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THE PROCUREMENT OPTIONS STUDY

Contraceptive Procurement in Mexico

JANUARY 2006

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

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EXECUTIVE SUMMARY

USAID and its cooperating agencies are studying procurement issues and options for countries that no longer receive USAID and/or international donor support for contraceptive commodities, including Brazil, Chile, Colombia, Costa Rica, and Mexico. This report summarizes the key findings from Mexico.

In Mexico, the majority of health services are provided by the Mexican Social Security Institute (IMSS) and the Mexican Secretary of Health (SSA). The IMSS offers services for all persons that are formally employed—and, in June 2005, covered approximately 54 million persons or 51 percent of Mexico’s population.¹ The SSA provides services to all individuals with no formal health coverage and serves as Mexico’s health safety net. Other government agencies also have their own specialized care networks, including the Institute of Social Security Serving the Workers of the State that provides care for state and federal employees. Employees of Petróleos Mexico and the armed forces also have their own health infrastructures. There is a well-developed commercial market for healthcare services, which includes private hospitals, clinics, and independent physicians—serving all socioeconomic levels.

USAID began its support to Mexico’s family planning program in the late 1970s. The withdrawal of its support for contraceptive commodities—after almost two decades—reflected the achievement of an overall supportive environment for reproductive health and family planning. In general, contraceptive prevalence had reached a mature level, the government’s support for family planning and reproductive health had been institutionalized, and the program had the technical and financial capacity to meet the family planning needs of the Mexican population. Interestingly, however, Mexico’s two major public health institutions—the SSA and IMSS—adopted different approaches for meeting their contraceptive needs.

Almost immediately after the phaseout of USAID support, the procurement responsibility for contraceptives (and all medications) for the SSA was decentralized. As a result, many state-level SSA agencies and key decisionmakers at that level were unfamiliar with the strategic importance of the family planning program and how to project and budget their contraceptive needs and had little direct procurement experience. As a result, many SSA facilities began experiencing contraceptive stockouts in the early 2000s. To address this gap, the SSA, at the central level, established a “coordinated” procurement mechanism for contraceptives through the United Nations Population Fund (UNFPA). These commodities are sourced through the international market using UNFPA’s procurement support. The SSA has made three consecutive annual procurements through the fund, achieving significant cost-savings for the states. However, despite the highly competitive prices available through this procurement mechanism, less than half of Mexico’s 32 states have participated in the coordinated procurement.

The IMSS has faced a unique set of challenges. The institute had been procuring contraceptives from commercial suppliers since the early 1990s and was never totally dependent on contraceptive donations from international donors. Although IMSS personnel were included in the early SSA discussions on identifying other contraceptive procurement options through UNFPA, ultimately the institute declined to participate, citing a fear of the length of the procurement process (and the possible stockouts that it could create) and also an uncertainty of the real cost savings given that distribution costs were not included in the UNFPA prices. As a result, the IMSS continued to procure its contraceptives through commercial suppliers at significantly higher prices. Today, however, the institute is under increasing pressure to improve the transparency of its procurement processes and is being criticized that it purchases too many medications from multinational pharmaceutical companies. The Mexican government is increasingly moving toward the purchase of interchangeable generic medications. As of January 2006, the

¹ Informe para la Asamblea General Ordinaria del IMSS, September 2005.

government's official list included 321 medicines—and there was an existing recommended modification to include various contraceptive products. The addition of contraceptive products to the list will present a major change for public sector institutions and likely reduce procurement costs significantly.

The review of Mexico's contraceptive procurement practices suggests that almost seven years after the phaseout of USAID support, public health institutions—particularly the Ministry of Health—are still facing some challenges in ensuring the availability of high-quality, affordable contraceptive supplies.

ABBREVIATIONS

CIF	cost, insurance, and freight (price)
COFEPRIS	Federal Commission for the Protection against Health Risks
CONAPO	National Population Council
IMSS	Mexican Social Security Institute
IPPF	International Planned Parenthood Federation
ISSSTE	Institute of Social Security Serving the Workers of the State
IUD	intrauterine device
MEXFAM	Mexican Foundation for Family Planning
NGO	nongovernmental organization
PAN	National Action Party
PEMEX	Petróleos Mexicanos
SEDENA	Secretariat for National Defense
SEMAR	Secretariat of the Navy
SSA	Mexican Secretary of Health
UMF	Family Medical Unit
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

OVERVIEW

Introduction

USAID and its cooperating agencies have been working to strengthen the planning process for achieving contraceptive security within the Latin America region. It is anticipated that by the end of 2008, USAID will have phased out its support for contraceptive commodities in the majority of the region's countries—although the timeline for graduation is different in each country. During 2004, the POLICY and DELIVER projects conducted assessments in five countries (Bolivia, Honduras, Paraguay, Peru, and Nicaragua) to determine their readiness in achieving contraceptive security.² As a result of these assessments, POLICY and DELIVER provided technical, consensus building, and policy and logistical support to help country programs prepare for and achieve contraceptive security.

To continue this regional effort for contraceptive security, the POLICY and DELIVER projects assessed potential procurement options in the eight Latin American countries where USAID is currently operating—Bolivia, Dominican Republic, Ecuador, El Salvador, Honduras, Nicaragua, Paraguay, and Peru. The study is designed to identify the legislative, normative, and programmatic issues that affect the procurement of contraceptives in these countries; and the procurement options currently being used in country programs that no longer receive USAID and/or international donor support for contraceptive commodities. There will likely be substantial lessons learned from the countries that have already graduated from USAID assistance; these five countries include Brazil, Chile, Colombia, Costa Rica, and Mexico—and have not received commodity support for several years. This report summarizes the key findings from Mexico.

Methods

The methodology for this procurement options study included key informant interviews with the government, particularly the Mexican Social Security Institute and the Mexican Secretary of Health; nongovernmental organizations (NGOs); and commercial sector partners. The analysis included the review of laws and regulations pertinent to reproductive health programs as well as public sector procurement. The study has also included the review of documents related to the structure of the overall health system, procurement norms and procedures, and other background information on the demographic and health situation in each country. The study also collected cost and pricing information for products distributed through public sector programs, social marketing programs, and the commercial contraceptive market through review of public sector procurements and site visits to pharmacies. In some cases, pharmaceutical distributors also provided cost, insurance, and freight (CIF) and distributor prices for products. Pricing information was collected on the top-selling commercial contraceptive brands (e.g., Microgynon and Depo-Provera) that have a regional presence—as well as the top-selling social marketing brands in each country.

² Taylor, Patricia A., Nora Quesada, Wendy Abramson, Varuni Dayaratna, and Leslie Patykewich. 2004. Regional Report: Contraceptive Security in Latin America and the Caribbean. Results and Recommendations. Arlington, VA: John Snow, Inc./DELIVER, and Washington, DC: Futures Group/POLICY Project.

BACKGROUND COUNTRY INFORMATION

Mexico is the second largest country in Latin America, with an estimated population of 106,202,903 (July 2005).³ In Mexico, there are 31 states and one federal district. The situation in the country is gradually improving, but low real wages, underemployment for a large segment of the population, inequitable income distribution, and few advancement opportunities for populations in the southern states represent the major economic and social concerns. The July 2000 elections marked the first time since 1910 that the ruling party, the Institutional Revolutionary Party, was defeated.



Mexico has a free market economy, with a mixture of modern and outmoded industry and agriculture, increasingly dominated by the private sector. Mexico's per capita income is one-fourth that of the United States—and there are major disparities within the country. The government is cognizant of the need to upgrade infrastructure, modernize the tax system and labor laws, and provide incentives to invest in the energy sector; but progress is slow. The major agricultural products are corn, wheat, soybeans, rice, beans, cotton, coffee, fruit, tomatoes, beef, poultry, dairy products, and wood products. The major industries include food and beverages, tobacco, chemicals, iron and steel, petroleum, mining, textiles, clothing, motor vehicles, consumer durables, and tourism. See Tables 1 and 2 for sociodemographic indicators for Mexico.

Table 1. Socioeconomic Indicators

GDP Per Capita (2004 US dollars) ²	\$9,600
Population Below the Poverty Line (2001) ²	40% (2003 est.)
Total Expenditure on Health (as a % of GDP 2002) ¹	6.1
Public/Private Breakdown of Health Expenditure ¹	44.9%/55.1%
Per Capita Total Expenditure on Health (2002) ¹	US\$550
Per Capita Government Expenditure on Health (2002) ¹	US\$247

Sources: (1) <http://www.who.int/whosis/country/indicators.cfm?country=mex>,
(2) <http://www.cia.gov/cia/publications/factbook/geos/mx.html>.

Table 2. Demographic Indicators

Total Population Estimate (2004) ²	106,202,903
Annual Population Growth Rate (1993-2003) ¹	1.6%
Total Fertility Rate (per woman) ¹	2.3
Infant Mortality (2004) ¹	25 females, 31 males/1,000 live births
Life Expectancy (2004) ¹	67.2 years
Contraceptive Prevalence (modern methods) (2000) ³	70.8%

Sources: (1) <http://www.who.int/countries/cr/en/>, (2) <http://www.cia.gov/cia/publications/factbook/geos/cs.html>,
(3) www.conapo.gob.mx.

³ www.cia.gov/cia/publications/factbook/geos/mx.html.

THE HEALTH SYSTEM IN BRIEF

In Mexico, the majority of health services are provided by the Mexican Social Security Institute (IMSS) and the Mexican Secretary of Health (SSA). The IMSS offers services for all persons that are formally employed—and, in June 2005, covered approximately 54 million persons or 51 percent of Mexico’s population.⁴ The SSA provides services to all individuals with no formal health coverage and serves as Mexico’s health safety net. Other government agencies have their own specialized care networks, including the Institute of Social Security Serving the Workers of the State (ISSSTE) that provides care for state and federal employees. Employees of *Petróleos Mexicanos* (PEMEX) and the armed forces also have their own health infrastructures. There is a well-developed commercial market for healthcare services, which includes private hospitals, clinics, and independent physicians—serving all socioeconomic levels.

The IMSS is the largest healthcare service delivery organization in Mexico and the largest provider of family planning services: 41.4 percent of all users report the IMSS as their source for family planning. Within the institute, delegations coordinate the provision of healthcare services. Within this context, the family planning program is still a vertical program—with the central oversight and management in several strategic areas. There are currently 37 delegations, one for each state—except Veracruz and the state of Mexico that have two—and four for the Distrito Federal. Primary healthcare services are offered in urban areas through Family Medical Units (UMFs). Throughout the Mexican Republic, 1,079 UMFs serve approximately 85 percent of the total demand for healthcare services within the IMSS.

IMSS-Oportunidades, an independent program founded more than 23 years ago, provides healthcare services in marginalized rural communities. Mexico’s federal government funds the program, and the IMSS administers the funds and provides technical support. The program targets 18 of Mexico’s poorest states, focusing on providing rural areas with populations less than 2,500 inhabitants with primary care services. Approximately 3,540 rural medical units provide services to about 10.5 million inhabitants (4.5 million indigenous people) in the 18 states.⁵

The SSA provides healthcare coverage to Mexico’s uninsured population and is the second largest provider of clinic-based family planning services in the country. The provision of healthcare is decentralized and organized at the state level. The central level of the SSA serves as a normative body and provides general oversight and guidance on strategic programs, including family planning. In September 2003, the Directorate for Reproductive Health was integrated into a new technical center—the National Center for Gender Equity and Reproductive Health. This center has increased financial and administrative autonomy and is responsible for strengthening all programs targeted toward women, including family planning. The objective is to integrate efforts related to gender equity, reproductive health, and maternal and infant health under a more efficient structure. While the SSA serves as the general safety net for the uninsured population, the government initiated a new pilot program in 2001 called “Seguro Popular” designed to develop a system of universal health coverage. In 2004, this program was institutionalized as part of the Health Protection System based on reforms made to the General Health Law in 2003 to ensure coverage of all essential services as well as some catastrophic illnesses.⁶

The ISSSTE provides healthcare services for state and municipal-level workers. The organizational hierarchy tends to be much more dynamic because of the frequent changes in senior-level positions; and, as a result, there is a much higher turnover among technical staff. ISSSTE received support from USAID for quality of care; information, education, and communication; and training in specific technical areas.

⁴ Informe para la Asamblea General Ordinaria del IMSS, September 2005.

⁵ Ibid.

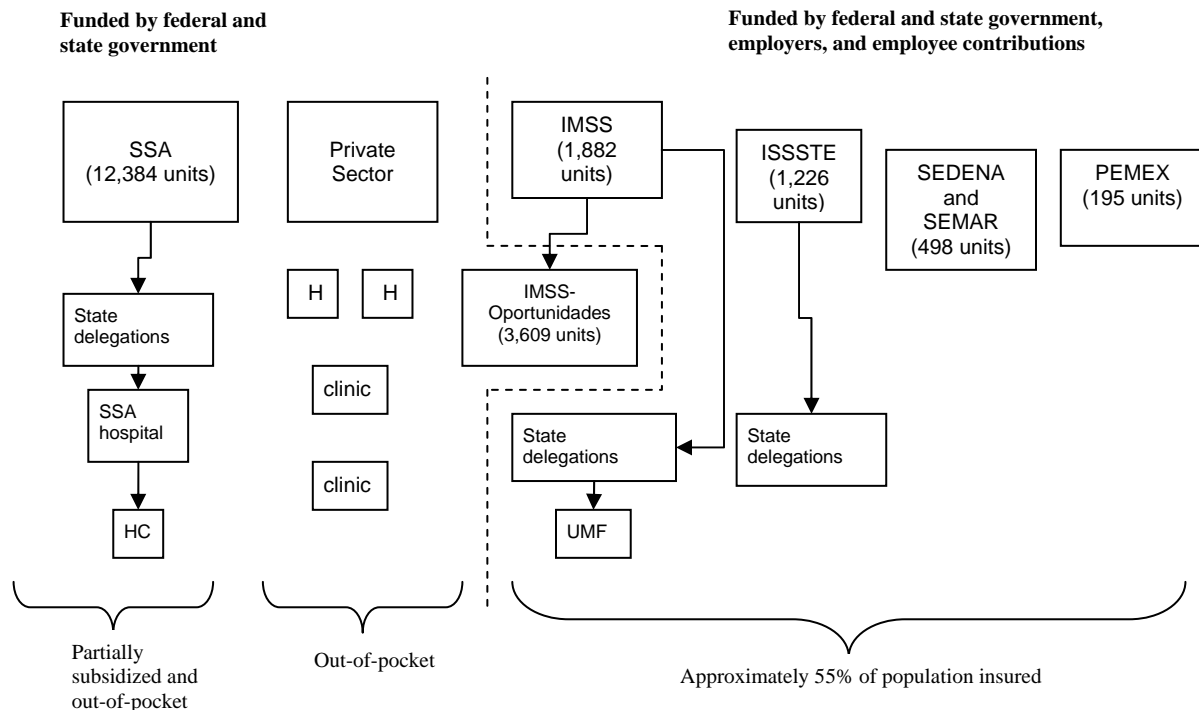
⁶ Hacia una política farmacéutica integral para México. Secretaría de Salud. Primera edición 2005.

They received less support in the form of commodity donations. Like most public sector institutions, ISSSTE is also facing a period of financial crisis. The family planning division, for example, in 1993, included approximately 25 technical and administrative staff. In 2003, the division only included three dedicated staff—with responsibilities that were even broader than family planning.

The federal employees employed by PEMEX—the government entity that manages the country’s petroleum reserves—also maintains its own separate health infrastructure. Both the Secretariat for National Defense (SEDENA) and the Secretariat of the Navy (SEMAR) also maintain their own health infrastructure in areas where they have army and navy bases. Each government institution is represented in Figure 1. Approximately 55 percent of the population is insured through employment with federal, state, and local governments and the formal sector.

The decentralization of government healthcare services in Mexico has been relatively recent compared with other Latin American countries. Although decentralization began in the early 1980s, the pace has varied among organizations. In 1983, Mexico started decentralization efforts through the SSA. At the time, only 14 states signed agreements with the federal government, representing a fairly limited initiative. During the Salinas administration, the decentralization process virtually stopped. Then during the administration of President Zedillo, decentralization was reinitiated and gradually implemented. Today, the SSA continues to be the most decentralized healthcare institution. The IMSS and ISSSTE remain centralized in many of their primary functions; but the IMSS has also, more recently, decentralized the procurement process for medications.

Figure 1. The Mexican Health System ⁷



Legend:
H = Hospital
HC = Health clinic

⁷ <http://quinto.informe.presidencia.gob.mx/docs/anexo/pdf/P142.pdf>.

The Federal Commission for the Protection against Health Risks (COFEPRIS), which was previously under the auspices of the Ministry of Health, has recently become a separate entity with more financial and legal autonomy. COFEPRIS is responsible for the registration of all medicines and medical supplies and quality control.

SUPPLY AND DISTRIBUTION OF CONTRACEPTIVE PRODUCTS IN MEXICO

Context

There has been strong political support for the Mexican family planning program for many years. Mexico is unusual in that the provision of family planning within all public health facilities is free across the board—and even government institutions (IMSS and ISSSTE) that serve only insured populations are obligated to provide free family planning services to non-beneficiaries. As a result of this strong support, Mexico’s reproductive health and family planning program generated significant results. In three decades, the total fertility rate decreased from six children per woman to an estimated 2.65 in 1997. The National Institute of Statistics, Geography, and Information (INEGI), in collaboration with the National Population Council (CONAPO), conducted Mexico’s last nationwide reproductive health survey in 1997. The results showed use of contraceptive methods increasing from 52.7 percent in 1987 to 63.1 percent in 1992 to 68.5 percent in 1997.⁸ CONAPO estimates that contraceptive prevalence increased to 70.8 percent by 2000; however, there has been no new contraceptive prevalence survey since 1997, and given current resource constraints, it is unclear when there will be another survey.

Figure 2. Contraceptive Prevalence (1976–2000)



Under President Fox’s administration, the SSA published its 2001–2006 strategic plan for reproductive health.⁹ The specific objectives to be achieved by 2006 included the following:

- Increase the use of contraceptives to 73.9 percent among women of reproductive age.
- Increase by 15 percent the number of women of reproductive age considered to be active users of family planning (compared with the number in the year 2000).
- Reduce the total fertility rate to 2.06 children per women.
- Reduce unmet need to 6.5 percent.
- Increase the use of contraceptives to 54 percent among users younger than 20 years of age.
- Reduce by 11 percent the total number of births registered to women between 15 and 19 years of age (compared with the number in the year 2000).

⁸ Cuadernos de Salud Reproductiva *Republica Mexicana*, Consejo Nacional de Población, September 2000.

⁹ “Programa de Acción: Salud Reproductiva”, Secretaria de Salud, Primera Edición, 2001.

Legal and Regulatory Framework for Family Planning

In general, Mexico is considered to have a strong legal and regulatory environment for reproductive health and family planning services. The fourth article of the Mexican Constitution establishes that all persons have the right to protect their health and that the law will define the bases and modalities for access to health services. On January 7, 1974, the General Population Law was approved, outlining the legal parameters for a new and explicit population policy. The law establishes the right of all individuals to make an informed decision on the number and spacing of their children and the right to the necessary information and services in order to exercise that decision. Article 16 of the law also establishes that all information, education, and health services related to family planning will be free of charge when provided by state organizations.

The Official Mexican Norm for Family Planning Services includes guidelines for the provision of services by outlining scientific and technological advances in contraception; and technical information about contraceptive methods, counseling and orientation, informed choice, and sexual and reproductive health rights. Established in 1994, these norms were updated in 2004 to include emergency contraception and the female condom. For the sustainability of family planning program, contraceptive supplies are included in List of Essential Medical Supplies, which guides the procurement of medications for all public sector institutions.

In addition to the strong legal context for the Mexican family planning program, the highest levels of Mexican government considered the program to be a top priority. The program received strong political support by the governing party that dominated Mexican politics for more than 70 years—the Institutional Revolutionary Party. This support was continued throughout the administrations of Luis Echevarria, Lopez Portillo, de la Madrid, Salinas, and Ernesto Zedillo. In the mid-1990s, President Zedillo updated the national population policy and made reproductive health one of its pillars. Mexico was one of the first countries to adopt the integrated reproductive health model that was promoted during the 1994 Conference on Population and Development. In July 2000, the National Action Party (PAN) won the presidential election, and President Vicente Fox entered office in 2001. The PAN has a more conservative orientation, and President Fox has demonstrated closer affiliations with the Catholic Church, although support for the family planning program has continued.

The Mexican family planning program also benefited from strong intersectoral coordination. CONAPO was tasked with overseeing international donor assistance. During the period of USAID support, CONAPO was the liaison between USAID and the public sector organizations receiving support. USAID and CONAPO formed an ongoing leadership committee of the major public sector service delivery institutions that served to direct, monitor, and supervise implementation of the USAID strategy. In addition to this committee, the SSA instituted an Inter-institutional Reproductive Health Group, including public sector organizations and civil society, and discussed and debated strategic issues in family planning and reproductive health.

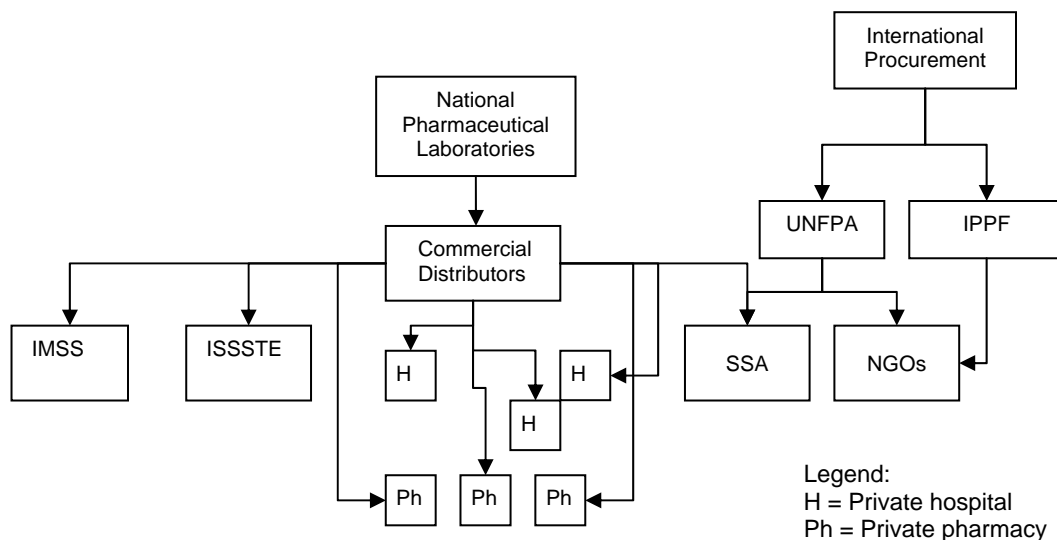
Supply and Distribution for Contraceptives in the Public and Private Sectors

In 2005, the Mexican government completed and published a comprehensive report on the supply and demand of pharmaceutical products. The report, “Toward an Integrated Pharmaceutical Policy for Mexico,”¹⁰ summarized the results of analysis on the worldwide, regional, and national pharmaceutical market and trends—related to sales volume and value, security, efficacy, quality of medicines, availability and accessibility of pharmaceuticals, and overall innovation and competitiveness in the Mexican

¹⁰ Hacia una Política Farmacéutica Integral para México. Secretaria de Salud. Primera Edición, 2005.

pharmaceutical industry. The report concludes by outlining objectives, strategies, and actions on a wide variety of issues, including strengthening the presence of national (Mexican) pharmaceutical laboratories, improving education and information related to interchangeable generic products, ensuring that all public sector institutions purchase generic products when appropriate, as well as implementing various modifications and adaptations to existing norms and regulations. Figure 3 outlines the supply and distribution chain in Mexico.

Figure 3. Supply and Distribution Chains in Mexico



The main provider of contraceptives has been and continues to be the public sector, which provides 72.3 percent of overall family planning services. According to the 1997 reproductive health survey, the public sector provided more than 80 percent of long-term and permanent methods, including 86.1, 81.2, and 84.7 percent of intrauterine device (IUD), tubal ligation, and vasectomy services, respectively. The private sector is the main provider of temporary methods and methods that can be easily obtained at the pharmacy, including injections (66.6%), condoms (65.1%), pills (58.7%), and other barrier methods (99.6%).¹¹

Public sector

The supply and distribution of medicines in the public sector is based on a system of jurisdictional warehouses at the state or delegation level that maintain high levels of inventory for all types of medicines, including contraceptives. The majority of procurements are done through public solicitations based on the *cuadro basico* or basic list for primary care and on supply catalogs for secondary and tertiary care. The public sector institutions have adopted different procurement mechanisms for contraceptives. The IMSS and ISSSTE primarily source their contraceptive commodities from local commercial suppliers. The SSA—which decentralized the procurement of all medicines in early 2000—established a coordinated procurement mechanism for contraceptives through UNFPA; these commodities are sourced through the international market using UNFPA’s procurement support. However, despite the highly competitive prices available, less than half of Mexico’s 32 states have participated in coordinated procurement mechanisms.

¹¹ Consejo Nacional de Población (CONAPO), *La Situación Demográfica de México*. Primera Edición México, 2000.

Private sector

In Mexico, there is a highly sophisticated pharmaceutical market with more than 224 pharmaceutical laboratories and 7,000 products.¹² The market includes all the major international manufacturers of contraceptives, contributing to a wide variety and availability of contraceptive products. There is also a local manufacturer of condoms, Denti-Lab, as well as the Mexican manufacturer, Aplicaciones Farmaceuticas, of the one-month injectable, Cyclofem. These large pharmaceutical laboratories distribute their products through commercial distributors to more than 20,000 points of sale, which include independent pharmacies, pharmacy chains, and pharmacies contained within large self-service or retail outlets. Three national-level wholesalers control approximately 60 percent of the market, and about 20 regional and local commercial distributors provide medicines.¹³ Many distributors have the capacity to offer delivery in less than 12 hours. The distributor's margin for most medicines averages about 15 percent, which is comparatively higher than in other countries in the region. However, the margin at the pharmacy level, which averages about 21 percent—is less than in many other markets.¹⁴ All pharmaceutical products are registered with the Ministry of Economy to establish their maximum consumer price. The condom market in Mexico is also well segmented, with over 35 condom brands and many more presentations. The market leader, Sico, is the most expensive brand available in the commercial market.

NGO sector

The Mexican Foundation for Family Planning (MEXFAM) is the Mexican affiliate of the International Planned Parenthood Federation (IPPF). MEXFAM provides services in the poor areas of 32 cities and indigenous regions. The foundation stopped receiving financial and technical support from USAID in September 1998—after a five-year phaseout strategy implemented under IPPF's Transition Project. Since the phaseout, MEXFAM has continued to procure contraceptive commodities through commercial providers, as well as using a part of their IPPF budget for commodities. The foundation estimates that the total commercial value of contraceptive commodities needed to serve its clients each year is approximately US\$300,000. MEXFAM uses IPPF funding each year to source some of its contraceptive needs but still procures a significant amount of contraceptive commodities using its own direct funding. In 2004, the foundation experienced several periods of complete stockouts. For example, for approximately three months, one of its condom products (with aroma) was out of stock. MEXFAM also had shorter stockout periods of Cyclofem and Lo-Femenal. In 2005, MEXFAM opted for most of the budget it receives from IPPF in cash in order to address some cash flow problems it was experiencing. As a result, MEXFAM's procurement levels for contraceptives in 2005 are significantly lower than during previous years.

The Mexican Federation of Private Associations (FEMAP) is an alliance of private family planning organizations that operate in poor areas within 87 cities and thousands of rural communities. USAID phased out support to FEMAP at the same time as MEXFAM. Because the federation received less of its operating budget from USAID, it was able to achieve higher levels of self-sufficiency (84%) by the time of phaseout. FEMAP has since experimented with various procurement sources for contraceptives. Ultimately, the federation was granted access to UNFPA's procurement mechanism. At the same time, FEMAP received a US\$300,000 grant from the Packard Foundation to start a revolving fund for contraceptives. The federation used this fund to purchase contraceptive commodities through UNFPA, which requires upfront payment for contraceptive supplies. FEMAP also created a separate, for-profit affiliate (called Salud Siglo XXI), which handles the commercial transaction of selling contraceptive supplies to its affiliates with a 20 percent margin. In addition, FEMAP established a separate social marketing organization (called Mate) to market and distribute its own line of social marketing products.

¹² Hacia una Política Farmacéutica Integral para México, Secretaria de Salud. Primera Edición 2005.

¹³ Ibid.

¹⁴ Ibid.

Procurement in the Public Sector

The laws and norms related to procurement in Mexico are complex. The primary laws that affect procurement include the Organic Law of Federal Administration (December 1976) and the Law of Procurements, Rentals, and Services for the Public Sector (March 2000). The Presidential Act published in the official newspaper in November 1996 establishes that the IMSS may only procure products and supplies that are part of the basic list and catalog of health sector supplies established by the General Health Council.

In addition, in June 2002, the Ministry of Health and the General Health Commission published an agreement stating that all public health institutions should buy interchangeable generic products when locally available in order to ensure better quality, price, and availability. Article 74 of the Regulation on Health Supplies issued by the federal government indicates that the commission will periodically publish the Catalog of Interchangeable Generic Products. As of January 3, 2006, the catalog had been updated 32 times and included 321 interchangeable generic medicines. However, no contraceptives are included on this list—although it has been officially recommended that the list be modified to include Desogestrel and Etinilestradiol, Levonorgestrel (tablets), Levonorgestrel and Etinilestradiol, and Medroxiprogesterona and Cipionato de Estradiol, and Noretisterona and Etinislestradiol, which are included in the list of essential medications as shown in Table 3.

Table 3. Contraceptive Formulations Included in the Basic List of Essential Medications

Generic	Presentation	Code
Desogestrel and Etinilestradiol	TABLET. Desogestrel 0.15 mg. Etinilestradiol 0.03 mg.	3505
Etonogestrel	IMPLANT. Etonogestrel 68.0 mg. Packaged with implant and applicator.	3510
Levonorgestrel	POWDER. The IUD contains: Levonorgestrel (micronizado) 52 mg.	2208
Levonorgestrel	TABLET. Levonorgestrel 0.75 mg.	2210
Levonorgestrel and Etinilestradiol	TABLET. Levonorgestrel 0.15 mg. Etinilestradiol 0.03 mg.	3504
Medroxiprogesterona and Cipionato de Estradiol	INJECTABLE. Acetato de Medroxiprogesterona 25 mg. Cipionato de estradiol 5 mg.	3509
Norelgestromina Etinilestradiol	PATCH. Norelgestromina 6.00 mg Etinilestradiol 0.60 mg. Packaged with 3 patches:	3511
Noretisterona and Estradiol	INJECTABLE. Enantato de noretisterona 50 mg. Valerato de estradiol 5 mg.	3515

The COFEPRIS is responsible for the registration and quality control of all medications and medical devices. The Official Mexican Norm (NOM-220-SSA1-2002) describes the procedures that the pharmaceutical industry must complete to successfully register any pharmaceutical product. Mexico's two major two public sector institutions—the SSA and IMSS—have adopted different strategies for contraceptive procurement. These two different approaches and related challenges are discussed in the following sections.

SSA

The SSA decentralized contraceptive procurement in 2000, so there are no official figures on the related total expenditures. However, the SSA has worked hard to help states procure their own contraceptives. In 1999, 35 percent of states and 67 percent of districts reported a total stockout for at least one contraceptive method in the previous year; and 87 percent of district warehouses and 33 percent of operations units reported being under-stocked in the last six months.¹⁵ Between 2002 and 2003, there was a general shortage of products throughout the country. Figure 4 illustrates the procurement process in the SSA.

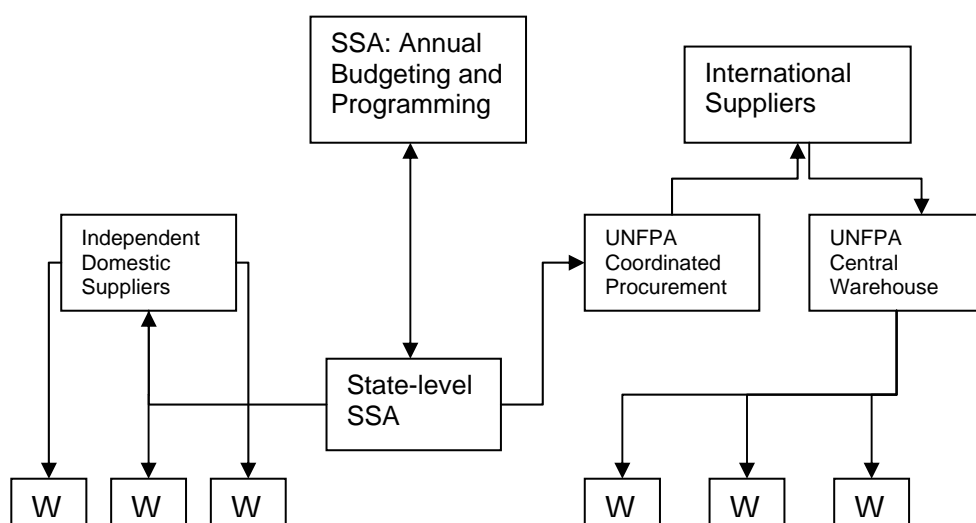
In 2002, the SSA began working with UNFPA to develop a system to procure contraceptives in a centralized, coordinated fashion, using UNFPA's procurement mechanism. The head of the Family Planning Department personally lobbied the states to encourage them to participate in the central procurement. The main attraction for the states was the competitive prices that could be achieved through international procurement. Ultimately, 16 states participated. UNFPA handled the international quality control procedures, importation and customs processing, and sanitary registration of the contraceptives purchased. In 2002, the estimated savings (compared with what the states would have paid for similar amounts of contraceptives on the commercial market) was approximately US\$3.9 million.¹⁶ The SSA has repeated this coordinated procurement process once a year since then; in 2006, it is estimated that the SSA will conduct two coordinated procurements to allow the states to reduce their initial outlay of capital.

Although the cost savings have been substantial, fewer states are participating today than during the initial procurement period because of some problems with the delivery of products, particularly condoms. The newly created COFEPRIS requires quality control tests on all condom shipments imported to Mexico; and as the overall capacity of commission's laboratory services is relatively limited, there have been delays in the process. In addition, the increased autonomy of COFEPRIS has made it more difficult to identify temporary solutions to some of the regulatory obstacles. This has meant, for example, that the SSA can no longer procure injectable contraceptives through UNFPA due to registration requirements. Other factors that have inhibited states' participation in the procurement process include the requirement that payment be in full and in advance—many states do not receive their budgetary allocations in full (and do not know in what increments they will receive their funds), and some state-laws prohibit government entities from purchasing supplies using advance payment. In addition, UNFPA may not issue fiscal receipts that are also required by most federal and state entities.

¹⁵ Quesada, N., S. Rao, and S. Kinzett. 2001. Mexico: Contraceptive Logistics System (DGSR): Review of Accomplishments and Lessons Learned. Arlington, VA: Family Planning Logistics Management/John Snow, Inc.

¹⁶ Rivera, G. 2005. Powerpoint Presentation: Technical Assistance for Acquisition and Control of RH Commodities. UNFPA.

Figure 4. Procurement Process in the SSA



W = State-level warehouse

In addition to developing the coordinated procurement option for contraceptives, the SSA has been involved in a rigorous effort to improve the availability of all medicines and medical supplies at the state level. In 2002, it conducted a state-level survey to assess overall supply and distribution practices. The survey revealed that the procurement of medicines by SSA facilities exceeded 1.7 billion pesos, approximately 13 percent of the total purchases in the health sector. The survey also revealed that the procurements were made from a relatively small group of providers; however, the states were not leveraging their purchasing power, causing significant differences in the procurement costs for medicines. There were approximately 35 providers of medicines in 32 states, but 11 of the providers accounted for more than 50 percent of the total purchases.

The survey also found that direct or alternate purchases were several times more expensive than purchases conducted through a formal bidding process. In an assessment of the warehousing practices, it was found that the state-level SSA has a complex distribution system, with some products passing through various levels before reaching the final point of distribution. The survey concluded that the efficiency in warehousing was low in most states and that the cost of distribution of medicines is significantly higher than the costs associated with the private sector.¹⁷ This analysis looked at the volume of product purchases (units) in comparison with total warehousing space (per square meter) and compared it to standards for the private sector, revealing that most states were well below the standard industry practice for the private sector. The analysis also revealed that distribution costs by the SSA represented approximately 12 percent of their total purchasing—again significantly higher than the standard for the pharmaceutical industry (4–6%) and the IMSS (7–8%).

The distribution and supply survey also attempted to analyze the issues related to stockouts at the facility level, concluding that the SSA had a serious overall problem, primarily concentrated during the beginning of the budgeting cycle. The four main reasons for stockouts included (1) lack of budget and time related to authorization of budget; (2) improper planning of demand; (3) inefficient procurement systems (long procurement processes, outdated/deserted codes, and poor selection of providers); and (4) complex

¹⁷ Practicas de Abastecimiento y Distribucion de Medicamentos, Encuestas a Secretarias de Salud Estatales, January 2003.

distribution and “push” inventory systems and low frequency of distribution. The survey concluded that most states needed at least a 60 percent budgetary increase for medicines.

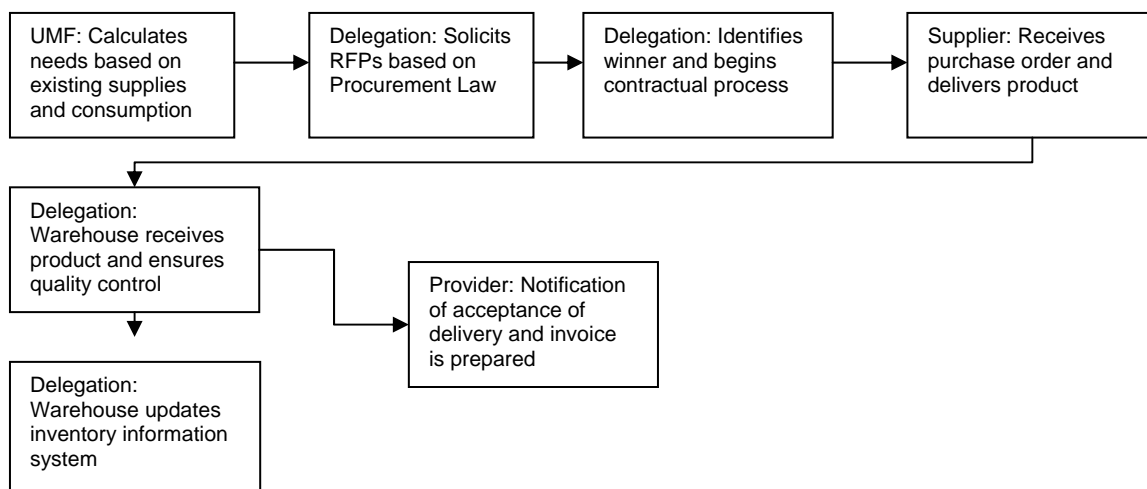
IMSS

As the largest healthcare service delivery organization in Mexico, the IMSS is also the largest provider of family planning services—with 41.4 percent of all users reporting the IMSS as their source for family planning. The institute is facing an increasing financial crisis, which is affecting many components of its program, including healthcare services. News stories appear frequently on the implications of the financial crisis—the impact on the quality of healthcare and the increasing shortages in essential medications. There are many possible solutions being debated, including increasing the age of retirement, increasing the federal government’s contribution to social security, reducing the number of personnel, and modifying the procurement system for medications. The IMSS has been procuring contraceptives since the early 1990s, was never totally dependent on contraceptive donations from international donors, and had experience in contraceptive procurement prior to USAID’s phaseout period. The gradual reduction in contraceptive donations occurred between 1991 and 1994.

The IMSS procures all of its contraceptive supplies from local pharmaceutical companies. The institute has succeeded in expanding the range of contraceptive options available to IMSS beneficiaries, including the newly launched (July 2003) sub-dermal implants manufactured by Organon. Although IMSS personnel joined in SSA’s discussions to identify other contraceptive procurement options through UNFPA, ultimately the institute declined to participate—fearful of the length of the procurement process (and the possible stockouts that it could create) and unsure of the real cost savings given that distribution costs were not included in the UNFPA prices.

The IMSS has only recently decentralized the procurement of contraceptives to the delegation level. In 2002, contraceptive procurements totaled more than US\$5.4 million. Given the recent decentralization of contraceptive procurement, more recent figures are not available. The procurement process undertaken at the delegation level is summarized in Figure 5. Each UMF is responsible for calculating its own needs for medicines and medical supplies. Procurement, accounting, and warehousing functions are decentralized.

Figure 5. Procurement of Contraceptive Supplies by IMSS



While the IMSS has made efforts to improve transparency in the procurement process and ensure cost-effectiveness, there is still debate around the institution's purchasing patterns from multinational pharmaceutical companies. To further improve transparency, the IMSS has created an Internet site called "IMSS Va a Comprar, IMSS Compro," which provides access to the general public of future tenders, as well as completed public procurements. Each delegation unit that purchases any type of good or services is obligated to include its tenders and procurement information in the National Supply System, which reported 6,514 total projects during 2004 and 3,387 during the first semester of 2005. During 2005, the IMSS filled an estimated 10 million prescriptions per month. The fulfillment of prescriptions (based on the availability of medicines) improved from 65 percent in 2002 to 94 percent in 2004—suggesting that supply levels overall have improved.¹⁸ However, the IMSS is still criticized for purchasing too many medications from multinational pharmaceutical laboratories. A recent article claimed that the institute was paying excessive prices for patented medicines, stating that "7 out of 10 pesos" of the procurement budget goes to patented medications and that the head of the IMSS had signed multi-year contracts with multinational suppliers.

Phaseout of USAID Support

USAID began providing population support to the Mexican family planning program in 1978; and for many years, USAID was the largest foreign donor to the program. Between 1985 and 1995, USAID's average budget for family planning was approximately US\$10 million annually. In 1996, the family planning budget increased to US\$13 million—approximately 10 percent of the total (US\$124 million) that Mexico assigned to its National Family Planning Program.¹⁹

In 1991, USAID designed a five-year phaseout strategy for population support to Mexico. The strategy included a memorandum of understanding between USAID and the various public sector organizations that received support. The objective was to outline the specific roles of the organizations and the steps toward graduation, including the reduction of donated commodities and the Mexican government's commitment to procure increasing levels of commodities. In 1992, USAID started reducing its contraceptive donations incrementally by 25 percent each year and, by 1996, had completely phased out donations. In 1996, the family planning budget increased to US\$13 million—approximately 10 percent of the total US\$124 million that Mexico assigned to its National Family Planning Program. The final period of USAID support from 1996 onward included technical assistance in several priority areas. Although originally set to end in 1997, support for the family planning program was extended an additional two years and ended in March 1999.

In 2003, the POLICY Project conducted in-depth interviews in Mexico to examine USAID's phaseout strategy from the perspective of key Mexican stakeholders.²⁰ In general, the informants interviewed agreed that USAID's phaseout strategy was well conceived and well planned. The planning process was also considered to be highly participatory. USAID formed a coordinating committee including CONAPO, SSA, IMSS, and ISSSTE; these members helped to develop the phaseout strategy. Most informants interviewed were also positive about the manner in which the phaseout was implemented.

UNFPA has worked in Mexico since 1972. The fund currently collaborates with CONAPO on a country program that focuses on two key areas: (1) sexual and reproductive health, supporting the development of innovative and accessible reproductive health services for urban and rural poor, the overall management of reproductive health services (including supply and logistical systems) and information, education, and

¹⁸ www.presidencia.gob.mx/buenasnoticias/?contenido=9042&pagina=198

¹⁹ Beamish, J. 1999. USAID-Mexico. Population, Family Planning and Reproductive Health Program, 1992–1999. Washington, DC: Population Reference Bureau.

²⁰ Interviews conducted by Ms. Cindi Cisek, June–August 2003.

communication activities; and (2) population and development strategies to strengthen the institutional capacity of state and municipal programs to design and coordinate population policies.²¹ Under the program of sexual and reproductive, UNFPA supports the SSA in the procurement, importation, and warehousing of contraceptive supplies through their international procurement mechanism.

²¹ See www.unfpa.org.mx/programa.htm.

COST STRUCTURE AND PRICE ANALYSIS

The assessment of supply and distribution channels for contraceptive products also included a review of the cost structure related to contraceptives. In Mexico, in the public sector, contraceptive products are distributed for free. The assessment also included a review of contraceptive prices for the private sector. For proprietary reasons, commercial manufacturers and distributors were reticent to share CIF prices so the estimates provided here are based upon estimated margins. In general, NGOs were more willing to share cost and pricing information.

Public Sector Procurement Costs

The SSA is only procuring three products—the Lo-Femenal oral contraceptive, Copper-T 380A, and the male condom—through UNFPA, as these products currently have the appropriate sanitary registration in Mexico. UNFPA provided the procurement prices for these contraceptives—but asked that the prices not be published due to their confidential nature. In general, the procurement prices are significantly lower than comparable products being purchased by the IMSS. The procurement prices for the IMSS, considerably higher than the prices paid by other programs in other countries, are listed in Table 4.

Table 4. Public Sector Procurement Costs for Hormonal Contraceptives²²

Product	Formulation	SSA	IMSS ²³ (US\$)
Oral Contraceptive	Desogestrel (.15 mg) and Ethinilestradiol (.03mg)	n/a	\$1.96
	Levonorgestrel (.15 mg) and Ethinilestradiol (.03 mg)	<i>confidential</i>	\$1.50
	Levonorgestrel (.75 mg)	n/a	\$2.86
Injectable	Medroxiprogesterona (25 mg) and Cipionato Estradiol (5.0 mg)	n/a	\$4.38
	Noretisterona (50.0 mg) and Estradiol (5.0mg)	n/a	<i>Not available</i>
Implant	Etonogestrel (68.0mg)	n/a	\$108.96
Patch	Norelgestromina (6.0 mg) and Ethinilestradiol .60 mg)	n/a	<i>Not available</i>
IUD	Copper-T 380	<i>confidential</i>	\$.67
	Copper-T 380 nulipara	n/a	\$6.86
	Copper-T standard & short	n/a	\$2.35
	Levonorgestrel (52.0 mg)	n/a	\$106.22
Male Condom	Condom	<i>confidential</i>	<i>Not available</i>

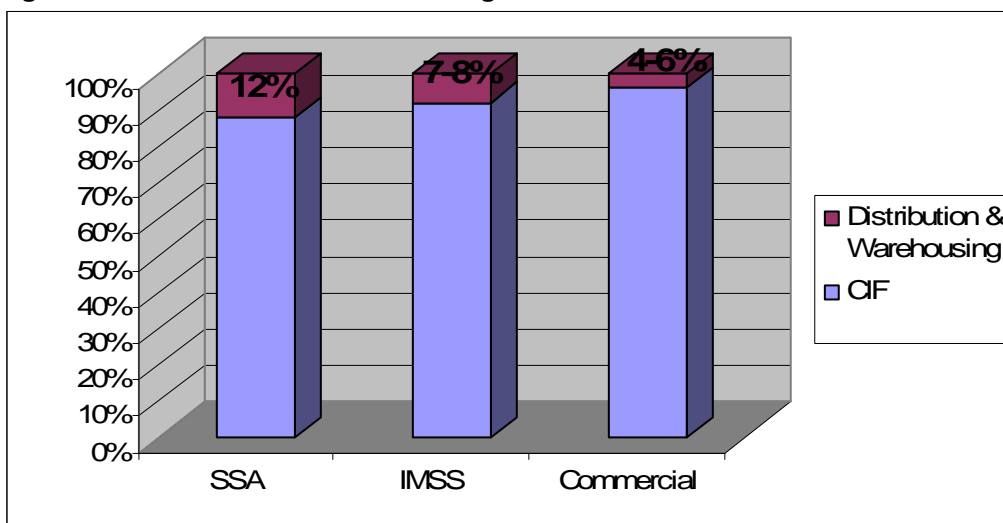
While it is was not feasible to analyze the cost structure of contraceptive products due to the lack of available data, the SSA conducted a comprehensive study to analyze distribution and warehousing costs in 2002 and concluded that its overall costs accounted for approximately 12 percent of the value of the inventory. Costs were much lower in the IMSS (estimated at 7–8%) and in the commercial sector (estimated at 4–6%), as shown in Figure 6.

²² Based on an exchange rate of 10.6 pesos to 1USD.

²³ Stated as the national average price on the IMSS official website:

http://200.34.143.57:8080/wijsp/PDF_IMSS/ComparativoPreciosAdquis_Detalle_D.pdf

Figure 6. Distribution and Warehousing Costs for Public and Commercial Sectors



In the NGO sector, MEXFAM provided information on its contraceptive procurement costs for 2004—stating that because of some cash flow problems in 2005, its contraceptive purchases had been significantly lower. Table 5 includes the contraceptive products and procurement costs.

Table 5. MEXFAM Contraceptive Procurement Costs in 2004

Method	Brand	Procurement Cost (US\$)
Oral Contraceptive	Lo-Femenal (IPPF)	\$0.33 per cycle
Injectables	Cylofem (IPPF)	\$0.89 per vial
Implants	Norplant (IPPF)	\$21.88 per unit
Patch	Evra (Jenssen)	\$11.25 per box (with 3 patches)
IUD	DIU Pregna (IPPF)	\$.064
	DIU Novaplus Mini GJ (Eurogine, Spain)	\$3.96
Condoms	Dentilab with aroma	\$0.164
	Prudence with aroma	\$0.189
	Generic condom (IPPF)	\$0.039
	Female condom (IPPF)	\$0.75
	Seguritec (Estrategias Merfin)	\$.071 per condom (foil only)

Retail Prices for Contraceptives

Commercial sector prices were collected for several contraceptive products available in pharmacy outlets. For each product, several price points were collected from different parts of the capital. The average prices for these products are summarized in Table 6.

Table 6. Retail Prices for Contraceptive Products

PRODUCT CATEGORY	PRODUCT BRAND	AVERAGE RETAIL PRICE (US\$)
Oral Contraceptive	Yasmine	\$19.81
	Microgynon	\$7.50
	Nordette	\$6.91
Injectable	Depo-Provera	\$22.97
	Mesigyna	\$10.09
Condom	Sico	\$1.22 per condom
	Dentilab	\$.59 per condom

CONCLUSIONS AND LESSONS LEARNED

This review of Mexico's contraceptive procurement practices shows that the major public sector health institutions have undertaken different strategies for addressing contraceptive security, and both the SSA and IMSS have encountered challenges along the way. While the SSA began to centrally procure contraceptive products during USAID's phaseout of support, almost immediately after phaseout, the procurement of all medications, including contraceptives, was decentralized to the state level. Most states had little awareness of the importance of the family planning program, limited experience in projecting and budgeting for their contraceptive needs, and limited direct procurement experience. As a result, many SSA facilities experienced stockouts of contraceptive supplies. Between 2002 and 2005, the SSA undertook aggressive strategies to assist state-level operations with identifying efficient and cost-effective mechanisms for ensuring a consistent supply of high-quality medications, including contraceptives.

On the other hand, the IMSS had significant experience in procuring contraceptives, as it had begun procuring significant quantities of contraceptives in the early 1990s. While the institute faced an overall financial crisis, the family planning program continued to be a high priority—and there is no evidence of prolonged periods of contraceptive stockouts. Most recently, however, the IMSS has come under increasing pressure to improve the transparency of its procurement process. Thus, the institute is working hard to automate its procurement processes and increase the availability of information available to the general public, including the purchase price and supplier of all procurements.

Legal and Regulatory Environment

The laws and norms related to procurement in Mexico are complex, and significant changes are happening at various levels of the system. The primary laws that affect procurement include the Organic Law of Federal Administration (December 1976) and the Law of Procurements, Rentals, and Services for the Public Sector (March 2000). In terms of pharmaceutical products, the increased autonomy of COFEPRIS has made it increasingly difficult for the SSA to use non-traditional mechanisms for procuring contraceptives, such as international procurement through UNFPA; and given the limited resources of COFEPRIS, it will take some time for them to address the many regulatory modifications being proposed at this time.

Supply and Distribution Mechanisms

Both the public and private sectors continue to play important roles in ensuring the supply and distribution of contraceptive commodities. There is a large, well-segmented contraceptive market—and multinational pharmaceutical companies have worked hard to establish their brands in the Mexican market. Based on a recent report published by the SSA, there is clear interest among the Mexican government in helping to foment change within the national pharmaceutical industry, particularly in relation to its position on interchangeable generics. The inclusion of contraceptives in the Catalog of Interchangeable Generics will have a major impact on reducing the cost of contraceptive supplies.

Public Sector Procurement

Although the public sector continues to be the major supplier of contraceptive products, there has been little interagency coordination to develop a national contraceptive security strategy. Each major public sector healthcare institution has pursued its own mechanisms for procurement, and there has been little initiative to increase leverage with commercial suppliers through a coordinated procurement strategy. As a result, the various public sector institutions are paying a wide variety of prices for contraceptive

supplies. The UNFPA procurement mechanism has provided a useful short-term alternative for the SSA. However, not all states are taking advantage of the mechanism, and even fewer states are participating today than in 2002. Given the increasing difficulties and the limited products available through UNFPA, the SSA will most likely need to consider new strategies to continue to ensure the availability of high-quality, cost-effective supplies.

USAID Phaseout

The phaseout of USAID support for contraceptive commodities reflected the achievement of an overall supportive environment for reproductive health and family planning. In general, contraceptive prevalence had reached a mature level, the government's support for family planning and reproductive health had been institutionalized, and the program and the public health sector had the technical and financial capacity to meet the family planning needs of the Mexican population. These critical factors set the stage for a smooth transition from USAID support. However, because procurement responsibilities for contraceptives were decentralized to the state level almost immediately after USAID's phaseout, there was a major disruption in the provision and supply of contraceptives. Most states were unprepared and unfamiliar with the processes for projecting, planning, and budgeting for their contraceptive needs. This represents a major lesson learned for other countries aiming to achieve contraceptive security.

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