

**USAID/MEXICO POPULATION ASSISTANCE
PROGRAM: MIDTERM ASSESSMENT OF
PRIVATE SECTOR COMPONENT**

POPTECH Report No. 96-072-038
May 1996

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Prepared for

U.S. Agency for International
Development
Bureau for Global Programs, Field
Support and Research
Office of Population
Contract No. CCP-3024-Q-00-3012

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The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

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EXECUTIVE SUMMARY

The USAID/Mexico Population Assistance Strategy for 1992 - 1997 has two broad objectives: 1) increase access to and use of modern family planning (FP) information and services in Mexico's poorest and most densely-populated areas; and 2) increase the financial self-reliance of public and private sector (population) agencies with which USAID has been cooperating for the past several years. Public sector agencies include the Ministry of Health (SSA), the Mexican social security systems for the "formal" work sector and GOM employees (IMSS and ISSTE, respectively), and the National Population Council (CONAPO). Private sector organizations include the Mexican IPPF-affiliate MEXFAM, and the Mexican Federation of Private Associations for Health and Community Development (FEMAP).

Since 1992 MEXFAM and FEMAP have been receiving USAID financial, technical, and commodity assistance intended to facilitate the two organizations' steps toward self-sufficiency. The primary vehicle for the non-commodity portions of this assistance has been the Transition Project (TP) of IPPF/WHO; but USAID assistance has also included technical support from Management Sciences for Health (MSH), JSI, The Futures Group/SOMARC, and the Population Council. The Transition Project is scheduled to end June 30, 1997. Technical assistance provided by the other participating CAs does not have an explicit end-date, but is generally assumed to be roughly co-terminus with the TP. This is particularly the case with SOMARC, which helps organize marketing studies and promotions for the several "centros de servicios medicos" (CSMs) established by MEXFAM under the TP.

POPTECH was asked by USAID to conduct an assessment of the two private agencies' performance in meeting their financial sustainability objectives. The assessment took place during the last two weeks in February, 1996. Shortly before the assessment team departed for Mexico, the USAID population assistance budget was significantly reduced as a result of Congressional cost-cutting and an Executive Branch-Congressional impasse over population assistance policy. The reduction in the Agency's population account (in combination with other efforts to streamline and focus Agency programming) strengthened the resolve of USAID/Washington to conclude USAID's population assistance activities in Mexico in the relatively near future, i.e., in keeping with the 1992 Strategy Statement. USAID/Mexico and MEXFAM, however, had anticipated a longer-term relationship, and are concerned that a near-term phaseout will be disruptive to MEXFAM's program.

Key Findings and Recommendations:

MEXFAM and FEMAP have played significant and valuable roles in promoting the reproductive health of Mexico's poorest citizens. Both organizations have strong, dedicated managers and staff. They have been creative in developing innovative ways to deliver FP information and services to "hard-to-reach" and marginalized population groups. USAID staff, in both Washington and Mexico, attach a very high value to the long-standing partnership with MEXFAM and FEMAP.

The two organizations have approached the challenges of an assistance phaseout in very different ways.

MEXFAM, assuming that USAID support would continue for several more years, has utilized TP resources to 1) continue most elements of its service and information delivery program, with emphasis on poor rural and peri-urban populations (the "social program"); and 2) launch a series of medical clinics (the CSMs), designed to serve middle-class clients--clinics which would generate enough net income (profit) to eventually replace USAID funds currently used to support MEXFAM's social program. The key finding of the assessment with regard to MEXFAM is that the CSMs will not achieve their projected earnings, although many of them may achieve a break-even point or realize modest profits if given enough time to develop a client base. Absent this expected income, major elements of the social program are vulnerable to significant and unanticipated cut-backs. The assessment team recommended that MEXFAM make some overdue adjustments now to the social program--including the near-elimination of the low-impact/high cost Industry program (PIN), and commodity-transfer activities such as the Program of Technical Cooperation (PCT)--and begin a rigorous strategic planning process designed to identify and develop a post-TP role for the organization. Given MEXFAM's late start in getting this process under way--and the CSMs' need for more time to attract and hold a client base--the team also recommended a one-year extension of support for MEXFAM. This support could be provided either via a one-year, no-cost extension of the TP, or through another assistance mechanism; but in either case would enable MEXFAM to address the phaseout challenge in a methodical and least-disruptive manner. The team further recommended that USAID continue contraceptive assistance to MEXFAM during this extended period, albeit at lower levels than in the past, and that the Agency assist MEXFAM to obtain more cooperation from commercial vendors of contraceptive products on matters of pricing and product registration.

As a de-centralized network of largely autonomous and self-supporting organizations, FEMAP is less vulnerable to reductions in USAID funding than is MEXFAM. FEMAP was therefore able to use TP funds and related technical assistance to strengthen its technical and management capacity, and to help

transfer these skills to some 18 of the organization's 44 affiliates countrywide. Indeed, FEMAP's leadership is not greatly concerned over the timing or consequences of a phaseout of USAID assistance--an exception being their still-unresolved need to secure favorable prices from pharmaceutical firms for oral contraceptives currently provided on a donation basis by USAID. The assessment team recommended that USAID also extend its assistance relationship with FEMAP for one additional year, and that both parties utilize this time primarily to address this contraceptive supply issue.

1. Background and Context

1.1 The USAID/Mexico Population Strategy

In January, 1992 USAID/Mexico presented a new population assistance strategy for Mexico for the period 1992-1996. The main objective of the strategy was to focus USAID population assistance efforts 1) where there was the most unmet need; and 2) where there was most potential for demographic impact. The strategy called for a significant streamlining of the number of discrete activities being carried out, and a consequent reduction in the number of Cooperating Agencies working in Mexico.

Another important objective of the strategy was to increase program self-sufficiency. For the public sector, this included a gradual decrease in the quantity of contraceptives donated by USAID to the MOH and IMSS, and a gradual increase in GOM contraceptive purchases in support of the national family planning program. The GOM was also expected to increase its overall budgetary support for the national program.

For the private sector, self-sufficiency objectives included: increased domestic (Mexican) support for MEXFAM and FEMAP, in both absolute and proportional terms; improvements in the two organizations' income generating capacity; and the establishment of mechanisms to ensure their long-term financial stability. USAID pledged to support such measures as:

- technical assistance and training in fund raising
- technical assistance and training in the identification of appropriate income-generation activities, e.g., laboratory services; for-profit family planning services in industrial establishments; fee-for-service agreements with IMSS, private insurers, etc.
- support for selected income-generating activities to test their operational feasibility and profit potential;
- support, with other donors, to establish an endowment(s) for private sector family planning agencies (including exploration of a possible debt swap)

In order to implement the strategy with a reduced number of CAs, Pathfinder International was charged with overseeing activities with the public sector, and IPPF/WHR assumed responsibility for the private sector. While other specialized CAs were to be involved in the Mexico program, their activities were to be coordinated through Pathfinder and IPPF/WHR.

1.2 The IPPF/WHR Transition Project

In June, 1992, IPPF/WHR and USAID signed a five year cooperative agreement for the US\$68.8 million Transition Project (TP). The project's six objectives were to:

- Increase access to family planning services
- Broaden the range of contraceptive methods available in skewed method mix settings
- Strengthen institutional capacity of the FPAs
- Develop strategies to improve and expand services
- Evaluate performance and impact of programs
- Document and disseminate lessons learned

In December, 1993, a USAID management review concluded that service *expansion* was incompatible with sustainability; IPPF/WHR subsequently changed its service goal to *maintanance* of FP service volume.

The TP defined sustainability as “the ability to recover the cost of family planning services previously funded by USAID with local income and to continue providing the same volume and quality of services to low-income populations.” Moreover, the TP identifies four indicators of sustainability--reflecting the notion that an organization's financial status is but one aspect of overall sustainability. These indicators are:

1. Service volume - “FPA ability to maintain their former volume of family planning services during the phaseout period and after USAID funding ends.” (This indicator was dropped at the end of 1993).
2. Client profile - “ability to identify and serve a clientele consistent with their mission.” (This was the basis for MEXFAM's continuation of support, under the TP, for its social programs).
3. Quality - “ability to maintain high levels of service quality both during and after phaseout period.” (MEXFAM is currently implementing, with MSH support, a “quality of medical care” program in all of the CSMs).
4. Financial - “able to replace funds formerly donated by USAID with local income and to what extent are they able to account for and control costs.” (Performance against this indicator depends heavily on the financial performance of the CSMs).

In Mexico, TP support was provided to both MEXFAM and FEMAP. The TP enabled the two organizations to 1) continue their then-current programs, while 2) helping them to develop and implement measures which would enable the

organizations to effectively replace USAID funds by the end of the project on June 30, 1997. MEXFAM utilized TP resources to continue most of its “social” program, i.e., the activities supported under the Matching Grant, and to launch 17 “Centros de Servicios Medicos” (CSMs). The CSMs were intended to generate enough income to replace the USAID funds used to support portions of MEXFAM’s social program. FEMAP utilized TP resources to upgrade the management capabilities of its affiliates through technical assistance, training and equipment purchases (computers and fax machines).

1.3 Purpose and Context of the Assessment

USAID (Mexico and Washington) asked POPTECH to conduct a mid-term assessment of the private sector component of the USAID population assistance program, but with special emphasis on the performance of MEXFAM and FEMAP in their efforts to achieve financial self-reliance. Given the relatively brief duration of the assignment (two weeks), and the many cooperating agencies involved (Futures/SOMARC, MSH, IPPF/WHR, Population Council, Georgetown Univ.) in the program, the team was expected to focus on the overall impact of the assistance effort, and not attempt to evaluate the performance of individual CAs.

Severe reductions in the USAID population account had been announced shortly before the assessment was organized, and had the effect of strengthening USAID/Washington’s resolve that the TP represented USAID’s terminal funding commitment to the two Mexican NGOs. USAID/Mexico, however, held a longer term view of the USG’s funding commitment, at least with regard to MEXFAM, and was planning a more drawn-out-phaseout schedule. An added task of the assessment team was therefore to recommend to USAID/M and USAID/W a reasonable phaseout plan in the context of these differing expectations and the Agency’s severe resource constraints.

2. MEXFAM

2.1 MEXFAM Overview

2.1.1 Mission, Social Policy and Strategies

MEXFAM's mission is to provide high quality and innovative services in family planning, reproductive health and sexual education. Its policy statement notes that "MEXFAM is a social service institution which dedicates all the donations it receives and any profits it may make from its operations to services directed to the most needy population of Mexico: the poor and the youth". MEXFAM works through six programs throughout Mexico. (TABLE 1). MEXFAM refers to the community doctors, the rural community-based distribution (CBD), the industrial program and the youth program as its "social programs," meaning these programs serve social welfare ends, directly related to its mission. The collaborative program (formerly called PAI or program of institutional support) is understood to serve both political and service delivery ends. Thirteen medical centers, (Centros de Servicios Medicos-CSMs) eleven of which were opened under the Transition Project, operate to generate income to cross-subsidize the social programs and to "anchor" the social programs.

Program	# of CYP	% of total reported CYP	# of new users	% of reported new users
API - community MDs in peri-urban areas	63,263	21%	97,352	33%
APEX - rural CBD	98,951	34%	146,152	50%
CSM - Medical Centers	12,866	4%	10,740	4%
PIN - Program with Industries	6,879	2%	38,117	13%
PJ - Youth Program	2,235	1%	738	<1%
subtotal	184,194	62%	293,099	100%
CT - Collaborative Programs	110,578	38%		
total	294,772	100%		

Over the life of the Transition Project, 1993 to the present, the reported number of new users and of CYP has significantly declined. Reasons include reductions in the collaborative and pass-through programs, closure of some clinics and centers for cost-reduction purposes, and in some measure the scaling back of activities in the strife-torn Chiapas region.¹

One of the Transition Project's sustainability indicators was an FPA's ability to identify and serve a clientele consistent with the FPA's mission. For MEXFAM, this clientele includes the women and men served by the social programs. The clientele targeted by the CSMs is at a higher socio-economic level. Using educational level as a proxy for socio-economic level, MEXFAM data indicate that the social programs and the medical centers do serve different clients. See TABLE 2 below which presents the level of education of sampled MEXFAM clients compared to data from the 1992 *Encuesta Nacional de la Dinamica Demografica* (ENADID) (percentage in parentheses). While the educational level of patients receiving services from the CSMs parallels the ENADID profile, clients in the social programs in Mexico City and in Ixtaltepec had less education than respondents in the ENADID sample.

TABLE 2: Level of Education of Sampled MEXFAM Clients in Three Programs (1996) Compared to ENADID 1992 Results					
Program and Location	without instruction	incomplete primary	complete primary	completed junior high school	completed high school and above
2 CSMs in Mexico City N= 110	3% (2%)	8% (10%)	19% (15%)	26% (29%)	44% (43%)
Community MDs in Mexico City N=50	10% (2%)	24% (10%)	40% (15%)	20% (29%)	6% (43%)
Community MDs in Acapulco, N= 70	3% (23%)	26% (21%)	31% (18%)	36% (17%)	4% (21%)
CBD in Ixtaltepec N=47	32% (23%)	47% (21%)	17% (18%)	4% (17%)	0% (21%)

Source: MEXFAM and ENADID

¹ In 1991 MEXFAM reported 401,307 new users and a CYP of 435,973 based on the old USAID conversion factors (note the CYP figure above is calculated on the basis of the revised CYP conversion factors.)

2.1.2 Structure and Staffing

MEXFAM consists of a central office in Mexico City with 35 payroll personnel and eleven small regional offices (*nucleos productivos*) with a total of 95 payroll personnel and many more clinical professionals working on commission. (See Annexes A and B.) Each *nucleo productivo* supervises one or two medical clinics and the several social programs which are implemented to varying extents in the geographic areas surrounding the *nucleo productivo*.² These programs include:

- The API, or community doctors program: MEXFAM assists private doctors and peri-urban communities to open and maintain small “consultorios” in underserved, low-income, urban areas. Previously, MEXFAM gave financial and technical support directly to an individual physician in the community; increasingly, however, MEXFAM works with the community to set up the small clinic (MEXFAM providing furniture, medical equipment, supplies and contraceptives) and recruits a physician to work in it. Should a physician decide to move his/her practice to a more affluent community, MEXFAM's and the community's investment in the consultorio remains in the community. The *consultorios* charge US\$4.50-12.00 for a variety of basic health care services. A family planning visit, including an exam, is approximately US\$5.00. Most *consultorios* receive contraceptives free from MEXFAM and sell them at a token fee. In 1995, the API program accounted for 21% of MEXFAM's total CYP, 33% of reported new users, and 12% of direct program costs. In 1995, API operated at a deficit of US\$248,444 without counting the value of contraceptives or indirect costs.
- The APEX, or rural community-based distribution program (CBD): This program targets the rural poor identified in the 1992 Private Sector Strategy. Services are provided by over 2000 volunteers (*promotoras*) who receive token payments or in-kind gifts, and who are supervised by MEXFAM employees and workers on honoraria at each *nucleo productivo*. While some *promotoras* sell contraceptives at minimal prices (consistent with MEXFAM's policy to recover costs when/where possible), most *promotoras* provide orals and condoms free. In 1995, the APEX program accounted for 34% of MEXFAM's CYP, 50% of new users, and 24% of direct program costs, and operated at a deficit of US\$615,975 without counting the value of contraceptives or indirect costs.

²Twenty-six percent of the total direct service delivery CYP is reported by the Tlalpan *nucleo productivo* situated in MEXFAM's headquarters; half of that derives from the large Community Doctors program in peri-urban areas covered by that *nucleo productivo*. Other *nucleo productivos* support far smaller programs; two of them report CYP <500 from direct service delivery. See Annex C.

- The IND, or program with industries: Primarily a program of IEC and distribution of free condoms and orals in urban and peri-urban factories, this program serves urban workers who could receive free services/supplies through Social Security (IMSS), albeit after a prolonged wait and/or with the possibility of a contraceptive stock-out. In 1995 the program accounted for 2% of MEXFAM's total CYP, 13% of new users, and 3% of direct program costs. Although established to generate income, last year the industry program operated at a deficit of US\$66,748 without counting the value of contraceptives or indirect costs.
- The *Gente Joven* (PJ), or youth program: MEXFAM reaches low-income urban youth (10-24 years) through a variety of innovative channels including community and athletic centers, schools, gang headquarters, and rock concerts. The message, given by youth to youth, stresses responsible sexuality and responsible parenthood. The program is not designed to generate CYP or new users; last year it accounted for 1% of MEXFAM's CYP and new users and 3% of direct program costs.³ In 1995 it operated at a deficit of US\$114,348 without counting the value of contraceptives or indirect costs.
- CSM, or medical centers: When the Transition Project began, MEXFAM had been operating two clinics in middle class neighborhoods in Mexico City for a number of years. Under the Transition Project, MEXFAM opened 15 additional clinics intended to generate income which would replace USAID-donated funds. Four of these new clinics, after opening, were downgraded to *consultorios* and the facilities and equipment turned over to local physicians. The others continue to serve middle class clients with a variety of medical services; family planning is, by design, a minor part of these services. Last year the CSMs accounted for 4% of MEXFAM's CYP and new users and 50% of total program costs. Program costs of all CSMs, including the two not funded by the Transition Project, were US\$1.5 million; the centers brought in US\$511,434 which MEXFAM used to support the social programs and the institution at large.
- PAI /PCT: Under this program of collaboration with GOM agencies, the Mexico City municipal government, non-governmental agencies and universities, MEXFAM provides these institutions with IEC materials and contraceptives and, in turn, reports the CYP represented by the donated contraceptive products. PAI-derived CYP in 1995 (110,578) is less than half

³ MEXFAM utilizes the indicator "Well informed user" to measure the impact of the *Gente Joven* program. By this measure, MEXFAM estimates to have reached 73,540 young people through its educational activities in 1995, and over one million young people during the last 12 years.

that reported in 1991 (250,546) when the Transition Project began; however, the relative importance of PAI-derived CYP in total MEXFAM CYP has not declined as greatly. In 1991 PAI accounted for 41% of MEXFAM CYP; in 1992, 53%; in 1993, 47%; in 1994, 43%; and in 1995, 38%. Over the last several months MEXFAM, in response to USAID concerns, has reduced the program further.⁴ In 1995 the program operated at a deficit of US\$72,182 without counting the value of contraceptives or indirect costs.

2.1.3 Financial Self-sufficiency

One of the key objectives of the Transition Project, in Mexico as in other countries, was to replace USAID funds with locally generated income. In the years preceding the Transition Project, 1988-1992, the annual USAID Matching Grant funds budgeted for MEXFAM averaged US\$1.3 million, exclusive of contraceptives. In 1995 USAID contributed over US\$2,000,000 to MEXFAM, including US\$1.39 million of Transition Project funding and US\$420,770 worth of contraceptives. MEXFAM will therefore need to replace approximately US\$1.8 million if it is to maintain the same program and client profile and cost structure after the Transition Project ends as it has had during the last year.⁵ See TABLE 3 which presents 1995 MEXFAM expenditures by source.⁶

Note that in this discussion, MEXFAM data are presented as provided by MEXFAM itself. The historical funding above was presented in terms of budgeted sums, whereas the following two TABLEs present actual expenditures.

⁴ Public sector institutions sometimes fail to stock their own FP service systems with adequate contraceptive supplies, leading to occasional stock-outs at public sector facilities. MEXFAM has doubtless performed an important public service by using its contraceptive supplies to minimize these stockouts. MEXFAM's cooperation nonetheless enables the GOM to avoid full responsibility for its own contraceptive procurement--a responsibility which the GOM accepted further to the 1992 MOU between the GOM and USAID/Mexico.

⁵This is an estimate. Certainly some of the costs accrued in 1995 in setting up the CSMs will not have to be repeated in the near future; however, in addition to the loss of direct funding, MEXFAM is potentially facing "second level" reductions. In 1995 MEXFAM earned US\$44,443 from the sale of USAID-donated contraceptives and US\$287,000 from the TP-supported clinics. If these activities are not maintained with other funds, they will not generate this income.

⁶MEXFAM provided expenditure data rather than income data because, as MEXFAM explained, in 1995 expenditures exceeded income and MEXFAM had to use some of their reserves to cover total expenditures.

TABLE 3: MEXFAM Expenditures by Source 1995		
Source	US\$	% of total expenditures
1. USAID		
Transition Project	1,392,091	24%
SOMARC	339,446	6%
value of USAID-donated contraceptives	<u>227,764</u> ⁷	<u>4%</u>
subtotal	1,959,301	34%
2. Other Donors		
IPPF	1,903,613	33%
Packard Foundation	171,547	3%
other international donors	<u>709,667</u>	<u>12%</u>
subtotal	2,784,827	48%
3. locally generated		
	1,069,601	18%
TOTAL	\$5,813,729	100%

Source: MEXFAM

TABLE 4 breaks out the use of USAID funds during 1995. Sixty-one percent of Transition Project funds and 47% of total USAID resources were invested in the CSMs. The remainder was used in support of social programs and other line items. Additionally, in 1995 MEXFAM used US\$143,777 of CSM-generated income as support for the social programs. See section 2.2 below for a discussion of CSM finances.

⁷ USAID records indicate that the value of contraceptive products received by MEXFAM in CY 1995 was \$420,770. The figure shown here (\$227,764) represents the value of contraceptive products distributed ("expended") by MEXFAM during CY 1995.

TABLE 4: MEXFAM Use of USAID Resources by Project - 1995						
	Source					
	Transition Project		SOMARC	contraceptives	Total	
	US\$	%	US\$	US\$	US\$	%
1. Direct Programs						
Community MDs - peri-urban areas	143,291	10%	335	63,144	206,770	10%
Rural CBD	279,486	20%	2,759	58,973	341,218	16%
Medical Centers	848,656	61%	69,695	3,478	921,828	43%
Industrial Program	17,015	1%		22,359	39,374	2%
Youth Program	25,674	2%	20	11,981	37,676	2%
special projects	0	0%	75	560	635	0%
subtotal	1,314,121	94%	72,884	160,495	1,547,500	72%
2. Collaborative Programs	42,970	3%		67,269	110,239	5%
3. Production of Materials	35,001	3%	2,905		37,906	2%
4. Program Support			190,738		190,738	9%
5. Investigation			5,046		5,046	0.2%
6. Admin and general services			10,624		10,624	0.5%
7. Fixed Assets			57,250		57,250	3%
TOTAL	1,392,092	100%	339,446	420,770	2,152,308	100%
exchange rate: 6 pesos/1US\$						

Source: MEXFAM

2.2 MEXFAM: Key Findings and Conclusions

1. **One of the key objectives of the Mexico portion of the Transition Project, i.e., the development of MEXFAM's capacity to replace USAID funds with domestically-generated resources, will not be achieved.**

Discussion: The TP was designed, *inter alia*, to help MEXFAM implement structural and financial adjustments which would enable the organization to continue its social programs at or near then-current levels without continued

reliance on USAID funds. Other USAID support provided to MEXFAM during the period of the TP was intended to complement and reinforce this effort; e.g., TA in management and financial systems was provided by Management Sciences for Health (MSH), logistics support by John Snow, Inc. (JSI), and marketing assistance by SOMARC to promote the new Centros de Servicios Medicos (CSMs).

The CSMs were the centerpiece of MEXFAM's sustainability strategy. The CSMs were intended to serve a predominately middle-income population willing to pay market or near-market prices for out-patient services such as routine lab tests, sonograms, dental work, ob/gyn exams, etc. Over time, these clinics were to generate the client base--and consequent income--needed to support not only the clinics' own operating expenses, but a substantial profit as well. This profit was to be used to pay a significant portion of the costs of MEXFAM's family planning service delivery program (the "social program") as described above. The TP provided start-up and operating costs of the CSMs, which were further supported by marketing assistance from SOMARC.

USAID, IPPF and MEXFAM agreed at the TP design stage that TP funds would also be used during the life of the project to continue support for MEXFAM's social program through the end-of-project date of June 30, 1997. This arrangement has allowed MEXFAM to continue most of its pre-TP social program (except for cutbacks in PAI), even while it concurrently launched and operated a growing number of CSMs. According to the logic of the TP, these CSMs would generate, by EOP 1997, enough profit to cover the USAID-funded component of those social programs. At present, USAID funds cover approximately 50 percent of social program costs (see Table 5).

Those USAID costs will not be replaced during the life of the TP for several reasons:

- a) The CSMs will not produce enough excess income to cover USAID's contribution to the social program. (See discussion point number 2 below.)
- b) MEXFAM's other efforts to reduce costs and generate revenues (See para. d below) were constructive; but they were too modest to substantively affect the organization's long-term financial viability. Still lacking, moreover, are MEXFAM steps to identify ways by which costs could be more fully recovered from clients.
- c) On this latter point (cost recovery) MEXFAM's strong commitment to its mission--to serving the poor--appears to have impeded MEXFAM's willingness to charge more for services, even in instances when that

poor clientele might have been able to contribute more for FP services and/or contraceptive products.

- d) MEXFAM did use this time to increase local contributions, e.g. from board members and other local donors, and from U.S. foundations; and it has strengthened its IEC materials sales activities. It has also “spun off” its programs in Catemaco, Tijuana and Hermosillo, which now function as autonomous affiliates no longer dependent on MEXFAM budgetary support. (MEXFAM is promoting the formation of similar affiliates in Toluca, Tuxtla and Guadalajara). And MEXFAM has established 215 small clinics (*consultorios comunitarios*) which receive technical assistance and IEC support -- but no financial support -- from MEXFAM. These changes, however, have not substantively affected MEXFAM’s social programs, all of which continue to operate at significant deficit.⁸ Specifically, in 1995 MEXFAM generated local income (income excluding funds and/or in-kind contributions from IPPF, USAID other off-shore donors) totaling a little more than US\$1 million. Approximately 27% of this amount, however, was comprised of “profits” generated by the CSM’s. (The TP allows MEXFAM to retain 100% of CSM income, while the TP covers 100% of the CSMs start-up and operational costs). Those CSM revenues will not be available to MEXFAM once the TP ends, as few if any of the surviving clinics are expected to become major profit centers.

One promising initiative currently being pursued by MEXFAM, in collaboration with the USAID mission and Pathfinder, is a prototype program of cooperation between MEXFAM and IMSS. Under this arrangement, which will be tested in a few demonstration areas in the near future, MEXFAM will provide--for cost-plus-fee-- training and technical oversight services to the rural IMSS family planning program. This is a very constructive development for several reasons, not the least of which is its contribution to MEXFAM’s financial self-reliance. The program’s anticipated net income, however, will be modest: the MEXFAM Executive Director believes that an expanded program of cooperation on this model will generate at most approx. US\$100,000 per year.

In brief, while MEXFAM has tried to develop other sources of income, none of the sources developed to date can be counted on to generate significant, lasting revenue-flows. MEXFAM’s social program, meanwhile, has not been

⁸ MEXFAM believes that this observation understates the extent to which it has reduced and retrenched its programs during the TP period. They point out, for example, that MEXFAM has eliminated activities in eight ‘non-priority’ states, such that they fund activities in only 20 states in 1996, vs. 28 states in 1991. This is technically correct. But it does not address the important fact that MEXFAM’s program costs during this period have not experienced a corresponding reduction.

subjected to any major adjustments, or intensified cost-recovery efforts, in anticipation of a reduction in USAID support for that program.

In fairness to MEXFAM, the leadership and board of the organization did not believe that they were under any significant pressure/commitment to produce such savings. Given MEXFAM's long and constructive relationship with USAID, a growing population assistance budget at USAID, and explicit encouragement from USAID/Mexico to think beyond 1997, MEXFAM would not, in its view, have been acting prudently if it had effected major reductions in its program during the TP period. Moreover, MEXFAM staff tended to view any significant cost-recovery efforts as inconsistent with their commitment to serve the neediest elements of the population.

The USAID/Mexico Representative underscores this view in noting his firm conviction that the Transition Project was never intended--either by USAID/Mexico or by USAID/Washington--to represent USAID's "terminal" funding relationship with MEXFAM. Rather, in his view, the TP was/is more correctly seen as the current funding mechanism for what was always intended to be a longer-range USAID support program for MEXFAM. From this perspective, USAID/Washington's call for a near-term phaseout (1997 or 1998), is revisionist thinking in response to recent and dramatic reductions in the Agency's population account. Whichever party has the "correct" assessment of original intentions, the key consequence of this conceptual environment in Mexico is the continuing existence of a still-large and costly social program which is only marginally less-vulnerable to a funding reduction now than it was three years ago.

- 2. While the majority of CSMs may achieve financial break-even or operate at a modest profit during the 1997-1998 period, they will not produce a level of profit needed to finance other MEXFAM programs currently supported by USAID funding. These CSMs may, however, provide an institutional supplement to other MEXFAM programs in geographic areas served by the clinics.**

Discussion: As noted above, the goal of the CSM's was to generate enough net income to support the USAID-funded portion of MEXFAM's "social" programs after the funding from the TP ended in mid-1997. In order to replace the funding from the TP, the CSMs would need to generate a net profit of approximately US\$1.8 million annually, beginning in mid -1997.

The CSMs consist of 13 clinics in various parts of the country. Two CSMs -- La Villa and Nezahualcoyotl ("Neza")--were operating before the start of the TP. La Villa, in Mexico City, began operations in 1966, and Neza, on the outskirts of the city, opened in 1984. With the exception of these two (largest and oldest) clinics, the other CSMs provide a very small volume of family planning

services. Their focus instead, and by design, is on the most profitable and sought-after health services, such as routine medical care, lab tests, sonograms, dental work, ob/gyn exams, etc.

The TP originally envisioned the establishment of 17 CSM's throughout the country. In mid-February of this year MEXFAM decided to "downgrade" four of the facilities to the status of "medicos comunitarios." At the present time there is little likelihood that additional clinics will be established under the TP. Eleven of these clinics began operating after 1994, and many did not open until the last half of 1995.

All CSM sites except La Villa receive TP funding. In addition to covering the CSMs' operating costs, the Project has paid the cost of launching the clinics, including most or all of the necessary equipment.

The 13 CSM clinics are located in the following areas:

- | | |
|-------------------------------|-----------------------|
| 1. La Villa, D.F. | 8. Tampico, Tamps. #1 |
| 2. Nezahualcoyotl, Mex. | 9. Tampico, Tamps. #2 |
| 3. Las Alamedas, Mex. | 10. Guadalajara, Jal. |
| 4. Morelia, Mich. | 11. Ixtaltepec, Oax. |
| 5. San Luis Potosi, S.L.P. #1 | 12. Monterrey, N.L. |
| 6. San Luis Potosi, S.L.P. #2 | 13. Naranjos, Ver. |
| 7. Veracruz, Ver. | |

In retrospect, it is now apparent that the original premise of the CSM initiative-- that a significant portion of the "social" programs could be supported from profits generated by the CSM clinics - was flawed. MEXFAM executive staff stated that they were lead to this classic "cross-subsidization" conclusion by the significant success of PROFAMILIA clinics in Colombia. Such comparisons, however, did not take into account PROFAMILIA's overwhelming dominance of the family planning clinical services sector in Columbia. The original premise also did not consider the highly competitive environment for health services in Mexico, nor the clients' ability to pay commercial rates in a very difficult economic period.

The competitive environment in Mexico includes many other health care providers, such as IMSS and ISSTE, which serve some 80% of the population in the "formal" and GOM sectors; a very high number of private "consultorios", hospitals and clinics which serve clients able and willing to pay extra for services outside the social security systems; and free services from MOH (SSA) facilities.

In terms of pricing, MEXFAM is aware of the competition's pricing, and takes it into account before establishing its own price schedule at each CSM clinic.

That said, individual CSM clinic managers have established their prices at some 10-40% (approx. 30% average) below competitors' prices for the same services. Without the benefit of any price elasticity data, the CSM managers feel that they need to significantly undercut their competitors' prices to gain the latter's clients.

CSM managers also believe that prices should not be raised at or near the same rate as inflation (currently averaging about 40% annually), as to do so would price clinic services beyond the reach of most potential clients. This may create a cost-profit squeeze which could jeopardize the survival prospects of the clinics. In difficult economic times, when there is little disposable income, it is questionable whether there needs to be such a large price differential for a client to switch to another clinic. (This assumes that the quality of service at the new clinic is perceived to be equal or better than services available at the client's former clinic). All of these factors indicate the need for a price elasticity study at each clinic, and the subsequent adjustment of prices in accordance with the studies' outcome.

A brief analysis of MEXFAM's own figures (See Annex D, "Ingresos y Gastos de 1995 A 1997"), reveals the following. The two original and largest clinics, La Villa and Neza, began operations in 1966 and 1984, respectively. In 1995, (using an average exchange rate of 6 Pesos to one Dollar), La Villa had a profit of US\$29,000, and Neza showed a loss of US\$18,000, for a combined net profit of US\$11,000. All of the clinics collectively lost US\$390,000 in 1995. MEXFAM projects that the clinics, collectively, will have a net profit of US\$15,775 in 1997. Thus, while MEXFAM's projections indicate a positive trend for all the clinics, the volume and price levels clearly would not return a significant profit in the foreseeable future, and will not generate revenues approaching an annual level of US\$1.8 million.

Most CSMs', however, do have the potential to be at least self-sustaining or to make a modest profit in the near or mid-term future, even while operating in a highly competitive and difficult economic environment. Moreover, the clinics can play another very important role. As self-supporting entities, the clinics could become "anchors" for MEXFAM's infrastructure in different areas of the country. As such, they would enhance MEXFAM's public image and add to its service delivery capacity in the geographic areas they serve.

- 3. The bulk of MEXFAM's program is focused on poor clients who, MEXFAM assumes, are unable to pay the costs of family planning services provided by MEXFAM. These programs are supported in significant measure by USAID and CSM-generated revenue, and are therefore highly vulnerable to reductions in USAID support.**

Discussion: As TABLE 5 below indicates, US\$508,433 of Transition Project funds and US\$223,726⁹ in USAID-donated commodities were used in support of MEXFAM's social programs.

Program	TP Expenditures	Value of USAID-donated contraceptives	SOMARC	USAID investment as % of direct program costs
API - community MDs in peri-urban areas	143,290	63,144	335	56%
APEX - rural CBD	279,485	58,973	2,759	46%
PIN - Program with Industries	17,014	22,359		43%
PJ - Youth Program	25,674	11,981	20	27%
PAI/CP - collaborative programs	42,970	67,269		74%
	508,433	223,726	3114	50%

Source: MEXFAM

Additionally, MEXFAM reports that income from the CSMs and from the sale of USAID-donated contraceptives was used to support these programs. Thirty-one percent of the locally generated income in 1995 accrues from the sale of USAID-donated commodities (US\$44,443) and from the clinics supported by the Transition Project (US\$287,618).

MEXFAM will have to decide whether and/or how to:

- more fully recover the costs of social programs; and/or
- more tightly control costs; and/or
- eliminate some programs altogether; and/or
- significantly reduce some programs; and/or
- generate additional local revenues; and/or
- secure new donors for these programs.

4. The scope of some social programs could be significantly reduced now without major negative impact on MEXFAM's current mission

⁹ USAID-donated contraceptives received by MEXFAM in 1995 was \$420,770. The lower figure cited here (\$223,726) is the value of USAID-donated contraceptive products actually distributed by MEXFAM in 1995.

or objectives. These include the programs with industries and GOM elements of the PAI/CT.

Discussion: In 1995 the PIN and PAI operated at a combined deficit of US\$139,000, excluding the value of USAID-donated contraceptives. Clients of the PIN and managers of programs receiving contraceptives through MEXFAM have - or should have - alternatives to MEXFAM provision of subsidized services/supplies. PIN clients are predominately urban factory workers and could obtain services and supplies free through IMSS. Public sector agencies currently receiving contraceptives through the PAI should be receiving their contraceptive supplies from the GOM--as pledged by the GOM in the USAID-GOM Memorandum of Understanding of 1992.

5. Because donors and MEXFAM did not take full advantage of the time provided under the TP to better position MEXFAM for a sustainable future, and because time was lost in launching and equipping the CSMs, an additional year is needed to accomplish planning and operational tasks left undone thus far.

Discussion: As noted above, MEXFAM did not undertake major cost saving or cost-recovery efforts in its social programs for several reasons--not the least of which was their expectation that time and (USAID) resources were not as constrained as the language of the TP might suggest. Indeed, given the ambiguity of USAID's position on post-TP funding, MEXFAM's reluctance to make painful changes is not difficult to understand.

Also as noted above, the CSMs as a whole will never be the profit centers they were originally designed to be. Some of them might produce enough excess income to cross-subsidize some elements of the social program; and many or even most of the current CSMs may achieve break-even, and become important elements in MEXFAM's overall service/training infrastructure. Their delayed launching, however, has not left the CSMs enough time to find and hold even this more modest market, nor to definitively establish their economic viability.

MEXFAM's leadership has more recently concluded that USAID does in fact plan to effect an orderly phaseout of financial assistance and that this phaseout date is approaching rapidly. Put differently, MEXFAM acknowledges USAID/Washington's decision that it (USAID) will not continue support for MEXFAM's social program beyond the life of the TP.¹⁰ For the reasons

¹⁰ The USAID-IPPF/WHR grant agreement for the TP (1992) makes the point that USAID did not plan to continue operational support for the involved FPA's after conclusion of the TP. USAID/Mexico and MEXFAM nonetheless maintain that none of the parties to the Mexico portion of the TP expected that the project's hemisphere-wide phaseout objectives were intended to apply in all of their aspects to Mexico.

discussed above, however, MEXFAM will not be prepared to cope with the consequences of a TP end-date of June 30, 1997.

The assessment team, the USAID/Mexico Representative and MEXFAM (Executive Director and Board members) did therefore examine the prospect of a one-year extension of USAID support for MEXFAM¹¹ --either through a one-year, no-cost extension of the TP (to June 30, 1998) or via another assistance mechanism; such an extension would enable MEXFAM to position itself for a successful role, post-TP. Specifically, that time would enable MEXFAM to 1) test the economic viability of the CSMs; eliminate non-performing CSMs; and definitively establish operations in successful CSMs; and 2) conceptualize/begin to implement changes in MEXFAM's type and mix of services and products-- changes which would enable the organization to play a continuing, vital role in the Mexican (and perhaps international) population community.

2.3 Recommendations:

- 1. USAID support for MEXFAM should be continued until June 30, 1998 in order to enable MEXFAM to complete the necessary planning and take the actions needed to develop a long-term, sustainable role for the organization.**

Discussion: By the end of June, 1997, the CSMs will not have had enough time in operation to demonstrate their economic viability. Moreover, MEXFAM staff, leadership and board members are only now confronting the genuine likelihood of a phaseout of USG assistance, and are belatedly -- if constructively -- moving to consider alternative role(s) for the organization in the context of reduced resources. The extra year of USAID support will enable MEXFAM to:

- a) closely monitor operations of the CSMs; strengthen and improve operations at CSMs which demonstrate strong prospects for commercial success (defined as their capacity to operate at break-even or better); and close down or spin off non-performing clinics. Specific tasks would include:
 - i. Decide, by the end of October, 1996, to eliminate the clinics that are not financially viable. Review the viability of the remaining clinics on at least a quarterly basis, and eliminate any found to be not viable.

¹¹Prior to the team's departure from Washington, the Director of the USAID Office of Population indicated G/PHN/POP willingness to consider an extension of USAID support for MEXFAM into 1998--with such an extension contingent upon MEXFAM readiness to use the additional time for substantive efforts toward program focus, cost containment/recovery and strategic planning.

- ii. Conduct a price elasticity study at each clinic and adjust prices accordingly.
 - iii. Explore, with SOMARC, the utility of conducting a new client profile and adjusting the CSM marketing strategy accordingly.
- b) conduct a comprehensive strategic planning exercise -- with participation by MEXFAM staff, management and board members -- and begin to implement the structural and programmatic changes which emerge from that exercise. This strategic planning effort would be carried out in collaboration with IPPF/WHR and would utilize outside consultant support as requested by MEXFAM. Specific tasks are described under Recommendation no. 3.2 below.

2. USAID should continue to provide contraceptives needed by MEXFAM until the end of the (extended) period of USAID assistance.

Discussion: A central conclusion of this assessment is that MEXFAM requires additional time to effect changes in its mission, structure and operations. Those adjustments will be difficult, and are not assured of success. This delicate process could be seriously compromised if USAID were to proceed with its planned phaseout of contraceptive donations to MEXFAM in 1997. Put differently, the shape of MEXFAM's program post-TP should be determined by the strategic planning process outlined below; it should not be driven by a precipitous cut-off in contraceptive supplies. That said, USAID should note that its likely cost for MEXFAM contraceptive supplies is expected to decline as MEXFAM significantly reduces its PIN (Industry) and PAI/PCT (contraceptive donations to collaborating agencies) programs. Indeed, the cost of USAID - donated contraceptives should not exceed US\$200,000 in 1996, and should be progressively less in 1997-1998.

On a related matter, MEXFAM does hope to purchase increasing amounts of its contraceptive requirements from IPPF/London, from which MEXFAM can purchase Lo-Feminal at or near the "USAID" price (US\$0.19 - US\$0.20 per cycle). To date, however, Wyeth Pharmaceutical has not attempted to register the Lo-Feminal product in Mexico; and GOM/Health Ministry inspectors have on occasion seized this and other non-registered contraceptive products (including condoms) distributed by MEXFAM. USAID can possibly facilitate/expedite MEXFAM's transition to contraceptive self-reliance by urging Wyeth to sell to MEXFAM (and FEMAP) their locally-marketed/locally registered products at reduced (i.e., "USAID") prices. Given the very small quantities involved, the sale of these products would not jeopardize Wyeth's other commercial interests in Mexico; and MEXFAM is prepared to file written affirmations with Wyeth

noting the former's pledge to distribute those products only through facilities and providers under the direct supervision and control of MEXFAM.

3. USAID should support MEXFAM in a rigorous strategic planning process.

Discussion: Although MEXFAM has engaged in two strategic planning exercises since the Transition Project began, the structure of the social programs in 1995 is very similar to that of 1991. The ending of USAID funding - approximately US\$2 million of USAID funds and contraceptives - makes a reassessment of the MEXFAM paradigm an urgent necessity. USAID should support MEXFAM in a rigorous assessment and planning process which should include:

- an analysis of the opportunities and threats in the Mexican environment;
- an assessment of strengths and weaknesses within MEXFAM including an analysis of the costs and outputs of the various programs; and an assessment of MEXFAM's structure, overhead and assets, in light of, in anticipation of, and planning for the end of USAID's provision of almost US\$ 2 million in funds and contraceptives;
- a redefinition, as appropriate, of MEXFAM's mission;
- development of strategies to:
 - * achieve its mission - these would be new and/or revised programs and products and would identify how to phaseout existing programs, if appropriate;
 - * achieve a level of self-financing sufficient to support these programs;
- development of specific activities to accomplish those strategies; and
- development of a strategic budget for 1997-2000.

See ANNEX E for a suggested strategic planning process.

3. Mexican Federation of Private Health and Community Development Associations (FEMAP)

3.1 FEMAP Overview

3.1.1 Mission, Social Policy and Strategies

The mission of FEMAP, a not-for-profit institution created in 1973, is to “improve the quality of life for Mexico’s underprivileged population.” FEMAP’s mission is achieved through the following community-based programs:

- Health, with emphases on primary care, maternal, child, adolescent and reproductive health;
- AIDS and drug abuse prevention;
- Environmental health and sanitation; and
- Economic development (micro-enterprises and community banks).

Originally founded as an educational and community development organization, FEMAP began life independent of USAID. With USAID support, FEMAP has grown into a national, decentralized federation with 44 associated members covering 95 cities and thousands of rural communities in twenty Mexican states and the Federal District. FEMAP is proud of two institutional characteristics: first, its reliance on a community-based approach that facilitates the establishment of its affiliated members in the localities they serve; and secondly, a philosophy of self-financing which FEMAP and its affiliates achieve through careful cost control, cost recovery and income generation.

Using educational level as a proxy for socio-economic status, available data indicate that FEMAP clients are drawn from the underprivileged of Mexico. FEMAP reports that 68 percent of its clients have six years of school or less; in contrast, recent demographic data indicate that 51 percent of Mexicans have such an educational level.¹² FEMAP data indicate that their clients’ average individual monthly income is US\$113, and that an average of 1.3 persons per family contribute to the family monthly income. Eighteen percent of the families served by FEMAP have a monthly family income of less than one minimum wage, while an additional 44% have family incomes less than two minimum wages.

¹² *Encuesta Nacional de la Dinamica Demographica, 1992, Principales Resultados* Instituto Nacional de Estadística, Geografía e Informática, 1994.

The number of family planning clients served by FEMAP has increased since FEMAP became part of the Transition Project in January 1993. Table 6 shows this growth:

	1992	1993	1994	1995
CYP		50,733	67,103	130,891
new users		46,096	53,293	64,207

Source: FEMAP

3.1.2 Structure and Staffing

FEMAP defines itself as an “operative foundation” which finances projects, administers resources (including in 1995, US\$432,000 of USAID-donated contraceptives), provides training and technical assistance, encourages the transfer of technology and supervises and evaluates projects. The Headquarters in Ciudad Juarez, with a staff of 44 employees, of whom ten are charged to the Transition Project, supervise and support five regional offices which in turn support the 44 affiliates, each of which is administratively and financially independent. Of the forty-four affiliates, 32 provide family planning services; the other 12 do not. FEMAP and its affiliates provide a wide range of programs and services, including health and family planning services to factory workers, first and second level care at eight hospitals and 42 outpatient care clinics, community-based distribution of contraceptives, HIV/AIDs prevention, work with youth, and research and training on environmental issues particularly relevant to poor communities.

3.1.3 Financial Self-sufficiency

FEMAP believes that the majority of the poor people it serves can and should pay at least a part of the cost of services/supplies they receive. About 70% of their current clients are paying all or part of the costs of services/supplies; FEMAP estimates that of these, perhaps 30% could afford to pay the full costs, the remainder (70%) could not. This conviction is one of the critical reasons they have achieved their high level of self-financing - 61% in 1995.

FEMAP has promoted financial self-sufficiency in a number of ways, including:

- As mentioned, although exceptions are made for people who absolutely can not pay one peso, FEMAP and its affiliates charge for all services and supplies provided;

- Promoters sell contraceptives and return approximately 15% of the proceeds to the local affiliate. (None of the proceeds, however, is returned to FEMAP headquarters in Cd. Juarez).
- Each affiliate is administratively and financially independent; any profit it may make remains within the local institution to support local activities;
- FEMAP, believing that all affiliates should be able to effectively plan, manage and cost out their activities, used Transition Project funds to upgrade the management capabilities of these affiliates. FEMAP reports that all affiliates are now administratively sound; they all have computers, computerized financial management systems, are on the internet and have FAX machines;
- The FEMAP Foundation, established in 1992 to provide support for particular FEMAP projects, has raised over US\$400,000 in the last three years. The Foundation, which solicits donations and grants as well as participates in extensive fund-raising activities for FEMAP, receives support, large and small, from corporations, foundations and individuals on the northern side of the El Paso/Ciudad Juarez border. (See Annex F.)
- FEMAP managers understood the Transition Project to be the transition to the end of USAID funding and have planned for this eventuality. While they estimate that 1-5 affiliates may not be able to maintain the same level of community programs after the Transition Project that they did during they Project, FEMAP's leadership is unworried. They take pride in being able to graduate from USAID support [and dependence] at the end of the Project and believe they and virtually all of their affiliates will continue work with little disruption.

FEMAP's confidence in its ability to continue the bulk of its activities after termination of TP support must be considered in the context of a stark reality--that FEMAP will have to continue those activities in the absence of TP financial assistance amounting to approximately \$750,000/year. FEMAP's confidence is based on the factors discussed above--and on FEMAP's practice of focusing a substantial portion of TP resources on training, management development and equipment--most of which are not recurrent costs.

3.2 FEMAP: Key Findings and Conclusions

- 1. FEMAP and its affiliates have effectively utilized the time and resources provided under the TP. FEMAP believes that most FEMAP and FEMAP affiliate programs will continue after termination of USAID assistance in June, 1997.**

Discussion: In contrast to the structure of the MEXFAM organization, the FEMAP network of affiliates is not strongly dependent on the “center” for financial support. Each FEMAP affiliate is a largely self-supporting entity, drawing the bulk of its resources from local donors--often including the principal officer(s) of the affiliates themselves. The affiliates nonetheless gain considerable advantage from their relationship with FEMAP, including their opportunity to access technical assistance provided to them by FEMAP/Juarez. This assistance has played a major role in promoting high standards of quality throughout the affiliates’ programs, and in setting norms for staff training, client management, contraceptive distribution & pricing, and in supporting the different IEC activities of the several affiliates. FEMAP has also been a reliable source of contraceptive supplies for the affiliates, via the former’s access to contraceptives provided by USAID and -- to a lesser extent -- by IPPF. The FEMAP system, therefore -- as a network and a program --is far less vulnerable to the consequences of a USAID phaseout than is MEXFAM. Indeed, FEMAP managers believe that their “looser” network is relatively well-positioned to deal with the phaseout, and are not distressed at the prospect of a cut-off in USAID funding after June 30, 1997.

Their confidence is in good measure a consequence of the several affiliates’ long-standing reliance on local support. But FEMAP has also made some hard choices along the way. Over the past four years FEMAP has eliminated donor-funded subsidies for a dozen non-performing and/or cost-inefficient affiliates; they have established and progressively expanded (without USAID support) a 35-bed hospital in Juarez--a facility which produces enough excess revenue to help cover the costs of other FEMAP (Cd. Juarez) programs; and they have negotiated at least preliminary procurement arrangements with contraceptive suppliers from which FEMAP plans to purchase commodities after USAID terminates contraceptive assistance. Actual procurement of these contraceptives, however, will be FEMAP’s greatest challenge in the future. (See discussion point number 3, below.)

- 2. FEMAP has been generally successful in applying an institutional philosophy of requiring client contributions for FEMAP services and supplies, even though its clients are from lower socio-economic strata.**

Discussion: TABLE 7 presents the results of FEMAP's commitment to self-financing. In 1995, FEMAP generated 61% of its total income from local sources.

TABLE 7: FEMAP Income/In-Kind 1995		
Source	US\$	% of total income
1. USAID		
Transition Project (IPPF)	753,392	19%
USAID/Mexico- contraceptives in-kind	432,000	11%
subtotal	1,185,392	30%
Family Health International	68,626	2%
Family Planning Management Development Project (MSH)	65,820	2%
SOMARC Project (Futures)	87,921	2%
Population Council	1,000	0%
subtotal CA support	223,367	6%
subtotal USAID	1,408,759	35%
2. Other donors		
Public Welfare Foundation	39,375	1%
Hewlett Foundation	66,000	2%
Institute for Development Training	10,703	0%
other income and donations	40,171	1%
subtotal other international donors	156,249	4%
3. locally generated income		
services and other	2,053,577	52%
local donations	354,065	9%
subtotal locally generated income	2,407,642	61%
TOTAL INCOME/IN-KIND 1995	3,972,650	100%

FEMAP's level of self-financing is admirable for an institution committed to serving underprivileged peoples and communities. As TABLE 7 indicates, an important factor behind this high level of self-financing is the sale of services and contraceptives. Presumably, the termination of USAID's contraceptive donations will lessen that level of self-financing, at least over the short-term; however, FEMAP's knowledge of its clients, combined with its commitment to sustainability, should enable continued success.

- 3. Although, as noted above, FEMAP does not anticipate difficulties in continuing its program in the absence of USAID financial support post-TP, it does face a challenge in replacing US\$566,000 in donated contraceptive products, and especially in replacing approx. US\$225,000 of this amount in oral contraceptives.**

Discussion: In 1995, USAID shipped to FEMAP US\$ 432,077 in donated contraceptives, consisting almost entirely of Lo-Femenal oral contraceptives and Panther condoms, but also including very small amounts of Copper-T IUD's, Norplant, and Depo-Provera. FEMAP also used some stocks that had been shipped in previous year(s), so that all USAID-donated contraceptives used in 1995 had a total value of US\$566,178. This total quantity of contraceptives used in 1995 consisted of 6.5 million Panthers, 1.2 million cycles of Lo-Femenal, and small quantities of the other products.¹³

The FEMAP network includes 44 independent "affiliates" in some 90 cities throughout Mexico, as well as FEMAP's own hospital in Ciudad Juarez. The affiliates use approximately 1,500 "promotoras" to deliver FP services in rural areas. To date, FEMAP has been giving the donated contraceptives to the affiliates and the promotoras at no charge. The affiliates and the promotoras then sell the contraceptives to those that can afford to pay (75.7% of all clients pay), and retain the proceeds. Thus far, none of these proceeds are returned to FEMAP headquarters, not even from FEMAP's own hospital in Juarez. The proceeds are retained for local expenses, and in the case of the promotoras, as their fee.

In addition to the USAID donated product, FEMAP has been buying US\$22,000 per year worth of Nordette 28, and Exluton from IPPF/London, and 60,000 cycles of Marvelon directly from Organon. These products are being sold to the affiliates. When USAID contraceptive donations cease, FEMAP will purchase commodities for resale to its affiliates, asking them for an advance payment prior to each order. In addition to receiving advances on new orders, FEMAP will also draw on a capital fund of US\$200,000 that it may use as "seed" money to purchase contraceptives. The difficulty then, in FEMAP's view, is to find reliable suppliers who can sell at a price that can be marked-up and still be affordable to the vast majority of its clients.

Replacing the condoms does not appear to present a significant problem. FEMAP has received a written offer from Aladan Corporation, valid through 12/31/97, for 8 million condoms (in lots of 250,000) at US\$0.045 per condom (FOB, El Paso, TX). FEMAP's affiliates are presently charging US\$0.0933 per

¹³ The oral contraceptives, however, represent nearly double the condoms' CYP (approximately 80,000 CYP for pills, vs. 43,000 CYP for condoms).

condom from those able to pay (76% or more). Therefore, there is enough margin to purchase the condoms (in lots of 250,000 per order, with an outlay of only US\$11,250 per order), sell them to the affiliates, and realize a modest profit.

Replacing the oral contraceptives presents a different challenge. As noted above, in 1995 FEMAP used 1.2 million cycles of USAID-donated Lo-Femenal, which the affiliates sold at US\$0.2533 per cycle. FEMAP has pointed out that IPPF/London sells Lo-Femenal to IPPF affiliates at a price of US\$0.191 per cycle, (1997 price, CIF). That price is far more favorable than any offer which FEMAP has received to date from commercial vendors. In the absence of such offers, FEMAP hopes that IPPF/London will sell Lo-Femenal to FEMAP at the low "IPPF" price. FEMAP believes that its affiliates and clients could absorb a modest mark-up above the IPPF price, and that FEMAP could afford to re-supply its network's OC needs if these OCs were continuously available to FEMAP at the IPPF price. FEMAP has noted its concern, however, that IPPF/London has sold contraceptive products (Nordette-28 and Exluton) to FEMAP only during the TP--and that as a non-member of the IPPF system, FEMAP may not be considered, by London, as an eligible future purchaser of contraceptive supplies (once the TP ends). Additionally, FEMAP is concerned that the manufacturer might request that IPPF not sell significant quantities (over one million cycles) if that manufacturer determines that those commodities might disrupt its domestic commercial market in Mexico.

As a potential alternative source of supply, Schering Mexicana has offered (in writing) to sell FEMAP Microgynon for US\$0.75 per cycle (1996 prices). FEMAP proposes that their affiliates then sell it to the public for US\$1.07. FEMAP estimates, however, that only 20% of their clients could afford to pay this price. In addition to Schering, Weyeth has just contacted FEMAP, informing them that they will be sending a sales proposal for Nordette.

In brief, FEMAP's contraceptive re-supply situation is not yet resolved--the key variable being the eventual purchase price which FEMAP will have to pay for oral contraceptives. USAID/Washington could help to promote a favorable outcome of this process by undertaking any or all of the steps discussed in the following recommendation.

3.3 Recommendations: FEMAP

- 1. FEMAP should be provided an additional year of USAID support during which time USAID would assist FEMAP to establish sustainable patterns of contraceptive procurement and cost recovery.**

At least one US-based manufacturer of condoms has offered to sell their product to FEMAP at a very favorable price (lower, in fact, than the "USAID" price). However, the best commercial (non-IPPF) price which FEMAP has been able to secure thus far for OCs is more than double the current USAID price. The approximately US\$900,000 cost of pills, if purchased at this price, would seriously hinder FEMAP's otherwise solid progress toward financial self-reliance. FEMAP plans to seek more favorable prices for OC's, and may eventually be successful in its efforts. As proposed in the case of MEXFAM, however, their efforts could be reinforced by the active participation of USAID. This participation would include--again, to the extent appropriate--the following:

1. USAID's consultation with pharmaceutical companies to inform them of the rationale for extending more favorable prices to both MEXFAM and FEMAP (most likely under the aegis of joint procurement by the two organizations). That rationale would note, for example, that the combined market share of both NGOs still represents a small, i.e., non-threatening, share of the total OC market in Mexico, and that those OC's are in fact a replacement of OC's currently purchased on the two organizations' behalf by USAID at the lower USG price.
2. Alternatively, and perhaps more creatively, USAID might consider taking full advantage of government purchasing provisions of NAFTA by consolidating its own OC purchase with MEXFAM and FEMAP purchases--a test, possibly, of potential joint contraceptive purchases in the future by the USG and the GOM.
3. Encouraging IPPF/London to continue contraceptive sales to FEMAP after the TP has ended.

PROLOGUE

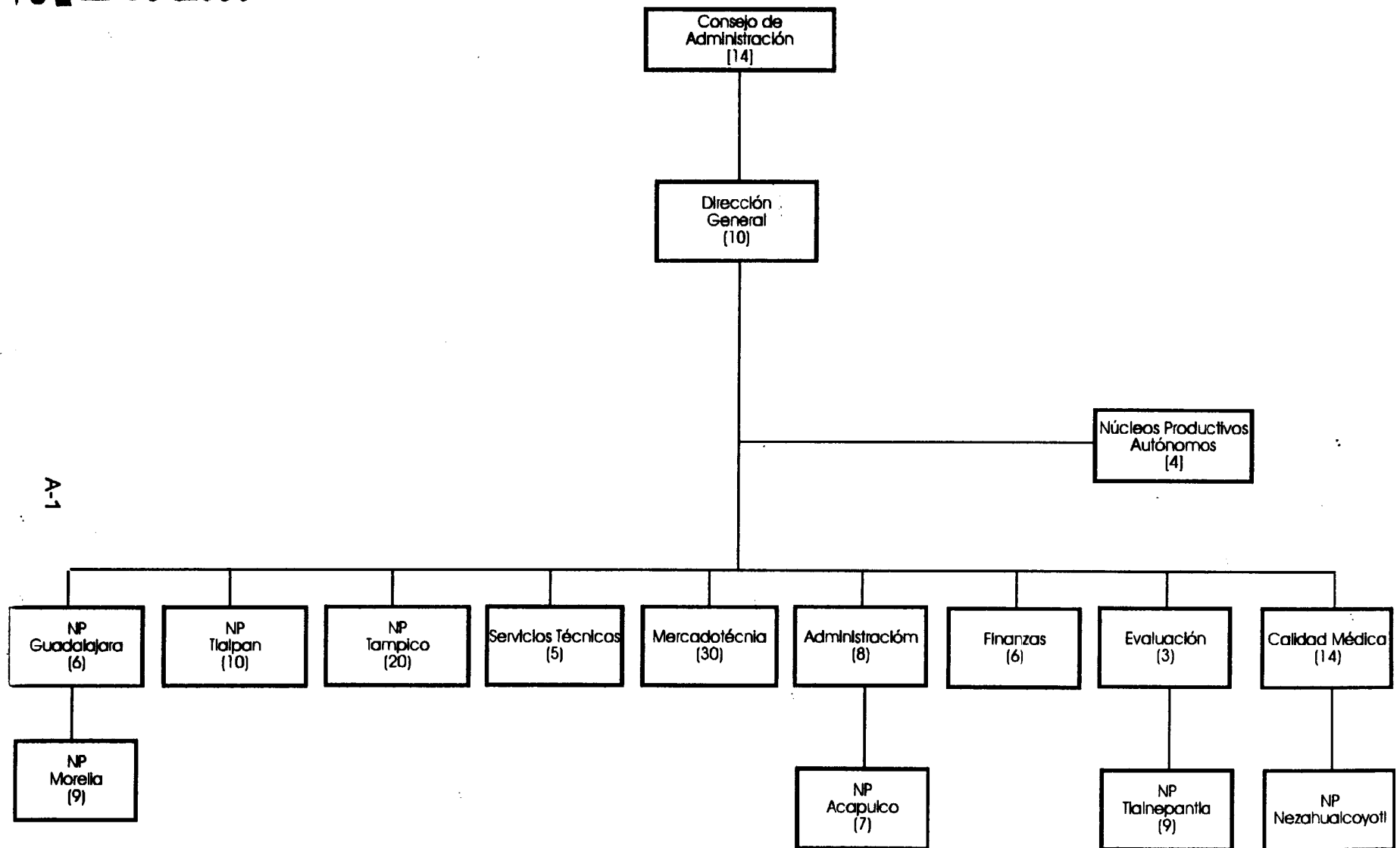
USAID, MEXFAM and FEMAP have enjoyed close and constructive cooperation for several years. In 1996, these long-term partners take evident pride in the results of that collaboration, even as they take the sometimes painful steps to end a key facet of the relationship, i.e., their roles as donor and beneficiaries. For USAID, faced with declining resources but mounting international challenges, it is a matter of having to allocate scarce resources among particularly needy programs -- a challenge foreseen by the Agency when it developed the Transition Project with IPPF/WHR four years ago. For MEXFAM and FEMAP, it is a matter of positioning themselves for self-reliant, long-term roles in a different Mexican environment than the one they so creatively faced many years ago. And for all three parties, it is a matter of forging a new kind of relationship, characterized not by dependence, but by equality and a shared sense of international priorities.

USAID, MEXFAM and FEMAP should begin now to develop the framework for a post-TP collaborative relationship. That framework could include, for example, the identification of a joint agenda for operations research activities which might be conducted in Mexico; trials/demonstrations of especially innovative ways to reach young adults, men or other hard-to-recruit population groups; utilization of MEXFAM and FEMAP as regional training centers and as sources of technical assistance for developing country programs; and as partners--with USAID, other USG agencies and US NGOs--in the development of responsible reproductive health policies and priorities, and their presentation at donors' conferences and other international fora.

As the title of the Transition Project implies, endings lead to new, but different beginnings.

ANNEXES

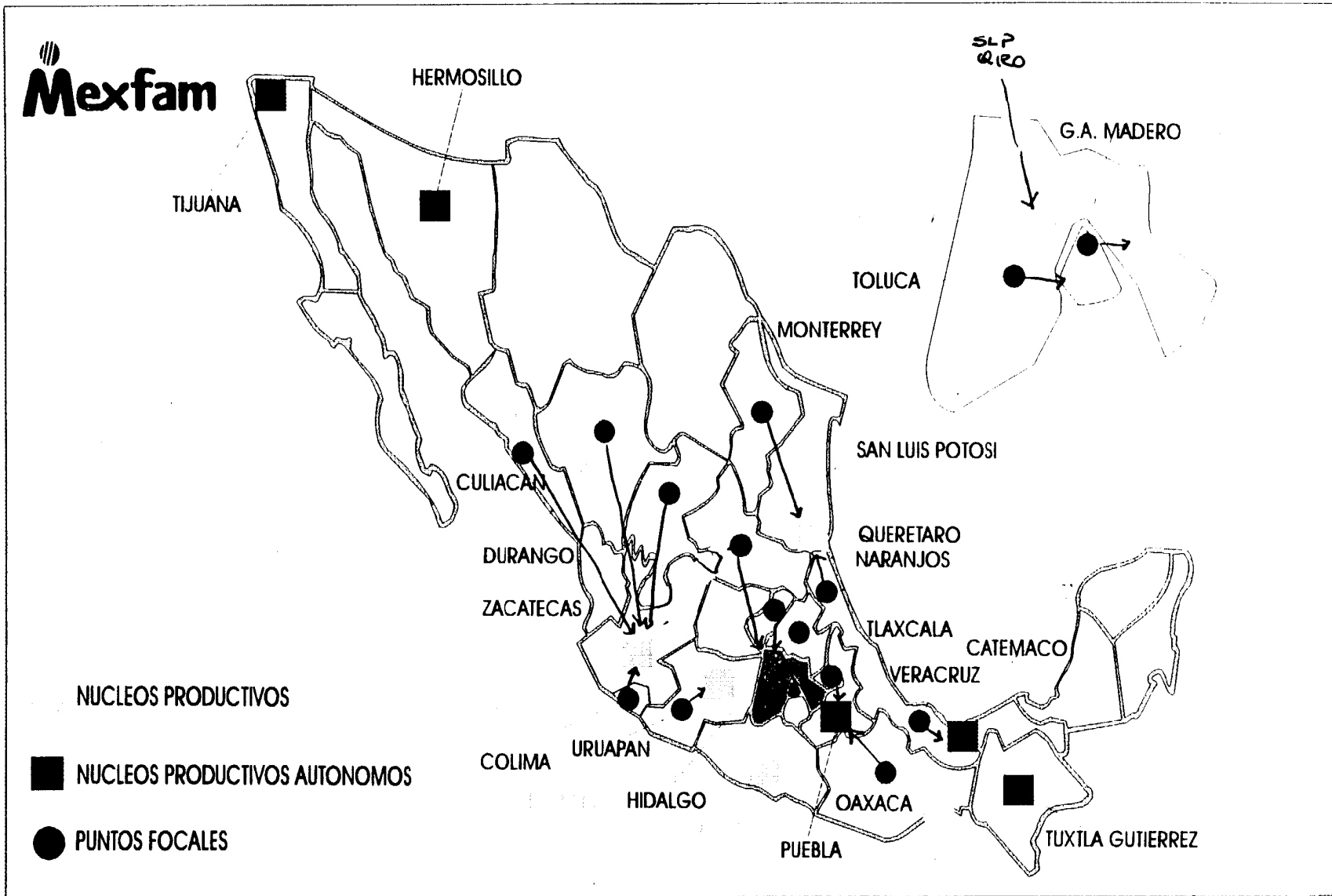
ORGANIGRAMA



A-1

ANNEX A

UBICACION DE NUCLEOS PRODUCTIVOS Y PUNTOS FOCALES



B-1

ANNEX B

**RESULTADOS OPERATIVOS 1995
POR TIPO DE PROGRAMA**

TIPO DE PROGRAMA	AÑOS PROTECCION PAREJA (A.P.P)	ACEPTANTES NUEVOS (A.N.)	USUARIOS BIEN INFORMADOS (U.B.I.)
PROGRAMA COMUNITARIO RURAL(P.C. RURAL)	99,009	146,152	79,714
PROGRAMA COMUNITARIO URBANO(P.C. URBANO)	63,265	97,352	16,536
CENTROS DE SERVICIOS MEDICOS(CSM)	12,866	10,740	11,562
PROGRAMA EMPRESARIAL(EMP)	6,879	38,117	7,701
PROGRAMA GENTE JOVEN(GJ)	2,234	738	258,017
SUBTOTAL	184,253	293,099	373,530
PROGRAMA DE COLABORACION TECNICA(CT)	110,578	1,809	19,771
TOTAL	294,831	294,908	393,301

ANNEX C

INGRESOS Y GASTOS DE 1995 A 1997 EN CENTROS DE SERVICIOS MEDICOS (N\$)

CLINICA	REAL 1995			PRONOSTICO 1996			PRONOSTICO 1997		
	GASTOS DE OPERACION	INGRESOS	DIFERENCIA	GASTOS DE OPERACION	INGRESOS	DIFERENCIA	GASTOS DE OPERACION	INGRESOS	DIFERENCIA
LA VILLA	1,170,657	1,342,896	172,239	1,654,110	1,684,220	30,110	1,971,757	2,070,277	98,520
NEZAHUALCOYOTL	854,465	747,565	(106,900)	869,409	967,000	97,591	1,067,567	1,174,776	107,209
GUADALAJARA	306,342	132,051	(174,291)	338,211	224,000	(114,211)	425,146	334,307	(90,839)
TAMPICO	796,475	194,038	(602,437)	738,128	738,700	572	1,003,199	1,113,332	110,133
MORELIA	581,289	271,761	(309,528)	437,649	436,000	(1,649)	662,867	704,900	42,033
VERACRUZ	233,248	89,635	(143,613)	251,289	171,500	(79,789)	349,273	348,500	(773)
S.L.P.	484,586	91,316	(393,270)	417,310	324,016	(93,294)	580,610	552,620	(27,990)
LAS ALAMEDAS	586,816	131,713	(455,103)	523,218	413,750	(109,468)	687,991	661,150	(26,841)
MONTERREY	249,598	12,819	(236,779)	279,446	139,265	(140,181)	406,388	358,310	(48,078)
IXTALTEPEC	APERTURA	0	0	331,795	289,250	(42,545)	411,250	400,300	(10,950)
NARANJOS	124,770	34,287	(90,483)	372,161	336,002	(36,159)	526,487	523,925	(2,562)
TOTAL N\$	5,388,246	3,048,081	(2,340,165)	6,212,726	5,723,703	(489,023)	8,092,535	8,242,397	149,862
TOTAL U.S.D.	898,041	508,014	(390,028)	776,591	715,463	(61,128)	851,846	867,621	15,775

D-1

ANNEX D

ANNEX E

SUGGESTED PROCESS FOR STRATEGIC PLANNING

1. Plan the Strategic Planning Process
 - Select consultants
 - Get members of the Board of Directors to “buy into” the importance of the process
 - Assemble complete program and financial data on all programs and departments of MEXFAM
 - Select members of the executive management group to attend the workshop
 - Share with and instruct all workshop participants to study prior to the workshop the program and financial data collected
2. Hold Strategic Planning Retreat (4-5 days in a place without distractions)
 - Undertake External Analysis:
 - Social
 - Political
 - Economic
 - Clients and communities
 - Donors
 - competitors
 - Analyze Opportunities and Threats to MEXFAM Success
 - Community priorities and demands
 - Donor priorities and resources
 - Potential competitive/collaborative relationships
 - Undertake analysis of MEXFAM’s strengths and weaknesses, including
 - Financial position
 - Personnel
 - Current mix of programs, services and products
 - Performance and reputation
 - Identify Strategic Issues (fundamental questions) re MEXFAM’s mission; type, level and mix of services; clients and partners in the field; costs; financing; and management
 - Redefine MEXFAM’s mission specifying a new/revised mix of programs, services and products
 - Develop Strategies which take advantage of opportunities, build upon strengths while they minimize or overcome weaknesses and threats
 - to achieve MEXFAM’s mission; and
 - to cope with the loss of USAID funds and to move forward on a financially sustainable basis.
 - Identify specific activities to implement each strategy.
3. Post- Workshop
 - Develop written report with SWOT analysis (strengths, weaknesses, opportunities and threats), new mission statement, presentation of strategies and identification of activities to implement each strategy.
 - Develop a strategic budget by costing out each activity.
 - Share report and budget with Board of Directors and executive management group for comments and revision.
 - Finalize report and budget and share as appropriate

ANNEX F

FEMAP Income 1995		
Source	US\$	% of total income
1. USAID		
Transition Project (IPPF)	753392	17%
USAID/Mexico- value of contraceptives	<u>801439</u>	<u>18%</u>
subtotal	1554831	36%
Family Health International	68626	2%
Family Planning Management Development Project (MSH)	65820	2%
SOMARC Project (Futures)	87921	2%
Population Council	<u>1000</u>	<u>0%</u>
subtotal CA support	223367	<u>5%</u>
subtotal USAID	1778198	41%
2. Other donors		
Public Welfare Foundation	39375	1%
Hewlett Foundation	66000	2%
Institute for Development Training	10703	0%
other income and donations	<u>40171</u>	<u>1%</u>
subtotal other international donors	156249	4%
3. locally generated income		
		0%
services and other	2053577	47%
local donations	<u>354065</u>	<u>8%</u>
subtotal locally generated income	2407642	55%
TOTAL INCOME 1995	4342089	100%