,403</td>
<td>399,798</td>
<td>927,451</td>
<td>925,000</td>
<td>1,014,816</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>5,464,292</td>
<td>5,145,614</td>
<td>5,730,512</td>
<td>4,759,250</td>
<td>5,025,163</td>
<td>6,355,910</td>
<td>6,690,753</td>
</tr>
<tr>
<td><strong>Expenditures</strong></td>
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<td></td>
</tr>
<tr>
<td>Medical services (clinics, laboratories, etc.)</td>
<td>60,018</td>
<td>24,529</td>
<td>758,131</td>
<td>1,133,317</td>
<td>816,801</td>
<td>495,234</td>
<td>655,677</td>
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<tr>
<td>Urban and rural family planning programs</td>
<td>1,020,590</td>
<td>1,510,361</td>
<td>1,359,328</td>
<td>734,837</td>
<td>1,005,666</td>
<td>1,393,273</td>
<td>975,900</td>
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<tr>
<td>Administration</td>
<td>155,132</td>
<td>175,462</td>
<td>156,885</td>
<td>36,907</td>
<td>6,997</td>
<td>58,991</td>
<td>38,953</td>
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<tr>
<td>Research and evaluation</td>
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<td>28,292</td>
<td>8,840</td>
<td>1,447</td>
<td>85,683</td>
<td>55,000</td>
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<td><strong>Total expenditures</strong></td>
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<td>1,738,644</td>
<td>2283144</td>
<td>1,906,508</td>
<td>1,915,147</td>
<td>2,002,498</td>
<td>1,670,493</td>
</tr>
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</table>

Source: MEXFAM financial records.
Table 23. MEXFAM’s Income and Expenditures, 1992 to 1998 (in U.S. dollars)

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<tr>
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<td>Donations</td>
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<td>594,765</td>
<td>409,996</td>
<td>493,673</td>
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<td>925,000</td>
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<td>4,759,250</td>
<td>5,025,163</td>
<td>6,355,910</td>
<td>6,690,753</td>
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<table>
<thead>
<tr>
<th>Expenditures</th>
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<tbody>
<tr>
<td>Family planning programs in collaboration with other institutions</td>
<td>153,239</td>
<td>128,389</td>
<td>88,988</td>
<td>75,505</td>
<td>63,207</td>
<td>2,102,812</td>
<td>1,907,780</td>
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<td>Training in family planning (human resources)</td>
<td>362,800</td>
<td>341,998</td>
<td>406,391</td>
<td>322,245</td>
<td>250,194</td>
<td>1,821,596</td>
<td>2,457,706</td>
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<td>MEXFAM direct programs (family planning and clinics)</td>
<td>3,624,615</td>
<td>3,901,959</td>
<td>3,359,141</td>
<td>1,946,462</td>
<td>2,967,594</td>
<td>228,789</td>
<td>317,323</td>
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<td>Family planning IEC materials</td>
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<td>84,772</td>
<td>134,466</td>
<td>4,585</td>
<td>8,018</td>
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<td>284,248</td>
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<td>Education programs, research and evaluation</td>
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<td>585,178</td>
<td>564,155</td>
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<td>Total expenditures</td>
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<td>5,202,335</td>
<td>3,774,888</td>
<td>4,642,224</td>
<td>5,476,269</td>
<td>6,324,029</td>
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</table>

Source: MEXFAM financial records.
Table 24. Percentage Distribution of MEXFAM's Income and Expenditures, 1992 to 1998

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<tbody>
<tr>
<td><strong>Income</strong></td>
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<tr>
<td>Donations</td>
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</tr>
<tr>
<td>USAID funds</td>
<td>22.1</td>
<td>32.5</td>
<td>35.1</td>
<td>31.7</td>
<td>19.7</td>
<td>17.0</td>
<td>9.8</td>
</tr>
<tr>
<td>USAID – value of commodities</td>
<td>6.2</td>
<td>6.1</td>
<td>3.9</td>
<td>1.6</td>
<td>4.0</td>
<td>1.8</td>
<td>5.7</td>
</tr>
<tr>
<td>Other international donors</td>
<td>58.4</td>
<td>46.0</td>
<td>43.4</td>
<td>44.1</td>
<td>45.0</td>
<td>36.6</td>
<td>34.2</td>
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<tr>
<td>Local donors</td>
<td>7.0</td>
<td>3.9</td>
<td>2.5</td>
<td>5.6</td>
<td>3.0</td>
<td>3.5</td>
<td>2.9</td>
</tr>
<tr>
<td>Sales (social marketing, CBD, pharmacies, etc.)</td>
<td>5.7</td>
<td>10.2</td>
<td>10.4</td>
<td>8.6</td>
<td>9.8</td>
<td>26.6</td>
<td>32.2</td>
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<tr>
<td>Medical services (clinics, laboratories, etc.)</td>
<td>0.6</td>
<td>1.3</td>
<td>4.7</td>
<td>8.4</td>
<td>18.5</td>
<td>14.5</td>
<td>15.2</td>
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<tr>
<td><strong>Total income</strong></td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Expenditures</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family planning programs in collaboration with other institutions</td>
<td>2.9</td>
<td>2.3</td>
<td>1.7</td>
<td>2.0</td>
<td>1.4</td>
<td>38.4</td>
<td>30.2</td>
</tr>
<tr>
<td>Training in family planning (human resources)</td>
<td>6.8</td>
<td>6.2</td>
<td>7.8</td>
<td>8.5</td>
<td>5.4</td>
<td>33.3</td>
<td>38.9</td>
</tr>
<tr>
<td>MEXFAM direct programs (family planning and clinics)</td>
<td>68.5</td>
<td>71.1</td>
<td>64.6</td>
<td>51.6</td>
<td>63.9</td>
<td>4.2</td>
<td>5.0</td>
</tr>
<tr>
<td>Family planning IEC materials</td>
<td>1.0</td>
<td>1.5</td>
<td>2.6</td>
<td>0.1</td>
<td>0.2</td>
<td>---</td>
<td>4.5</td>
</tr>
<tr>
<td>Administration</td>
<td>13.7</td>
<td>14.0</td>
<td>18.9</td>
<td>22.3</td>
<td>17.0</td>
<td>9.5</td>
<td>9.0</td>
</tr>
<tr>
<td>Education programs, research and evaluation</td>
<td>7.1</td>
<td>4.9</td>
<td>4.4</td>
<td>15.5</td>
<td>12.1</td>
<td>14.6</td>
<td>12.4</td>
</tr>
<tr>
<td><strong>Total expenditures</strong></td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
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</table>

Source: MEXFAM financial records.
Table 25 shows that, from 1992 to 1998, FEMAP expanded the number of its affiliates from 30 to 44 and the number of promoters in its community program from 7,000 to 8,300. Within the community service programs, more than 8,000 promoters provided information and education services to 1.2 million people and contraceptive methods to more than 87,000 new users in 1997. While the number of promoters and new users fluctuated during the 1990s due to changes in FEMAP’s policy regarding distributing free contraceptives, the general trend for both was upward. The volume of medical services provided by FEMAP increased consistently and dramatically during the 1990s, and the total number of such services was close to one million in 1997, with services ranging from general consultations to cancer screening, prenatal and postnatal visits, and reproductive health care. Even though the number of new users of family planning increased from 1992 to 1997, the total number served in 1997 was less than 10 percent of the number of overall medical services provided. This proportion underscored FEMAP’s shift in emphasis from family planning to more general health services.


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<tbody>
<tr>
<td>Affiliates</td>
<td>30</td>
<td>42</td>
<td>44</td>
</tr>
<tr>
<td>Out-patient care clinics</td>
<td>42</td>
<td>47</td>
<td>47</td>
</tr>
<tr>
<td>Hospitals</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Community Programs</td>
<td>30</td>
<td>32</td>
<td>36</td>
</tr>
<tr>
<td>Promoters</td>
<td>7,000</td>
<td>8,200</td>
<td>4,272*</td>
</tr>
<tr>
<td>Persons informed through I&amp;E activities</td>
<td>571,474</td>
<td>1,228,699</td>
<td>916,276</td>
</tr>
<tr>
<td>New users of family planning</td>
<td>49,857</td>
<td>87,424</td>
<td>45,444*</td>
</tr>
<tr>
<td>Couple-years of protection provided (CYP)</td>
<td>54,843</td>
<td>190,854</td>
<td>183,845</td>
</tr>
<tr>
<td><strong>Medical Services Program</strong></td>
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</tr>
<tr>
<td>Medical services provided**</td>
<td>160,158</td>
<td>968,956</td>
<td>1,175,175</td>
</tr>
</tbody>
</table>

* The decrease in the number of promoters and users from 1997 to 1998 was due to community program budget cuts; nonetheless, notice how practically the same number of CYPs is maintained, indicating the continuity of users of family planning even with the decrease of promoters and new users for 1998. After assimilating the impact of losing 100 percent of the operating budget for FEMAP’s family planning community programs, the numbers of promoters for 1999 increased by 1,166 new promoters, to 5,438.

** The services cover a wide range, including general and specialized consultations, cancer screening, prenatal visits, family planning, reproductive health care, deliveries, minor and major surgeries, hospitalizations, etc.

Given its mission to serve Mexico’s underprivileged population, FEMAP carried out periodic assessments of its client population to identify their key social and economic characteristics. The definition of poverty was based on an index derived from a combination of 22 socioeconomic indicators such as income, education, economic activity, and dwelling characteristics. In 1993, about 85 percent of FEMAP clients lived below the poverty line; in 1997, this figure reached 88 percent. Based on this assessment, FEMAP rightly concluded that it was able to serve its intended population while achieving progress toward self-sufficiency.

FEMAP gave high priority to ensuring quality of care in its services. One important aspect of quality of care identified in FEMAP’s market studies was the amount of time clients waited to receive services. For years, FEMAP conducted Patient Flow Analyses, with assistance from the U.S. Centers for Disease Control and Prevention (CDC) in earlier years and with assistance from FHI beginning in 1995. The most recent Patient Flow Analysis was conducted in 1997 and found that, where client volume was high, client waiting time was high and the amount of provider-client contact time was low. Such findings were used to design operational changes that included remodeling the medical units and reducing waiting time through establishment of an “information module.” This module, a procedure to improve patient flow, was a reception desk where clients had initial contact with the clinic, received pertinent information on the clinic’s services, and then were referred to the appropriate service provider.

**FEMAP’s Road to Sustainability**

Many factors helped explain FEMAP’s transition to greater sustainability, including leadership, good management, and an array of other organizational characteristics that are summarized in a case study of FEMAP. The approach included a combination of cost and market analyses, cost control and recovery, and fundraising. More recently, FEMAP broadened the approach to include an entrepreneurial venture and a revolving fund for commodities. The key steps in FEMAP’s approach to sustainability were the following:

- **Cost studies:** Beginning in 1990, FEMAP undertook its first cost study at the main affiliate in Cuidad Juárez. This initial study became the basis of the institution’s strategy for controlling and reducing prices. In 1993, with assistance from the Population Council, FEMAP worked with seven affiliates to determine their operational costs, the cost of services provided, and the disposition to and level of self-sufficiency. Analysis of costs became an ongoing part of FEMAP’s effective management.

- **Market studies:** In 1993, with assistance from the FPMD project of MSH, FEMAP conducted three market studies of the organization’s actual market, potential market, and competition in both the public and private sectors. These studies provided information about how clients viewed FEMAP’s services as well as the clients’ ability to pay for those services. This market information was then used for setting fees and modifying the range and quality of services to better serve clients. The methodology for the market studies was developed by FEMAP’s central office and was replicated by a number of affiliates.

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112 Management Sciences for Health, 1999 draft.
“Q-P-V” strategy: Based on the cost and market studies, FEMAP developed an operating strategy that led to greater self-financing. The organization strove to achieve high Quality and low Price of services, which generated an increased Volume of services. A key institutional policy stipulated that clients pay for services and supplies whenever possible. Part of the process of carrying out this strategy involved improving the organization’s management capacity at the central office and among affiliates; it also involved identifying ways to control and reduce costs for both clinic services and the community-based program. Standards were set for productivity and service quality across program areas. Between 1993 and 1996, FEMAP reduced the actual costs of its medical services by 85 percent (from an average of 11.38 to 1.69 Mexican pesos per service offered), while reducing the price for such services to clients by 76 percent (from 13.60 to 3.20 Mexican pesos). These price reductions occurred gradually and followed the findings of FEMAP’s operations research studies.

FEMAP Foundation: Established in 1992, the Foundation is FEMAP’s fundraising arm; it seeks grants and donations from international and Mexican sources.

FEMAP’s strategy for 1998 to 2000 included ambitious plans to expand its sources of revenue and control costs. In 1998, a chain of 13 pharmacies was established. While FEMAP stopped receiving general institutional support from USAID in 1997, the entire cost of the pharmacy program was funded by USAID in 1998. FEMAP staff received training in managing the pharmacy business from MSH’s Drug Management Program.114

The Packard Foundation granted FEMAP US$300,000 in November 1997 to initiate a plan for replacing USAID-funded contraceptive commodities and for generating income. In 1998, FEMAP set up a revolving fund to implement its Pooled Procurement Service for the purchase and sale of contraceptive commodities, drugs, medical and surgical equipment, and other supplies. This fund was deemed critical to replacing the commodity donations previously provided by USAID. Through the sale of products, FEMAP anticipated that it would be able to expand significantly the volume of commodities bought and sold. Initially, products were sold through the medical programs in the clinics and hospitals of FEMAP affiliates, the community-based distribution (CBD) programs, social marketing programs, and pharmacies. A later phase of this service would extend the market beyond FEMAP’s existing network.

Tables 26 and 27 shown FEMAP’s income and expenditures from 1992 to 1998. The organization’s income increased steadily during this period, growing from US$3.1 million in 1992 to US$8.2 million in 1998. A large part of this increase was due to FEMAP’s dramatic success in selling its medical services and in attracting local donations, which typically came from private sources in the community in which an affiliate was located. Also shown in Table 26 is information on USAID funding and commodity support for FEMAP. The combination of these two USAID income sources ranged from 14 percent to nearly 29 percent of all income during the 1992 to 1998 period. By 1998, less than 6 percent of the organization’s income was from USAID, although the equivalent of another 20 percent was provided in the form of commodities. Starting in 1999, FEMAP was purchasing 100 percent of its contraceptive commodities.

FEMAP's success in expanding its volume of services and its profits occurred as a result of reductions in the price of its services. Between 1992 and 1998, income from the sale of medical and community-based services increased from more than US$2.1 million to US$5.1 million. Interestingly, as a proportion of all income, the sale of medical services declined from about 68 percent in 1992 to about 60 percent in 1998, although these percentages are applied to a much larger base at the later period. By 1997, FEMAP's fee-charging medical services had become fully self-sustaining. Some of the facilities providing medical services were generating enough income to support community programs. Although income from the new pharmacy program is included in the table as part of "Sales," it was too early to expect a profit from this new endeavor; however, all 13 pharmacies were functioning in 2000. Because the opening of each pharmacy was gradual, the level of profitability varied; all of the pharmacies had increased their initial stocks, some had increased their total number of employees, and some had increased sales.

Efforts to increase support through the FEMAP Foundation were effective: Donations from local sources increased from nearly US$194,000 in 1992 to more than US$835,000 in 1998. As a proportion of all income, these donations rose from about 6 percent in 1992 to 10 percent in 1998, although fluctuations occurred in the intervening years.

In sum, FEMAP made considerable progress in expanding locally generated revenues. In 1992, 30 percent of its overall operating expenses were covered by locally generated money and, by 1998, more than 84 percent of its expenses were so covered. Thus, FEMAP had more than succeeded in replacing income provided previously by USAID.

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Table 26. FEMAP, Income and Expenditures, 1992 to 1998 (in U.S. dollars)

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<tr>
<td>Donations</td>
<td></td>
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<tr>
<td>USAID funds</td>
<td>$440,019</td>
<td>$1,011,015</td>
<td>$831,723</td>
<td>$931,108</td>
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<td>USAID value of commodities</td>
<td>$0</td>
<td>$0</td>
<td>$90,330</td>
<td>$280,873</td>
<td>$962,576</td>
<td>$1,481,767</td>
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<td>Other international donors</td>
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<td>$159,965</td>
<td>$173,933</td>
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<td>Local donors</td>
<td>$193,939</td>
<td>$272,481</td>
<td>$572,995</td>
<td>$490,438</td>
<td>$655,469</td>
<td>$638,728</td>
<td>$835,311</td>
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<td>Sales (social marketing, CBD, pharmacies, etc.)</td>
<td>$18,353</td>
<td>$246,216</td>
<td>$337,186</td>
<td>$472,227</td>
<td>$111,087</td>
<td>$154,661</td>
<td>$137,035</td>
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<td>Medical services (clinics, laboratories, etc.)</td>
<td>$2,123,755</td>
<td>$3,308,050</td>
<td>$3,800,100</td>
<td>$3,901,000</td>
<td>$4,036,010</td>
<td>$4,633,100</td>
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<td>Other*</td>
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<td>$101,441</td>
<td>$106,718</td>
<td>$169,939</td>
<td>$302,838</td>
<td>$156,413</td>
<td>$119,495</td>
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<tr>
<td>Total income</td>
<td>$3,131,036</td>
<td>$5,616,858</td>
<td>$6,203,966</td>
<td>$6,534,534</td>
<td>$7,066,270</td>
<td>$8,062,629</td>
<td>$8,245,907</td>
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</table>

<table>
<thead>
<tr>
<th>Expenditures</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Medical services (clinics, laboratories, etc.)</td>
<td>$2,017,567</td>
<td>$3,351,719</td>
<td>$3,851,250</td>
<td>$3,990,050</td>
<td>$4,050,000</td>
<td>$4,635,200</td>
<td>$4,839,650</td>
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<td>Other programs</td>
<td>$778,240</td>
<td>$2,126,587</td>
<td>$2,118,791</td>
<td>$2,257,467</td>
<td>$1,333,697</td>
<td>$2,847,562</td>
<td>$2,603,817</td>
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<td>Administration</td>
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<td>$112,494</td>
<td>$231,660</td>
<td>$198,151</td>
<td>$1,143,376</td>
<td>$97,214</td>
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<td>$100,683</td>
<td>$78,990</td>
<td>$30,114</td>
<td>$66,249</td>
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<td>Other (if needed)</td>
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<td>$0</td>
<td>$0</td>
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<tr>
<td>Total expenditures</td>
<td>$3,053,790</td>
<td>$5,691,483</td>
<td>$6,280,691</td>
<td>$6,475,782</td>
<td>$6,593,322</td>
<td>$7,697,837</td>
<td>$7,706,006</td>
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</tbody>
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* Other income includes income from investments, rentals, contracts, etc.

Source: FEMAP financial records.
Table 27. Percentage Distribution of FEMAP’s Income and Expenditures, 1992 to 1998

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<td><strong>Donations</strong></td>
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<td>18.0</td>
<td>13.4</td>
<td>14.2</td>
<td>11.8</td>
<td>10.2</td>
<td>5.8</td>
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<tr>
<td>USAID value of commodities</td>
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<td>---</td>
<td>1.5</td>
<td>4.3</td>
<td>13.6</td>
<td>18.4</td>
<td>20.0</td>
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<td>Other international donors</td>
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<td>12.1</td>
<td>7.5</td>
<td>4.4</td>
<td>2.3</td>
<td>2.2</td>
<td>1.0</td>
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<td>Local donors</td>
<td>6.2</td>
<td>4.9</td>
<td>9.2</td>
<td>7.6</td>
<td>9.3</td>
<td>7.9</td>
<td>10.1</td>
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<tr>
<td>Sales (social marketing, CBD,</td>
<td>0.6</td>
<td>4.4</td>
<td>5.4</td>
<td>7.2</td>
<td>1.6</td>
<td>1.9</td>
<td>1.7</td>
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<td>Pharmacies, etc.)</td>
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<td>Medical services (clinics,</td>
<td>67.8</td>
<td>58.8</td>
<td>61.3</td>
<td>59.7</td>
<td>57.1</td>
<td>57.5</td>
<td>59.9</td>
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<td>laboratories, etc.)</td>
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<tr>
<td>Other*</td>
<td>1.6</td>
<td>1.8</td>
<td>1.7</td>
<td>2.6</td>
<td>4.3</td>
<td>1.9</td>
<td>1.5</td>
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<tr>
<td><strong>Total percent of income</strong></td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total income in U.S. dollars</strong></td>
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</thead>
<tbody>
<tr>
<td>Medical services</td>
<td>66.0</td>
<td>58.9</td>
<td>61.3</td>
<td>61.6</td>
<td>61.4</td>
<td>60.2</td>
<td>62.8</td>
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<td>Other programs</td>
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<td>37.3</td>
<td>33.7</td>
<td>34.9</td>
<td>20.2</td>
<td>37.0</td>
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</tr>
<tr>
<td>Administration</td>
<td>4.7</td>
<td>2.0</td>
<td>3.7</td>
<td>3.0</td>
<td>17.4</td>
<td>1.3</td>
<td>0.9</td>
</tr>
<tr>
<td>Research &amp; Evaluation</td>
<td>3.8</td>
<td>1.8</td>
<td>1.3</td>
<td>0.5</td>
<td>1.0</td>
<td>1.5</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>Total percent of expenditures</strong></td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
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<td>$7,706,006</td>
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* Other income includes that from investments, rentals, contracts, etc.
Institutional and Social Marketing

MEXFAM and FEMAP used two additional strategies to improve sustainability while increasing clients’ access to services: institutional marketing and social marketing. The aim of the institutional marketing strategies was to increase the public’s familiarity with the institutions and their services and, in turn, to increase service use. With assistance from the USAID-funded Contraceptive Social Marketing Project (SOMARC), MEXFAM developed a comprehensive marketing strategy that included creating and promoting a new institutional image (primarily through a logo) and developing marketing plans for the MEXFAM clinics. In 1997, a services marketing workshop was held for MEXFAM’s medical service centers that resulted in the development of individual clinic marketing plans and implementation of a variety of service marketing activities. For example, a number of the medical centers adopted a package of services referred to as the Healthy Woman (Mujer Saludable) package, which included a gynecological visit, pap smear, and family planning consultation. Similar effort was directed to FEMAP to support evaluating and redefining its corporate image and conducting training in marketing of services for affiliates with clinic services. Both MEXFAM and FEMAP established marketing departments to manage the commercial promotion and sale of their services and products.¹²

The second strategy, used by both NGOs, involved a pilot intervention to increase access to oral contraceptives in rural areas through social marketing, while generating income for local programs. This intervention involved negotiating the purchase of contraceptive commodities from a commercial source. In 1997, both MEXFAM and FEMAP procured low-dose oral contraceptives at a reduced price from the manufacturer, Schering Mexicana, and in turn sold the product in rural areas at affordable prices. Both institutions launched the sale of Microgynon in April 1997 and, by late 1997, total sales by the two organizations had reached more than 24,000 cycles of pills. It was hoped that this pilot project would assist both organizations in instituting the administrative, financial management, and distribution systems required for the sale of commercial products, thereby ensuring the future for locally generated income.¹³

Subsequent to the pilot, FEMAP expanded this social marketing strategy nationally without USAID assistance and expanded the volume and frequency of its commercial purchases with its revolving fund for commodities. FEMAP’s policy on distribution of commercial products required its affiliates to pay for all products on 45-day credit terms.

In developing the pilot project, MEXFAM adopted a policy for distribution of all contraceptive products that required its regional programs to provide a 50 percent deposit on the cost of contraceptives received. Subsequently, MEXFAM increased its purchase of other commercial products (other pills, one type of IUD, and condoms), so that by September 1997 it had purchased commercial products worth more than US$200,000, or about 20 percent of the total product value for a 12-month period. The remaining products were procured with donor commodity support. MEXFAM also established a revolving fund for the purchase of contraceptive commodities.¹⁴

¹³ Cisek, C., 1998c.
If successful, these efforts would enable both NGOs to procure and manage their commodity requirements independent of donor commodity contributions and would represent a growing source of revenue. As of 1999, both MEXFAM and FEMAP were purchasing all contraceptive commodities without donor support.

Service Delivery Operations and USAID-Supported Technical Assistance

A number of USAID-supported CAs assisted MEXFAM and FEMAP during the 1990s in their transition to more sustainable programs. IPPF was the principal CA in this effort, providing both funding and technical assistance. It also helped to coordinate the activities of the other CAs (MSH, the Population Council, SOMARC, and JSI) working with these NGOs. The CAs provided technical assistance and training in several areas of service delivery operations—management, training, commodities and logistics management, and research and evaluation.

Management

The management challenge for MEXFAM and FEMAP was to improve their technical and financial sustainability. An underlying assumption in the assistance to both institutions was the importance of client-oriented services that required high standards for quality of care. This emphasis was considered key for both NGOs to develop a competitive advantage in terms of the quality of services offered.

**MEXFAM.** During the 1990s, MSH and the Population Council assisted MEXFAM in its strategy to establish a number of new medical service clinics, which represented its main approach to reaching sustainability. Assistance was provided for several years to help the central office set up diversified clinic management and financial information systems. As a result, by 1997 MEXFAM's central office had established a cost accounting system to monitor the performance of its clinics through a unit cost analysis methodology and an integrated reporting system covering financial information and service statistics. As of 2000, eight of the 12 MEXFAM clinics were providing the requisite information to the central office for analysis; the other four were trained and developed their own capacity for processing and analyzing the information.

MSH also assisted MEXFAM in developing and institutionalizing medical quality standards to improve quality of services and to focus its services on clients, which helped increase the demand for services. A Medical Quality Unit was established at MEXFAM in 1997 to implement a quality management system involving periodic training and quality monitoring through audits of medical records.

Through a subcontract with the National Public Health Institute during 1998, MEXFAM senior staff were trained and a pilot program was carried out to assist the medical centers in using two new tools—a clinical guide and sentinel events monitoring—in the quality improvement system. A review of the use of the clinical guide and quality monitoring procedures was carried out in 13 MEXFAM clinics in August 1999. The results varied across clinics. In some clinics, the procedures were well established; in others, there were difficulties with implementation due to
the lack interest of the staff or lack of infrastructure. Each clinic was rated on implementation so the results could be used to improve future performance if the staff so chose.

MSH also worked with MEXFAM on reviewing its procedures for physician payment. These procedures had not previously been standardized and were based on cash received from clients rather than on true operating costs. Given the variability in provider payments and their impact on the cost of services, developing a standard system for provider payment was considered important for the sustainability of the Medical Services Clinics. MEXFAM gradually moved to a payment scheme that allocates 60 percent of the client fee to general physicians and 40 percent to MEXFAM. When physicians own the equipment they use to provide a service, they retain 65 percent of the fee and MEXFAM keeps 35 percent. As of 1999, changes in the payment structure for specialized physicians had not been made.

After years of assisting MEXFAM, MSH learned several lessons about the effectiveness of its efforts to improve NGO sustainability. Significant institutional changes are difficult when the mission and internal culture are threatened, which was the case with USAID’s push for sustainability. A decentralized organizational structure coupled with effective management is likely to lead to greater financial sustainability than a highly centralized organization. Among lessons learned that MEXFAM identified for the CAs in 1997 were 1) a recommendation to decentralize both financial and marketing decisionmaking, 2) the recognition that cost monitoring and control are key to sustainability, and 3) that investments in quality of care are critical.120

FEMAP. As was mentioned in the discussion of FEMAP’s approach to sustainability, two first steps in this process, carried out in 1993 and 1994, involved conducting cost studies and market studies. The Population Council worked with FEMAP to develop a detailed methodology for analyzing the costs of family planning services provided by FEMAP affiliates.121 A cost analysis manual was produced and has been used by FEMAP as an institutional standard for estimating and monitoring costs and expenditures.

In a complementary effort, MSH assisted FEMAP in designing and testing instruments to gather information for client profiles at the clinic and community-based distribution levels and for market studies. Here, too, FEMAP produced manuals for conducting these studies that were used by its affiliates. The results of these studies were then used to develop sales plans and cost recovery strategies for FEMAP affiliates.

In the second half of the 1990s, MSH assisted FEMAP in developing and implementing an instrument for monitoring affiliate performance, this tool was used among all FEMAP affiliates to model the successful management practices of the highest performing affiliates. The instrument assisted the affiliates in identifying future training needs and management strengthening needs for reaching higher levels of sustainability. FPMD also assisted FEMAP in developing its sustainability strategy for 1998 to 2000. Both of these efforts involved providing technical assistance and training to staff of the central office and affiliates. For example, in working with central office staff, core competencies were developed in management information system (MIS) development, pooled procurement (combining commodities needed for all affiliates in order to purchase them at one time to obtain a lower unit price), and pharmacy

120 Dobrowolski, D., 1999.
management. A proprietary MIS/accounting tool was developed and was scheduled to be pilot tested with affiliated programs. This tool was proprietary in the sense that it was owned solely by FEMAP and could be marketed and sold to other potential users. Marketing of this tool was expected to begin once the testing was complete.

Based on its work with FEMAP during the 1990s, MSH planned to prepare a brochure on 10 successful NGO management practices that may be useful in future South-to-South endeavors.122

Training

A number of training activities were supported with assistance from CAs, some of which were carried out during the course of the management development work described above. Training in logistics management also occurred but is discussed in the next section.

- During 1997 and 1998, the clinic administrators at MEXFAM became solely responsible for developing and managing their clinic’s marketing plans. SOMARC conducted a series of market planning workshops to help the clinic administrators develop skills to plan their marketing activities and to establish targets for service delivery, expenditures, and gross and net revenues. Such skills were deemed necessary for the clinic administrators to assess their clinic’s performance and the potential impact of marketing activities.

- With IPPF funding, SOMARC conducted a workshop in 1998 for MEXFAM staff on product sales techniques and administration. It was designed to improve the selling skills of its sales force and to help MEXFAM’s central marketing department understand the importance of monitoring and controlling its sales operations. This workshop was followed by a financial administration workshop for clinic administrators to help them improve their basic financial management skills before USAID support ended.

Commodities and Logistics Management

A recent assessment of the status of contraceptive commodity supplies at MEXFAM and FEMAP presented a rather dismal picture for the future. The assessment projected that both NGOs had sufficient contraceptive supplies only until March 2000. It was anticipated that they would have increasing difficulty acquiring the quantities of supplies they would need for their clients, particularly those clients from marginal urban and rural populations who had been paying for their contraceptive supplies at a price below the value of the donated products. (The value of contraceptive products was based on the low unit costs, based on high volume, that USAID in Washington paid for contraceptives.) To ensure future supplies, either commodities would have to be procured locally, at a much higher unit cost (two to three times more than USAID paid), or from international suppliers. MEXFAM was not a large enough purchaser to attract international suppliers so it bought some condoms and pills locally, using funds from IPPF’s Western Hemisphere Region office and from the sale of donated products.123

In 2000, FEMAP was expected to use its revolving fund to buy 100 percent of the contraceptives it needed from international and domestic suppliers. FEMAP developed its own brand of condom, which was scheduled to go on the market in May 2000, and FEMAP plans to develop

122 Management Sciences for Health, 1999 draft.
its own brand of oral contraceptive pill. Both of these products will be affordable to FEMAP’s target audiences. In addition to fulfilling the contraceptive needs of FEMAP’s affiliates, this revolving fund generated profits that covered 50 percent of the operating costs of FEMAP’s national office in 1999.\textsuperscript{124}

MEXFAM staff, at the central level and at its centers, and FEMAP staff to a lesser extent, received training in logistics management and forecasting of contraceptive commodity needs, with technical assistance from John Snow, Inc. (JSI), through the Family Planning Logistics Management project. MEXFAM developed logistics supervision guidelines and a logistics manual for use at the central level and in its centers.\textsuperscript{125} As of 1999, this material was being used in all of MEXFAM’s operative centers. FEMAP had already implemented a logistics system, which was improved with FPLM’s support.

In general, the training was considered useful for making logistics systems at both institutions function efficiently based on donated contraceptive supplies. Although there was concern from the 1999 assessment that many of the methods and practices in logistics management learned by the two NGOs were no longer valid given the end of USAID support and the new sustainability strategies, FEMAP was expected to continue to use this logistics management system and to update and strengthen the system through the design of new software.\textsuperscript{126} MEXFAM also reported that it had the technical basis for the logistics management system being used. However, some modifications are expected to be carried out according to the new system of product purchasing.

**Research and Evaluation**

Several CAs worked with MEXFAM and FEMAP over the years to conduct research and evaluation activities important to the organizations’ missions. Since one purpose of research is to test new approaches, it was expected that not all of the results would lead to useful innovations. Some examples of research and evaluation conducted during the 1990s with the NGOs include:

- As part of the social marketing program, SOMARC and the Population Council assisted FEMAP in conducting an operations research study to determine the geographic coverage needed to reach target audiences in remote rural areas. The results of the research suggested that the effective coverage of pharmacies extended beyond the communities in which they were physically located, and that the larger the pharmacies had more extensive geographic reaches. Furthermore, since husbands often make purchases for their wives, geographic coverage was not limited to the clients coming to the pharmacy.\textsuperscript{127}

- The Population Council worked with MEXFAM from 1991 to 1994 on using continuous quality improvement managerial techniques to institutionalize operations research. The result was a range of changes being implemented in eight MEXFAM clinics after services at the two study clinics in Mexico City improved considerably. In one study clinic, the

\textsuperscript{124}José Enrique Suárez (FEMAP), 2000.
\textsuperscript{125}Quesada N (FPLM). Communication to USAID/Mexico, 21 July 1997 (e-mail memo); USAID/Mexico R4: 1996 Results Review and Resource Request for 1999. Mexico City: USAID/Mexico, March 1997.
\textsuperscript{126}José Enrique Suárez (FEMAP), 2000.
\textsuperscript{127}Foreit, K. and M. C. Cyzek, 1998.
The proportion of clients rating services as "excellent" increased from 16 percent to 41 percent, while at the other clinic this proportion increased from 26 percent and 46 percent. Based on this experience, the Council developed a training manual titled "Quality of Care Improvements in Family Planning Organizations." As of 1999, these managerial techniques were still being applied at MEXFAM clinics and the training manual was still being used.

Also with assistance from the Population Council, MEXFAM tested an approach to recruiting clients to its clinic services: interactive touch screen kiosks were installed in shopping centers near its clinics. The information offered by the kiosks was expected to help potential users decide, from a range of reproductive health services, which services they might need. During a three-month period, 1,800 individuals used the kiosks; however, only 114 new users were identified as referrals from the kiosks and clinic managers concluded that this was not an effective recruitment strategy.

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SECTION 6
MEXICO’S FUTURE CHALLENGES

The phase-out of USAID assistance, which had been the predominant external funding source for Mexico’s population and reproductive health programs, was the primary reason that external financial aid for population programs decreased sharply in Mexico during the 1990s. Reductions also occurred in UNFPA and IPPF assistance. No other bilateral or multilateral donor is expected to emerge in the coming years; one exception could be the World Bank, which may become a source of support in the health sector.

USAID population assistance to Mexico represented a small but important part of the resources devoted to family planning and reproductive health during the 1990s. In the public sector, this assistance enabled special efforts that led to improvements in both access and quality of services. In the private sector, it helped two family planning organizations become more self-sustaining. With the end of USAID assistance to both sectors, Mexico still faces some important challenges.

Fortunately, Mexico benefits from having a fairly strong health service infrastructure that covers approximately 90 percent of the population. Further, the institutional structures (including CONAPO and the health delivery institutions), the programmatic capabilities of these institutions, and the political will are sufficiently strong to expect effective implementation of health programs. The increasing involvement of public and private institutions, including some joint government and nongovernmental projects, together with civil society in the reproductive health and rights arena bodes well for assuring that services will be of high quality and will meet people’s needs.

Nevertheless, despite extraordinary progress since the mid-1970s in expanding access to services, many of those involved in the USAID-Mexico program considered the job unfinished when USAID assistance ended; some even felt that USAID’s phase-out could reverse some of the successes. They described the emergence of two Mexicos: one that made extraordinary progress in the last quarter of the 20th century and another that was left behind. As the USAID-Mexico population program was coming to an end, these observers saw an “historic” opportunity to reach the “marginalized half” of the country and to prevent potentially calamitous public health problems from reversing progress made. Indeed, there are still sizable segments of the population—the underserved groups—that lack adequate access to quality services and who lag behind the rest of the population in terms of development and fertility. In the context of the Mexican economic crisis of the late 1990s, these underserved groups require even more assistance to ensure access to services.

Underserved Groups and Unmet Needs

The underserved groups include people living in rural areas, women with little or no education, indigenous groups, adolescents, and the poor. These groups may be decades behind the rest of Mexico in terms of development and fertility rates.

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The most recent data on contraceptive prevalence (from 1997) point to important differences between these underserved groups and the rest of the country. The rural population still lags behind the urban population in contraceptive use, for instance. The urban-rural gap in contraceptive use was 73 percent to about 53 percent, or a gap of 20 percentage points for all of Mexico. The gap was slightly larger in the priority states.

Less educated women have much lower levels of contraceptive use than women with higher levels of education. In the priority states, the prevalence of family planning use among reproductive-age women, in union with secondary or higher level of schooling, was 74 percent in 1999, compared to only 45 percent among women with no formal education. MEXFAM has estimated that two-thirds of the unmet need for family planning in Mexico is concentrated among women with little formal education and who live in rural areas and urban slums.

Constituting about 10 percent of Mexico's total population, the indigenous population is the most marginalized group in Mexico. This group has been left out of the development process and it has exceptionally low rates of education and social and economic status, along with high rates of poor health indicators and fertility. For example, in 1995, CONAPO reported that while the national TFR was just under 3, the fertility rate among indigenous women was 3.8. In fact, since this estimate is based on municipalities with a predominantly but not exclusively indigenous population, the fertility rate of indigenous women is assumed to be even higher.

Other gaps exist in serving the population's contraceptive needs. In 1995, the proportion of women in union who wanted to space or limit their pregnancies but who were not using any form of family planning was 16.1 percent nationally. In the priority states, that number was 19 percent, with the highest levels in Oaxaca, Chiapas, and Guerrero. A substantial unmet need existed for birth spacing among low parity women and for limiting births among higher parity women. By 1997, unmet need had declined in most of the priority states. Nationally, the unmet need reached a level of 12.1 percent, and for the priority states the unmet need indicator decreased to 15.7 percent.

Representing nearly one-fourth of the Mexican population, adolescents continue to be an underserved group. A conservative but illustrative indicator showed that in 1997 as many as 29.7 percent of 15- to 19-year-olds in union had an unmet need for family planning. In 1999, one out of six births was to an adolescent; that year, more than 370,000 babies were born to mothers ages 15 to 19. Many of these births were probably unplanned, some of these babies were unwanted, and many of the babies were born to unmarried teens.

Some observers consider the needs of adolescents in Mexico to be among the most important modern challenges for public and nongovernmental organizations. Married adolescents ages 15 to 19 have the lowest level of contraceptive use, at about 43 percent in the priority states (although this proportion increased from 33 percent in 1992). Many young couples lack motivation to postpone their first birth. A recent MEXFAM survey of more than 3,500 youth

133 MEXFAM, 1997.
138 CONAPO, 1997h.
139 CONAPO, 2000.
ages 13 to 19 and living in urban areas served by MEXFAM found that only 51 percent of males and 32 percent of females used contraception at first intercourse. Many of the females surveyed did not use contraception because they wanted to get pregnant. In addition to the lack of motivation among adolescents to use contraception, the most prevalent contraceptive methods in Mexico—sterilization and IUDs—may not be the most suitable methods for this age group.

Identifying unmet needs for contraception may entail a broader approach to defining the concept. For example, additional needs may exist among women who are not in union (especially adolescents) but who are sexually active. Current users of contraception may also have unmet needs; for example, some current users who definitely want to postpone or avoid pregnancy may be using ineffective methods or may be using a method incorrectly. Others—former contraceptive users—may not have been satisfied with the method they were using and so discontinued use even though they wanted to postpone the next pregnancy or avoid another pregnancy altogether. These women may need better information or access to different contraceptive methods. For example, a 1996 survey of 132 women seeking postabortion care at a hospital in Oaxaca found that one out of five of these women had been using some form of contraception when the aborted pregnancy occurred. In addition, the group of contraceptive users who rely on traditional family planning methods—approximately 12.3 percent of all contraceptive users in Mexico—may be among those individuals with unmet contraceptive needs.

Unmet need for family planning services contributes significantly to the practice of abortion. Conversely, high quality and accessible contraceptive services can help improve and protect women’s health by enabling them to avoid unwanted pregnancy and abortion. Abortions are often conducted under dangerous conditions. Estimates based on data from sociodemographic surveys show that the annual number of abortions has decreased steadily between 1985 and 1997, as shown in Table 28. It is estimated that in 1995 around 110,000 induced abortions occurred in Mexico, and that this number decreased to 101,862 in 1997.

Additional information shows that, in 1987, 22.7 percent of married women of fertile age who had ever been pregnant declared to have had at least one abortion (spontaneous or induced); by 1992 this percentage was 19.8 and by 1997 it was 19.0.

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<tr>
<th>Table 28. Annual Number of Abortions, 1985 to 1997</th>
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<td>Annual number of abortions in Mexico</td>
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<td>230,000</td>
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Source: Estimates provided by CONAPO, 2000.

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140 MEXFAM, 1999
143 Estimates provided by CONAPO, 2000.
Only in recent years has unsafe abortion been recognized by Mexican officials as a public health problem. While the government is carrying out some activities to reduce abortion and prevent abortion complications, the challenge of providing access to legal abortion services is still not resolved. As such, few programs have been implemented to improve the quality of services received by women who seek care for abortion complications. Two examples of efforts that did seek to improve health care services for women treated for abortion complications were operations research activities carried out in a public hospital in Oaxaca with funds from the European Union and in six IMSS hospitals in the Mexico City metropolitan area with funds from USAID (through the INOPAL project). Both interventions included a focus on strengthening the linkage between emergency care and family planning services. The purpose of this linkage was to help reduce subsequent unwanted pregnancies and abortion by helping to ensure that women left the hospital with information about contraceptive methods and, when they desired it, a contraceptive method for their use. Interventions that included family planning counseling during the woman’s stay in the hospital improved the information women received about different methods and increased women’s acceptance of a contraceptive method before leaving the hospital.

To reduce deaths from abortion complications, which are preventable and easily treated, women will need the information and means to avoid future unwanted pregnancies and unsafe abortions. To this end, models of postabortion care services that are cost-effective, accessible, and sustainable will need to be tested in other institutions and at different levels of the health care system.

**Service Delivery**

To help address the needs of underserved populations, continued efforts are required to expand access to and improve the quality of family planning information and services.

**Access**

In light of the Mexican government’s decentralization program and the continuing needs of underserved populations, some attention should be focused on how best to segment the market for family planning and reproductive health services. In an era where many countries are moving toward greater privatization of health services, Mexico has moved in the opposite direction, with the public-sector institutions becoming an even more prominent provider of health services (nearly 73 percent) and the role of private pharmacies declining to 13 percent. It may be time for CONAPO, in concert with IMSS, SSA, ISSSTE, and private-sector organizations, to look critically at this issue and to assess other countries’ experiences. In addition, the issue of charging user fees to achieve program sustainability has not been adequately considered and evaluated in Mexico.

Reasons for nonuse of family planning, based on the 1997 survey, show that access problems still exist. In the priority states, as in the whole country, lack of access to family planning services is the principal reason women do not use contraception. Access is even more critical in

144 Ana Langer, et al. 1999 “Improving Postabortion Care with Limited Resources in a Public Hospital in Oaxaca, Mexico”; and Fuentes Velasquez et al., 1998.

the rural areas. In the priority states in 1997, 20 percent of married women of reproductive age who did not desire any more children said that lack of access to services kept her from using a family planning method; in rural areas, 27 percent of married women who wanted to limit their births did not use contraception because they did not have access to services. Furthermore, and highlighting the need for postpartum counseling and services, about 13 percent of couples not using family planning but who wanted to space or limit their pregnancies assumed that breastfeeding was protecting them from conception.146

**Quality of Care**

Significant progress was made in improving quality of care primarily because of the extensive training efforts, especially training in counseling and informed consent. Evaluation of these efforts showed an ongoing need for training — including refresher training — to assure that providers keep up-to-date with contraceptive advances and that they receive reinforcement on the importance of quality of care and serving client needs. Continual strengthening of service-quality skills through training is particularly important in the areas of policies and procedures that guarantee the right of couples to choose the number and spacing of their children and their choice of method and ensuring clients' informed consent to use family planning. The persistence of an “outmoded” interventionist style in the public sector underscores the need to motivate both providers and program administrators to recognize and adhere to the new emphasis on freedom of choice and informed consent.147 Furthermore, training needs to be expanded to institutionalize these practices throughout the national programs of the three public health institutions. Informed consent of family planning clients remains particularly important among special populations such as indigenous groups and rural dwellers, whose needs have traditionally been neglected.148 Given the importance of informed consent to good quality services in the public sector, such endeavors will need to be an ongoing part of public information, education and communication efforts, and training for public health providers.

Examining the method choice in Mexico may prove relevant to quality of care issues, given that female sterilization was used by nearly 44 percent of married women of reproductive age in 1997. There is no question that this method is reliable and effective, but it is provider-dependent. Furthermore, there are relatively few countries in the region where this method is selected by such a large proportion of women. (Brazil and the Dominican Republic both have female sterilization use rates of 40 percent and 41 percent, respectively, and both have similarly high levels of overall contraceptive prevalence.149) Especially given the concern with demand for services based on prior knowledge of contraceptive options, it would behoove the various Mexican institutions to examine this issue.

Another issue related to method choice that may merit examination is the fact that the proportion of all modern contraceptive method users has stayed constant during the 1990s in Mexico, which indicates that the percentage of Mexican couples using traditional methods also has remained the same. It is likely that users of traditional methods are primarily the underserved populations.

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Operational Needs

More attention to management, training, IEC, and research and evaluation is needed to ensure that basic components of the service delivery programs remain strong and effective. Improvements in knowledge of family planning and reproductive health, especially among underserved populations, will depend on the availability of IEC materials and on stronger and more effective distribution systems for those materials. In the area of research and evaluation, more effort is needed in the public sector to decentralize research skills. The technical skills required for research and evaluation do exist in Mexico in both the public and private sectors. However, the cost of much of the research and evaluation activities has been beyond the means of Mexican institutions and donor support was essential to support these crucial activities. Similarly, production costs of IEC materials and mass media campaigns were generally funded externally, since the needed resources were not available through government budget allocations.

Developing and evaluating innovative strategies is another operational aspect of programs that will be key for the future. This was an important part of the USAID-Mexico agreement from the beginning, not only for improving programs but also for mobilizing Mexican resources and program support. The ability to demonstrate the benefit of an intervention was critical for making high-level policy makers aware of the issues and stakes involved, and it led to the institutionalization of well-tested and effective program strategies. Support for such research was financed externally, but internal mobilization may be feasible. For example, two of the recent national demographic surveys (ENADID, 1992 and 1997) were funded and carried out by the Mexican government. Among other things, these surveys were crucial for assessing the changes that occurred under the implementation of the USAID-Mexico agreement.

Many concerns remain about the functioning of the commodities and logistics systems in both the public and private sectors. Evaluations of these systems included numerous specific recommendations for the proper functioning of the new system and improvements throughout IMSS. In 1999, FPLM assessed a sample of SSA facilities in eight states and found that, while some aspects of the system were adequate, critical deficiencies undercut its functioning and its sustainability. More attention needs to be given to this component of service delivery programs.

South-to-South Cooperation

Mexican institutions have been working on South-to-South cooperation in the field of reproductive health for several years. The South-to-South program at the SSA’s DGSR, funded by UNFPA between 1996 and 1999, was a first attempt in this direction and involved transferring skills and knowledge to health care providers from 14 other developing countries. While this South-to-South work was not the direct result of the USAID-Mexico agreement, USAID’s CAs provided assistance for the initiative. The SSA took the lead, although other institutions also have been involved. For example, SSA and IMSS provided clinical training to medical personnel from Russia and countries in Latin America, Asia, and Africa in vasectomy and minilaparotomy methods. Following a modular, short-term, and practical approach, more than 220 managers and service providers from governmental and nongovernmental institutions

150 IMSS and FPLM/JSI, 1999.
151 SSA and FPLM/JSI, 1999.
have been trained in Mexico. Major training subjects have included policy making, reproductive health services, management, programs for adolescents, and women’s health. A set of videos has been produced covering these issues and follow-up missions to the participating countries are envisioned in the future.\(^{152}\) Other Mexican institutions, including MEXFAM, FEMAP, and the Instituto Nacional de Salud Pública, have also been active in exporting their successful approaches. However, given the demands and program needs within Mexico, it is difficult for the government and the private-sector institutions to carry out South-to-South activities systematically to ensure impact in recipient countries without support from the international donor community.

In promoting South-to-South initiatives, three basic principles of success or lessons learned, from Mexico and elsewhere, are that a) practical experiences, not theory, should be shared; b) short-term, on-the-job, and customized training should be provided as part of a strategy of human resource development; and c) governments need to be involved in policy dialog, although not necessarily in project execution.\(^{153}\)

\(^{152}\) Partners in Population and Development and Inter-institutional Group on Reproductive Health of Mexico, 1999.

SECTION 7
CONCLUSIONS

The purpose of this chapter is to provide a summary picture of the major achievements of the USAID-Mexico strategy, based on its impact on access and quality, and to highlight some of the main lessons learned from the implementation of this strategy.

Impact on Access and Quality

It is difficult, if not impossible, to isolate the contributions of a single program to the changes and improvements that occur in reproductive health in any country or institutional setting. However, in the case of Mexico, even if many other factors contributed to family planning program achievements, it is clear that the USAID-Mexico program itself had a number of highly beneficial effects. The evidence for this conclusion is provided below.

Key Demographic Indicators

Three population-based demographic indicators suggest that Mexico moved in the direction that its government and donors had anticipated and that the country came very close to achieving the targets set in 1995. The rate of growth of the Mexican population declined from 2.2 percent in 1992 to 1.8 percent in 1999, nearly reaching the Mexican government’s goal of 1.75 percent by 2000. Similarly, the total fertility rate dropped from 3.2 in 1990 to 2.5 in 1999, very close to the goal of 2.4 in 2000. Finally, the level of contraceptive prevalence among married women of reproductive age increased from 63.1 percent in 1992 to 68.4 percent in 1997, just short of the goal of 70.2 percent by 2000.

Access to Family Planning Services

Contraceptive use is a measure of access to family planning services. In the priority states, which were the focus of the USAID-Mexico strategy, the level of contraceptive prevalence increased from 58.2 percent to 64.1 percent between 1992 and 1997, an increase that was slightly greater than that for the country as a whole. Another important indicator of access is the gap in family planning use between urban and rural populations. For all of Mexico, this gap closed by almost six percentage points from 1992 to 1997, reaching levels of urban and rural use of 73.3 percent and 53.6 percent, respectively. For the priority states, the gap closed by almost seven percentage points, with levels of urban and rural use of 71.5 percent and 49.1 percent, respectively. Occurring during only five years, these changes are positive signs that access improved.

Public-Sector Service Delivery

Public-sector health institutions, for years the predominant source of family planning services in Mexico, actually expanded their role in family planning service delivery from 1992 to 1997. In all of Mexico, 72.6 percent of contraceptive users received their services from public-sector institutions in 1997, up from 66.6 percent in 1992. Among priority states, these institutions played an even greater role, serving 75.8 percent of all contraceptive users. Given the impressive
levels of expenditure by the Mexican government (US$238.5 million in 1997) compared to the combined expenditure of the two largest family planning NGOs (US$13.2 million in 1997), it is not surprising that the government's role increased.

Under decentralization, population and health services have largely become the responsibilities of the individual states in Mexico. However, previous and current experience with decentralization suggest that it is essential to prepare the states for their new responsibilities. In particular, improving local technical capacity, which typically varies and is not strong, is an essential prerequisite to successful decentralization.

The government's training efforts between 1992 and 1997, along with various strategies to improve access to contraceptive methods (particularly longer-term methods), resulted in sizable increases in the number of new acceptors of surgical methods and IUDs at IMSS, SSA, and ISSSTE. At the same time, the overall percentage of female sterilization users (a figure based on national survey data) stayed the same, although the absolute numbers of women increased. On the other hand, the percentage of women using IUDs increased while the proportion using hormonal methods declined. Government information, education, and communication activities also appeared to have had notable success given the large decline—from 20 percent to 8 percent—in the proportion of nonuse of family planning attributable to lack of awareness of methods.

Training

This report has described the various efforts that were carried out in the 1990s to improve service quality and to increase access to longer-term contraceptive methods. As an example of these efforts, training on a range of topics related to family planning and reproductive health reached more than 68,600 service providers: 70 percent were from IMSS, 12 percent were from SSA, and 18 percent were from ISSSTE. A huge effort was undertaken to provide training in counseling and informed consent, since these comprise key elements of high quality services, and about 40 percent of all trainees attended such sessions. As a corollary to the training activities directed at service providers, the government also supported large-scale IEC efforts on informed consent and informed demand to enhance client awareness and their role in decisionmaking about their contraceptive needs. This activity is considered one of the most important advances made by public institutions under the USAID-Mexico strategy aimed at improving program quality.

Between 1992 and 1999, training activities moved away from a narrow focus on family planning to a broader reproductive health approach, yet one lesson learned from the training activities and the post-training evaluations is that the concept of reproduction is, at best, poorly understood by some service providers and clients. Thus, the components of a reproductive health approach involving the concepts of comprehensive and integrated care, together with the need for a gender perspective, are not well appreciated or often included in service provision. For example, women usually are not screened for reproductive health needs other than those for which they explicitly state a need at the health facility. This finding highlights the need for continuing both preservice and refresher training activities.

Another lesson relates to the lack of evaluation of some of the training models. The cascade training model, which established networks of trainers, did not appear to be very effective;
however, since no evaluation was conducted, it was not possible to establish its effectiveness. One example of a training model that worked successfully, however, was the IMSS-PRIME model, which was tested before introduction at primary care levels. This pilot project used an integrated approach, using a participatory, client-centered methodology that strengthened staff skills at peripheral units. Since it was found that only a few projects included the gender perspective as an integral part of their approach, further efforts are required to operationalize gender concepts and to ensure their inclusion in reproductive health services.

Quality of Care

During the 1990s, the Mexican government also supported a major effort to emphasize the reproductive health context for family planning and to improve the quality of care provided to clients. The impact of the training, IEC, and reproductive health activities and programs can be seen, to some extent, in the results of the national surveys and the several evaluation studies that were conducted. Progress was clearly made in enhancing the reproductive health agenda and programs and a wide range of activities reflect these areas of emphasis:

- A reproductive health program for adolescents — the first one in Latin America — reflects the need for segmenting markets and expanding services to underserved groups.
- An emphasis on quality of care, including expanding the choice of methods available, led to the introduction of no-scalpel vasectomy, and minilaparotomy at health facilities, and training for clinical staff in insertion and removal of implants was also carried out following introductory clinical trials.
- USAID technical assistance helped increase access to hormonal methods, IUDs, and post-obstetric contraceptive services; one example was the USAID-supported training of rural-based nonphysician staff in family planning, with an emphasis on IUD insertion. The result of this training was that new IUD acceptors increased threefold at rural facilities operated by IMSS-Solidaridad.
- Training in prenatal care, delivery, postpartum and neonatal care, and family planning for lay midwives has helped to extend and improve their capability for providing services, thus improving quality of care.
- Technical assistance was provided for developing training curricula for interpersonal counseling.
- To strengthen managerial capabilities, continuous quality improvement (CQI) techniques were implemented in both the public and private sectors, allowing staff to highlight and remedy operational problems.

Standardization of Norms

One of the first steps to improve quality of services initiated by the Mexican government was the production of an up-to-date set of service delivery norms for family planning. This effort was undertaken by an interinstitutional committee composed of public and private institutions involved in providing reproductive health services and included family planning NGOs and women’s groups. USAID CAs provided technical assistance through the provision of guidelines and recommendations based on internationally accepted norms and protocols and also helped with publication and distribution. However, while distributing copies of norms for RH services is an essential step in improving quality of services, it is not a sufficient step. Unless institutions
set up mechanisms or opportunities for staff to study norms and put them into practice, they will not necessarily be read nor will they have an effect on services.

Research and Evaluation

Given the wide range of service delivery topics that can be addressed through operations research, it is incumbent on the local community of researchers, who have been involved in its implementation, to review the various studies and produce a synthesis of results that will be useful in the particular setting or country. These results should be accompanied by a list of recommendations for improving health services. In Mexico, an impressive compendium of results and recommendations on family planning services was produced.\(^{154}\)

Reproductive Risk Approach

The concept of reproductive risk became a useful strategy in the public sector’s effort to increase access to and use of family planning. The Mexican government, particularly IMSS, developed and used this strategy to foster commitment among providers to focus on the need for family planning and as a way to promote use of family planning among clients. Over time, this concept also may have led to problems with lack of informed consent: It appears that, in some cases, providers applied the concept of reproductive risk too rigidly, overlooking the rights of women and couples to decide for themselves what types of methods would best suit their needs. To overcome such problems, public-sector health institutions carried out a major and still ongoing, effort to train (and in many cases, retrain) providers to follow the principles of informed choice and consent. In addition, part of CONAPO’s mass media campaign, Planifica es cuestión de querer, was designed to promote “informed demand” among potential clients; in other words, to get clients to become aware of their own needs for contraception and to decide for themselves on the best way to meet those needs.

While instances of successful IEC interventions are included in this report, it should be noted that some important lessons were learned from implementing the less successful campaigns. Some of the IEC materials were not necessarily linked to a service delivery or training strategy and, in some cases, effective dissemination plans were not developed. In other cases, audience research involved overlap or duplication of subjects and themes. Continued emphasis on close collaboration among the public-sector and private-sector institutions would prevent this occurrence in the future. The fact remains, however, that as a result of the implementation of the USAID-Mexico strategy, a wide variety of proven, high-quality IEC materials have been produced and are available for use either within Mexico or in other developing countries; their continued use in reproductive health programs should be encouraged.

Adolescents

Adolescents, as a group, are among the most significant challenges facing both the public and private sectors and, as such, the USAID-Mexico collaboration strategy included a number of activities designed to improve adolescent sexual and reproductive health. The SSA developed a specific program based on an integrated model with service provision, IEC, training, and evaluation components in their health centers and hospitals. The IMSS developed a three-pronged strategy: an urban focus in which providers were trained in adolescent services, an

\(^{154}\) Vernon and Palma, 1998.
urban-poor focus with an IEC component designed to increase community participation, and a focus on rural and indigenous populations, implemented through service units and a network of IMSS-Solidaridad community personnel, with an emphasis on training and research. The ISSSTE included training of its staff in adolescent reproductive health services as a central component. CONAPO’s IEC activities were carried out through a diffusion of television and radio spots focused on adolescents and the establishment of a telephone information service for adolescents called Planificatel. Based on program experience, it is clear that greater efforts will be required to increase coverage among this target group, since married adolescents between the ages of 15 and 19 years have the lowest level of contraceptive use, at about 43 percent in the priority states. Many young couples continue to lack the motivation to delay their first birth. For instance, one MEXFAM survey in 1999 found that only half of young men and about one-third of young women had used contraception at first intercourse. Many of the young women claimed they had not used contraception since they wanted to get pregnant. An additional problem discovered was that the most popular methods nationally, such as sterilization and IUDs, are not appropriate for this target group and that other methods need to be promoted.

**Domestic Violence**

A training module for identifying and managing domestic violence was developed. The module was used to sensitize approximately 400 health care professionals about domestic violence and to develop strategies to recognize and provide proper management of detected violence cases. While such training undoubtedly increased the participants’ knowledge about how to identify and manage cases of domestic violence, some of the participants felt that the training was not sufficient for providing such services at the level of primary health care facilities. This result may indicate the need for centers that are specialized in assisting domestic violence victims.

**Reproductive Health Outreach**

One innovative intervention supported by the USAID-Mexico strategy was to send a team of clinicians on a periodic basis to rural hospitals and selected rural medical clinics to extend access to modern contraception, especially longer-term methods such as voluntary surgical contraception (VSC) and IUDs that require more well-trained personnel. These sessions were found to be very effective in reaching women in isolated communities. The great majority of women served by this outreach were satisfied with the timing of the session and with the procedure itself, and they liked the strategy of holding such sessions for a group of women, thus reducing the fear of being operated on.\(^{155}\) To ensure quality of care among users of VSC and IUDs, these service providers were trained not only in contraceptive technology and family planning norms but also in counseling and informed consent. Similarly, a campaign involving both promotional and health care activities was developed to increase access to reproductive health services among marginal urban populations. This campaign involved home visits as well as sessions at schools for students and their parents.

Additional lessons learned relating to quality of care pertain to family-friendly clinics and postabortion care. Family-friendly clinics were based on the baby-friendly and mother-friendly hospital models and could be implemented at ambulatory care facilities as an application of comprehensive reproductive health care. Key components of this strategy included:

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\(^{155}\) IMSS, “Evaluacion de las Jornadas Quirurgicas en hospitales y unidades medicas rurales del IMSS. Informe Final de Resultados, March 1999.
1) developing benchmark process indicators for promotion, training, service delivery, and health promotion; 2) developing and testing evaluation instruments for assessing and certifying clinics; and 3) training staff to participate actively in the process. During the testing of alternative models for postabortion care, it was found that inclusion of additional counseling topics, such as a discussion of the client’s emotional state and her reproductive intentions, was associated with higher levels of acceptance of postabortion family planning services, greater satisfaction with the information received, and increased continuation of contraceptive use.

**NGO Sustainability**

The accomplishments in the private sector involving MEXFAM and FEMAP are encouraging, although the final word on the outcome of the focus on sustainability was not available at the time this report was prepared. Both NGOs appeared to be surviving the end of USAID assistance: FEMAP appeared to be thriving and MEXFAM seemed poised to do so. However, the NGOs’ original mandates of reaching the most marginalized segments of the population were only partially accomplished.

**MEXFAM.** This NGO witnessed impressive growth in its medical clinics program and in the income derived from these clinics. The number of provided medical services increased greatly after 1992 and the income from such services—negligible in 1992—now represents more than 60 percent of MEXFAM’s total income. In its community program, the number of community-based promoters doubled, the number of new acceptors was increasing, and the number of people reached through information and education efforts increased during this period. While MEXFAM’s total income in 1998 was about one-third greater than in 1992, the transition in source of income from donations to sales of services was outstanding.

Several key lessons were learned through provision of technical assistance to MEXFAM in its efforts to improve financial sustainability. First, significant institutional changes are difficult to implement when the mission and existing organizational culture are threatened. Second, a decentralized organizational structure coupled with good management capabilities is likely to lead to greater financial sustainability than a highly centralized model. Among the lessons learned that MEXFAM prepared for USAID CAs in 1997 was the recommendation to decentralize both financial and marketing decisionmaking and the recognition that cost monitoring and control and investment in quality of care are key to sustainability.  

**FEMAP.** FEMAP experienced substantial institutional growth, with an increase of about 50 percent in the number of its affiliates and an increase of nearly 20 percent in the number of community promoters. More noteworthy is that the number of people reached through its information and education activities more than doubled. FEMAP’s income between 1992 and 1998 increased about 2.5-fold. This enormous growth resulted from a rise in sales and income from medical services as well as local donations.

Both MEXFAM and FEMAP succeeded in replacing USAID support and, thus, in meeting the original objectives of the Transition Project. It is not possible to comment on improvements in the quality of services because no reliable trend data are available from either institution. The profile of each organization’s clients suggests that MEXFAM stayed closer to its mission of

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serving low-income populations while FEMAP concentrated its service delivery efforts on the middle classes.

**Cost Studies**

Cost analysis to determine the actual operational costs and the costs associated with providing services is an important first step for cost control and cost recovery efforts. Once a cost analysis is carried out, institutional standards on service prices and staff productivity can be developed and implemented as part of a sustainability plan. This lesson was borne out by the series of cost studies carried out by FEMAP, with technical assistance through USAID. A detailed costing methodology was developed for FEMAP and a cost analysis manual was produced; the manual is being used to estimate and monitor costs and expenditures.

**Future Prospects**

To judge the future sustainability of both organizations, it would be necessary to examine the income and expenditure reports for 1999 and 2000, which were pending at the time this report was prepared. However, the shifts that occurred in client profiles and in the organizations' directions are the inevitable result of the move toward greater sustainability.

**USAID-Mexico's Strategic Approach**

The USAID-Mexico agreement ushered in the last phase of USAID assistance to Mexico, and the strategic approach that guided the implementation of this agreement appears to have been effective. The four principal components of the strategy involved targeting assistance at priority states, consolidating the range of activities and agencies providing technical support, mobilizing Mexican resources for family planning and reproductive health programs, and coordinating the work of the cooperating agencies.

**Targeting**

The USAID-Mexico strategy concentrated its assistance on priority states because it was determined that such assistance would have the greatest impact in working with the government institutions. Priority states were defined based on three demographic indicators: percent rural population, infant mortality rate, and total fertility rate. CONAPO, the Mexican Population Council, prepared a list of the selected priority states that then became the focus of USAID’s assistance. This method of identifying the states with the greatest needs proved to be a valuable tool for focusing USAID assistance, since Mexican national survey data (as presented elsewhere in this report) suggest a somewhat greater impact in these states. At the same time, it must be remembered that some efforts—such as training and IEC—were also carried out in nonpriority states to help institutionalize their benefits throughout the three public health institutions.

Consolidating efforts and resources around fewer activities also occurred to some extent, although there were still six institutions (four in the public sector and two in the private sector) that benefited from a range of activities. Additionally, there were between 14 and 20 CAs that provided technical assistance and training for much of the last phase of USAID technical assistance. Consolidation of efforts was emphasized from the beginning, through
interinstitutional coordination during the USAID-Mexico strategy planning process, thus allowing for structuring and organizing projects among the several public-sector institutions to prevent overlap and duplication of efforts.

Consensus was achieved among the public institutions to establish five general lines of action within the USAID-Mexico strategy: 1) service delivery, 2) IEC, 3) training, 4) evaluation and research, and 5) supervision and follow-up. Reinforcing the service-delivery component received 37 percent of total funding; IEC activities received 29 percent; personnel training received 17 percent; and evaluation and research activities received 10 percent. The remaining funds were allocated to supervision and follow-up activities.

While the above figures relate to the total budget, each participant institution established its priorities according to its own institutional needs. Thus, IMSS decided to allocate the majority of funding to reinforcing the service delivery component, SSA devoted its efforts to enhancing its IEC strategy, ISSSTE decided to reinforce personnel training, and CONAPO’s projects were aimed at implementing a communication strategy and developing rigorous evaluation studies.

**Resource Mobilization**

Mobilizing Mexican resources was a key part of USAID’s strategy, resulting in the increase of local resources in both the public and private sectors. The increase in Mexican resources spent by the public-sector institutions for family planning and reproductive health in the 1990s (from US$67 million to US$239 million) was extraordinary. In addition, the increase in income from local sources through the sale of services and local donations, for MEXFAM and FEMAP combined, increased from US$2.4 million in 1992 to US$6.9 million in 1998. The process of developing innovative strategies and evaluating ongoing ones assisted in making local resource mobilization a reality. Technical assistance in demonstrating the benefits of key programs and activities was crucial in the process of making high-level policymakers aware of the issues and stakes involved.

Coordinating technical assistance by the 14 or so CAs was a critical part of the agreement and was the responsibility of USAID, and the contribution of the CAs to programs in Mexico underscores one of the unique aspects of USAID assistance. No other donor could call on these tremendous resources to provide technical expertise and assistance for expanding and improving service delivery programs in family planning and, more recently, in reproductive health.

USAID’s role was considered not only to have been catalytic but also fundamental to the national family planning program in Mexico. Important to mention in this regard is the effort developed by Pathfinder to provide support for strategic planning. Officials from key Mexican institutions and USAID are in agreement that together they achieved significant successes in improving the quality of family planning services, expanding the reach of the national family planning program, lowering fertility, and slowing the population growth rate. In addition, the public-sector and private-sector programs in Mexico appear to have evolved to the point of not having to rely on USAID funding or technical assistance for continued service delivery. It should be recognized, however, that some quarters continue to contend that the end of USAID funding has had deleterious effects on in-country programs. To counter these negative effects they recommend continued collaboration among Mexican programs, USAID, and the CAs to ensure that Mexican programs will have access to new technology and information as they strive to expand access to the remaining underserved groups, improve service quality, and assist other countries’ programs through South-to-South initiatives.
### APPENDIX A:
### LIST OF ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVSC</td>
<td>formerly AVSC International, now EngenderHealth</td>
</tr>
<tr>
<td>BHM</td>
<td>Basic Health Management, Inc.</td>
</tr>
<tr>
<td>BTO</td>
<td>bilateral tubal occlusion</td>
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<tr>
<td>CA</td>
<td>cooperating agency</td>
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<tr>
<td>CBD</td>
<td>community-based distribution</td>
</tr>
<tr>
<td>CDC</td>
<td>United States Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>COESPOs</td>
<td>Consejos Estatales de Población (state-level population councils)</td>
</tr>
<tr>
<td>CONAPO</td>
<td>Consejo Nacional de Población (National Population Council)</td>
</tr>
<tr>
<td>CPR</td>
<td>contraceptive prevalence rate</td>
</tr>
<tr>
<td>CQI</td>
<td>continuous quality improvement (Programa de Mejora Continua)</td>
</tr>
<tr>
<td>CYP</td>
<td>couple-years of protection</td>
</tr>
<tr>
<td>DGSR</td>
<td>General Directorate of Reproductive Health</td>
</tr>
<tr>
<td>ENADID</td>
<td>Encuesta Nacional de la Dinámica Demográfica (National Survey of Demographic Dynamics)</td>
</tr>
<tr>
<td>FEMAP</td>
<td>Mexican Federation of Private Health and Community Development Associations</td>
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<tr>
<td>FHI</td>
<td>Family Health International</td>
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<tr>
<td>FPLM</td>
<td>Family Planning Logistics Management project</td>
</tr>
<tr>
<td>FPMD</td>
<td>Family Planning Management Development project</td>
</tr>
<tr>
<td>I&amp;E</td>
<td>information and education</td>
</tr>
<tr>
<td>IEC</td>
<td>information, education, and communication</td>
</tr>
<tr>
<td>IMSS</td>
<td>Instituto Mexicano de Seguridad Social (Mexican Society Security Institute)</td>
</tr>
<tr>
<td>INEGI</td>
<td>El Instituto Nacional de Estadística, Geografía e Informática</td>
</tr>
<tr>
<td>INOPAL</td>
<td>Investigación Operativa en Planificación Familiar y Atención Materno-Infantil para América Latina y el Caribe (Operations Research in Family Planning and Maternal and Child Health for Latin America and the Caribbean)</td>
</tr>
<tr>
<td>INTRAH</td>
<td>Innovative Technologies for Health Care Delivery (at the University of North Carolina School of Medicine)</td>
</tr>
<tr>
<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
</tr>
<tr>
<td>ISSSTE</td>
<td>Instituto de seguridad y Servicios de los Trabajadores del Estado (Social Security Institute for State Workers)</td>
</tr>
<tr>
<td>IUD</td>
<td>intrauterine device</td>
</tr>
<tr>
<td>JHU</td>
<td>Johns Hopkins University</td>
</tr>
<tr>
<td>JSI</td>
<td>John Snow International</td>
</tr>
<tr>
<td>LAC</td>
<td>Latin American countries</td>
</tr>
<tr>
<td>MEXFAM</td>
<td>Mexican Foundation for Family Planning</td>
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<tr>
<td>MOU</td>
<td>memorandum of understanding</td>
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<tr>
<td>MSH</td>
<td>Management Sciences for Health</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>NSV</td>
<td>no-scalpel vasectomy</td>
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<tr>
<td>OR</td>
<td>operations research</td>
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<tr>
<td>PAC</td>
<td>Programa de Ampliación de Coberturs (Coverage Extension Program)</td>
</tr>
<tr>
<td>PCS</td>
<td>Population Communication Services (of Johns Hopkins University)</td>
</tr>
<tr>
<td>POPTECH</td>
<td>Population Technical Services project</td>
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<tr>
<td>PRIME</td>
<td>Program for International Training in Health</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>PROGRESA</td>
<td>Programa de Educación, Salud, y Alimentación (Program on Education, Health, and Nutrition)</td>
</tr>
<tr>
<td>SDP</td>
<td>service delivery point</td>
</tr>
<tr>
<td>SOMARC</td>
<td>Contraceptive Social Marketing project</td>
</tr>
<tr>
<td>SSA</td>
<td>Secretaría de Salud (Ministry of Health)</td>
</tr>
<tr>
<td>STD</td>
<td>sexually transmitted disease</td>
</tr>
<tr>
<td>TFGI</td>
<td>The Futures Group International</td>
</tr>
<tr>
<td>TFR</td>
<td>total fertility rate</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations International Children’s Emergency Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>VSC</td>
<td>voluntary surgical contraception</td>
</tr>
</tbody>
</table>
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