USAID/MEXICO

POPULATION, FAMILY PLANNING & REPRODUCTIVE HEALTH PROGRAM

1992-1999


SONORA
CHIHUAHUA
COAHUILA DE ZARAGOZA
MEXICO
NUEVO LEON
BAJA CALIFORNIA SUR
DURANGO
SINALOA
ZACATECAS
TAMAULIPAS
SAN LUIS POTOSI
AGUASCALIENTES
NAYARIT
GUANAJUATO
QUERETARO DE ARTEAGA
HIDALGO
JALISCO
MEXICO
TLAXCALA
DISTRITO FEDERAL
MICHOACAN
MORELOS
PUEBLA
VERACRUZ
GUERRERO
OAXACA
YUCATAN
QUINTANA ROO
CHAMPECHE
TABASCO
BELIZE
CHIAPAS
GUATEMALA
HONDURAS
EL SALVADOR

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SUMMARY

The United States Agency for International Development (USAID) provided assistance to Mexico for its population, family planning, and reproductive health programs for more than twenty years. During the last phase of this assistance, 1992-1999, USAID's strategy focused on helping Mexico achieve a sustainable increase in contraceptive use by improving access to and the quality of family planning and reproductive health services, especially in rural areas. Assistance was provided to four public-sector institutions—Consejo Nacional de Población (CONAPO), Instituto Mexicano del Seguro Social (IMSS), Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE), Secretaría de Salud (SSA)—and to two private-sector organizations, the Fundación Mexicana para la Planeación Familiar (MEXFAM) and the Federación Mexicana de Asociaciones Privadas de Salud y Desarrollo Comunitario (FEMAP).

USAID's strategy included targeting assistance to the public sector in nine priority states, consolidating activities, mobilizing Mexican resources, and coordinating population assistance while streamlining USAID management. With USAID assistance, the public sector increased its role as the major source of family planning and reproductive health services in Mexico, serving almost three-quarters of all users. Efforts to reach the underserved rural populations helped close the gap in contraceptive use between the rural and urban populations. Training providers increased the number of users of surgical methods and intrauterine devices (IUD). Expanded information, education, and communication (IEC) activities increased awareness of contraceptive methods. Special efforts were made to reach adolescents and to emphasize the reproductive health context of family planning. Government efforts to improve informed consent and increase informed demand also enhanced services.

In the private sector, both MEXFAM and FEMAP expanded their programs while decreasing their dependence on

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donor assistance. MEXFAM's medical clinics program grew, increasing the number of clinics and services provided, as well as the income derived from these clinics. The clinic profits were used to support and expand MEXFAM's social programs for the underserved. During this period, MEXFAM reduced its reliance on donations and became more self-sufficient from sales of services. FEMAP also increased the number of its affiliates, the number of community promoters, and the number of people reached by IEC activities. FEMAP's income increased dramatically, primarily due to a large increase in sales and income from medical services.

Overall, Mexico has a strong health infrastructure, capable institutions, strong programs, and the political will to ensure the delivery of quality services to all Mexicans. Nonetheless, significant challenges remain. People living in isolated rural areas, indigenous groups, adolescents, and the poor are decades behind the rest of the country in terms of access to the quality family planning and reproductive health services available to the majority of the Mexican population. With the end of USAID assistance, addressing the needs of these groups becomes more difficult, but no less critical.

INTRODUCTION

For twenty years beginning in 1978, the United States Agency for International Development (USAID) provided assistance to the government of Mexico and to private-sector agencies for their population, family planning, and reproductive health programs. For many years, population assistance was the most important part of USAID's program in Mexico. It was considered globally important and complemented U.S. foreign policy objectives. The last phase of USAID assistance, 1992-1999, focused on reducing assistance and increasing self-sufficiency. Assistance to the private sector ended in September 1998, and to the public sector in March 1999.

This booklet summarizes the last phase of USAID assistance and is intended to give program managers, policymakers, and donors information about USAID's program in Mexico. It shares lessons learned that may be appropriate for use in other settings and indicates the challenges that remain. For more detailed information, see the complete report titled *USAID/ Mexico Program of Collaboration in Family Planning and Reproductive Health, 1992-1999*.

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THE MEXICAN CONTEXT

Mexico is the second most populous country in Latin America and the Caribbean, with more than 98 million inhabitants in 1999. While this is almost double the country's population in 1970, the annual rate of population growth has declined steadily during the last three decades, from 3.3 percent in 1970 to 1.8 percent in 1999, a drop due primarily to decline in fertility. In 1970, a Mexican woman had an average of 6.8 children. By 1999, this total fertility rate had declined to about 2.5 children per woman. Because of past high fertility levels and declining mortality, Mexico's population is also relatively young. This young and growing population will continue to put demands on the country's economic and service infrastructure for many years.

Almost three-quarters of the population lives in urban areas. Each year, many Mexicans move from the increasingly degraded rural areas to the urban areas in search of jobs. In the rural areas, an estimated two-thirds of the population is underemployed or unemployed. Mexico's gross national product, US$3,840 per capita (1998), is about average for the region as a whole, yet it masks great disparities in income and quality of life across the country.

While the Mexican government currently favors programs and policies to lower fertility and population growth, prior to 1972 the government saw population growth as positive. From 1940 to 1970, Mexico enjoyed political stability and economic growth. By the late 1960s and early 1970s, however, rapid population growth was adversely affecting the country's development. In 1974, President Luis Echeverría established the Consejo Nacional de Población (National Population Council or CONAPO) to oversee a government-sponsored national family planning program.

In 1977, under the guidance of President José López Portillo, CONAPO developed its first population program with the explicit goals of promoting slower population growth through decreased fertility and fostering the distribution of population across regions. The subsequent administrations of presidents de la Madrid, Salinas, and Zedillo continued to pursue these goals.

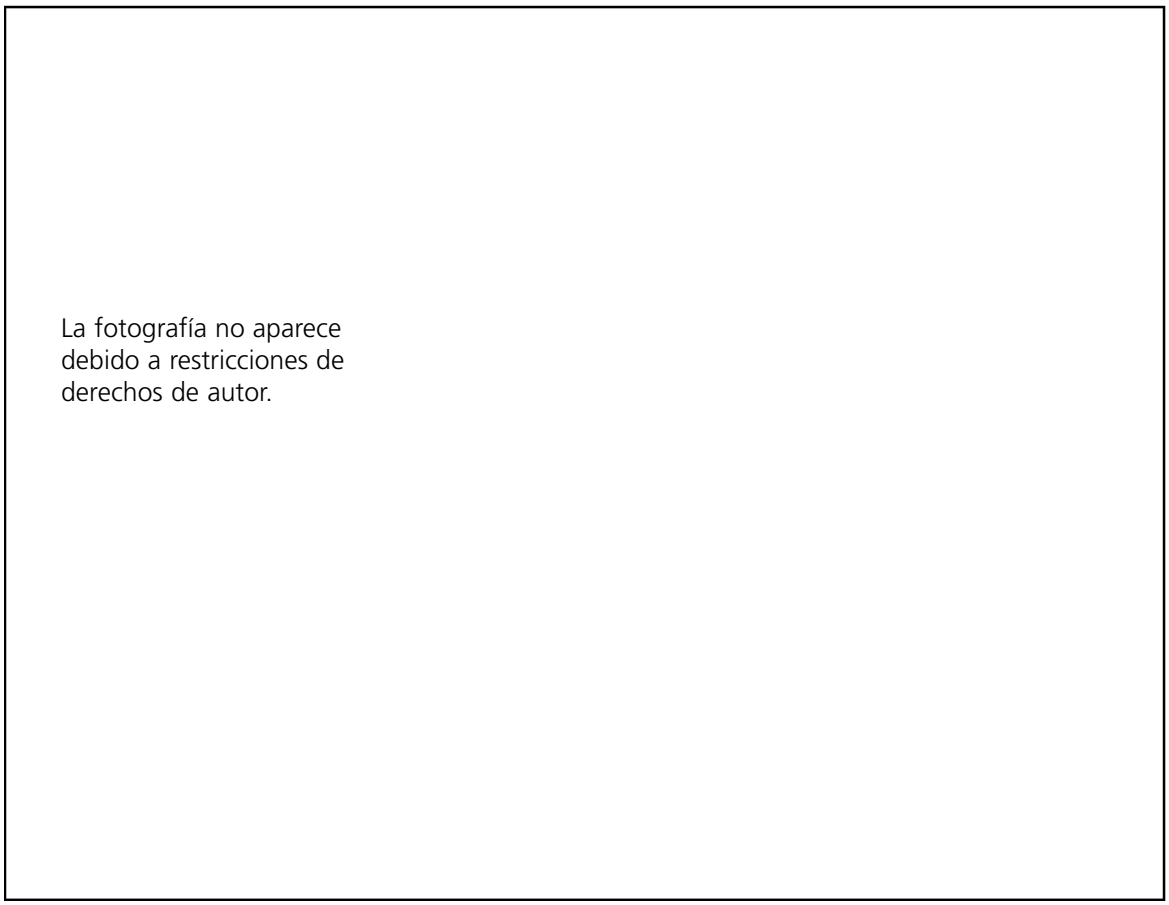
Today, about nine-tenths of the population is served by the health service infrastructure.

In the mid-1990s, President Zedillo's administration updated the national population policy and established reproductive health as its centerpiece. Mexico was one of the first countries in the world to adopt the integrated approach to reproductive health promoted at the 1994 International Conference on Population and Development (ICPD). In 1995, the government revised targets for 2000: to reduce the annual population growth rate to 1.75 percent, lower the total fertility rate to 2.4, and achieve a contraceptive use rate of 70.2 percent. In addition, the Zedillo administration emphasized health sector reform, continuing government efforts to decen-

tralize health care and offering a basic package of health services to previously underserved segments of the population.

Mexico made great progress toward its demographic goals during the 1990s. Today, about nine-tenths of the population is served by the health service infrastructure. Women's ideal family size declined from 4.5 children in 1976, to 3.1 children in 1995, and to 2.9 children in 1997. More women are using contraception to plan their childbearing. The contraceptive use rate has risen from 63.1 percent of married women in 1992 to 68.4 percent in 1997. Seventy-three percent of these women receive their contraceptive and counseling services from the public sector. Despite these changes, several of Mexico's 32 states lag behind the national contraceptive use averages. Many women in rural areas, adolescents, indigenous groups, and the poor still need greater access to family planning and reproductive health services.

TWENTY YEARS OF USAID SUPPORT



U.S. AND MEXICO COLLABORATION IN FAMILY PLANNING AND REPRODUCTIVE HEALTH

USAID first provided support to Mexico's population program in 1978. For many years, USAID was the largest foreign donor to Mexican family planning programs; from 1985 to 1995, USAID's average yearly contribution was US$10 million. In 1996, U.S. assistance totaled US$13 million, or about 10 percent of Mexico's national family planning budget of US$124 million.

USAID assistance has been provided through approximately 20 U.S.-based nongovernmental organizations (called cooperating agencies or CAs) working in population. In turn, these groups have provided technical and financial assistance to Mexican governmental institutions and to MEXFAM and FEMAP, two nongovernmental organizations (see Box, page 9).

THE LAST PHASE OF USAID POPULATION ASSISTANCE, 1992-1999

In 1991, USAID developed a five-year population strategy (1992-1997) to guide the last phase of its population assistance to Mexico. A Memorandum of Understanding (MOU) was drafted to govern U.S.-Mexico collaboration during this period and to coordinate activities among various key groups. The major implementing agencies of the MOU in the public sector were CONAPO, IMSS, ISSSTE, and SSA. In 1992, USAID also began a project with the two private-sector groups, MEXFAM and FEMAP.

USAID's strategy during this time was to help Mexico achieve a sustainable increase in contraceptive use by improving the accessibility and quality of family planning and reproductive health services, especially in rural areas. The strategy had four principal components:

For many years, USAID was the largest foreign donor to Mexican family planning programs.

- **Targeting Assistance to the Public Sector in Nine Poor and Mostly Rural States**
  USAID support to government institutions focused on the following priority states: Chiapas, Guanajuato, Guerrero, Hidalgo, the State of Mexico, Michoacán, Oaxaca, Puebla, and Veracruz. CONAPO chose these predominantly rural states with high total fertility and infant mortality rates to maximize the impact of USAID assistance. Assistance to the private sector targeted low-income and underserved populations throughout the country.

- **Focusing Resources on Fewer Activities**
  USAID focused assistance on fewer, but higher impact activities, including improving clinical family planning services and quality of care; extending commercial distribution systems for temporary contraceptive methods; intensifying information and communication efforts; and strengthening research and evaluation capabilities. USAID also reduced the number of organizations providing technical assistance in Mexico from 20 in 1992, to 14 in 1998, and to 7 in 1999.

- **Mobilizing Mexican Resources**
  Key to the agreement was gradually reducing and—originally by early 1997—ending USAID population assistance to Mexico. (This date was later extended to March 1999 when the assistance program officially ended.) At the same time, the government of Mexico committed to increasing its funding of public-sector population activities. In the private sector, USAID's goal was to enable MEXFAM and FEMAP to become self-sustaining organizations.

- **Coordinating Population Assistance and Streamlining USAID's Management**
  USAID chose to provide technical assistance and a limited amount of contraceptives to six Mexican organizations involved in population activities and assigned a Population Development Office to oversee the implementation of this assistance. Pathfinder International coordinated the disbursement of funds for public-sector assistance, helped the public-sector institutions obtain specialized assistance from the CAs, and assisted with monitoring and evaluation activities. In the private sector, the International Planned Parenthood Federation (IPPF) coordinated fund disbursement. Although there was some overlap, one group of CAs focused on the public sector and another group on the private sector.

USAID'S PUBLIC—AND PRIVATE—SECTOR PARTNERS IN MEXICO

PUBLIC-SECTOR PARTNERS

Consejo Nacional de Población (CONAPO), or National Population Council, is responsible for population and education programs, and promotes and conducts demographic and social research. In addition to its central secretariat, CONAPO has decentralized state population councils called Consejos Estatales de Población (COESPOs) that are financially supported by each state.

Instituto Mexicano del Seguro Social (IMSS), or Mexican Social Security Institute, provides social services to private- sector employees and underserved populations in both urban (IMSS) and rural (IMSS-Solidaridad) areas.

Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE), or Social Security Institute for State Workers, offers services to government employees and teachers.

Secretaría de Salud (SSA), or Ministry of Health, coordinates the national health program, and is responsible for providing services to those who are not covered by social security.

PRIVATE-SECTOR PARTNERS

Fundación Mexicana para la Planeación Familiar (MEXFAM), or Mexican Foundation for Family Planning, is the Mexican affiliate of the International Planned Parenthood Federation. It provides services in the poor areas of 32 cities and in indigenous regions.

Federación Mexicana de Asociaciones Privadas de Salud y Desarrollo Comunitario (FEMAP), 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 poor areas of 87 cities and in thousands of rural communities.

PROGRAM ACHIEVEMENTS

The last phase of USAID population assistance to Mexico focused on three key points:

- improving access to services;
- improving quality of services; and
- sustainability of private-sector programs.

IMPROVING ACCESS TO PUBLIC SERVICES

Although the majority of Mexican couples use contraception to plan their families, great disparities exist in contraceptive use between rural and urban areas, between women with different levels of formal education, and by state of residence. By targeting assistance in nine priority states, USAID and the government of Mexico hoped to close some of these gaps and improve access to services for these more difficult to reach populations.

From 1993 to 1997, the number of public-sector health care facilities in Mexico increased by 17 percent, from 13,500 to more than 15,800. Much of this expansion took place in the rural areas through the IMSS-Solidaridad program and within the Secretaría de Salud—the number of health care facilities in the rural priority states grew from 6,800 to 7,800. The number of service providers (physicians and nurses) also grew by about 20 percent during this time, both nationally and in the priority states.

According to the Secretaría de Salud, this expansion of service delivery, along with USAID-supported training and communication efforts, contributed substantially to lowering the number of underserved Mexicans from 10 million in 1995 to 1.5 million in 1999.

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IMPROVING THE QUALITY OF SERVICES

Several factors had a positive impact on the quality of family planning services offered by IMSS, Secretaría de Salud, and ISSSTE in the priority states during the USAID/Mexico program.

- **Improved Technical Competence, Interpersonal Relations, and Choice of Methods**

  In 1994, the Secretaría de Salud published a set of national service delivery norms for family planning to be distributed by all of the public-sector agencies. From 1992 to March 1999, USAID supported training 68,624 family planning providers in the new service-delivery norms, expanding the quality, range, and accessibility of contraceptive methods.

  More than 26,700 public-sector providers, many of them doctors and nurses, received training in counseling from 1993 to 1999. The Secretaría de Salud established 47 centers for training in no-scalpel vasectomy. By the end of 1998, 151 units offered this new technique, and the number of vasectomies increased from 736 in 1990, to 5,197 in 1998. Similarly, access to IUDs expanded through the training of rural-based nonphysicians (for example, nurses) in family planning. From 1992 to 1998, the

number of women accepting IUDs at the IMSS-Solidaridad clinics in 12 states increased from about 64,000 to more than 168,000.

The IMSS and EngenderHealth (formerly AVSC International) also established a network of trainers to expand training coverage. While this model focused on training providers from the central level down to the primary service-provider level, the IMSS and the University of North Carolina PRIME project used a reverse strategy. Primary providers were trained first and formed the base of a pyramid of service providers. This expanded into a multidisciplinary (family physicians, nurses, social workers) and multilevel (primary, central, state) network in the states of Puebla, Tlaxcala, and Guanajuato.

While the Mexican government's goal is eventually to train all public-sector providers, IMSS and ISSSTE made substantial progress by training 42 percent and 38 percent of their respective staffs countrywide.

Expanded Information, Education, and Communication

Knowledge about family planning methods, including types of methods and where to get them, is key to access and quality. Like contraceptive use, knowledge of methods is generally high in Mexico. However, in 1992, 20 percent of women in union who did not want any more children did not use any method of contraception; they said they did not know about any contraceptive methods, where to get them, or how to use them. By 1997, this percentage dropped to 16 percent, and all women surveyed knew of at least one method of contraception. In the poor, mostly rural priority states, the percentage had dropped from 25 percent in 1992, to 20 percent in 1997.

USAID support emphasized information, education, and communication (IEC) activities throughout the public sector. These activities were designed to increase use of services, as well as improve the quality of care. The development and distribution of IEC materials helped providers explain methods and inform clients about the various methods. Special efforts were made to ensure that clients received proper counseling and provided their informed consent for permanent contraceptive methods, such as vasectomy and female sterilization.

USAID support emphasized information, education, and communication (IEC) activities throughout the public sector.

Between 1993 and 1999, almost 14 million copies of 280 different IEC materials—brochures, posters, flipcharts, manuals, guidelines, videos—were produced. These materials were used to inform more than 15 million people about family planning and reproductive health.

The Johns Hopkins University Program for Communication Services (JHU/PCS) helped implement audience research, materials pretesting, and strategic planning at the public-sector agencies. CONAPO received assistance with its successful mass media campaign, *"Planifica, es cuestión de querer"* (Plan your family, it's a matter of wanting to). Survey results show that this campaign favorably influenced peoples attitudes on family planning. JHU/PCS assisted IMSS in their outreach to adolescents by developing a sex education manual to improve the knowledge, attitudes, and behaviors of adolescents.

Providing an Appropriate Constellation of Services

During the 1990s, significant progress was made in improving reproductive health care and placing family planning in the context of reproductive health. Several norms and standards of care were published to guide service delivery. Among these were the treatment and prevention of sexually transmitted diseases and management at IMSS and Secretaría de Salud sites; cervical cancer screening by Secretaría de Salud rural nurse supervisors; health monitoring of children under age 5 and of pregnant women by SSA health auxiliaries; and prenatal, delivery, and postpartum care for traditional birth attendants at IMSS, which also adapted the Reproductive Health Program for indigenous communities, taking care to respect their cultural and traditional values.

Ensuring access to an adequate supply of contraceptives is key to high quality services.

All the public-sector institutions also implemented activities to address the special reproductive health needs of adolescents in Mexico. At the national level, CONAPO carried out a series of communication activities to help raise the age of first union and first pregnancy and to increase access to information on reproductive health care. As a result of the combined public efforts, institutional programs for adolescents were strengthened and new activities created, especially through provider training. Twelve percent of the personnel in the priority states received training. Access to services for adolescents also increased. The Secretaría de Salud developed the Program for Attention to Adolescent Sexual and Reproductive Health in its health centers and hospitals, and the number of consulting rooms (modules) for adolescents increased from 33 in 1993, to 259 in 1998. A wide range of educational materials aimed at adolescents was produced and distributed.

TECHNICAL ASSISTANCE

In addition to the support provided to improve access and quality, USAID provided targeted technical assistance in several key areas to improve service delivery operations.

Management

USAID support of management in the public sector took several forms. Assistance with annual evaluation meetings for the three public-sector service delivery institutions—IMSS, ISSSTE, and Secretaría de Salud—permitted them to expand their agendas and increase the number of participants. These venues allowed management to highlight issues, such as integration of family planning and reproductive health, and educate staff about evaluation and logistics. Each institution has now budgeted to continue these meetings.

With the assistance of the Management Sciences for Health (MSH) Family Planning Management Development Project, the government created the program Programa de Mejora Continua (Continuous Quality Improvement, or CQI) from 1994 to 1998. A quality monitoring unit was created within the Secretaría de Salud General Directorate of Reproductive Health, and several quality improvement activities were initiated in three states. Program successes include reductions in waiting time and increases in postobstetric contraceptive services. The Secretaría de Salud and MSH prepared a manual for implementing CQI that will be used for further training.

Family Health International helped the Secretaría de Salud gather information on the costs of its family planning services, including costs per user, and productivity per provider. This information is helping the Secretaría optimize use of financial resources, plan for the expansion of services, and forecast implications of changes in its distribution of family planning methods.

- **Commodities and Logistics**

  Ensuring access to an adequate supply of contraceptives is key to high quality services. Through the Family Planning Logistics Management project, USAID helped the Secretaría de Salud and the IMSS improve their contraceptive supply and distribution systems by training in logistics management, forecasting, improving warehouse conditions, working with donors, and adapting to decentralization. The public-sector institutions also made great progress in achieving self-reliance in purchasing contraceptives. From 1992 to 1995, the Mexican government increased the share of contraceptives it purchased from 25 percent to almost 100 percent. By the end of 1999, all public-sector institutions were purchasing their entire supplies of contraceptives.

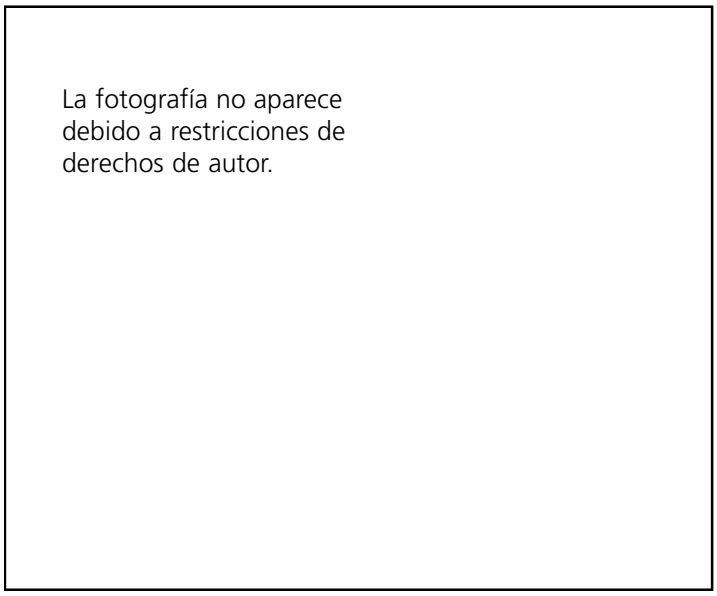
- **Research and Evaluation**

  Particular importance was given to research and evaluation activities within the USAID/Mexico assistance strategy. While the Secretaría de Salud, the IMSS, and the ISSSTE produced substantial data on service delivery, CONAPO conducted several studies to evaluate the USAID/Mexico assistance strategy as a whole. Several cooperating agencies provided financial and technical assistance in this research and evaluation. Pathfinder International prepared three

comprehensive reports detailing the situation of family planning nationally and in the priority states. The Population Council (INOPAL and FRONTIERS projects) aided the public institutions through research on improving service delivery. These efforts increased the capacity of the public-sector institutions to do research and evaluation using standard evaluation instruments and models. These activities also produced a great deal of statistical information on family planning and reproductive health in Mexico and deepened information about priority groups (adolescents, rural and urban populations, indigenous groups).

SUSTAINABILITY OF PRIVATE-SECTOR PROGRAMS

The private sector serves almost 30 percent of contraceptive users in Mexico. Pharmacies serve about half of these clients (16 percent) and other private agencies serve the remainder (13 percent). The 1992 USAID/Mexico strategy included assistance to the two major family planning organizations working in Mexico, MEXFAM and FEMAP, which focus their services in some of the country's poorest areas.



MEXFAM was established in 1965 as the Mexican affiliate of the IPPF. Headquartered in Mexico City, it had 35 centers in 25 states in 1999. FEMAP was founded in 1973 with the mission to "improve the quality of life for Mexico's underprivileged population." Its headquarters are in Cuidad Juárez, and it has 44 affiliates in 87 cities and in thousands of rural communities.

The final phase of USAID/Mexico assistance to FEMAP and MEXFAM focused on increasing domestic support, improving the organizations' income-generating capacities, and establishing long-term financial stability. Historically, both organizations have been very dependent on donor assistance. USAID provided an average of US$1.3 million per year to MEXFAM from 1988 to 1992. During the same period, FEMAP received about US$406,000 per year.

From 1992 to 1998, most of USAID's assistance to MEXFAM and FEMAP was provided through IPPF's Transition Project. MEXFAM received US$9.1 million through the Transition Project and contraceptives worth about US$1.8 million. FEMAP received US$5.4 million from the project and an additional US$4.5 million in contraceptives.

MEXFAM

MEXFAM's approach to sustainability in 1992 focused on expansion of its medical clinics program. With assistance from IPPF's Transition Project, MEXFAM established new medical centers to provide a range of health services to middle-class clients. The number of clinics increased from 2 in 1992 to 14 in 1998. The income generated from these clinics was used to subsidize the organization's five "social programs," including assistance to community doctors in poor urban areas, a rural community-based distribution program, a factory-based program, and a youth program.

The community doctors were given equipment for their consulting rooms and assistance with rent and other office expenses for two years. After that time, it was expected they would be self-sustaining; otherwise they were dropped from the program. As a result, the number of community doctors in the program grew from 316 in 1992, to 350 in 1995, and fell back to 250 in 1998. To increase the sustainability of its programs, MEXFAM also started to charge for its services in 1992 and to sell contraceptives in 1997. These changes created a temporary drop in the number of new clients between 1993 and 1996. By 1998, the number of new clients surpassed the number for 1993, suggesting that the program and its clientele had adjusted to the fee-for-service program. A profile of clients at three MEXFAM service sites showed that the medical services were reaching a more educated, presumed middle-class population, and the community doctors and community-based distribution programs were reaching less-educated, low-income groups.

Part of the success of MEXFAM's medical clinic program was due to improved clinic management and financial information systems. With support from the Population Council, MEXFAM established sys-

tems for cost accounting and for integrated financial and service statistic reporting. By 2000, eight of the 14 clinics were providing the necessary information to the central office for analysis, and the others had received training and were processing and analyzing their own information.

MEXFAM also received assistance through USAID to develop and implement medical quality standards. Management Sciences for Health helped establish a Medical Quality Unit in 1997 to implement a quality management system, and standards were established for paying physicians based on client fees and ownership of clinic equipment. The Population Council also worked with MEXFAM in the early 1990s to make studies on improving quality part of routine activities. This work resulted in development of a training manual titled *Quality Improvements in Family Planning Organizations* that is still being used at MEXFAM clinics.

During this final period of USAID assistance, MEXFAM was very successful at decreasing its dependence on donor funding and increasing its locally generated income. In 1992, almost 94 percent of its income came from donations; by 1998 this had dropped to under 53 percent. Locally generated income, from the sale of health services and products through the medical clinics, pharmacies, social marketing, and community-based distribution programs, grew to more than 47 percent. In 1998, the locally generated income alone (US$3.2 million) was twice the average annual donation from USAID (US$1.4 million) from 1992 to 1998. By 1998, MEXFAM was also able to purchase all of its contraceptives with local funds, and its 14 medical clinics were generating annual profits of US$360,000. These funds were allocated to MEXFAM's social programs in the clinics' service areas and covered about one-third of their costs. Given the important nature of these social programs and the populations they serve, MEXFAM does not expect these programs to be self-supporting.

With assistance from the Contraceptive Social Marketing Project (SOMARC), MEXFAM developed a marketing strategy that included a new logo for the organization and marketing plans for the medical clinics. SOMARC helped MEXFAM create a marketing department and provided training to clinic administrators. Several of the clinics marketed a package of services called the *Mujer Saludable* (Healthy Woman) which included a gynecological visit, Pap smear, and family planning consultation. In rural areas, MEXFAM launched a pilot social marketing project to increase access to oral contraceptives. By purchasing contraceptives at a reduced price and selling them at affordable prices in the rural areas, MEXFAM increased its locally generated income. In addition, the organization began requiring its regional programs to pay a 50 percent deposit on the cost of contraceptives received. These efforts increased MEXFAM's ability to purchase contraceptives without donor support.

During this final period of USAID assistance, MEXFAM was very successful at decreasing its dependence on donor funding and increasing its locally generated income.

Nonetheless, the switch from dependency on USAID-donated contraceptives and the USAID logistics management system to independent procurement is difficult and costly. While MEXFAM has been able to recover some costs, its long-term commodities procurement system is not yet self-sustaining. Locally procured supplies typically have higher unit costs, and other sources of revenue will be required if MEXFAM is to continue to provide highly subsidized contraceptives.

FEMAP

FEMAP also increased the scope of its program from 1992 to 1997. The number of its affiliates grew from 30 to 42, while the number of community promoters (members of the local community who use and promote contraception) increased from 7,000 to 8,200. The number of new users of family planning grew from almost 50,000 in 1992, to more than 87,000 in 1997. At the same time, the volume of medical services provided increased dramatically from 160,000 to almost 969,000. The majority of these services were general health services, reflecting FEMAP's de-

Provider and client costs in the clinic and community-based distribution programs declined significantly.

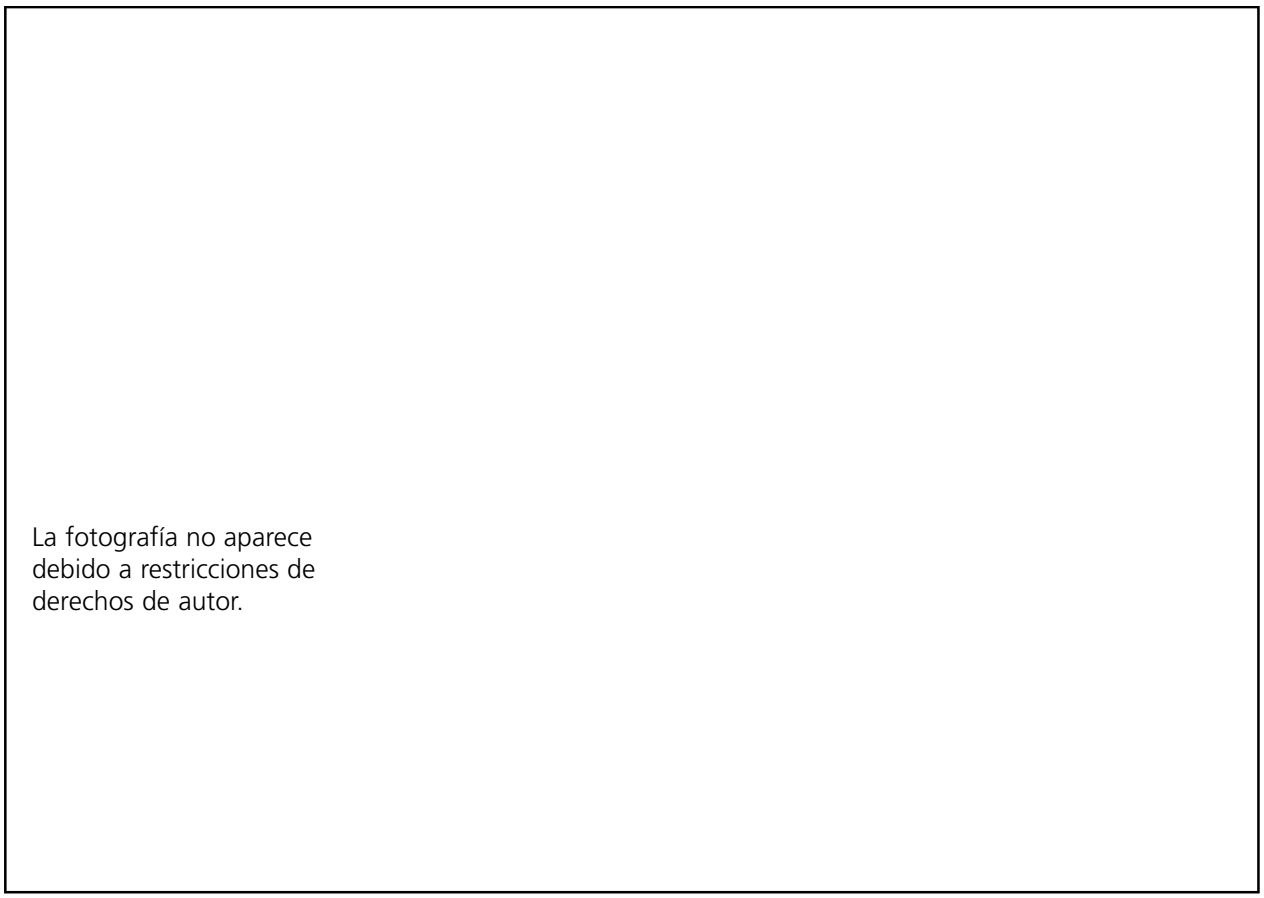
emphasis of family planning. Between 1997 and 1998 there was a temporary drop in the number of community promoters, causing a decline in the number of new contraceptive users for the year. In 1999, numbers of both groups again increased.

Periodic evaluations of FEMAP's clientele showed that about 85 percent lived below the poverty level in 1993. In 1997, 88 percent did so, indicating that FEMAP was continuing to reach its intended populations.

FEMAP's move towards sustainability was assisted by a number of studies. With assistance from the Population Council, FEMAP undertook cost studies at seven affiliates and developed a cost manual. These results became an ongoing part of FEMAP's management strategy. In 1993, with assistance from the Family Planning Management Development Project of Management Services for Health, FEMAP conducted studies of its actual and potential markets, and the competition in the public and private sectors. FEMAP also developed manuals to train its affiliates on conducting these studies. The results were used to set fees and modify the range of services provided. Research conducted with help from SOMARC and the Population Council showed that pharmacies served not only their immediate communities but also outlying areas. In addition, husbands often make purchases for their wives, so coverage is not limited to the individuals who actually come to the pharmacy.

These cost and market studies enabled FEMAP to develop a strategy to provide high-quality, low-price services to generate a high volume (Q-P-V strategy). Efforts were made to control and reduce costs in the clinic and community-based distribution programs, and productivity standards were set in a range of program areas. Between 1993 and 1996, the actual costs of medical services declined by 85 percent (11.38 pesos to 1.69 pesos per service), and the price paid by clients fell by 76 percent (13.60 pesos to 3.20 pesos). With help from Management Services for Health, FEMAP also developed an instrument for monitoring the performance of affiliates, and for identifying needs for training and management strengthening. In 1992, FEMAP established a foundation to seek grants and donations.

FEMAP's income increased substantially from 1992 to 1998, from US$3.1 million to US$8.2 million, largely due to the success of the organization's efforts to sell its medical services and attract local donations. USAID supplied about 14 percent of FEMAP's income in 1992. In 1998, this dropped to about 6 percent, but an additional 20 percent was donated in the form of contraceptives. With assistance from the USAID-funded SOMARC, FEMAP began sales of affordably priced oral contraceptives in the rural areas, later expanding this program nationwide and requiring its affili-



ates to pay for contraceptives and other supplies on 45-day credit terms. In 1999, FEMAP set up a revolving fund for the purchase and sale of contraceptives and other supplies. Funded by the U.S.-based David and Lucile Packard Foundation, this new system allowed FEMAP to purchase all of its own contraceptives by 1999.

The percentage of FEMAP's income from sales and services actually declined a bit from 1992 (68 percent) to 1998 (62 percent), but these sales more than doubled in dollar value (from US$2.1 million to US$5.1 million). This shows the dramatic expansion in the volume and profits of FEMAP's services. The FEMAP Foundation also increased its ability to attract local donations, from 6 percent of all income in 1992 to 10 percent in 1999. All told, by 1998, FEMAP was covering 84 percent of its overall expenses from locally generated revenues.

REMAINING CHALLENGES

During the 1990s, USAID population assistance to Mexico led to improvements in access to and the quality of family planning and reproductive health services. It also enabled MEXFAM and FEMAP to become more self-sustaining. Overall, Mexico has a strong health infrastructure, capable institutions, strong programs and the political will to ensure the delivery of quality services to all Mexicans. However, with the end of USAID assistance, the challenges that remain become even more critical and may dictate whether or not the progress of the last quarter century continues. Despite the positive overall picture, several groups in Mexico are underserved and may have unmet reproductive health and family planning needs.

The urban-rural contraceptive use rates are 73 percent (urban) and 53 percent (rural), a gap of 20 percentage points. In the priority states, this gap is even wider. Women with less education have much lower levels of contraceptive use than women with more education; this, too, is highlighted in the priority states. An estimated two-thirds of the unmet need for family planning in Mexico is among less educated women living in rural areas or urban slums.

Mexico has a strong health infrastructure, capable institutions, strong programs, and the political will to ensure the delivery of quality services.

The indigenous population, about 10 percent of the country's total, is even more marginalized. They have extremely low educational, social, and economic status, poor health, and high fertility rates. Adolescents ages 15 to 19 are another disadvantaged group. They are about one-quarter of the population, and one in six births in 1999 was to an adolescent. Married couples ages 15 to 19 have the lowest levels of contraceptive use, and as many as 30 percent have an unmet need for family planning.

The unmet need for family planning—the proportion of women in union who want to space or limit their pregnancies, but who are not using any form of contraception—was 12 percent in 1997. The unmet need for family planning, however, is most likely greater than current definitions indicate. Many sexually active women who are not in a union have unmet need for contraceptives, as do women who have discontinued methods, may not be using them correctly, or are using an inappropriate method given their reproductive desires. Some of these women have abortions, and many risk complications from unsafe abortion procedures.

To address the needs of these groups, efforts must continue to expand access to and improve the quality of family planning and reproductive health services. The public sector provides the majority of services, and its role has been increasing. While government efforts to decentralize services have improved coverage, tailoring services to the needs of specific groups will increase the market for family planning and reproductive health services in both the public and private sectors, especially given the current emphasis on charging users for services.

There have been significant improvements in the quality of care provided, but evaluations show the need for strengthening key skills in counseling and informed consent, especially among special populations such as indigenous groups, rural residents, and adolescents, whose needs have often been neglected.

LESSONS LEARNED

A number of lessons emerged from USAID/Mexico collaboration in the 1990s, many of which can be used in other countries to improve programs and collaboration.

TARGETING ASSISTANCE

- Focusing assistance on nine priority states identified by CONAPO as having the greatest need (defined by their percent rural population, infant mortality rate, and total fertility rate) was a valuable tool for allocating resources.

CONSOLIDATING ASSISTANCE

- Efforts to consolidate assistance where practical are beneficial. The last phase of USAID assistance to Mexico focused on fewer, but higher impact activities. Aid was provided to six institutions, and technical assistance was channeled through a number of cooperating agencies.

MOBILIZING LOCAL RESOURCES

- Mobilizing local resources was key to USAID's strategy in Mexico. The process of generating and evaluating innovative strategies helped mobilize domestic resources.
- The ability to demonstrate the benefits of successful programs was crucial to making high-level policymakers aware of the issues and to gaining their support.

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COORDINATING EFFORTS

- USAID's ability to call on numerous cooperating agencies, such as the International Planned Parenthood Federation, to provide technical assistance and to serve as coordinators is an important aspect of its donor support.
- Coordination among institutions was facilitated by gaining consensus on the five main functions of the USAID/Mexico strategy: service delivery, IEC, training, evaluation and research, and supervision and follow-up.

SUSTAINING PROGRAMS

- Studies to determine actual operating costs are necessary for cost control and cost recovery efforts. This information enables institutions to set realistic standards for the prices of services and for staff productivity.
- Cost monitoring, cost control, and investments in quality of care are key to sustainability.
- Significant institutional changes are very difficult to bring about if the mission and internal culture of the organizations are threatened.
- Financial and marketing decisionmaking should be decentralized.

DELIVERING SERVICES

- Large-scale IEC efforts on informed consent and informed demand—when clients become aware of their own needs for contraception and decide for themselves the best way to meet those needs—improve clients' awareness about and participation in decisionmaking.

- Collaboration between the public and private sectors to develop an up-to-date set of service delivery norms is an essential step in improving the quality of services. Sufficient copies of the norms must be distributed, along with specific opportunities for staff to study and implement the norms.
- The concept of reproductive health, along with other models of comprehensive care, is not well understood by providers in Mexico. Establishing norms or standards of care for each of the components in reproductive health is necessary, but not sufficient in training providers.
- Including additional counseling topics (e.g., discussion of patient's emotional state, her reproductive intentions) in postabortion care is associated with higher rates of acceptance, satisfaction, and continuation of postabortion family planning.

DECENTRALIZING SERVICES

- Decentralization has made family planning and reproductive health services the responsibility of each state. It is essential to prepare each state for this new role, especially by improving local technical capacity.

MANAGEMENT

- Training staff in CQI techniques enables them to identify and remedy operational problems. Success of the process depends on the commitment and support of senior management.

TRAINING STAFF

- Using different training models, including the cascade training-of-trainers model, and an inverted pyramid model that begins with primary providers is an effective way to upgrade provider skills.
- A training module on domestic violence helped service providers identify and manage domestic violence cases. The training alone is not sufficient to ensure provision of care for such cases, and there is probably a need for centers that specialize in assisting victims of domestic violence.

Practical experiences, not only theory, should be shared.

- Training lay midwives in prenatal care, delivery, postpartum and neonatal care, and family planning helped extend and improve their service delivery skills.
- On a periodic basis, sending a team of health personnel to rural hospitals and medical clinics to provide modern contraceptives, especially longer-term methods, helps extend coverage.

RESEARCH

- In order to better share research results, it is important for local researchers to produce a synthesis of results and a list of recommendations for use in particular settings (e.g., local, national).

TECHNICAL COOPERATION WITH THIRD COUNTRIES

- Practical experiences, not only theory, should be shared.
- Short-term, on-the-job, customized training should be provided.
- Governments need to be involved in policy dialogue, but not necessarily in service delivery or project implementation.

CONCLUSION

Building on a solid base of USAID involvement in Mexico since 1978, the final phase of USAID assistance to Mexico was successful in expanding access to and the quality and sustainability of reproductive health and family planning services. The strategic approach taken by USAID and its Mexican partners was instrumental in making effective use of resources, while moving toward the end of U.S. assistance.

The increases in contraceptive use and knowledge and the decline in nonuse due to lack of knowledge are all signs of increased access. Similarly, substantial progress was made in closing the gap between contraceptive use in the rural and urban areas. Improvements in the quality of services were achieved through extensive training, management, research and evaluation activities. The private-sector institutions expanded their services while simultaneously replacing USAID assistance with locally generated income.

Further evaluations will provide more information about the effects of ending USAID assistance and the ability of Mexico to continue its ambitious programs. No doubt further adjustments will need to be made to accommodate the drop in donor assistance. The Mexican agencies will need continued access to new technologies and innovative programs as they strive to address the needs of underserved groups, improve service quality, and share their expertise with each other.

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APPENDIX

Cooperating Agencies Assisting the USAID Population Program in Mexico, 1998

ASSISTANCE TO PUBLIC SECTORS

EngenderHealth, Inc. (formerly AVSC International)
Training (quality of care, access to services)

Carolina Population Center: The Evaluation and MEASURE Evaluation projects
Evaluation

Family Health International (FHI)
Research and evaluation

Pathfinder International
Coordination of disbursement of large proportion of funds for public sector assistance; research and evaluation

The Futures Group International (TFGI): The POLICY project
Policy research and evaluation

University of North Carolina, INTRAH: Program for International Training in Health (PRIME)
Training (quality of care)

ASSISTANCE TO PRIVATE SECTOR

Georgetown University/Institute for Reproductive Health
Access to services (natural family planning)

International Planned Parenthood Federation (IPPF)
Coordination of private sector assistance and of Transition Project

The Futures Group International (TFGI): Social Marketing project (SOMARC)
Management, sustainability (social marketing)

ASSISTANCE TO PUBLIC AND PRIVATE SECTOR

Basic Health Management, Inc. (BHM): Population Technical Services project (POPTECH)
Evaluation

John Snow, Inc. (JSI): Family Planning Logistics Management project (FPLM)
Logistics and commodities

Johns Hopkins University (JHU): Population Communication Services (PCS)
Information, education, and communication

Management Sciences for Health (MSH): Family Planning Management Development project (FPMD)
Management, training (quality of care, marketing)

The Population Council: INOPAL projects and FRONTIERS
Research and evaluation (operations research)
(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.)

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