



USAID
FROM THE AMERICAN PEOPLE

LESSONS LEARNED FROM PHASEOUT OF DONOR SUPPORT IN A NATIONAL FAMILY PLANNING PROGRAM THE CASE OF MEXICO



August 2005

This publication was produced for review by the United States Agency for International Development. It was prepared by Sarah Alkenbrack and Carol Shepherd, POLICY Project.

POLICY is funded by the U.S. Agency for International Development (USAID) under Contract No. HRN-C-00-00-00006-00, beginning July 7, 2000. The project is implemented by Futures Group in collaboration with the Centre for Development and Population Activities (CEDPA) and Research Triangle Institute (RTI). For more information, please contact:

POLICY Project
c/o Futures Group
One Thomas Circle, NW, Suite 200
Washington, DC 20005
Tel: (202) 775-9680
Fax: (202) 775-9694
Email: policyinfo@futuresgroup.com
Website: www.policyproject.com



LESSONS LEARNED FROM PHASEOUT OF DONOR SUPPORT IN A NATIONAL FAMILY PLANNING PROGRAM THE CASE OF MEXICO



August 2005

By Sarah Alkenbrack and Carol Shepherd, POLICY Project

DISCLAIMER

The authors' views expressed in this publication do not necessarily reflect the views of the Agency for International Development or the United States Government.

Cover photos provided by (clockwise from upper left):

Courtesy of Dr. Miguel Linares

© CCP, Courtesy of Photoshare

© 2000 Rick Maiman/David and Lucile Packard Foundation, Courtesy of Photoshare

© 2000 Rick Maiman/David and Lucile Packard Foundation, Courtesy of Photoshare

Contents

Acknowledgments	v
Executive Summary	vi
Abbreviations	ix
I. Introduction	1
II. The National Family Planning Program Before Phaseout	2
A. History of Mexico's Family Planning Program	2
B. Policy Environment	2
C. Financing of Family Planning	2
D. Key Stakeholders	2
E. Factors Influencing the Decision to Phaseout	3
III. Phaseout Planning	4
A. Design of the Phaseout Plan	4
B. Components of the Phaseout Plan	4
IV. Implementation of Phaseout	6
A. Logistics and Procurement Component of Phaseout	7
B. Financing Component of Phaseout	8
C. Other Components of Phaseout	10
V. Evaluating the Phaseout Process	12
A. Strengths of Phaseout	12
B. Weaknesses of Phaseout	12
C. Opportunities During Phaseout	17
D. Threats During Phaseout	17
VI. Evaluating the Family Planning Program in a Post-phaseout Environment ..	21
A. Policy Environment	21
B. Current Coordination Mechanisms	21
C. Legal and Regulatory Environment	22
D. Demand for and Use of Family Planning	22
E. Procurement	25
F. Public-Private Partnerships	27
G. External Support from Other Donors	27
H. Structure of Organizations	27
I. Special Programs for Adolescents	28
J. IEC Activities	28
K. Sustainability of NGOs	29
L. Research and Evaluation	29



VII. Lessons Learned from Phaseout in Mexico	30
A. Phaseout Planning.....	31
B. Technical Components	32
C. Implementation	32
D. Communication.....	32
E. Political Will and Commitment	32
F. Financing.....	33
G. Capacity Building to Promote Sustainability	33
H. Research and Evaluation	33
I. “Readiness” of Phaseout	34
J. Keeping a Positive Attitude	34
Appendices	
A. Organizations Involved in Interview Process	35
B. Overview of Organizations.....	36
C. Phaseout Design	38
D. MEXFAM Expenditures, 1995	39
E. Institutional Changes.....	40
F. Challenges of Consolidated Procurements.....	41
G. Service Delivery in the NGOs	43
Bibliography	44

Acknowledgments

This study provides an in-depth look at a country that has graduated from family planning donor assistance. The authors would like to thank the Office of Population and Reproductive Health, Bureau of Global Health, U.S. Agency for International Development (USAID) for providing funding to carry out this study. In addition, the authors would like to thank Cindi Cisek, who conducted interviews with stakeholders from Mexico's family planning program and contributed to an earlier draft of the report; Jeff Sine, who conceptualized the study and contributed to data analysis and an earlier draft of the report; the CTOs of the POLICY Project, Rose McCullough, Elizabeth Schoenecker, Mai Hijazi; Alan Bornbusch, Tanvi Pandit, and Joan Robertson from the Commodities Security Logistics Division, for their input and feedback throughout the study; Marie McLeod from USAID, for taking the time to provide insight on the phaseout process; and the many stakeholders from public and private family planning organizations in Mexico who spent many hours providing detailed accounts of phaseout (names are not mentioned in order to ensure confidentiality). The authors are grateful to the following people who provided assistance in identifying individuals and data sources: John Townsend, Ricardo Vernon, and Mariana Lopez. Finally, the authors would like to thank the many individuals who provided input into the research design and reviewed the final report: Mary Kinkaid, Nancy McGirr, Karen Hardee, Jay Gribble, Margaret Rowan, Suneeta Sharma, Harry Cross, and Rachel Sanders.

Executive Summary

Throughout the world, a number of countries are facing withdrawal of funding and technical assistance for their family planning programs. This trend, known throughout the family planning community as “phaseout” or “graduation,” is occurring for various reasons. In many countries, phaseout is linked to the success of the family planning program and the ability of the country program to become self-reliant. As donors, missions, and governments make decisions to phase-out family planning support and create strategies for transitioning to an independent program, there is a need to reflect on experiences from past phaseouts. This case study of Mexico provides an in-depth look at a national family planning program before, during, and after phaseout and documents the lessons learned from that process.

The Mexican national family planning (FP) program is one of the strongest public sector programs in existence today. The United States Agency for International Development (USAID) played an important role in strengthening Mexico’s FP program, providing support between 1974 and 1999. National indicators show that much progress was made during this time. Thus, the strength and success of the program was one of the most important factors driving the decision to end donor support for family planning.

In 1992, USAID and the major public sector institutions of Mexico’s FP program signed a memorandum of understanding (MOU). A “grant agreement” was signed between USAID and the International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR), the organization coordinating phaseout in the nongovernmental (NGO) sector. USAID convened two committees and selected a coordinating body to take the lead on each committee.

The USAID phaseout plan for the public sector had a contraceptive commodities component and a technical assistance component. The public sector worked primarily in low-income and underserved populations in nine priority states (which later

became 14 priority states). The NGO sector strategy, in contrast, did not differentiate between commodities and technical assistance. Although the phaseout plan mandated provision of support in the priority states, other areas outside the priority states also received assistance through NGOs, both directly from IPPF and indirectly through the central offices of the Mexican Family Planning Association (MEXFAM) and the Mexican Federation of Private Health and Community Development Associations (FEMAP). The main focus of the transition project was to improve income-generating capacity of NGOs and improve long-term sustainability.

Mexico’s final period of assistance was scheduled between 1992 and 1997. However, support was extended until 1998 in the NGO sector and until 1999 in the public sector. While Mexico’s FP program transitioned away from USAID assistance in the phaseout years, a number of external events took place that had a significant impact on the FP program and the phaseout activities: the International Conference on Population and Development (ICPD), the 1994-1995 financial crisis; an increasing HIV/AIDS prevalence; and the shift toward a decentralized political and health structure.

During phaseout, the Health Secretariat (SSA) provided logistics training first at the national level, then at the state and district levels, training stakeholders in 28 of 32 states during the phaseout period. Public sector training sessions focused largely on logistics functions but placed little emphasis on procurement strategies. NGO training focused on forecasting, warehousing and inventories, applications of logistics monitoring, budgeting for procurement, and information, education, and communication (IEC) activities. Both MEXFAM and FEMAP also received support from collaborating agencies outside the IPPF Transition Project, most of which focused on sustainability.

By 1995, the SSA began procuring contraceptives centrally on behalf of all states that wanted to procure, and then distributed contraceptives to the

state level. However, due to large cushion-stocks for some methods, and large unexpected donations, the quantity required was minimal. It was not until after phaseout that organizations in both sectors needed to procure in large quantities and by this time, technical assistance from USAID was no longer available to assist organizations. In addition, a number of regulations restricted international procurements thereby forcing organizations to procure domestically, where unit costs were extremely high.

Organizations in both the public and NGO sectors used a variety of innovative resource mobilization strategies to replace donor funding during phaseout. NGOs generated revenues through user fees and contraceptive sales and were therefore able to develop a balance between meeting the institution's financial needs and maintaining access to services for its low-income populations. Both organizations increased sustainability, with FEMAP being particularly successful.

A great deal of funding during phaseout focused on strengthening communication campaigns and mass media outreach activities. These programs were effective in influencing peoples' attitudes about family planning. The phaseout program also placed a strong emphasis on research and evaluation activities in the public sector. However, funding for research activities ended with the termination of USAID support, making it difficult to evaluate the phaseout process.

Documentation of Mexico's experience highlights a number of strengths and weaknesses. The three major strengths of the process were that the phaseout plan reflected the priorities of Mexican institutions; improved management led to an increase in donor support; and a strong IEC component of the program led to increased awareness and demand for family planning.

The weaknesses of phaseout are easily identifiable in hindsight, but may not have been obvious in the planning phase. Lack of coordination and collaboration was perhaps the biggest weakness. A series

of external events took place during phaseout, and there is evidence to suggest that some of these events could have been anticipated, for example, the financial crisis and decentralization. Moreover, stakeholders could have done a better job of responding to these events during phaseout. Also clear from the Mexico case study is the need to have reliable research studies to both plan for and evaluate phaseouts, and the need to make financial allocations more predictable. In addition, messages about phaseout were inconsistent and, as a result, stakeholders were not as prepared as they might have otherwise been for the end of support. The high turnover of USAID staff also created challenges for continuity.

The lack of technical assistance and attention to procurement at the state level was another shortcoming of the process. Due to lack of expertise in negotiating procurement contracts, and overcoming regulatory obstacles, state decisionmakers either spent too much money for too little product or did not procure. Moreover, large cushion-stocks during phaseout ensured that most organizations did not need to procure large amounts of contraceptives until after the termination of assistance. Large, unexpected donations from another donor contributed to these cushion-stocks, underscoring the need for donor coordination during phaseout.

A final challenge of phaseout was the timing of the implementation of special programs, which focused on adolescent, rural, and indigent populations and occurred in the middle of phaseout. Although this shift was long overdue in Mexico, it came too late for programs to be institutionalized before withdrawal of USAID support. Many programs that were initiated during phaseout have since been discontinued.

The Mexico evaluation also identified opportunities and threats. The main opportunity was the strong legal foundation that governs provision of family planning services in Mexico. Threats included the loss of attention to family planning during phaseout; the financial crisis; donor policies that rein-



forced donor dependence; competing priorities and corresponding lack of financial commitment to family planning at the state level; price-gouging by domestic suppliers; restrictions on cost recovery; and the cost of reaching vulnerable populations.

Six years after the completion of USAID's assistance to Mexico, the national FP program is still strong but has gone through a difficult transition. Though it has covered much ground, no component of the program has achieved true self-reliance and, in fact, some program momentum has been lost. Although national program indicators such as contraceptive prevalence, total fertility rate, and unmet need have improved, this progress masks the coverage gaps that exist, especially for those programs serving special populations.

The 12 most important lessons learned from the Mexico case study are as follows:

- A phaseout plan should be flexible in order to respond to changes in the external environment.
- Multisectoral collaboration and strategic thinking are important for planning and implementing a phaseout.
- Donor coordination is crucial throughout the process.
- Donors and governments should make an effort to institutionalize skills and funding for supervisory and management positions.
- Sufficient timing is required to make progress in any given intervention.
- Donors should attempt to send consistent messages to the beneficiaries of assistance.
- Advocacy plays an important role in garnering support from governments at all levels.
- Donors should work with governments to reexamine the impact of free-for-all approaches and policies governing publicly provided services.
- Donors should attempt to institutionalize technical capacity for independent procurement.
- Donors should earmark phaseout funding for post-phaseout research and monitoring and evaluation activities.
- Multiple criteria exist for evaluating the “readiness” of a program and these may vary across countries.
- Maintaining a positive attitude during phaseout is important.

Abbreviations

AIDS	Acquired immune deficiency syndrome
CA	Cooperating agency
CBD	Community-based distribution program
CCO	Operations Coordination Committee
COESPO	State-level population council
CONAPO	Consejo Nacional de Población/National Population Council
CONFETRIS	Federal Committee of Protection Against Public Health Risks
CPR	Contraceptive prevalence rate
CS	Contraceptive security
CTO	Cognizant technical officer
DGSR	General Directorate of Reproductive Health
FP	Family planning
FEMAP	La Federación Mexicana de Asociaciones Privadas de Salud y Desarrollo Comunitario/ The Mexican Federation of Private Health and Community Development Associations
FPLM	Family Planning Logistics Management Project
HIV	Human immunodeficiency virus
IEC	Information, education, and communication
ICPD	International Conference on Population and Development
IMSS	Instituto Mexicano del Seguro Social/Mexican Institute for Social Security
IPPF/WHR	International Planned Parenthood Foundation/Western Hemisphere Region
ISSSTE	Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado/ Institute of Security and Social Services For State Workers
IUD	Intrauterine device
JHU/PCS	Johns Hopkins University Population Communication Services
JICA	Japan International Cooperation Agency
LAC	Latin America and the Caribbean
LMIS	Logistics management information system
MAISA	Model of Integrated Care for the Health of Adolescents
MEXFAM	Fundación Mexicana para la Planeación Familiar/Mexican Family Planning Association
MOU	Memorandum of understanding
NGO	Nongovernmental organization
OECD	Organization for Economic Cooperation and Development
PAI	Program of institutional support
PAN	National Action Party
PRI	Institutional Revolutionary Party
RH	Reproductive health
SOMARC	Social Marketing for Change Project
SPARHCS	Strategic Pathway for Achieving Reproductive Health Commodity Security
SSA	Secretaria de Salud/Health Secretariat
TFR	Total fertility rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

I. Introduction

As an increasing number of national family planning programs mature and graduate from donor assistance, there is a need to reflect upon earlier phaseouts to identify effective strategies for improving the long-term impact of donor investment. Stakeholders in donor agencies, missions, governments, and collaborating agencies show a keen interest in identifying strategies that promote a smooth transition away from donor assistance. Documenting these experiences will enable stakeholders to apply lessons to future phaseouts.

This study was conducted to document the lessons learned from a country that has undergone phaseout of family planning (FP) assistance. Mexico was chosen for an in-depth study for a number of reasons. The country has a long history of family planning and a large public sector. It also graduated from family planning donor support five years before the onset of this study. This situation therefore provided one of the longest timeframes available among graduated countries, allowing a comprehensive assessment of how programs fare in the post-phaseout environment.

The case study of Mexico gives an overview of the phaseout process and summarizes the lessons learned from the evaluation of that process. The research addressed these questions:¹

- What was the general design of phaseout?
- What was the general context in which phaseout occurred?
- How did elements of the family planning program (policy, finance, service delivery, logistics) change as a result of phaseout?
- What were the strengths and weaknesses of the phaseout process in Mexico?

- To what extent did phaseout prepare Mexico for independence from donor support? This was measured by the contraceptive prevalence rate (CPR), disparities in contraceptive use (program equity), funding, management, and public/private mix.
- What are the most important lessons learned from the phaseout process that stakeholders can apply to future phaseouts?

The first activity in this study was a literature review and mapping of the phaseout planning and implementation processes. POLICY Project conducted key informant interviews with 20 past and present leaders of public sector, nongovernmental, and donor organizations (see Appendix A for a list of organizations), using a semi-structured survey. The survey instrument was modeled on the Strategic Pathway for Achieving Reproductive Health Commodity Security (SPARHCS) framework and diagnostic tool.² The survey included questions about all components of Mexico's family planning program: planning, coordination, financing, procurement, logistics, services, and the policy environment. Interviewees were asked questions relevant to their respective positions. All interviews were recorded, transcribed in Spanish, and translated into English. A content review analysis of all transcribed interviews was conducted over six months and numerous meetings were held to share interpretations and discuss findings.

To supplement the data obtained from the interviews, the research team collected quantitative information on program inputs and outputs, and reviewed both published and unpublished literature on Mexico's FP program.

¹ A key question facing donor agencies, missions, governments, and collaborating agencies working in the family planning and reproductive health sector is knowing when a country is ready for phaseout. The decision to phaseout support to a country is based on a complex range of factors, however, and may override a country's "readiness" to assume independence from donor support. Thus, the questions of whether or not Mexico was ready, or how readiness can be determined, were not addressed in this study.

² SPARHCS consists of a framework and diagnostic guide that can be used to assess a FP program and can help identify challenges and opportunities for achieving contraceptive security.

II. The National Family Planning Program Before Phaseout

A. HISTORY OF MEXICO'S FAMILY PLANNING PROGRAM

The Mexican national FP program is one of the strongest public sector programs in existence today. As a result of almost three decades of substantial political support, the program has advanced considerably since its inception in 1974. In 2003, the total contraceptive prevalence rate (CPR) was 74.5 percent³ for married women of reproductive age and the total fertility rate was 2.5 children per woman (SSA, 2005)—a change from 29 percent and 6.5 children per woman between 1970–1975 (UNDP, 2004). The rate of natural population growth in Mexico decreased from more than 3 percent in the mid-1970s to 1.9 percent in 1995 (USAID, 1997) and is estimated at 1.45 percent for 2004 (UNDP, 2004).

The United States Agency for International Development (USAID) played an important role in strengthening Mexico's FP program. USAID started providing financial and technical support to Mexico's FP program in 1974, shortly after the program's inception. Nearly three decades later, due to the success of the program, USAID and Mexican FP organizations reached an agreement and designed a strategy to gradually phaseout support for contraceptives and technical assistance over a five-year period from 1992 to 1997.⁴

B. POLICY ENVIRONMENT

Since its inception, the FP program has received strong political support, mainly from the Institutional Revolutionary Party (PRI), which dominated Mexican politics for more than 70 years until the early 1990s. This favorable policy environment is reflected in the country's policies, laws, and regulations that pertain to family planning.

³ 66.2 percent for modern methods.

⁴ Unless otherwise mentioned, the phaseout strategy discussed in this report refers to phaseout of all population assistance, including commodities and technical support.

According to the general population law of 1974, all state organizations must provide free information, education, and health services and supplies (including contraceptives) related to family planning. The implementation of the law had major implications for the future direction of the FP program: free services and supplies would be financed by the government and donors (Beamish, 1999).

Other evidence of a long history of government commitment to family planning includes the population policy of 1975 and the inter-institutional list of essential medical supplies, which included contraceptives long before phaseout.

C. FINANCING OF FAMILY PLANNING

Before phaseout, financing needs for Mexico's public sector FP organizations were met through a combination of budget allocations from donors, the central treasury, the state, and contributions from workers' salaries (in the case of social security organizations). Between 1985 and 1995, USAID's average annual budget for family planning in Mexico was approximately \$10 million (Beamish, 1999). Consistent with the law, government agencies do not ask for contributions for FP and reproductive health (RH) services, and there has been no push to override this law, even though government agencies do charge for other health services and most medicines.

D. KEY STAKEHOLDERS

The Mexican FP program is orchestrated through a wide range of public sector organizations and NGOs. The major players in the public and nongovernmental sectors at the time of phaseout are described below (see Appendix B for more details).

Public sector institutions

The public sector FP program is the major provider of clinic-based FP services in Mexico. The National Population Council (Consejo Nacional de Población, or CONAPO) is the organization involved in program planning while the majority of services are provided by the SSA, and two parastatal organizations, the Mexican Institute for Social Security (IMSS) and the Institute of Security and Social Services for State Workers (ISSSTE).

Nongovernmental sector institutions

The nongovernmental sector serves almost 30 percent of contraceptive users in Mexico through pharmacies (16%), other organizations, and private agencies (Beamish, 1999). MEXFAM and FEMAP make up the bulk of the nongovernmental sector FP program. Both NGOs offer FP and RH services in specific states and have developed innovative ways to deliver FP information and services to hard-to-reach and marginalized population groups, using outreach programs with community volunteers. Historically, both organizations have depended on donor assistance, mostly from USAID.

Donors

Before phaseout, USAID was the largest foreign donor to the Mexican FP program. USAID provided assistance through approximately 20 U.S.-based cooperating agencies (CAs) in the form of money and technical assistance to Mexico's public and NGO institutions. The United Nations Population Fund (UNFPA) also provided substantial support, while other donors and foundations funded individual projects within the FP program.

Interagency reproductive health working group

The RH Working Group is composed of public sector organizations and NGOs⁵ and played an important role in the development of the national program. The main task of this inter-institutional

group is to coordinate all actions concerning RH in the public and nongovernmental sectors (Personal communication, USAID; World Bank, 1991). Donors are excluded from this group, making it impossible to use it as a foundation for phaseout activities.

E. FACTORS INFLUENCING THE DECISION TO PHASEOUT

Although this paper does not address whether Mexico was ready for withdrawal of USAID's FP assistance and support for contraceptives, it is important to understand the factors affecting the decision to phaseout. One of the most important factors driving the decision to end FP support was the strength and success of the FP program. National indicators showed that much progress had been made since the early 1970s. People in Mexico, including government officials, considered family planning a priority. As mentioned by one interviewee, the government of Mexico began signaling its readiness to move forward without assistance from USAID at the beginning of the 1990s.

Another factor affecting the decision to phaseout support for family planning was the shift that occurred in funding priorities at the donor level, both in Mexico and throughout the rest of the world. HIV/AIDS prevalence rates were increasing at a dramatic rate throughout Mexico, Latin America and the Caribbean (LAC region), and the rest of the world. This undoubtedly affected the amount of donor funding available for family planning.

A final factor that may have weighed into the decision to phaseout was the world's perception of Mexico as a rich country that no longer required assistance from donors. The per capita income was \$5,379 in 1990 (World Bank, 1991). In the context of dwindling resources, family planning in Mexico did not take priority among donors.

⁵ This group was previously called the "Family Planning Inter-Institutional Group," but when FP became integrated into RH, the name changed to the "Reproductive Health Working Group."

III. Phaseout Planning

This is an overview of phaseout, including the design of the phaseout process (the plan) and its technical components.

A. DESIGN OF THE PHASEOUT PLAN

After the decision in 1992 to phaseout support for family planning, a MOU was signed among USAID and the major public sector institutions involved in phaseout: CONAPO, SSA, IMSS, and ISSSTE. There was a separate “grant agreement” signed between USAID and the IPPF/WHO, the organization coordinating phaseout in the NGO sector. This was referred to as the IPPF Transition Project. USAID convened two committees; a coordinating body was selected to take the lead on each committee.

Coordinating committees

The public sector phaseout committee was named the Operations Coordination Committee (CCO) or the “phaseout committee” and was composed of USAID, CONAPO, SSA, IMSS, and ISSSTE. CONAPO played the lead role in coordinating phaseout, since it is legally responsible for coordinating donor assistance for population activities in Mexico. Since CONAPO does not have a service delivery system, the SSA was delegated as the lead institution responsible for distributing contraceptives during phaseout. The phaseout committee performed a situation analysis of the FP program; defined the goals, objectives, and activities for the public sector phaseout plan; and was responsible for monitoring the plans and activities outlined in the phaseout strategy (Personal communication, EngenderHealth).

IPPF led the committee responsible for phaseout of assistance to the two major NGOs offering family

planning: FEMAP and MEXFAM (Beamish, 1999). IPPF was responsible for disbursing funding for technical assistance and donated commodities and for monitoring implementation of phaseout activities and training over the five-year period.

Terms of reference for phaseout

The USAID phaseout plan for the public sector had a contraceptive commodities component and a technical assistance component. The NGO sector also had a five-year strategy but, unlike the public sector plan, it did not outline a clear plan for phasing out commodity distribution.

B. COMPONENTS OF THE PHASEOUT PLAN

Public sector plan

The public sector plan had components for both commodities and technical assistance. In the commodities component, commodities were reduced by 25 percent every year for four years, beginning in 1992. During this time, the government of Mexico planned to procure increasing levels of commodities to replace donations.

In the technical assistance component, the phaseout committee tried to maximize USAID’s impact in Mexico’s low-income and underserved populations. The phaseout committee decided to focus the majority of phaseout resources on nine poor and mostly rural states and on peri-urban areas of Mexico City.⁶ They focused resources on underserved communities and special populations within the targeted states. (Traditionally, the FP program had emphasized general development of households, largely in urban communities, so this was a new approach.)

⁶ These nine priority states—Chiapas, Guanajuato, Guerrero, Hidalgo, Estado de Mexico, Michoacan, Oaxaca, Puebla, and Veracruz—are primarily in the central and southern regions of Mexico. They constitute 54 percent of the total Mexican population, 67 percent of the rural population, and 53 percent of women of reproductive age. CONAPO developed the selection criteria, which included percent of rural population, infant mortality rate, and total fertility rate (FEMAP interviewee).

Within the priority states, the committee focused on these aspects of family planning:

- increasing access and improving quality of FP service delivery
- building capacity of health personnel in remote areas
- designing IEC activities aimed at hard-to-reach groups
- conducting research on fertility practices, as well as demographic studies and operations research (CONAPO, 1992)

NGO sector plan

During phaseout, MEXFAM and FEMAP received financial assistance for technical assistance and

donations of contraceptives.⁷ Other USAID assistance external to the IPPF Transition Project complemented this assistance. Major phaseout activities included:

- improving income-generating capacities, through cost recovery and increased domestic donor support
- ensuring long-term financial sustainability

The NGO sector's six major objectives for phaseout are outlined in Appendix C (Bowers et al., 1996). Although the phaseout plan mandated provision of support in the priority states, other areas also received assistance, both directly from IPPF and indirectly through the central offices of MEXFAM and FEMAP.

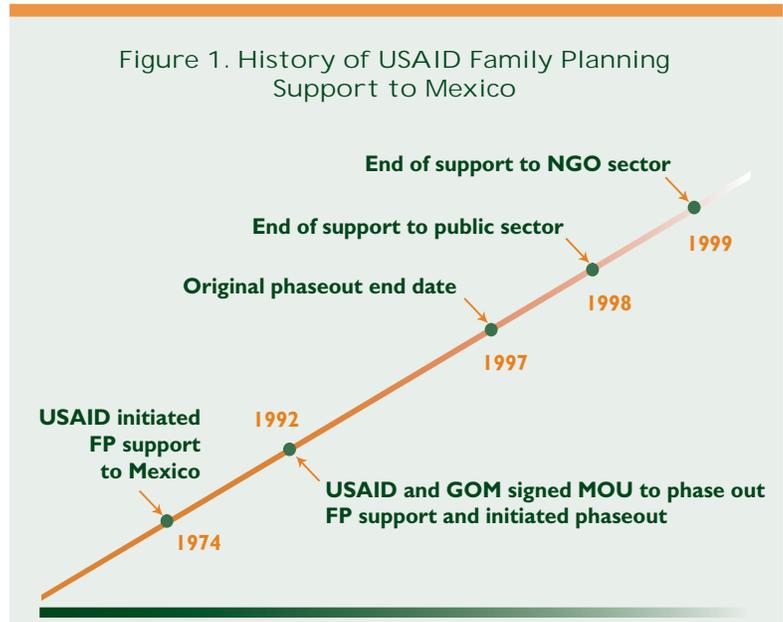
⁷ During phaseout, MEXFAM received \$9.1 million for technical assistance and \$1.8 million worth of contraceptives; FEMAP received \$5.4 million for technical assistance and an additional \$4.5 million in contraceptives during phaseout (Programa de Apoyo para Extender los Servicios de Planificación Familiar y Salud Reproductiva, CONAPO, 1992).

IV. Implementation of Phaseout

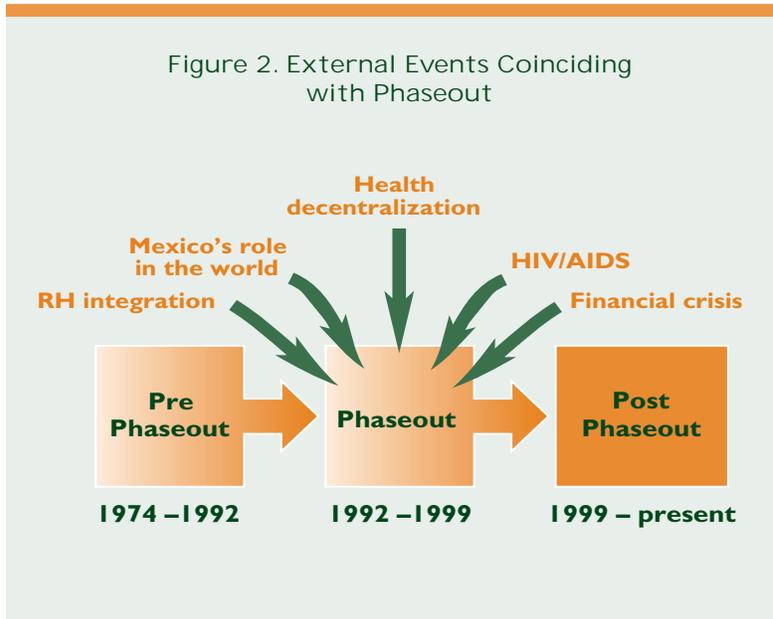
The phaseout program began in 1992 and was scheduled to end in 1997. However, support was extended until 1998 in the NGO sector and until 1999 in the public sector (see Figure 1).

While Mexico's FP program transitioned away from USAID assistance in the phaseout years, a number of external events took place that had a significant impact on the FP program and the phaseout activities (see Figure 2).

After the 1994 ICPD, integrating family planning into a broader RH framework became a government priority. This shift coincided with the 1994–1995 financial crisis and an increasing prevalence of HIV/AIDS. During the financial crisis, resource allocation was highly politicized with respect to allocations to and within the health sector.



Since the 1980s, the national health law governing decentralization of health operational responsibilities and budgeting to the states has undergone numerous amendments to clarify attributions, obligations, and functions of the states. When phaseout began, 14 states (out of 32) were already functioning under a decentralized system.



When President Ernesto Zedillo was elected in 1995, the central government still maintained control over many of the financing and budgeting elements of these decentralized states, and controlled the management of health services to the other states. Zedillo pushed decentralization forward and by 1999, the states were responsible for managing more than 70 percent of their healthcare budgets—a substantial increase from 1994 when they were responsible for less than 25 percent (Jaimes, no date). Changes to the decentralization law have continued to evolve since the end of phaseout (Personal communication, CONAPO).

A. LOGISTICS AND PROCUREMENT COMPONENT OF PHASEOUT

Distribution of USAID contraceptives

When phaseout of contraceptives began,⁸ all FP organizations in the public and NGO sectors—with the exception of SSA—were already procuring at least a portion of their contraceptives and all had their own vertical programs. The SSA distributed donated contraceptives to its state offices and to the central level social security institutions during phaseout. In the NGO sector, IPPF distributed contraceptives to the two major NGOs, MEXFAM and FEMAP. Public sector contraceptive donations were reduced by 25 percent annually over four years. It is unclear what method the NGO sector used to phaseout commodities, but it appears that it was less gradual than the process that took place in the public sector.

Logistics training and technical assistance during phaseout

In the SSA, training was carried out first at the national level, then at the state and district levels. At the district level, USAID trained medical coordinators and warehouse managers from 16 states—the targeted states as well as other states. Together these states consumed 70–80 percent of all contraceptives provided by the SSA in 1992 (Bowers et al., 1996.) When this support ended in 1995, the SSA prepared a training program for 12 additional states, using combined federal and state funds. Thus, stakeholders in 28 out of 32 states received training in logistics during phaseout.

The logistics support to the public sector focused largely on logistics functions such as distribution, supervision, the logistics management information system (LMIS), warehousing, and forecasting. Training at the state and district levels placed little emphasis on procurement strategies, mainly because procurements were conducted centrally and the government did not foresee this changing. Technical assistance to the NGOs was provided to the central level and focused on designing forms

for collecting monthly and quarterly data on contraceptive use and flow; training staff at NGO regional and central offices in the use of these forms; warehousing and maximum-minimum inventory levels; training in and applications of logistics monitoring; contraceptive forecasting and preparation of procurement budgets; and IEC activities (Bowers et al., 1996). Both NGOs also received support from collaborating agencies outside the Transition Project, most of which focused on sustainability.

Procurements during phaseout

By 1995, the SSA began procuring contraceptives centrally on behalf of all states that wanted to participate. The SSA then distributed contraceptives to the state level. However, the quantity required by the SSA was minimal, given their large cushion-stock for some methods, mainly pills and IUDs that it had accumulated during phaseout years. Much of this cushion-stock was the result of a large and unexpected donation given by UNFPA in 1995, which covered the need for both pills and IUDs for approximately 3.5 years. UNFPA continued to provide donations during phaseout and included technical assistance for logistics but not for procurement.

Similarly, the NGOs were able to maintain large cushion-stocks for many years following phaseout. This cushion-stock was a result of USAID donations, which allowed the NGOs to maintain the number of clients throughout the transition period without allocating significant funds to contraceptives. In 1998, FEMAP began procuring 10 percent of its annual consumption, which increased to 30 percent in 2000. It wasn't until 2002 that the organization completely ran out of USAID reserves (Personal communication, FEMAP). MEXFAM procured its own contraceptives throughout the entire phaseout period but still had a substantial cushion-stock on which to survive.

As recommended in the mid-term phaseout review in the NGO sector, many of the CAs consulted with international pharmaceutical companies to con-

⁸ Phaseout issued a 25 percent reduction in the level of donated contraceptive commodities in each of four years, beginning in 1992.

vince them of the benefits of offering favorable prices to MEXFAM and FEMAP and to encourage consideration of a joint procurement. However, this could not take place in the public sector since organizations were required by law to procure from domestic suppliers.

B. FINANCING COMPONENT OF PHASEOUT

This section describes financing mechanisms of Mexico's FP program in both the public and nongovernmental sectors and the strategies that organizations used to mobilize resources during the transition period.

Public sector financing strategies

As USAID funding for contraceptives was reduced, public sector organizations had to develop new strategies for securing contraceptives. They were restricted by law on what they could charge for contraceptives and therefore had to lobby for increased support from other donors (for short-term solutions) and from the Mexican government. The organizations had trouble meeting their needs, in part due to competition for resources for other health and non-health priorities.

Mobilizing donor funding. During phaseout, the public sector agencies started looking for other support from the European Union, the Japan International Cooperation Agency (JICA), and UNFPA. In 1994, Mexico joined the Organization for Economic Cooperation and Development (OECD), which meant that it was no longer eligible for nonrefundable donor support from certain countries. In fact, JICA was in the midst of implementing a reproductive health project in Mexico at this time and had to withdraw funding upon learning that Mexico had joined (Personal communication, SSA). Mobilizing resources from donors was also complicated by the world's perception of Mexico as an oil-rich country that did not require support.

Increasing government financial commitment.

The phaseout plan called for the Mexican government to gradually increase its financial support to

replace USAID funding for FP services and supplies. Mexican government funds were assigned to the SSA annually and delivered in monthly budgetary allocations, beginning in April of each year. The SSA also began lobbying for increased funding for contraceptives from the Ministry of Finance, but this met with little success due to competing priorities.

NGO sector financing strategies

The phaseout plan focused on helping the two major NGOs, MEXFAM and FEMAP, expand their networks/affiliates and move closer to sustainability. At the beginning of phaseout, MEXFAM was investing only 10 percent of its own funds into its operating budget, with the remaining 90 percent coming from donors. By 1995, 18 percent of MEXFAM's costs were locally generated (see Appendix D). FEMAP, in contrast, was less dependent on donors and was already generating funds and developing strategies for generating local resources through new programs, with a vision of becoming self-sufficient in the future.

Mobilizing donor finances. Both NGOs received assistance from non-USAID donors and collaborating agencies, most of it coming in small amounts and earmarked for a specific purpose. At the beginning of phaseout (1992), FEMAP established a foundation to solicit donations and grants and manage its fundraising activities (Bowers et al., 1996). As a result, FEMAP increased its donations from 6 percent of all income in 1992 to 10 percent in 1999 (Personal communication, FEMAP). A private citizen donated \$600,000 to implement an adolescent program and the Hewlett Packard Foundation donated \$300,000, which was used to set up a revolving fund for contraceptives (Personal communication, FEMAP).

Generating revenues through user fees and contraceptive sales. Beginning in 1992, user fees became an important part of the financing framework for MEXFAM and FEMAP. In 1997, both NGOs began selling donated contraceptives during phaseout because they felt pressured to receive income and were warned that subsidies would

end; the organizations gradually raised prices for contraceptives. By monitoring costs and improving efficiency, they developed a balance between meeting the institution's financial needs and maintaining access to services for low-income populations.

In charging for services and supplies, the two NGOs employed different strategies. MEXFAM expanded its clinics to create a "self-financing backbone," which targeted mainly middle-income clients. (Beamish, 1999). Although MEXFAM's fees were equal to the cost of services there were exemptions for people who were unable to pay, and donors covered these costs (Personal communication, MEXFAM). FEMAP, in contrast, used a low-cost/high-volume strategy, believing that even the poorest clients are able and willing to pay for services.

During phaseout, FEMAP and its affiliates continued to charge for all services and supplies, even though the majority of its clients lived below the poverty level. FEMAP provided exemptions for people who absolutely could not pay, but about 70 percent of clients were able to pay all or some of the costs of services and supplies.

Cross-subsidizing social programs. Both MEXFAM and FEMAP planned to use revenues generated through user fees, clinics, and contraceptive sales to cross-subsidize the social programs that were not self-sufficient on their own. This approach was modeled on the PROFAMILIA program in Colombia.

Other financing strategies (FEMAP only)

FEMAP's approach during phaseout was to initiate sustainable income-generation projects. As a result, it was the more successful of the two NGOs and was therefore able to use money generated by its affiliates to fund community programs. Each affiliate is administratively and financially independent, so all profits remained with the local institutions to support local activities. Some of the strategies that helped FEMAP improve

sustainability were the social marketing program, pharmacies, and the revolving fund.

Social marketing. One of FEMAP's most successful interventions was its social marketing program, which focused on low-income groups and helped subsidize the community development program. With assistance from the USAID-funded SOMARC, FEMAP began sales of affordable oral contraceptives in rural areas during phaseout, and later expanded this program (Personal communication, MEXFAM). To accomplish this, FEMAP created a corporation to manage its social marketing efforts. FEMAP also created another organization called Salud Siglo XXI, a for-profit corporation to purchase and sell contraceptives, medical products, and medicines at a low price to its members. With the resources generated from this, FEMAP was able to finance other program areas (Personal communication, FEMAP). Contraceptives are distributed through FEMAP's affiliates and community volunteers. Still today, there is no national distribution of FEMAP's products.

Pharmacies. FEMAP also endeavored to improve the financial sustainability of its affiliates' clinics by creating a chain of pharmacies at some of the clinics, using the last donation from USAID (\$900,000). FEMAP invested \$50,000 for each pharmacy for three years. There are now 12 pharmacies in the chain. An interviewee described how they were financed:

"The first year we spent \$25,000 [per pharmacy]: \$15,000 for the operation of the program and \$10,000 for purchasing inventory. The second year we gave them \$15,000: \$5,000 for the operation of the program and \$10,000 for the purchasing of inventory. In the third year we gave them \$10,000 more for purchasing inventory, so there was \$30,000 in inventory-generating resources. The sales turnover of a \$30,000 inventory is enough to support the entire adolescent program."

- Interviewee from FEMAP

The pharmacies were particularly successful in generating resources and moving FEMAP toward self-sustainability. Research studies showed that they served not only their immediate communities but also outlying areas (Personal communication, MEXFAM).

Revolving fund. FEMAP's third initiative was a revolving fund, started with funding from the Hewlett Packard Foundation. Through the fund, FEMAP invested in the development of its own products, the most popular being the Zebra condom.

Members paid a markup of 20 percent for centrally procured supplies, which provided a financial surplus for FEMAP. The return from the revolving fund grew throughout the years. However, it remains difficult to find reliable suppliers who can offer a price that—when marked-up—is still affordable to the majority of clients (Bowers et al., 1996).

C. OTHER COMPONENTS OF PHASEOUT

IEC campaigns

The IEC activities conducted under USAID were extremely important to the FP program in the public sector. During the first three years of phaseout, approximately 36 percent of overall funding specified in the MOU was devoted to IEC activities (Seltzer et al., 1996). With USAID support, communication campaigns and mass media outreach were relatively strong.

The IEC activities were designed to raise awareness of the importance of family planning in order to increase use of services and improve quality of care. The development and distribution of materials helped providers explain methods and inform clients about each available method. Efforts were made to ensure clients received proper counseling about each method. Between 1993 and 1999, approximately 14 million copies of 280 different IEC materials were produced, including brochures, posters, flipcharts, manuals, guidelines, and videos.

CONAPO's mass media campaign "Planifica, es cuestion de querer" ("Plan your family, it's a matter of wanting to"), was effective in influencing peoples' attitudes about family planning (Beamish, 1999).

Although IEC activities were not outlined in the phaseout plan for the NGO sector, they have always been an integral component of the organizations' outreach programs.

Research and evaluation

The phaseout placed a strong emphasis on research and evaluation activities in the public sector. These activities helped build the capacity of public sector institutions to do research and evaluation using standard instruments and models. The studies also provided a great deal of insight on priority groups (Beamish, 1999). This information was useful for planning and evaluating the FP program, but funding for research activities ended with the termination of USAID support.

Institutional and human resource changes

The phaseout of USAID support necessitated major changes not only to the FP program but also in the institutions themselves. Some of these changes were directly related to the impact of phaseout; others were attributed to changes needed for adapting to an evolving program, notably the shift to a reproductive health framework, which resulted in the creation and merger of departments. The financial crisis and decentralization also affected these changes.

Many organizations, especially MEXFAM and FEMAP, viewed phaseout as an opportunity to become more efficient. Specific projects that had once required additional personnel now had ended and high staffing levels were no longer necessary. There was a strong desire to improve efficiency and do "more with less."

"With eight people, we went on doing what we had been doing with 30, which proves that we had too many people."

—interviewee from FEMAP

Despite the opportunities for some organizations to become more efficient, downsizing served as a disadvantage to the weakest social security institution, ISSSTE. Since 1993, the number of people working in family planning at the central level has decreased from 25 to three. These three employees are responsible for the entire RH program, leaving them insufficient time to dedicate to FP. For details of these structural changes, see Appendix E.

Implementation of special programs in the public sector

IMSS/Solidaridad (S), the branch of IMSS responsible for carrying out family planning for the uninsured population in rural areas, did not receive support for implementing “special programs” (focusing on adolescent, rural, and indigent populations) until well into phaseout. IMSS/S used much of the assistance to improve counseling in adolescent RH programs and, beginning in 1998, introduced a community-based model of integrated

health, with RH being a major component. An interviewee describes this program’s rationale:

“The first focus of the program was education, health, and nutrition opportunities, including nutrition for pregnant and breastfeeding women and food for children five and younger. The second priority was integrated care for adolescents. Why [is it important to focus on adolescents]?... [B]ecause the reproductive pattern of the people in these areas is that by 17 or 18 years old they’ve already found a partner.”

—interviewee from IMSS



V. Evaluating the Phaseout Process

During key informant interviews, stakeholders were asked to reflect on the experiences of the phaseout program. This information was used to synthesize a list of strengths, weaknesses, opportunities, and threats affecting the phaseout process.

A. STRENGTHS OF PHASEOUT

The phaseout plan reflected the priorities of Mexican institutions and was not imposed by USAID. Interviewees felt that the design of the phaseout process was successful as it was “supported by Mexican institutions because there was consensus. It was not imposed by USAID” (Personal communication, Pathfinder). Institutions were able to draft a plan that corresponded to their priorities at the time.

“Once it was proven that it was possible to build clinics and manage them well from a financial point of view, we received additional support. We were able to build more and more clinics, some with donations of USAID, others with donations from Holland, and some with MEXFAMs own funds.”

—interviewee from MEXFAM

Improved management led to increased support from donors. The clinics and affiliates of NGOs were successful as a result of improved clinic management and financial information systems during phaseout. As this greatly improved self-sustainability in the clinic/affiliate component, a number of donors and foundations increased their support.

IEC activities were a strong component of the phaseout program and led to improvements in knowledge and use of family planning. A strong focus was placed on IEC during phaseout. Manuals on sex education were produced for

adolescents to improve their knowledge, attitudes, and behavior. As a result, demand for family planning increased substantially.

B. WEAKNESSES OF PHASEOUT

Intrasectoral collaboration for family planning was weak. Intrasectoral collaboration was weak during phaseout, and most of the planning was done at the national level. As one stakeholder mentioned, the public and nongovernmental sectors “never got together...although [stakeholders agree that] they should have collaborated” (Personal communication, FEMAP). The lack of collaboration resulted in missed opportunities to raise awareness about events external to the FP program, such as decentralization. It also resulted in a missed opportunity for the public and nongovernmental sectors to work together to achieve economies of scale through joint procurements and market segmentation.

In addition, collaboration between donors would have ensured that contraceptive donations do not interfere with organizations’ need to phase in resources. The large, unexpected donation from UNFPA was a result of poor donor coordination, and it led to unexpected long-term problems that outweighed the short-term benefits (Quesada et al., 2001). This caused some warehouses to be overstocked and some to be understocked due to insufficient coordination among the various supply levels (Bowers et al., 1996).

Ideally, the inter-institutional RH working group, which met regularly, would have been the group to plan and implement the phaseout program, given the wide range of stakeholders in the public and nongovernmental sectors participating in the working group and their extensive experience in the FP program. However, this group did not involve donors and did not discuss phaseout. According to one interviewee, USAID attempted to bring the sectors together, but there was some resistance from the government, largely because

the government wanted to keep its own inter-agency working group distinct from any USAID-organized group (Personal communication, USAID).

Inter-institutional collaboration between organizations in the public sector phaseout committee was poor. Even among the organizations directly involved in phaseout, the general feeling from public sector interviewees was that participation in the program design stage was unequal and communication was inadequate. The staff of IMSS/S said they “weren’t part of the planning stage” and that they didn’t even “learn of the discontinuation until 1996” (Personal communication, IMSS/S). The interviewee representing ISSSTE expressed frustration with a perceived secondary role in planning, noting that the SSA and IMSS often excluded ISSSTE from bilateral technical meetings (Personal communication, ISSSTE). He described the planning process as “inappropriate,” noting that the “lack of information limited my ability to hold stronger negotiations to plan for the reduction of contraceptive supplies” (Personal communication, ISSSTE).

Coordination between national and subnational levels was weak. Public sector interviewees also observed that representatives from state governments should have been included in the phaseout plan. States knew in a general way that USAID was preparing to phaseout, but concrete news of the phaseout did not reach the states until the late 1990s, after the last donations had already been made. One stakeholder mentioned that the central SSA office was responsible for coordinating with donors and the states, and that the government did not encourage USAID to work directly with the states, which may explain this lack of coordination.

Coordination of phaseout with national plans was weak. The lack of coordination between phaseout planning and other events occurring in the health and political sphere is evident in many aspects of phaseout. For example, the topic of decentralization had been on the political agenda

since the early 1980s, but was never addressed in the planning process for phaseout. Even within the FP sector, there was no coordination between phaseout and the national population strategy developed by CONAPO. When USAID developed its phaseout strategy in 1992, the national population strategy was already in place. When a new population strategy for 1995–2000 was created in the middle of phaseout, no mention was made of the phaseout process; institutions considered it separate from other donor-funded activities and, as a result, did not mention phaseout as a key activity in the population strategy.

The phaseout plan committee’s anticipation of and response to external events was inadequate. A number of changes took place in the external environment during phaseout.

Interviewees pointed to several sources of information to suggest that the public sector planning committee could have done a better job of anticipating and planning for decentralization, and adapting the phaseout plan when decentralization became a reality. At the time decentralization was reinstated, USAID still had plans to provide assistance for several more years. Resources could have been reprogrammed to assist states in creating budgets and lobbying for adequate funding, developing guidelines and strategies for contraceptive procurement, and building states’ capacity to manage FP programs (Personal communication, SSA).

Stakeholders also felt that although the financial crisis was beyond the control of stakeholders, a more in-depth analysis of the public financing environment two years earlier would have helped stakeholders anticipate this crisis and better respond to it.

Although interviewees felt that not taking decentralization more seriously was a weakness in the MOU, it is important to understand why decisionmakers did not address decentralization in the phaseout plan. First, USAID, by law, dealt directly with the central level through CONAPO and the SSA. It was SSA’s responsibility to pass

information to the states and, according to one interviewee, the SSA discouraged donor interactions at lower levels (Personal communication, SSA). Second, many phaseout committee members were not aware that decentralization had advanced, since a narrow body of stakeholders created the phaseout plan in isolation from broader health and government planning. Finally, the phaseout committee likely did not realize the impact decentralization would have on procurements since the SSA was determined to maintain a central procurement mechanism. Therefore, there was little reason to provide training for procurement or logistics at the state level (Anonymous). This helps justify why USAID did not address procurement as a component in the logistics training at the decentralized level. Nevertheless, in future phaseouts, donors should encourage efforts to anticipate these external events in the planning phase.

Use of state-level data for planning masked local disparities and resulted in inequitable resource allocations. A number of interviewees stated that the criteria for selecting the targeted states⁹ should have gone beyond just state-level sociodemographic indicators, and that focusing on simple averages resulted in missing some important, poorly developed parts of the country (Personal communication, SSA). For example, while contraceptive prevalence was said to be 80 percent in Mexico’s major cities, it was only 40–50 percent in mountainous areas and as low as 9 percent in communities in extreme poverty (Personal communication, MEXFAM).

Many stakeholders questioned the willingness to address the needs of underserved populations and suggested that the committee should have identified priority states on the grounds of “justice and equity.” One stakeholder complained that the northern and central states were left out, as well as states that were mostly rural. “There wasn’t enough focus on the states that were left behind.” This

resulted in huge disparities—targeted states received upgrades in skills and infrastructure, while other states received little training or investment in management skills. Stakeholders believed that USAID’s investment could have had a bigger impact had it been more widely dispersed throughout the country, as noted by this interviewee:

“There were objections in the states that didn’t receive any help. They complained that they were not included. Some strategies could [have been] established to benefit (even partially) almost all the states in the country ... [for example, by supporting all states to participate in workshops for state FP heads.]”

—interviewee from ISSSTE

Financial allocations during phaseout were unpredictable. Another criticism of implementation was the pattern of year-to-year phaseout resource allocations. Most stakeholders in both the public and nongovernmental sectors stated that financial allocations were difficult to predict from year to year and that they never knew how much they would be getting. Although it is often difficult to predict funding on an annual basis, stakeholders felt that the erratic allocations complicated the efforts of organizations’ leaders to create their budgets.

“The reality was that each year funds were assigned according to different projects... The Mexican Social Security Institute gained resources over time... Initially 5 percent was assigned for each of the different organizations that took part, but in the end [the last year] the Mexican Social Security Institute took almost 80 percent.”

—interviewee from IMSS

⁹ Priority states in which USAID focused its assistance during the phaseout period.

State-level decisionmakers did not receive training for procurement. At the time of decentralization, stakeholders at the state level had received little training in conducting procurements, negotiating lower costs, and overcoming regulatory obstacles. Moreover, the General Directorate of Reproductive Health (DGSR) had little knowledge or experience in estimating the costs of contraceptives (Personal communication, CONAPO). States that were procuring on their own had little negotiating power, in part because of the small volume, but also because of their lack of experience. These problems, in addition to the shortage of money, resulted in many states not procuring contraceptives or spending too much money for too little product.

Large cushion-stocks of supplies delayed the need for procurement. The large cushion-stocks of supplies received by USAID (in the NGO sector) and UNFPA (in the public sector) served as a disadvantage to organizations. One stakeholder claimed that “[USAID] tried to leave our warehouses full of supplies.” This created overstocks and prevented organizations from conducting trial procurements during phaseout. When the time came to procure, most stakeholders had little experience and no access to technical assistance. This underscores the need for donor coordination during phaseouts.

Messages from USAID officials about the end of phaseout were inconsistent. Some interviewees criticized USAID for sending mixed signals about terminating support during phaseout. Even though the phaseout agreement in the NGO sector stated that USAID would not continue operational support after completing the Transition Project,

mixed signals led MEXFAM to believe that support would continue, as noted by the comment below (Bowers et al., 1996).

As a result, MEXFAM did not undertake cost-saving or cost-recovery efforts in its social programs until late into phaseout. When NGOs began selling products in 1997, these revenues became important for improving sustainability. Had they started these sales earlier, they would have been better prepared financially to face the transition.

Other events led stakeholders to believe support would continue past 1999. In 1996, for example, financial support to the FP program increased to its highest amount ever—just one year before support was scheduled to end. In 1997, an extension to public institutions was granted, based on an assessment by USAID that recommended more time to achieve benchmarks and further institutionalize interventions. The NGO sector also was granted a one-year extension.

According to several stakeholders from former collaborating agencies, even in the final months of the phaseout program, USAID/Mexico was asking for suggestions about where to provide additional technical assistance and what strategic opportunities existed for USAID. In March 1999, when USAID ended its support to the Mexican FP program, some stakeholders felt that “discontinuity was really abrupt” (Personal communication, CONAPO), even though they had been planning for an impending phaseout for seven years. The evaluation report stated that “USAID/Mexico and MEXFAM, however, had anticipated a longer-term relationship, and are concerned that a near-term phaseout will be disruptive to MEXFAM’s program” (Bowers et al., 1996).

“A senior USAID official came to Mexico [and] asked me what my main worry was. Our main worry was that we had been told that support was going to be withdrawn in three years. He told me not to worry, that three years was a lot of time, and that support could change in three years. But it didn’t change ...”

—interviewee from MEXFAM

This inconsistency between USAID officials influenced government and NGOs' response to phaseout. FEMAP, which was never completely dependent on USAID support anyway, had expected this withdrawal and was better prepared to deal with it than MEXFAM and the public sector organizations were.

In contrast to remarks about mixed messages being sent by USAID, other stakeholders were said to have delivered consistent messages that phaseout would, in fact, take place as scheduled (Personal communication, USAID). This could be explained by the fact that multiple stakeholders were involved in the phaseout process and communication and perceptions may have been distorted. Nevertheless, the important lesson learned is that donors should try to send clear, consistent messages so that stakeholders will prepare for the withdrawal of assistance.

Special programs were introduced too late to make an impact and were therefore unsustainable. Most interviewees agreed that the shift in program emphasis to special populations (focusing on adolescent, rural, and indigent populations) was long overdue in Mexico, but that this support came too late for programs to be institutionalized before the withdrawal of USAID support. The interviewee from IMSS/S, for example, stated that for his branch of the institution, USAID assistance

for special populations started in 1996, just one year before the original end date for the phaseout period.¹⁰

While the programs in these areas made important advancements during the final phase of USAID support, there remains a significant amount of work to be done for these special populations, and many of the programs that were started during phaseout have since been cut. Some interviewees felt that there were important, broader national program gaps that should have received more emphasis in the design of the phaseout plan, such as IEC, training, quality of care, research, and monitoring and evaluation.

High turnover of USAID staff created challenges for continuity. During phaseout, USAID mission directors changed twice. This “high turnover” among key USAID positions and vacancies during some “very important...strategic months” was cited as a factor that weakened implementation, since there was no one to liaise with key government leaders (Personal communication, Pathfinder). However, this may have been a perception not shared by others. Other stakeholders mentioned that despite these well-publicized and unavoidable events, there was coverage from USAID most of the time, and USAID in no way was neglecting the program (Personal communication, USAID).

“New modalities were being implemented just as USAID was phasing out and there was not sufficient time to replace U.S. resources with domestic resources... It was important to ensure the quality of the services and... consolidate the progress made in rural and indigenous area—and among the least developed populations. When USAID withdrew its support, these programs had not been [institutionalized].”

—interviewee from CONAPO

¹⁰ The end date for the phaseout period was later extended to 1999, giving institutions such as IMSS/S an additional two years of support.

C. OPPORTUNITIES DURING PHASEOUT

The strong legal foundation governing the FP program protects against changes in political support. Laws granting free contraceptives to public health institutions hold the government accountable for ensuring access to FP services and supplies.

D. THREATS DURING PHASEOUT

There was a loss of attention to family planning during phaseout. It is difficult to know whether integration of family planning into a larger framework of reproductive health either improved or hindered support for family planning. Throughout the world, the impact of integration of family planning has shown that either result can occur. However, a few stakeholders shared the perspective that the integration into reproductive health contributed to a reduction in support for family planning.

“Another more serious problem occurred when the concept of family planning was changed to reproductive health. All of a sudden family planning was lost in the reproductive health framework, and ...the interest and attention they placed on the family planning program in Mexico was reduced—regardless of where it came from, whether political or presidential. This is what has happened...in all countries.....there is not the same intensity.”

—interviewee from FEMAP

It is unclear how much of this was perception and how much was due to other events taking place at the same time. Family planning, believed to be “less indispensable than direct medical care” (Personal communication, EngenderHealth), received more cuts than other programs within the health sector.

The 1994–1995 financial crisis limited availability of funding to public sector organizations. The 1994–1995 financial crisis compromised access to the resources necessary to cope with phaseout. As a result, other priorities competed with family planning, and the central government was not able to meet budget requests made by public sector FP organizations. For example, the Ministry of Finance allocated approximately half the amount requested by SSA for FP commodities during the crisis.¹¹

Donor policies reinforced donor dependence and limited the opportunities to promote self-sustainability. One interviewee expressed concern about USAID’s “very old policies that limit the capacity of the programs.” This individual believed that USAID’s policies and guidelines limit efficiency by favoring donor-dependent institutions over those that have taken steps toward self-reliance. The more successful organizations still required

additional resources for expanding their programs but this funding was not available. This illustrates the challenge donors are faced with when making decisions about resource allocation. There is often a trade-off between allocating resources to strengthen capacity and allocating resources to improve efficiency of more competent organizations. One interviewee mentioned that it might be effective for donors to allocate resources based on the organization’s capacity to use the resources.

Other donor regulations limited Mexican organizations from making the most of their donated resources; they were prohibited from creating an endowment fund, or generating interest on USAID money, as demonstrated by this quote from an NGO interviewee:

¹¹ More recently, the DGSR increased its budget for family planning by 1,300 percent between 2000 and 2003.

“It was ridiculous to have a million dollars and not be able to earn interest on it. At the time, there were interest rates that ranged from 30 percent to 60 percent—that would have yielded a lot of money. We would have been able to make our money work in a better way.”

—interviewee from FEMAP

Changes to these policies could increase the potential for program expansion and improve sustainability in future donor-funded FP programs.

After decentralization, state-level decision-makers were responsible for family planning but did not view it as a priority. The phaseout plan did not specifically identify a need for high-level advocacy to increase political support for family planning and, indeed, such advocacy may not have been necessary in the beginning, given that the policy environment for family planning was extremely favorable. However, when states took over responsibility for budgeting, forecasting, and procurement in 1998, there were a number of priorities that competed with FP funding, and organizations did not allocate substantial funding to contraceptives. This was due to lack of awareness of the benefits of family planning and competition with other health services that, according to stakeholders, were equally or more urgent than family planning.

The social security organizations’ delegations¹² had less responsibility for budgeting than the states did. Therefore, competing priorities at the state level were less of a problem for the social security institutions than for SSA. Some stakeholders mentioned that members of Congress were not adequately informed about the meaning of “graduation” and, as a result, family planning was not a priority for them (Personal communication, ISSSTE).

Although Johns Hopkins University Population Communication Services (JHU/PCS) project provided technical assistance for advocacy activities, these activities focused largely on IEC campaigns. It wasn’t until after phaseout that a paradigm shift occurred. The role of advocacy became much broader, and stakeholders began using advocacy as a tool for garnering support from high-level stakeholders. As one interviewee stated, allocation of resources to state FP programs depends on the ability of the program manager to advocate for resources at the state level (Personal communication, SSA). However, there was a lack of a strategic focus at the state level: stakeholders were not thinking about the ramifications of an inadequate supply of contraceptives or about the future costs of supply shortages, such as abortions and unplanned pregnancies.

“What I’ve learned while talking with people at the state level is that they [state government officials] don’t consider the family planning program important, because they don’t see a change during their time in office.... They don’t plan in advance, they generally plan for the present time.... They prefer to spend money on hospitals, antibiotics, pesticides for dengue fever, because those are actions for the present, they have to find a solution for those issues at the moment...”

—interviewee from SSA

¹² The organizational structure of the decentralized units served by the social security institutions in Mexico are called delegations. The SSA, in contrast, serves states.

Advocacy would have been helpful for keeping family planning a priority and bringing it to the attention of high-level policymakers and state governmental authorities—especially in a decentralized environment. Such advocacy will help officials make the link between investing in family planning and improving overall health and development (Personal communication, SSA).

Price-gouging by domestic suppliers made contraceptives inaccessible. Trade protection regulations prohibited most organizations from procuring from international vendors, whose unit prices are often much lower than the local market. Therefore, when public sector organizations began procuring on their own, they were required to procure domestically. NGOs could procure internationally but if an international vendor had a representative in Mexico, contraceptives had to be purchased from the local supplier at the higher price (Quesada, 2000). Schering and other domestic pharmaceutical companies took advantage of this situation, setting prices as much as five times higher than those of the international market (see Table 1). This made contraceptives very expensive—and inaccessible—for many individuals. (No data were available about prices in the international market, so USAID 1999 prices in U.S. dollars are used here for comparison purposes.)

The higher pricing structure of the domestic pharmaceutical industry can be explained in part by the fact that domestic vendors distribute supplies to the state and delegations, rather than just the central level. But these high unit costs offered by the commercial sector made it difficult for

organizations to procure a reliable supply of contraceptives.

Provision and promotion of free contraceptives in the public sector limits NGO sector revenue generation. The public sector’s policy to provide and promote free family planning services and commodities to anyone, regardless of socio-economic status or ability to pay, has further complicated the efforts of NGOs to implement or raise user fees.

“We have worked a lot in order to educate and train the people, and the governmental policies throw it all away because the Health Secretariat says that contraceptives are free...All this process is ruined because they tell everybody that contraceptives should be free... This is an important obstacle...”

—interviewee from FEMAP

As a result of public sector policies, the market in Mexico is not well segmented. Pricing differences among institutions and lack of communication and collaboration between the public and NGO sectors complicate efforts by the NGOs to increase demand for their services and mobilize new resources. Due to the strong public sector in Mexico,

Table 1. MEXFAM: Unit Costs for Contraceptives Supplied by USAID and Local Vendors in 1999

Method	Number of Units	USAID (US\$) Cost per Unit	Local Vendors (US\$) Cost per Unit	Price Difference (%)
Oral contraceptives	1,500,000	0.21	1.16	+552%
Condoms	3,500,000	0.056	0.115	+205%
IUD: Copper T	30,000	1.20	2.63	+219%

Source: From MEXFAM's forecast of supply requirements for 1999. Cited by Quesada, 2000.



cross-subsidization of the entire FP program was a challenge, and NGOs had to lower their expectations for achieving self-sustainability so quickly. A market segmentation study would have been helpful in identifying where the public and NGO sectors could work together to best serve the RH needs of the Mexican population.

Serving hard-to-reach populations increases program costs. It is expensive to serve hard-to-reach populations because these groups often have the highest unmet need for family planning.¹³ Recruiting and retaining healthcare workers to

serve such groups often requires financial incentives for the staff, because such areas are often far from where the healthcare workers live. Many clients in these areas are exempt from paying fees at MEXCAM clinics, thereby hindering self-sustainability of the program.

“The further out we need to go to provide the service, the higher the costs of the programs and the more difficult it becomes to retain the service of qualified staff who are assigned to areas in extreme poverty. That becomes an extremely difficult challenge.”

—interviewee from MEXFAM

¹³ Unmet need is the proportion of women in union who want to space or limit their pregnancies, but who are not using any form of contraception.

VI. Evaluating the Family Planning Program in a Post-phaseout Environment

In hindsight, it is easy to see where the programming of phaseout resources could have been more effective, but no matter how resources were programmed, the phaseout process would have presented challenges. Such is the case when transitioning away from dependence on donors.

The withdrawal of donor resources did not result in an equal replacement of government resources—as envisioned in the phaseout plan—due to many factors external and internal to the FP program. Even though USAID withdrew its assistance in 1999, the transition to independence from donor support is still taking place.

What is the prognosis for Mexico’s program? Much of the answer is provided in the new national reproductive health survey (only preliminary results were available at the time of this study). The following section summarizes major developments that have taken place in family planning in Mexico since USAID phased out its support for family planning in 1999.

A. POLICY ENVIRONMENT

Although support for family planning is still relatively strong, some interviewees have the perception that since the election of President Vicente Fox and the National Action Party (PAN) in 2001, support for the FP program has weakened. The PAN has a more conservative orientation and has demonstrated closer affiliations with the Catholic Church than former administrations.

One respondent described this declining political support as a “non-verbalized but a real brake applied to family planning,” but also stated that “it was simply a perception that the government isn’t supporting the program in the way that it always had” (Personal communication, EngenderHealth). These statements imply that this perception may be due to the timing of a number of events that have contributed to decreasing attention for family planning:

- the financial crisis
- competing priorities both inside and outside the health sector
- integration of reproductive health services
- decrease in program support once USAID phased out of population assistance

Despite this loss of attention, however, the government is still in favor of family planning. In fact, after phaseout, the family planning norms were revised and now permit emergency contraception to be sold over the counter. This is a contentious issue throughout the world and Mexico is one of few countries to have passed this regulation, demonstrating the progressive nature of the Mexican government. Another sign that support for family planning is strong is the creation of the City Council for Population Policies—a council of civil society, academic organizations, and some international organizations that will continue to support dialogue and guide the policy debate on population.

B. CURRENT COORDINATION MECHANISMS

Although the NGO and public sector FP programs in Mexico continue to function independently of one another, the interagency working group is still in existence. This group lapsed in the early years of the Fox administration, but public pressure allowed the group to be reinaugurated by the SSA in November 2002. The group continues to meet monthly to discuss and debate strategic issues in family planning and reproductive health.

Most stakeholders in the public and NGO sectors agree that other coordination and collaboration mechanisms dwindled after phaseout, but there is some evidence that organizations are beginning to collaborate, notably with logistics functions. The consolidated procurements are bringing organizations together, and IMSS and ISSSTE may partici-

pate in the near future. If FEMAP and MEXFAM also become vested in this process, economies of scale would benefit all organizations.

C. LEGAL AND REGULATORY ENVIRONMENT

The legal and regulatory structure governing performance of FP services has continued to evolve. Some of these post-phaseout changes were based on USAID-funded research studies that defined weaknesses and areas of improvement in the regulatory structure governing family planning (Personal communication, CONAPO).

Laws granting free contraceptives to public health institutions are still in place.¹⁴ This means that public sector institutions cannot charge for contraceptives, which eliminates an important mechanism to meet funding shortfalls. In recent years, policy changes increased the range of RH services that are provided free to all, such as prenatal and postnatal checkups (Personal communication, SSA).

A regulatory change governing managerial activities at CONAPO also has been made since phase-out. In 2000, the general population law was amended, creating a direct link between CONAPO and the COESPOs (state-level population councils). This amendment provides a legal context and regulations for the COESPOs and supports their new role in implementing the national population program at the state level (Personal communication, CONAPO). This was an important change accompanying the shift to decentralization.

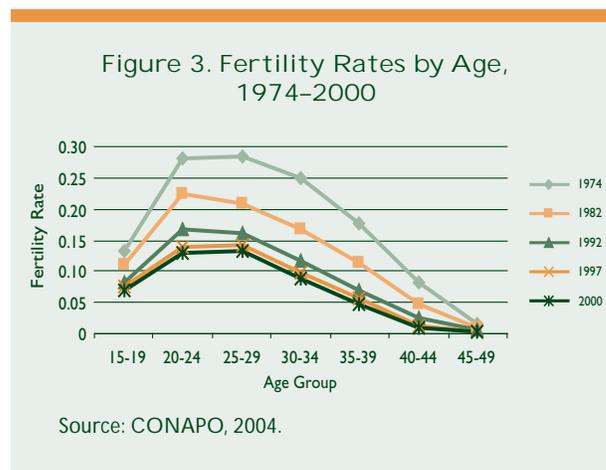
Another key regulatory change, made after phase-out as a result of lobbying by the SSA, permits the SSA to procure contraceptives on the international market. This regulation also has encouraged collaboration between the SSA and its state offices, which are now participating in consolidated procurements coordinated by the central level. These procurements help to achieve economies of scale and to negotiate price reductions. At the time of this case study, the social security organizations had not yet lobbied to change the procurement

regulation and were still required to purchase domestically.

In 2000, the regulation requiring states to assign funds to a line item for contraceptives and family planning was revised. Funding for family planning and contraceptives is now incorporated into a more general category of medical services, giving state governments more flexibility with their budget allocations. This change was made after a review of the budget found “too many categories in the budget that were very detailed, and difficult to manage” (Personal communication, CONAPO). However, it is not mandatory for states to report the amount they are spending on contraceptives, making FP expenditures less transparent than they were before this change. This does not necessarily mean that allocations to family planning have decreased, but simply that it is more difficult to track and hold stakeholders accountable for investing in family planning.

D. DEMAND FOR AND USE OF FAMILY PLANNING

Fertility rates of women in their reproductive years decreased during phaseout (see Figure 3). The largest decrease was among women ages 20–24, followed by women aged 25–29. In 2000, the total fertility rate (TFR) was 2.4 children per women, down from 3.1 children per women when phase-out began in 1992.



¹⁴ 1974 General Law on Population and the General Law on Health.

Throughout the phaseout period, the overall CPR in Mexico increased steadily, climbing from 63.1 percent in 1992 to 68.5 percent in 1997 (see Table 2). In the post-phaseout period, CPR continued to climb at about 0.7 percentage points annually to reach 74.5 in 2003, 66.2 percent of which was for modern methods (UNDP, 2004).

Table 2. CPR and Unmet Need by Residence and Education Level

	CPR (%)			Unmet Need (%)	
	1987	1992	1997	1987	1997
Urban	61.5	70.1	73.3	15.9	8.9
Rural	32.5	44.6	53.6	45.7	22.2
No education	23.7	38.2	48.0	45.8	21.8
Incomplete primary	44.8	56.4	61.3	32.7	16.9
Total	52.7	63.1	68.5	25.1	12.1

Source: Secretary of Health (Mexico), 2001.

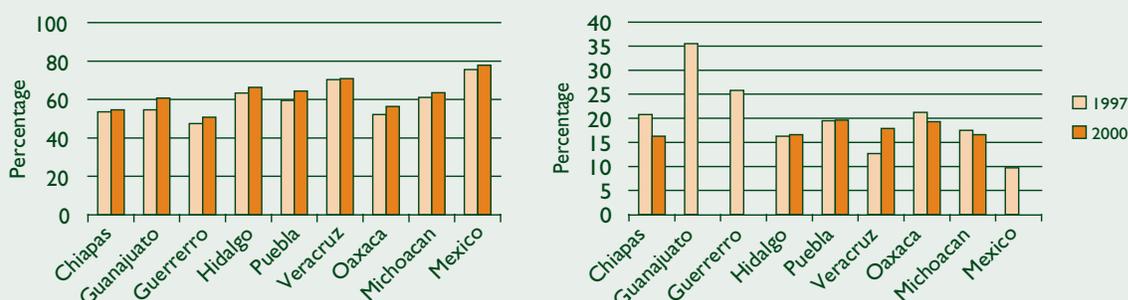
During phaseout, much progress was made in narrowing the gap in CPR and unmet need between urban and rural populations and among women with different levels of education. However, there is still much progress to be made among these populations.

High unmet need among some groups is linked to an increased number of unintended births, and often an increased number of abortions. Here are a few observations on trends in both CPR and unmet need:

- Women with no education have lower levels of contraceptive use than women with even a small amount of education. At the end of phaseout, unmet need was highest among women with no education (see Table 2).
- In 1997, there was still a difference of 20 percentage points in contraceptive prevalence between urban (73.3) and rural (53.6) areas. Unmet need decreased during phaseout but was still much higher in rural areas (22.2) than urban (8.9) in 1997 (see Table 2).

There are also disparities across states. Six of the nine original targeted states still have CPRs of less than 65 percent, and unmet need actually increased in Hidalgo, Puebla, and Veracruz between 1997 and 2000 (see Figure 4). Unfortunately, data on unmet need were not available for Guanajuato, Guerrero, and Mexico for 2000.

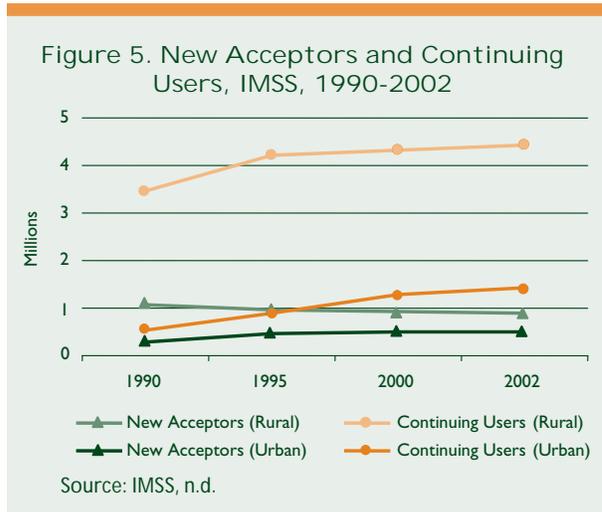
Figure 4. CPR and Unmet Need by Priority States, 1997 and 2000



Source: ENADID 1997; Cuadernos de salud reproductiva: República Mexicana. Consejo Nacional de Población. September 2000. Mexico City.

New Family Planning Users

In terms of attracting new users during and after phaseout, the urban areas fared slightly better than rural areas, as shown by data from IMSS, the largest service provider in the country (see Figure 5). For



continuing users, numbers increased at similar rates in the rural and urban areas during phaseout. However, these figures mask disparities among states and do not reveal the movement of clients that has taken place between sectors.

Adolescent Reproductive Health

In 1999, one in six births occurred to adolescents ages 15 to 19 who make up 25 percent of the population. Married adolescent couples have the lowest levels of contraceptive use: in 1999, approximately 30 percent had an unmet need for family planning.

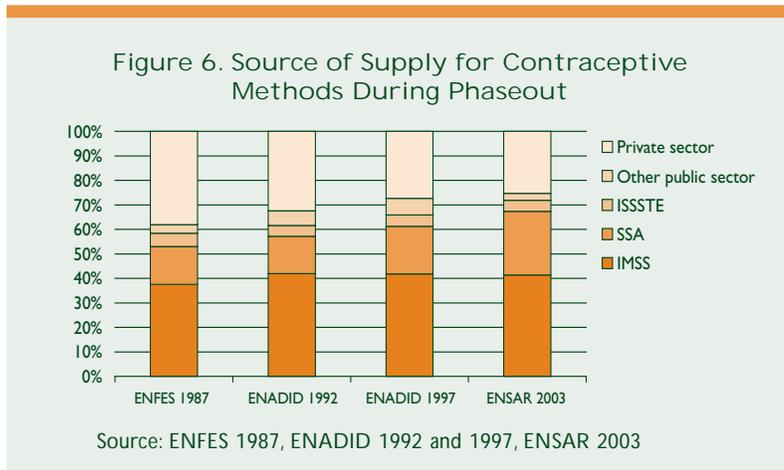
Knowledge, Attitudes, and Practice of Family Planning

Knowledge of contraception and where to get it improved during

phaseout. In 1992, 20 percent of women in union who did not want any more children said they did not use contraception, and they did not know about any contraceptive methods, where to get contraceptives, or how to use them. This percentage dropped to 16 percent by 1997 and all women surveyed had heard of at least one method.

Source Mix

During phaseout, there was little change in the source of methods used by public sector family planning clients (see Figure 6). The market share of the public sector far exceeds that of the NGO sector, with IMSS/Régimen Ordinario (RO) and IMSS/S¹⁵ serving the greatest number of clients. The share of FP services being offered by SSA experienced the greatest growth during phaseout, while FEMAP and MEXFAM collectively noticed a drop in their shares of the market. This decrease was a result of a temporary drop in users as clients adjusted to a cost-recovery system. Although those trends pertained to both the public and NGO sectors, more specific information about the NGO sector is available. Both FEMAP and MEXFAM experienced a temporary decrease in new clients in response to the introduction of their fee-for-service program in 1992. By 1998, the number of new

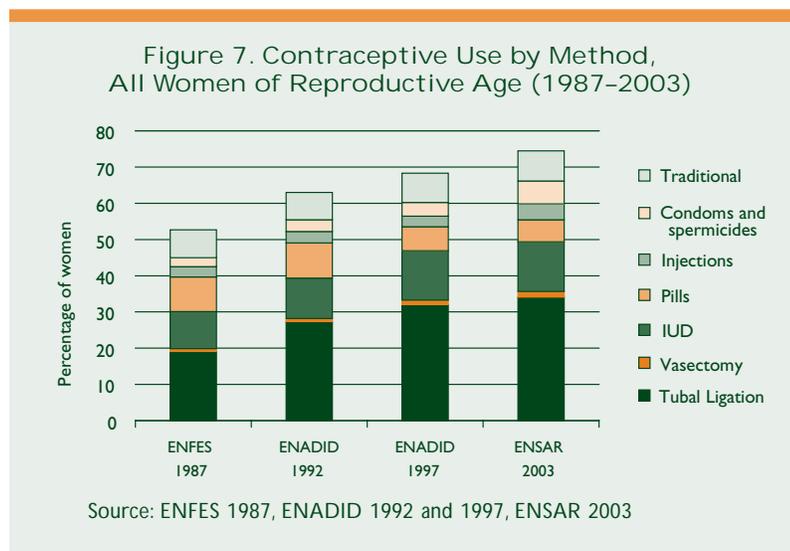


¹⁵ IMSS/RO (Regimen ordinario) serves the privately employed and federal employees in urban areas; IMSS/S (solidaridad), now called IMSS/O (oportunidades) offers health services to the uninsured people of urban and rural areas.

users in both organizations had surpassed the levels at the beginning of phaseout, after clients adjusted to the fee-for-service program (Beamish, 1999). However, it is important to note that many women no longer have financial access to FEMAP's services. Pill users who depended on FEMAP's low-cost services for years, for example, now have to pay almost five times more than the price they paid before phaseout, now that FEMAP is no longer receiving free donations (Personal communication, FEMAP).

Method Mix

During phaseout, CPR for all methods increased, with the exception of pills. This is likely a result of the high cost of pills supplied by the domestic market (see Figure 7).



The method mix did not change substantially during phaseout and tubal ligation still accounts for 45 percent of all contraceptive use. However, there is some evidence suggesting that the choice of contraceptive products has increased in recent years, and new procurement mechanisms enable organizations to expand their method mix. For example, IMSS now supplies 12 temporary methods, and two permanent methods—an increase from 1995 when they supplied only four temporary methods and two permanent methods.

E. PROCUREMENT

One interviewee observed that price gouging by domestic suppliers after phaseout strained relations between the commercial pharmaceutical sector and government organizations/NGOs for four years after the phaseout period.

“Schering [pharmaceutical company] manipulated things in such a way that ... IPPF couldn't sell to us at an international price. We had to purchase them [contraceptive products] locally at the price Schering imposed on us. We ended up in a fight with them... We no longer use Schering products and neither does the SSA... The final dispute arose because IPPF sold Microgynon to us at an international price, USD\$0.25. Then Schering/Mexico tried to accuse us of dumping products.”

—MEXFAM interviewee

As part of its strategy to minimize costs, MEXFAM now monitors unit costs more carefully. MEXFAM no longer procures through Schering and has instead switched to Lo-Femenol as its pill brand. Since Lo-Femenol was not available in the national commercial market after phaseout, MEXFAM was permitted to procure it from the international market, thereby obtaining “international prices” from IPPF. These prices were lower than any other pill product available in the domestic commercial market (Personal communication, MEXFAM).

FEMAP also faced high unit costs from domestic suppliers after phaseout. From 2000 to early 2003, the number of clients served by FEMAP declined, largely because prices from domestic suppliers were too high to replace donated contraceptives. FEMAP now purchases its contraceptives from an international procurement agent (UNFPA) at much lower unit prices. These arrangements were made in 2003, after several difficult post-phaseout years (Personal communication, FEMAP).

Consolidated procurements organized by SSA

To improve efficiency and to streamline the procurement process for all states procuring on their own, the SSA's DGSR began to consider other procurement options after phaseout.

“We realized that the states were undergoing a very critical lack of supply that was deeply affecting the development of the program. Not having contraceptives is like having a car with no gasoline.”

—interviewee from SSA

Together with CONAPO, the SSA lobbied for changes in regulations that restricted procurements in international markets. Organizations also received advocacy support from JHU/PCS. This marked an important regulatory change (Personal communication, CONAPO).

The Family Planning Department within the SSA then began discussions with UNFPA to investigate the feasibility of a centrally coordinated purchase of contraceptives from UNFPA—the “pooled procurement.” At the same time, lobbying by the SSA convinced the states to participate in the consolidated procurement rather than procuring on its own.

The advantages of consolidated procurements are many: lower unit costs; less need for training in procurement at the state level; increased economies of scale; and improved coordination between organizations, mostly in the public sector. In conjunction with the consolidated procurement, UNFPA handles the international quality control procedures, importation and customs processing, and sanitary registration of the contraceptives purchased. They also provide free logistics training

for all participating states, as an incentive for additional states to participate (Personal communication, SSA). Many states are saving significantly under this arrangement, and many now have a reserve they can use for future contraceptive purchases and additional support. Despite the many advantages of the consolidated procurement, there are also many challenges (see Appendix F).

Recently, UNFPA and the SSA's DGSR have closely collaborated to streamline the process of consolidated procurements, now implemented in 22 out of 32 states. The SSA hopes to convince all states to participate (Personal communication, SSA). Currently, the consolidated procurement does not include the state of Mexico, which has the highest number of potential users. The interviewee from the SSA felt confident that in the future, consolidated procurements will be carried out more smoothly now that Mexico has experience. UNFPA also has offered to make two deliveries throughout the year, rather than just one, thereby preventing many stockouts.

The consolidated procurements have been so successful that some of the NGOs have joined to procure contraceptives. There is also a possibility that IMSS and ISSSTE will participate in the consolidated procurements in the near future.¹⁶ Increasing the volume of contraceptives procured through collaboration with other organizations would strengthen the group's negotiating power. Some states request condoms for HIV/AIDS programs through the consolidated procurements, resulting in larger volumes and lower costs.

Already, price gouging by domestic companies has moderated to some extent, in an attempt to compete with the UNFPA external procurement and international procurements by NGOs. A new proposal from one of the domestic suppliers of the international procurement offered to respect international prices. This is a sign that the domestic suppliers perceive the FP market as an attractive investment.

¹⁶ At the time of the interviews, IMSS and ISSSTE had not yet lobbied for the regulatory change that would allow them to procure internationally.

F. PUBLIC-PRIVATE PARTNERSHIPS

There has been some success with public-private partnerships since phaseout ended, mainly with MEXFAM. After phaseout, MEXFAM provided IEC services, developed educational materials, and expanded FP services for people served by the SSA. MEXFAM also negotiated “provisional agreements” to provide services to police departments and schools (Personal communication, MEXFAM). These public-private partnerships serve former public-sector clients with reputedly higher quality services than they would otherwise receive, reducing the burden on public-sector providers and generating income for MEXFAM (Personal communication, MEXFAM).

G. EXTERNAL SUPPORT FROM OTHER DONORS

After phaseout, donors and foundations increased their contributions to MEXFAM significantly. The Hewlett Packard Foundation, Doxon, the Bill and Melinda Gates Foundation, the VEXTRON Foundation, the Finnish Foundation, JICA, and others have all contributed substantial funding to MEXFAM. MEXFAM depends on this funding to provide support for the programs in the rural and urban underserved communities, where it is not able to recover its costs. Donors also cover user fees for MEXFAM clients who are exempt from paying for services and supplies (Personal communication, MEXFAM).

More recently, MEXFAM has begun to seek and obtain support from local Mexican foundations such as Vamos Mexico, which supports programs in rural communities in two states. A U.S.-based Rotary club teams with a local Rotary club in Mexico to support services in a mountainous area of another state (Personal communication, MEXFAM).

MEXFAM has developed a “specific projects” approach to match donors’ interests with its own objectives and missions (Personal communication, MEXFAM). It is also exploring the possibility of using donor funds to market new products, such

as monthly injectables, that not many companies sell.

Although MEXFAM has been successful in diversifying its donor support base, it recognizes this as a temporary solution to phaseout. Indeed, several foundations have recently announced intentions to reduce commitments to MEXFAM and currently, one of MEXFAM’s medium-term objectives is to “increase revenues [through operations, thereby becoming] less dependent on external resources (Personal communication, MEXFAM).

FEMAP is not as vulnerable as MEXFAM to reductions in donor funding since its affiliates are largely autonomous and self-supporting organizations. However, it still receives some external support from donors.

H. STRUCTURE OF ORGANIZATIONS

Services in Mexico’s FP program have undergone changes since USAID’s withdrawal of assistance. Some of these changes are a direct result of the withdrawal of USAID support; others have taken place in response to the financial crisis, the shift to decentralization, integration of reproductive health, and an evolving FP program.

Staff reductions have taken place at each of the public sector organizations, mainly because organizations had less to manage after phaseout and did not require the same level of staffing. The supervisory roles that were once funded by USAID were eliminated after phaseout and management responsibilities were moved to medical units at the delegation or state level (Personal communication, ISSSTE). Currently, in the social security organizations, a reproductive health team is tasked with overseeing performance of the delegations,¹⁷ reporting to the central level, coordinating the units, supervising, providing technical assistance, and conducting medical training.

As noted by an ISSSTE interviewee: “The organizational structure that developed with USAID support is, unfortunately, being gradually lost” (Personal communication, ISSSTE). ISSSTE has been affected most severely, having had to reduce its central

¹⁷ IMSS and ISSSTE are organized by delegations, rather than states.

areas of coordination. Disparities among states exist, especially among the targeted states and states that did not receive technical assistance; there is a need to level the playing field and improve equity in this respect—a challenge in an environment that is still constrained for resources.

I. SPECIAL PROGRAMS FOR ADOLESCENTS

Both the public and NGO sectors have strong adolescent reproductive health programs.

Public sector

IMSS/S is responsible for implementing special programs among public sector organizations. One of the most successful programs is the Model of Integrated Care for the Health of Adolescents (MAISA). The program addresses family planning as a component within an integrated model of reproductive health promoting women's health and education (Personal communication, IMSS/S).¹⁸ Between 1998 and 2003, the percentage of adolescent users of services increased from 3 to 20 percent, relative to the client base of IMSS/S. There is evidence that the program has been effective in preventing unplanned pregnancies among adolescents.

In the NGO programs in the rural areas, female community health workers provide family planning outreach activities, including distribution of contraceptives and information in underserved areas. NGOs have greater flexibility and have experienced greater continuity with their program strategies. One interviewee described the importance of the social programs:

“[T]he work [NGOs] do in terms of going door-to-door and following up with users...has been extremely valuable. The government can't do that because the government changes after a while. What gives strength to a program, and what guarantees it, is the civil society... They do things in a much better way...their commitment is personal.”

—EngenderHealth Interviewee

NGO sector

One of the largest social programs created by MEXFAM is the Gente Joven (Young People) program, financed by the Hewlett Packard Foundation and the Bill and Melinda Gates Foundation. The program delivers messages using a youth-to-youth approach that stresses responsible sexuality and responsible parenthood. It attempts to reach low-income urban youth (ages 10–24) using innovative channels, including community and athletic centers, schools, gang headquarters, and rock concerts. The sustainability of this program is in question, however, due to the termination of support from the Hewlett Packard Foundation, and possibly from the Gates Foundation.

FEMAP runs an adolescent program that is much less donor-dependent than the Gente Joven program. It is called “FEMAP for healthy young people,” and the model is similar to that of IMSS/S in that it promotes healthy behavior and includes reproductive health as a component. This project, the first to be financed by FEMAP's own resources, has been implemented within health centers and hospitals in Saltillo. In 2003, the program generated almost 50,000 new users per year and had 8,000 promoters (Personal communication, FEMAP).

J. IEC ACTIVITIES

The IEC activities during phaseout were successful and one interviewee claimed that he is now “capitalizing a great deal on information, education, and communication” as he carries out his RH program at a university (Personal communication, SSA).

¹⁸ These numbers are approximate and there is very little data to illustrate this change.

“Well, I’ve changed the way I think, and I owe a lot to the communications people who supported me. A characteristic of our program was the development of really nice materials, properly developed. I should give proper credit to this: I think that support was very important to the program.”

—interviewee from SSA

After phaseout, however, because of a withdrawal in funding, IEC activities have weakened (Personal communication, IMSS/S). There has been some success in garnering support from the pharmaceutical industry to support IEC activities. Some pharmaceutical companies have recently begun producing educational materials and supporting radio and television campaigns started by USAID. However, current IEC activities target mainstream populations only, making it difficult for organizations working in rural regions, which require promotional materials in different dialects and with pictures and symbols that can be easily understood by illiterate populations.

K. SUSTAINABILITY OF NGOS

The NGOs, especially FEMAP, have increased sustainability levels but are still challenged with providing contraceptive methods and services at a low enough cost to make them affordable, while charging enough to recover their operational costs. Despite staff cutbacks during phaseout, both NGOs expanded their clinics and affiliates. MEXFAM increased its clinics from 2 to 14 and FEMAP increased its affiliates from 30 to 42¹⁹ (see Appendix G). The number of social programs or community health programs in both organizations also increased during this time (Beamish, 1999).

In conclusion, NGOs had more flexibility than the public sector did to overcome the financing challenges that resulted from phaseout. NGOs

were innovative and, to a large extent, successful, although their transition to self-reliance is incomplete. They continue to create initiatives that further their program and promote sustainability, realizing that this is the only way to ensure the success of their programs.

“We go on creating initiatives... it’s the only way to ensure the continuity of the program... [Donors] should support other countries... but it is no one’s obligation. When someone thinks that it is the other person’s obligation to help me, then I will obviously do nothing to help myself. Attitude is essential.”

—interviewee from FEMAP

L. RESEARCH AND EVALUATION

Since the withdrawal of USAID, there have been major cuts to activities at CONAPO related to monitoring and evaluation and research. This has severely restricted information needed to evaluate programs.

“We have had problems identifying the resources necessary to repeat our national demographic and health survey... We have had really strong restrictions in that sense... very limited information [from] other sources such as the census.”

—interviewee from CONAPO

As a result, organizations have struggled with designing, monitoring, and evaluating programs because they have had no updated data with which to make decisions since phaseout. This will change with the release of the final results from the 2003 National Reproductive Health Survey.²⁰

¹⁹ Thirty-two of these clinics offer family planning services.

²⁰ At the time of this study, only preliminary results from the 2003 National Reproductive Health Survey were available.

VII. Lessons Learned from Phaseout in Mexico

Six years after the completion of USAID’s assistance to Mexico, the national FP program is still strong, but has gone through a difficult transition. Though it has covered much ground, no component of the program has achieved true self-reliance and, in fact, some program momentum has been lost. Although national-level program indicators such as CPR, TFR, and unmet need have improved, this progress masks the coverage gaps that exist, especially for those programs serving special populations (Personal communication, CONAPO). Since evaluation mechanisms have weakened in the post-phaseout era, there has been little opportunity to evaluate progress made at subnational levels.

As Mexico continues to address new challenges, a number of factors will affect the FP program. First, a huge segment of the population is living in poverty, which will challenge the government to find resources to provide free FP services to such a large number of people. Second, the NGO sector is not ready to step into the FP market in any significant way, meaning that a large burden will rest on the government for some time to come. And finally, Mexico has not yet come through its demographic transition and its needs will continue to grow for some time to come.

There are signs of optimism, however. Here are a number of opportunities that will serve the program well:

- The economy is no longer in a state of flux, decreasing the pressure on the government to allocate resources to programs that respond to what often appear to be more immediate needs, such as medicines and medical equipment.
- The shift to a broader reproductive health context is now complete and on balance; most interviewees agreed that this shift is healthy for family planning (Personal communication, EngenderHealth).
- States and delegations have come to terms with their new responsibilities under decentralization.

- Demand for family planning is strong. One interviewee noted that “family planning is deeply rooted in the culture of the people.” Family planning is acknowledged as a right and people have long been “convinced of the benefits of family planning.” “The community’s [and government’s] acceptance of the program” ensures that women and men will demand that access to services be maintained (Personal communication, IMSS/S).
- Organizations in both the public and NGO sectors have identified successful mechanisms for procurement, and forecasting skills and logistics systems are continually evolving. This has created new opportunities for collaboration between organizations.
- Although there are concerns about equity—particularly for marginalized communities—the program’s strong infrastructure will help to ensure that most women have physical access to services.
- Program leaders are forging ahead with new initiatives, grappling with new challenges in an ever-changing environment. Mexican institutions take the issue of informed choice seriously and continue to emphasize improving systems so that all women who seek services make fully informed and free choices.
- New methods are being incorporated into a new system of norms and standards, including emergency contraception and the female condom and efforts are being made to encourage more male participation in family planning (Personal communication, SSA).

Documenting lessons from Mexico has great relevance for donors, governments, and program planners as they design sustainable programs that help countries move toward FP self-reliance. Before phaseout of donor support in Mexico, few countries had experienced a phaseout of population support and there were few, if any, evaluations of the process, thereby providing little insight on how the process should progress.

Some of the lessons documented in this report apply to the general phaseout process that any graduating country will undertake; others are applicable to countries with economic, political, or demographic characteristics similar to Mexico.

Here is a summary of some of the most important lessons learned, which have been documented in this report.

A. PHASEOUT PLANNING

A phaseout plan should be flexible enough to respond to changes in the external environment. One of the most valuable lessons learned in Mexico is that a phaseout plan should be a flexible template, in which stakeholders are able to shift resources and approaches as called for in the program's environment. As shown from this case study, political, economic, and social changes play important roles in shaping a family planning program. The phaseout plans that were developed in 1992 were based on a system that existed at that time, but were not specifically designed to allow the system to adapt to changes like the fiscal crisis, decentralization, and the shift toward reproductive health. Future phaseouts will benefit from understanding how these events can affect a FP program. Future phaseouts should strive to anticipate, and prepare contingency plans for, changes in the external environment.

Multisectoral collaboration and strategic thinking are important for planning and implementing a phaseout. A strategic approach, involving a wide range of stakeholders from all sectors and all levels of organization, benefits every stage of a phaseout. In Mexico, it was noted that multisectoral collaboration was weak during phaseout and that communication links between sectors—and even within sectors—could have been strengthened. Sharing experiences, planning strategically, and identifying mutually beneficial strategies would have been helped stakeholders. Further collaboration in the future could help broaden the choice of contraceptive methods that are available throughout the country and could create improved economies of scale for procurements. Collaboration

also can help keep clients informed about the availability of methods at other sources.

Institutionalizing a multisectoral planning team as the body responsible for contraceptive security (CS) initiatives often meets with challenges because of stakeholders' competing priorities. However, a CS working group is a common feature of programs today and often includes representatives from ministries, NGOs, medical providers, the pharmaceutical industry, international procurement agents, civil society, and policymakers. The group coordinates activities and promotes continuity between reproductive health activities, and would likely be the most appropriate group to coordinate the phaseout planning process.

Donor coordination is necessary during phaseout of family planning support. Coordination among donors ensures that resources are used efficiently and donors' efforts are not duplicated. Coordination is particularly important during phaseout of contraceptives. When organizations are grappling with the transition to independent procurement, unsolicited donations can create negative impacts. In Mexico, for example, UNFPA's donation of pills and IUDs and cushion-stocks from USAID donations, especially in the NGO sector, prevented organizations from conducting trial procurements and gaining the experiences necessary for a seamless transition. It also resulted in changes in the government's budgetary expectations and contributed to both overstocks and stockouts since organizations did not know how to manage the excess supply.

Decisionmaking should be informed by research and evaluations specific to populations being served, rather than by broad indicators. USAID was said to have relied mostly on national and state-level FP program outcome indicators to identify areas of need during phaseout. The consequence was that some poor communities did not receive phaseout support because they were in states with good overall program indicators. Community-level data and political factors need to be taken into account when deciding where to focus support.

B. TECHNICAL COMPONENTS

Donors and governments should make an effort to institutionalize skills and funding for supervisory and management positions. During the transition period, substantial USAID funds were spent on training, technical assistance from international and national experts, management, and supervision activities. In the post-phaseout era, it is clear that these activities were not institutionalized in Mexico's FP program. It is also clear that funding is no longer available to continue providing the same degree of technical assistance in this arena.

In the years following phaseout, institutional capacity to carry out FP activities weakened in both the public and NGO sectors. In the public sector, this was largely due to staff members at subnational levels taking on new responsibilities for which they had little training under the newly decentralized structure.

“During that [USAID] period, supervision activities were strengthened a great deal because there was money to travel... This is one of the important restrictions currently. When USAID's support ended, supervision activities weakened a lot... This lack of oversight was perceived by providers as less motivation for implementing activities... The lack of monitoring had an impact on the delivery of services.”

—interviewee from EngenderHealth

C. IMPLEMENTATION

Sufficient timing is required to make progress in any given intervention. A phaseout is not the optimal time to introduce new programs, given that substantial time, resources, and technical assistance often are required to institutionalize programs. In

Mexico, interviewees criticized the phaseout plan for introducing such a new-program emphasis during a phaseout period, and recognized that USAID's investment in these programs did not have the return it should have had. Future phaseouts should consider not only program needs, but the time and resources required to make an impact in a given intervention.

D. COMMUNICATION

Donors should attempt to send consistent messages to the beneficiaries of assistance.

Clear communication about the timing and terms of phaseout would help organizations develop new strategies that prepare them for self-reliance. Such communication would allow them to cope in a phaseout era, either by identifying new means of external support or taking over the responsibilities themselves.

Some stakeholders in Mexico's FP program complained that—as a result of mixed messages—they did not prepare for phaseout the way they should have because they did not believe it was coming to an end. Although there is disagreement among interviewees as to whether or not clear messages were sent, future phaseouts will benefit from clear communication regarding the timing and expectations of phaseout.

E. POLITICAL WILL AND COMMITMENT

Advocacy plays an important role in garnering support from governments at all levels and is an important component of a phaseout plan.

In the absence of a firm understanding of the importance of family planning, decisionmakers at all levels may not understand the importance of investing in family planning. Even when support for family planning is strong, support does not always result in sufficient government financial commitment, due to competing priorities both within and outside the health sector.

In Mexico, after decentralization, a concerted effort to raise awareness for family planning among state

government leaders would have benefited the phaseout process. However, it was not until the end of phaseout that donors and collaborating agencies started using advocacy as a tool to garner support from state-level and national decisionmakers. Until then, advocacy was limited to IEC activities. After phaseout, however, advocacy activities have been used to instigate important changes in the regulatory structure of the FP program.

In future phaseouts, broadening the role of advocacy and bringing “policy champions” to the table in the planning stage of phaseout could help strengthen government commitment, and in turn help improve program sustainability.

F. FINANCING

Donors should work with governments to reexamine the impact of policies that encourage free-for-all approaches to publicly provided services. In theory, policies that mandate free contraceptives promote equal access for all citizens, but in reality, governments are often unable to live up to these promises. In resource-constrained environments, it is often difficult to commit to providing free contraceptives. For this reason governments are introducing alternative financing mechanisms and policies that improve financial access. For example, in Mexico, improved collaboration with the private sector and examination of pricing strategies could result in expansion of the NGO sector, thereby decreasing the financial burden on the government by shifting users to the NGO sector.

Strategies for improving financing need to be developed with close consideration of the environmental context of a country. For example, some countries may benefit from introducing targeted strategies that direct resources for family planning to those most in need. Market segmentation studies can help identify appropriate market niches and pricing strategies for each organization and can help determine whether policies promote access to family planning.

G. CAPACITY BUILDING TO PROMOTE SUSTAINABILITY

Donors should attempt to institutionalize technical capacity for independent procurement. Transitioning to independent procurement has been cited as one of the most challenging aspects of phaseout. Most institutions in Mexico that sought to purchase contraceptives from the domestic commercial market immediately after phaseout experienced considerable difficulty. They were not prepared or well-equipped to negotiate acceptable procurement arrangements, especially at the state level, because they had not received adequate training for procurements. Instead, they used a trial-and-error approach.

According to one respondent, donors could have supported training programs to better assist states with forecasting and budgeting. In addition, the introduction of a database would have facilitated the procurement process (Personal communication, SSA). As noted by one interviewee, most of the learning took place after phaseout:

“Procurement of contraceptives has ...been a very difficult problem...It was done but there was a big shortage until the consolidated purchase within the Health Secretariat was organized...in [1999]. [The] learning process all took place after 1999. My point is that ... when the USAID memorandum terminated, the states were disorganized and the federal level had no control.”

—interviewee from Pathfinder

H. RESEARCH AND EVALUATION

Donors should earmark phaseout funding for post-phaseout research and monitoring and evaluation activities. There is a great need to institutionalize research skills and the use of research results to inform service and program

design, so that program design and evaluation are based on sound, reliable, up-to-date data, specific to the populations being served. Donor-dependent countries making the transition to self-reliance would benefit from having funding in place to conduct a national survey, since funding for research often is one of the first activities to be cut when donors withdraw assistance. Including funding for a national reproductive health survey in a phaseout plan would benefit organizations as they evaluate and plan FP programs.

I. "READINESS" OF PHASEOUT

There are multiple criteria for deciding when a country program is ready for phaseout and these criteria may vary between countries and over time. A number of factors weigh into the decision to phaseout support for family planning in a country. Although this study did not address the reasons for phaseout of FP support in Mexico, interviewees provided insight on factors affecting the decision to phaseout. The decision to phaseout is most often based on a combination of political, financial, and sociodemographic factors. Ideally, a country situation analysis is conducted, but other factors also carry considerable weight.

The factors affecting the decision to phaseout support to Mexico's FP program were never articulated specifically. Based on interviews in the case study, the decision was most likely influenced by a combination of Mexico's relatively high per capita income; longstanding political support to the FP program by government and general population; relatively "good" FP program indicators; political pressure from the U.S. Congress to reduce population activities; budget cuts from USAID; and competing priorities affecting donor funding, such as the HIV/AIDS epidemic and other health emergencies. It also appears that the government of Mexico signaled to the U.S. government that it was

ready to move forward without assistance. These were all important factors affecting USAID's decision to phaseout. The judgment of "readiness" may vary across countries and even individuals, but such criteria provide some idea of how the decision to phaseout is calculated and may be useful in evaluating a program's readiness in the future.

J. KEEPING A POSITIVE ATTITUDE

Maintaining a positive attitude during phaseout is important. A positive attitude can help organizations bridge the transition between donor dependence and self-reliance. As with any process, a positive attitude can make a world of difference in overcoming obstacles. As one interviewee stated, phaseout was a process whose time had come and program leaders had the right frame of mind and attitude to make the transition, despite the challenges they encountered. Such a mindset will go a long way in helping organizations as they bridge the transition to independence.

"I don't think anyone is ever prepared for phaseout. Maintaining a positive attitude is very important."

—interviewee from FEMAP

A positive attitude and forward thinking, as the FEMAP interviewee noted, is paramount in Mexico's FP program's continued quest to achieve self-reliance. On balance, the evidence suggests that such forward thinking and a strategic mindset already are at play. Under such leadership, Mexico's national FP program is likely to continue to make positive strides.

Appendix A

Organizations Involved in Interview Process

(Names of individuals are not listed here to provide confidentiality)

Health Secretariat (SSA)
Pathfinder
IMSS-Solidaridad, Family Planning
MEXFAM
UNFPA
EngenderHealth, Mexico
USAID
IMSS, Family Planning Division
**ISSSTE, Department of Women's and
Family Health**
John Snow, Inc.
FEMAP Ciudad Juarez Hospital, FEMAP
Population Council, Mexico
CONAPO

Appendix B Overview of Organizations

PUBLIC SECTOR ORGANIZATIONS

National Population Council (CONAPO):

Established in 1974, CONAPO is an inter-institutional organization that coordinates the country's population and demographic planning and policies. According to Mexico's law on international support, CONAPO coordinated program planning for all organizations receiving support. During the period of USAID support, CONAPO served as a liaison between USAID and the public sector (including social security institutions) that it supported. It also played an important role conducting research, much of which was specific to family planning.

The Health Secretariat (SSA): The SSA serves as Mexico's health safety net by providing services to all individuals who do not have formal health coverage. Within the SSA sits the General Directorate of Reproductive Health (DGSR), formerly the General Directorate of Family Planning. The DGSR was one of the key players involved in the planning and implementation of Mexico's phaseout plan in the public sector. Until 1991, 100 percent of SSA's commodities were donated by USAID.

Mexican Social Security Institution (IMSS):

IMSS is the larger of the two social security organizations and serves a greater number of people than any other organization in the country. It functions through two operational systems. IMSS Régimen Ordinario (IMSS/RO) offers health services to the privately employed and federal employees in urban areas, while IMSS/Solidaridad (IMSS/S), now called IMSS/Oportunidades, offers health services to uninsured people in urban and rural areas. The objective of the IMSS/S program is to serve the marginalized population in the least developed states. The program provides primary care to 11 million people in 17 states, roughly 30 percent of the population. Ninety percent of the program's clients are indigenous agricultural workers, comprising 46 different ethnic groups.

Institute for Social Services and Security for

State Workers (ISSSTE): ISSSTE is another social security institution providing services for state and federal employees and teachers. Workers are entitled to purchase any health service covered by insurance, including contraceptives and FP services. Employees pay a monthly fee of 2 percent of their salary as employee contributions and additional funding comes from the government (Personal communication, ISSSTE).

NGO SECTOR

MEXFAM. Established in 1965, MEXFAM is the Mexican affiliate of the International Planned Parenthood Federation. Since 1984, MEXFAM has been offering FP services in the poor areas of 32 cities and indigenous regions. Prior to phaseout, it depended on a wide range of donors to meet its program needs.

MEXFAM works through six programs. The community doctors program, the rural community-based distribution program (CBD), the industrial program, and the youth program are referred to as the "social programs" because they all serve social welfare ends. The collaborative program (formerly called PAI, or program of institutional support) serves both political and service-delivery ends. The sixth program is service delivery through medical centers, which generate income to cross-subsidize the social programs (Bowers et al., 1996). This structure has changed, since the major emphasis of the program now is on clinics and youth programs (Quesada et al., 2001).

FEMAP. Founded in 1973, FEMAP is a decentralized network of largely autonomous and self-reporting NGO family planning organizations. FEMAP operates in poor areas in 87 cities and thousands of rural communities. Before phaseout, there were 30 affiliates (Personal communication, FEMAP).

FEMAP relies on a community-based approach that allows its affiliates to establish themselves in the localities they serve. Affiliates are self-financing, which FEMAP achieves through careful cost control, cost recovery, and income generation (Quesada et al., 2001). FEMAP and its affiliates provide a range of services: family planning services to factory workers; hospital and outpatient care; community-based distribution of contracep-

tives; HIV/AIDS prevention; youth programs; and research and training on issues relevant to poor communities.

Although it targeted low-income groups, FEMAP still managed to be one of the least donor-dependent organizations, with USAID being its only source of international support at the time of phaseout.

Appendix C Phaseout Design

The program document outlined these phaseout activities in the public sector:

Family planning service delivery. By training health workers, the parties to the MOU aimed to increase access to the most effective methods and improve quality of services.

Expansion of family planning and reproductive health (RH) service-delivery capacity in rural areas. By incorporating different types of community personnel, the parties to the MOU aimed to increase capacity of health personnel in rural areas and among indigenous groups.

IEC activities. By increasing and intensifying reproductive health and family planning IEC activities, the parties to the MOU aimed to reach “hard-to-reach” groups.

Research. By conducting research on contraceptive methods, the parties to the MOU aimed to increase the range of methods available. They also planned to support demographic studies and operations research.

The major objectives of the NGO sector included:

- increasing access to family planning services
- broadening the range of contraceptive methods available in skewed method mix settings
- strengthening institutional capacity of MEXFAM and FEMAP
- developing strategies to improve and expand services²¹ (Bowers et al., 1996)
- evaluating performance and impact of programs
- documenting and disseminating lessons learned

²¹ A USAID management review in December 1993 concluded that service expansion was incompatible with sustainability and, at this point, the NGO phaseout project changed its service goal to “maintenance of service volume.”

Appendix D

MEXFAM Expenditures, 1995

MEXFAM Expenditures by Source, 1995

Source of Funds	US\$	% of Total Expenditures
USAID		
Transition Project	1,392,091	24
SOMARC	339,446	6
Value of USAID-donated contraceptives	227,764	4
Subtotal	1,959,301	34
Other Donors		
IPPF	1,903,613	33
Hewlett Packard Foundation	171,547	3
Other international donors	709,667	12
Subtotal	2,784,827	48
Locally generated	1,069,601	18
Total	5,813,729	100

Source: MEXFAM records, supplied during interview.

Appendix E Institutional Changes

CONAPO has undergone recent structural changes. Two general management divisions have become three general directorates, with changes in names and functions. Education and communication general directorates merged; population now has only one department; and, for the first time, CONAPO's structure incorporates the term "reproductive health" (Personal communication, CONAPO).

In 2003, CONAPO created the City Council for Population Policies—a council of civil society and academic organizations, as well as some international organizations—to support dialogue and guide the policy debate on population, with the overall objective of enhancing the performance of the National Program on Population. This change was made in response to the decrease in attention and funding for family planning that was evident after phaseout.

SSA also underwent restructuring during phaseout. After ICPD in 1994, the DGSR was created to merge the family planning and MCH management units. A more recent reorganization is underway with the SSA now. The DGSR will be eliminated, although the process has been on hold for some time while the government finalizes decisions about the new structure. A new coordination unit may be established, but at the time of this study it was not entirely clear where reproductive health will fall within the new organization. It may be within the broader context of a women's care unit, focusing on health (Personal communication, EngenderHealth).

IMSS has suffered significant staff reductions since phaseout. IMSS personnel are now responsible for establishing norms but are no longer involved in supervisory activities or technical support. These responsibilities have been shifted to medical units at the delegation level, where there is an RH team made up of a doctor, nurse, and social worker. This RH team is tasked with overseeing performance of the delegations, reporting to the central

level, coordinating the units, supervising, providing technical assistance, and conducting medical training.

IMSS/S personnel changes were minor because it never completely depended on USAID for its operation. It received USAID support indirectly through IMSS until 1996, when USAID began to provide direct funding. Since phaseout, IMSS/S has eliminated some USAID-funded personnel responsible for training and operations.

ISSSTE was forced to downsize substantially in response to funding reductions during phaseout; since 1993 the number of people working in family planning at the central level has decreased from 25 to three. These three employees are responsible for the entire health program, leaving them insufficient time to dedicate to family planning. Similar reductions have taken place in the ISSSTE delegations. These cuts have been most severe in supervision and monitoring and evaluation functions, again because many of the supervisory activities were partially donor-funded (Personal communication, ISSSTE). Although phaseout undoubtedly had a negative impact on ISSSTE, the dramatic changes that ensued can be attributed in part to the financial crisis, which affected ISSSTE more severely than other organizations because ISSSTE was one of the weaker organizations to begin with. These events coincided, leaving ISSSTE no choice but to reduce its central area of coordination.

FEMAP underwent some administrative changes, mainly at the level of community programs, and used downsizing as a way of becoming more efficient. Specific projects that had once required additional personnel had ended and high staffing levels were no longer necessary.

MEXFAM has shifted its focus toward clinical services since phaseout. To improve supervision of activities and personnel, MEXFAM reorganized its operational structure into five regions, with a manager of clinical services in each region (Personal communication, MEXFAM). MEXFAM also began to work with adolescents and youth in addition to the general population.

Appendix F

Challenges of Consolidated Procurements

Despite the advantages of consolidated procurements, challenges have arisen that the SSA did not foresee before commencing this process. As one respondent described, “We didn’t have the slightest idea of what we were getting into when we started because we thought it was very easy” (Personal communication, MEXFAM). Some of these obstacles still present a challenge, while others have been circumvented. These challenges include:

Advance purchases. Payment for procurements is required in full, in advance of the purchase. However, states do not receive their full budget in advance and cannot always predict the size or timing of their funding, thus states often did not have the financial resources to make payments in advance. This was not a problem in the NGO sector because FEMAP and MEXFAM had their own resource base and did not require upfront payments from their affiliates.

Legislation around documentation of expenses. To make payments for products or services, a tax receipt must be presented to the government. This is a legal requirement for any expense incurred at the federal or state levels. Since UNFPA could not legally provide a commercial receipt, states lobbied their legislative bodies to accept a copy of the importation invoice as proof of purchase, thereby overcoming this regulatory barrier.

Long delays. There are numerous administrative procedures, at the national and international levels, governing the consolidated procurement. These procedures have resulted in delays between ordering and distribution of contraceptives. For example, international quality controls are performed by the general directorate and UNFPA, and domestic quality controls are carried out by the Health Department. The Secretariat of Health needs to authorize all labels on contraceptives and, after authorization, products need to be registered by the Federal Committee of Protection Against Public

Health Risks (CONFETRIS). There are also administrative procedures that need to be carried out to allow products to clear customs. Complying with these formalities often results in extended delivery times (Personal communication, SSA). For new suppliers, these procedures take about eight months.

To overcome these barriers and ensure that the same procedures do not need to be repeated for each tender, international suppliers are now required to enroll in a national registry. However, there is a payment associated with this enrollment, which many suppliers are reluctant to make because there is no guarantee that it will be worthwhile.

Misconception of cost savings. During the first consolidated procurement, unanticipated delays caused states to spend more than they expected, since they were forced to make emergency purchases when contraceptive supplies were depleted. (When contraceptives finally were delivered in the amounts originally requested, states already had emergency supplies.)

In addition, there are additional costs that make international procurements less attractive than originally thought. These costs require further analysis. First of all, the bulk price does not include delivery to the states by the international supplier. The domestic market suppliers include these costs. UNFPA provides substantial savings (40–50%) on contraceptive products, but as one respondent from the case study stated, “When we add importation duties, customs duties, taxes, and the cost of storage and distribution, then ... costs are almost the same [as purchasing domestically]” (Personal communication, IMSS). Further analysis of the marginal costs of procuring internationally, relative to the domestic costs, is required to better understand the advantages and disadvantages of consolidated procurements.



Distribution problems. Initially, there were problems with the distribution of UNFPA’s consolidated supply in that “the whole procurement amount was received all together—it wasn’t divided per state... [O]ur own personnel had to go to the customs office to break up the order”

(Personal communication, SSA). This caused further delays and costs in the delivery of contraceptives to their respective destinations. The SSA did not have enough experience to anticipate this distribution problem.

Appendix G

Service Delivery in the NGOs

FEMAP Service Delivery, 1990–2001

Method	Pre-Phaseout (1990)	Phaseout (1992–1998)		Post-Phaseout (2000)	Latest Available Data (2002)
		1992	1997		
# of clinics	30	42		44	47
# of community doctors	-	7,000	8,200	-	-
# of new FP users	-	50,000	50,000	-	-

Source: Data from FEMAP taken during interviews

MEXFAM Service Delivery, 1990–2001

Method	Pre-Phaseout (1990)	Phaseout (1992–1998)			Post-Phaseout (2000)	Latest Available Data (2002)
		1992	1995	1998		
# of clinics	2	2	7	14	16	26
# of community doctors	-	316	350	250	-	-

Source: Data from MEXFAM taken during interviews



Bibliography

- Beamish, Julia. 1999. *USAID/Mexico Population, Family Planning and Reproductive Health Program 1992–1999*. Washington, DC: Measure Communication Project.
- Bowers, Gerard, Laurel Cobb, and Douglas Wear. 1996. *USAID/Mexico Population Assistance Program: Midterm Assessment of Private Sector Component*. Arlington, VA: POPTECH Project Report No. 96-072-038.
- Consejo Nacional de Poblacion (CONAPO). 1992. *Programa de Apoyo para Extender los Servicios de Planificación Familiar y Salud Reproductiva*. Mexico City: CONAPO.
- Consejo Nacional de Poblacion (CONAPO) website, Accessed November 20, 2004. <http://www.conapolgob.mx>
- Consejo Nacional de Poblacion (CONAPO). 2000. *Cuadernos de Salud Reproductiva: República Mexicana*. Mexico City: CONAPO.
- ENADID Encuesta Nacional de la Dinámica Demográfica, 1992. *Metodología y Tabulados*, INEGI: Aguascalientes.
- ENADID Encuesta Nacional de la Dinámica Demográfica, 1997. *Metodología y Tabulados*, INEGI: Aguascalientes.
- ENFES Ecueta Nacional de Fecundidad y Salud, 1987, SSA.
- Instituto Mexicano del Seguro Social. No date. “El Programa IMSS–Oportunidades.” PowerPoint presentation.
- Jaimes, Carlos Moreno. No date. “La descentralización del gasto en salud en México, una revisión de sus criterios de asignación.”
- Quesada, Nora, Sandhya Rao, and Steve Kinzett. 2001. *Mexico Contraceptive Logistics System (DGSR): Review of Accomplishments and Lessons Learned*. Arlington, Va.: Family Planning Logistics Management/John Snow, Inc.
- Quesada, Nora. 2000. *Mexico: Contraceptive Logistics System: Review of Accomplishments and Lessons Learned–Nongovernmental Organizations (1992–1999)*. Arlington, VA: Family Planning Logistics Management/John Snow, Inc.
- Secretaria de Salud, Mexico (SSA). 2005. “*Encuesta Nacional de Salud Reproductiva 2003: Principales resultados*”/“*National Reproductive Health Survey 2003: Principal Results*.” PowerPoint presentation.
- Secretary of Health, Mexico. 2001. *Programa de Acción: Salud Reproductiva*. First Edition. Mexico City: Ministry of Health.
- Seltzer, Judith R., Karen Johnson Lassner, and S. Ken Yamashita. 1996. *Midterm program review of the US-Mexico Program of Collaboration on Population and Reproductive Health*. Arlington, VA: POPTECH Project Report No. 96-083-49.
- USAID Congressional Presentation 1997. Accessed November 30, 2004. <http://www.usaid.gov>
- United Nations Development Program website. Accessed December 21, 2004. <http://unstats.un.org/unsd/demographic/social/population.htm>
- UNFPA website. Accessed November 21, 2004. http://www.unfpa.org/swp/2003/presskit/pdf/indicators_eng.pdf
- World Bank. 1991. *World Development Report, 1991*. Washington, DC: World Bank.

