

Family Planning in  
**Mexico**

The Achievements  
of 50 Years

April 2015

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## Preface

This publication is one of eight case studies that were developed as part of a broader review entitled *Family Planning in Latin America and the Caribbean: the Achievements of 50 Years*. As its title implies, the larger review documents and analyzes the accomplishments in the entire region since the initiation of U.S. Agency for International Development (USAID) funding in the early 1960s. The reader of this case study may wish to access the executive summary or the report in its entirety at:

<http://www.cpc.unc.edu/measure/publications/tr-15-101>

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## OVERVIEW

### COUNTRY SITUATION

Mexico's estimated 2014 population of 119.7 million makes it the second largest country in Latin America after Brazil.<sup>1</sup> The United Mexican States (commonly called Mexico) includes 31 states and the Federal District (Mexico City), the seat of the federal government. Mexico City has a population of approximately 20 million and is the largest city in Latin America, and one of the largest cities in the world. Seventy-eight percent of the Mexican population is urban.<sup>2</sup>

The Mexican economy is the second largest in the Latin American region and is closely tied to that of the United States. Despite this proximity, Mexico experienced only a relatively short downturn in 2008-2009 related to the world financial crisis. However, the H1N1 epidemic greatly affected the country in 2009, and had a negative economic impact.<sup>3</sup> This downturn has since reversed, and the economy appears to be on a modestly positive trend. Growth in gross domestic product (GDP) has remained fairly stable at around 3 percent per year in recent years. It grew by 3.9 percent in 2012, but at a slightly a slower pace (1.7 percent) in 2013.<sup>4</sup> Since the beginning of President Enrique Peña Nieto's administration in 2012, many reforms have been made in energy, fiscal policies, and labor market and financial sector regulations that have affected the overall economic health of the country.<sup>5</sup>

Mexico is an upper-middle income country according to the World Bank; however, the country has a highly unequal distribution of wealth.<sup>6</sup> While national indicators of health and well-being have shown marked improvements in the last 20 years, there are huge differences in progress among states. In 2012, it was estimated that nearly half (45.5 percent) of the population was living in poverty, and approximately 9.8 percent were living in extreme poverty. Poverty rates are much higher among the indigenous populations; in 2012, 72.3 percent of indigenous people lived in poverty or extreme poverty.<sup>7</sup> There is some encouraging evidence that poverty among the indigenous populations is declining at rates faster than among the general population.<sup>8</sup>

Mexico faces particular challenges related to its long border with the United States; every year hundreds of thousands of migrants pass through Mexico on their way to the U.S. Some remain in the U.S. and others eventually come back to Mexico. The Mexican cities on the U.S. border face some of the worst problems of violence and drug-trafficking in the region.

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<sup>1</sup> Consejo Nacional de Población (CONAPO). *Datos y Proyecciones*. Mexico City, Mexico: CONAPO; 2014.

<sup>2</sup> Ibid.

<sup>3</sup> United Nations Children's Fund. *The Rights of Children and Adolescents in Mexico: A Present Day Agenda*. Geneva, Switzerland: UNICEF; 2009.

<sup>4</sup> World Bank. Country Overview-Mexico. Washington DC: World Bank; 2013. Retrieved from: <http://www.worldbank.org/en/country/mexico/overview>

<sup>5</sup> Ibid.

<sup>6</sup> World Bank. *México*. Washington, DC: World Bank; 2014.

<sup>7</sup> Consejo Nacional de Evaluación de la Política de Desarrollo Social (CONEVAL). *CONEVAL Informa los Resultados de la Medición de Pobreza 2012*. [Comunicado de Prensa No. 003.] Mexico City, Mexico: CONEVAL; 2013.

<sup>8</sup> Moreno-García V, Patrinos H. *Indigenous Peoples and Poverty in Mexico*. [Indigenous Peoples Country Brief; No. 7.] Washington, DC: World Bank; 2011.

Mexico provides an example of a country that has translated its economic progress into solid achievements in the health arena, including in family planning (FP). Stable institutions and a strong government commitment to reproductive health for several decades have resulted in a robust family planning program.

Table 1 shows the impressive achievements of the Mexican FP program since 1987. Overall contraceptive prevalence rates (CPR) increased approximately 20 percentage points, from 52.7 percent in 1987 to 72.5 percent in 2009. The rate of growth in contraceptive prevalence during this period was an impressive 1.2 percentage points per year; the fastest period of growth (1.7 percentage points per year) occurred from 1997 to 2003. The total fertility rate (TFR) declined from 4.0 children per woman in 1987 to 2.3 in 2009.

Modern contraceptive prevalence rates (MCPR) increased from 44.6 percent in 1987 to 63.7 percent in 2009. During this period, MCPR peaked in 2003 at 69.3 percent, and declined to 63.7 percent in 2009. Local experts attribute the slight decline in MCPR to various factors, including less attention to FP in the poorest states and persistent stock-outs of FP methods in the public sector.

The percentage of women with unmet need for family planning of 9.8 percent is relatively low by international standards. According to the 2009 Encuesta Nacional de Dinámica Demográfica (ENADID, National Demographic Survey), there continues to be a sharp differential in unmet need between rural (15.9 percent) and urban areas (8.1 percent).<sup>9</sup>

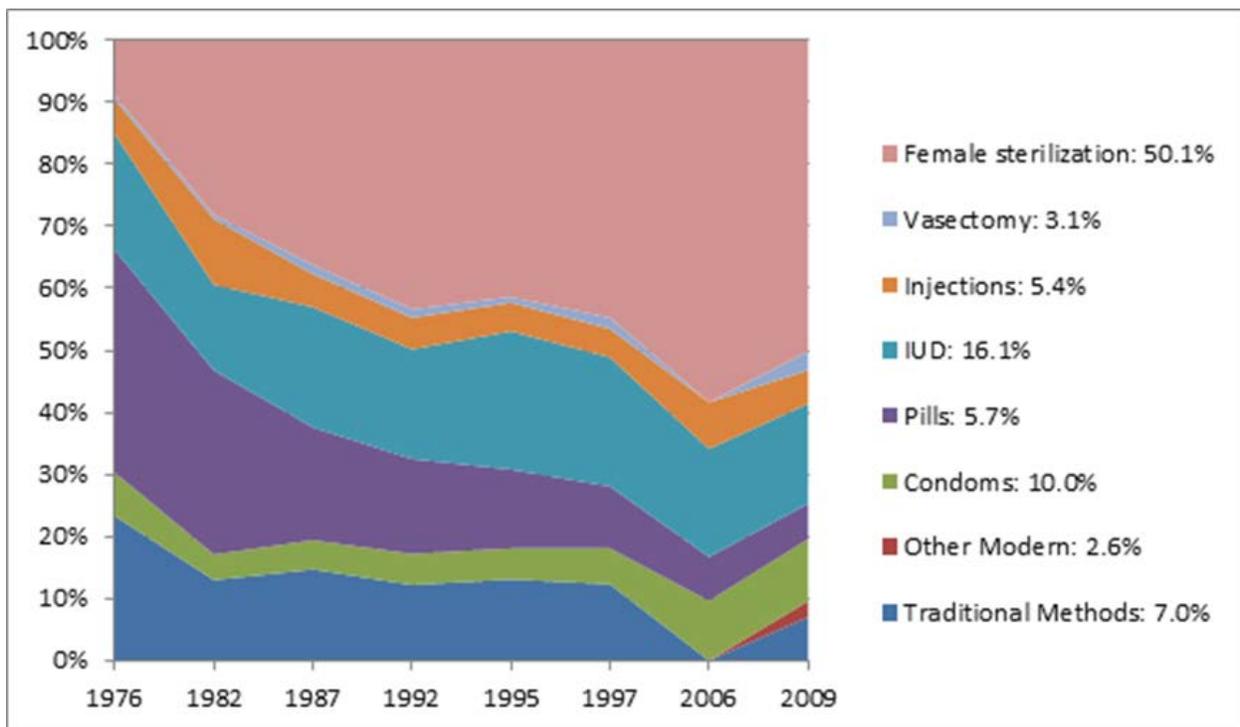
**Table 1: Trends in Fertility, Contraceptive Use, and Unmet Need for Women Married/in-Union Aged 15-49, Mexico, 1987-2009**

	1987	1992	1995	1997	2003-05	2006-08	2009
Total Fertility Rate	4.0	3.2	2.9	2.8	2.4	2.3	2.3
Contraceptive Prevalence Rate (%)	52.7	63.1	66.5	68.5	73.7	70.9	72.5
Modern Contraceptive Prevalence Rate (%)	44.6	50.9	53.4	56.2	69.3	66.5	63.7
Unmet Need (%)	-	-	16.1	12.1	9.9	12.0	9.8

Source: ENSF 1987; ENPF 1995; ENADID 1992, 1997, 2003, 2006, 2009. The data presented in this table were obtained through DHS Statcompiler for 1987 only. Data on 1992, 1995, 1997, 2003-05, 2006-08, and 2009 were not available in Statcompiler and instead were obtained directly from the national Web sites of the local agency conducting the survey.

<sup>9</sup> Urbina Fuentes M. El Programa de Anticoncepción en México en los Últimos 12 Años: ‘Back to the Future.’ 15<sup>th</sup> Congreso de Investigación en Salud Pública; 2013.

In 2009, approximately half (50.1 percent) of married women using contraception had undergone female sterilization; high levels of use of this method dates back to the mid-1990s. A rate of 50 percent or more is considered “skewed” in international comparisons.<sup>10</sup> Method skew refers to a high level of reliance on a single method. This may be potentially problematic as it may indicate that women do not have access to a wide range of methods due to supply issues or provider promotion of specific methods. A second concern is that reliance on a single method increases the program’s vulnerability to procurement problems related to that method. However, since a broad range of family planning methods are available, the heavy reliance on female sterilization may reflect cultural and other factors. Based on 2009 data, the intrauterine device (IUD) was the next most popular method (16.1 percent), followed by condoms (10.0 percent). Among women under the age of 25, condoms were the most popular method, followed closely by the IUD (figure 1). In 2009, only 5.4 percent of the population used injectable contraception, a relatively low proportion for Latin America, although use of injectables was considerably higher in rural areas (9.1 percent). Use of traditional family planning methods declined from 12.3 percent in 1997 to 7.0 percent in 2009.



Source: ENSF 1987; ENPF 1995; ENADID 1992, 1997, 2003, 2006, 2009.

Note: Percentages at right of the legend are for 2009 data only. The percentages in the legend refer to the most recent survey (2009)

**Figure 1: Method mix (Mexico, 1976-2009).**

<sup>10</sup>Bertrand JT, Sullivan T, Knowles EA, Zeeshan MF, Shelton J. Contraceptive method skew in low- and middle-income countries: continuing concerns despite modest improvement. *Intern Perspect Sexl Reprod Health*. In press.

## Adolescents

Key informants and policy makers interviewed agree that adolescent pregnancy remains a troubling issue in Mexico. While TFR declined markedly for all married women of reproductive age (MWRA) as shown above, the adolescent birthrate (ABR) among girls aged 15-19 increased from 84.6 per 1,000 in 1998 to 87.4 per 1,000 in 2008.<sup>11</sup> However, there are some discrepancies; government statistics reported to the World Bank indicate an ABR of 67 for 2009 and an ABR of 63 for 2012.<sup>12</sup> Other data suggest that adolescent pregnancy remains a problem. At the time of the 2010 Census, 6.6 percent of all girls 15-17 years old and 19.2 percent of all girls 18-19 years old were pregnant or had a child.<sup>13</sup> Furthermore, girls were having slightly more births in 2010 than in 2000 at each separate age in the range from 15 to 19, suggesting that the cause of the increase in adolescent pregnancies is not earlier age at first motherhood.<sup>14</sup> Girls with lower educational levels and lower socioeconomic status are more likely to become mothers at an earlier age. While only 4.3 percent of girls in the highest income quintile become mothers before the age of 20, this figure is three times higher (12.1 percent) for girls in the lowest income quintile.<sup>15</sup>

## Indigenous Populations

Approximately 8 percent of the population (9.1 million) self-identify as indigenous according to the most recent census.<sup>16</sup> The indigenous population of Mexico remains the most marginalized ethnic group in the country. While data on health and social indicators for indigenous populations are not available, the states with large indigenous populations (over 12 percent indigenous) – Chiapas, Oaxaca and Veracruz – have social and health indicators that are much worse than those of the wealthier states. For instance, the maternal mortality ratio for those states is four times that of MMR in the states with next highest MMR (Nueva Leon and Coahuila).<sup>17</sup> Indigenous women are three times more likely to die in childbirth than non-indigenous women.<sup>18</sup>

Modern contraceptive use among indigenous women (defined as women who speak an indigenous language) was 58.3 percent compared to 73.5 among non-indigenous women as of 2009. Unmet need for contraception was 21.5 percent among indigenous women as compared to

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<sup>11</sup> United Nations Economic Commission for Latin America and the Caribbean (CEPAL). *CEPALSTAT—Tasa de Fecundidad Adolescente (1990-2008)*. Santiago, Chile: CEPAL; 2013.

<sup>12</sup> World Bank. *Population Dynamics by Country and Group*. Washington, DC: World Bank; 2012.

<sup>13</sup> Instituto Mexicano de la Juventud. *Encuesta Nacional de Juventud 2010—Resultados Generales*. Mexico City, Mexico: Instituto Mexicano de la Juventud; 2011.

<sup>14</sup> Rodríguez Vignoi J. *Reproducción Adolescente y Desigualdades en América Latina y el Caribe: Un Llamado a la Reflexión y a la Acción*. Santiago, Chile: Latin American and Caribbean Demographic Centre (CELADE); 2009.

<sup>15</sup> Ibid.

<sup>16</sup> Instituto Nacional de Estadística y Geografía. *Perfil sociodemográfico Estados Unidos Mexicanos. Censo de Población y Vivienda 2010*. México City, Mexico: Instituto Nacional de Estadística y Geografía; 2010.

<sup>17</sup> Freyermuth Enciso G. *Mortalidad materna. Inequidad institucional y desigualdad entre mujeres*. Centro de Estudios e Investigaciones Superiores (CIESAS) y Comisión Nacional de Evaluación (CONEVAL), México; 2010.

<sup>18</sup> Maternal Health in Mexico: A Perilous Journey. *The Economist*, June 24, 2010. London Economist Newspaper Limited, 8688, 55.

9.0 percent for non-indigenous women. Furthermore, over 30.7 percent of indigenous women in union reported never having used a contraceptive, compared to only 12.8 percent among non-indigenous women.<sup>19</sup>

## THE EARLY YEARS (1960–1980)

From the earliest days, Mexican professionals were leaders in the family planning movement despite a pronatalist population policy, which was in place from 1947 until the early 1970s.<sup>20</sup> In fact, the first contraceptive pill was synthesized in 1951 from hormones from Mexican yams; however, the inventor Carl Djerassi did not have the equipment to test, produce, or distribute it.<sup>21</sup>

Organized private sector family planning efforts began in 1958 with the establishment of the Pro-Maternal Health Association (APROSAM), followed a few years later (1965) by the Foundation for Population Studies (FEPAC). FEPAC, now known as MEXFAM, became the International Planned Parenthood Federation (IPPF) member association in 1967. Both organizations combined research on contraceptive method effectiveness and acceptability with service provision. Research was an important part of the program from the earliest days. A 1964 study of contraceptive prevalence in Mexico City found that approximately one out of every four women in union (25 percent) was using some form of contraception (mostly rhythm, withdrawal, or a combination of vaginal douches).<sup>22</sup>

The U.S. Agency for International Development (USAID) did not have an office in Mexico during the earliest days of the country's family planning movement. USAID supported some development activities in Mexico between 1951 and 1964, but was asked to leave in 1965, when its involvement in Mexico's development efforts was deemed inconsistent with the Mexican government's independent stance towards development. By the time USAID returned in 1977, family planning was fairly well-established in both the private and public sectors.<sup>23</sup>

Although USAID closed its Mexico office in 1965, USAID's training programs still impacted the Mexican family planning programs of the early 1970s. In 1973, dozens of leading doctors and academics from Mexico's top medical schools attended training on population and family planning sponsored by USAID. These people became strong advocates of the population law passed in 1973, and the official population policy issued a year later.<sup>24</sup>

The first dedicated family planning program in the public sector was initiated by the National Nutritional Institute in 1968. Several of the larger health agencies such as the Instituto Mexicano

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<sup>19</sup> Mendoza Victorino D, Hernandez Lopez MF, Valencia Rodriguez JA. Perfil de la Salud Reproductiva de la República Mexicana. *La Situación Demográfica de México 2011*. Mexico City, Mexico: Consejo Nacional de población; 2011.

<sup>20</sup> Nagel JS. 1978. Mexico's population policy turnaround. *Pop Bull.* 1978. 33(5):1-40.

<sup>21</sup> Nikolchev A. A brief history of the birth control pill. *Need to Know on PBS*. Washington, DC: Public Broadcasting Service; May 7, 2012.

<sup>22</sup> Reartes D, Freyermuth G. Programa salud sexual y reproductiva para adolescentes [unpublished manuscript]. 2011.

<sup>23</sup> Bowers G, Danart A. An informal history of USAID/Mexico, 1977-2003 [unpublished manuscript]. 2005.

<sup>24</sup> Bowers & Danart, 2005.

de Seguro Social (IMSS, Social Security Institute) and what is now the Secretaría de Salud (SSA, Secretariat for Health) began offering family planning services in 1972 when Mexico's first National Family Planning Program was officially created. In 1974, Mexico adopted an antenatalist population policy and simultaneously established the Consejo Nacional de Población (CONAPO, National Population Council). CONAPO was an inter-institutional government-led organization that became a powerful force in the country. This coalition of government and nongovernmental organizations (NGOs) developed the demographic goals, objectives, and targets for Mexico's national development plans. It also conducted research on population-related issues. In addition, CONAPO provided technical assistance and support to both private and public sector programs in service delivery and promotion of family planning.<sup>25</sup>

Mexico had one of the earliest community-based distribution (CBD) programs (initiated by the public sector in 1973).<sup>26</sup> Community promoters provided information, barrier methods, and referrals to clinical services.

By the late 1970s, some Mexican programs were providing services to adolescents. In 1978, the Centro de Orientación para Adolescentes (CORA, The Center for Orientation of Adolescents) was founded to address the lack of sexuality education for adolescents within a culturally sensitive framework. With USAID support, CORA became a regional leader in the adolescent field.<sup>27</sup> CORA's programming emphasized the value of educating young people and their parents or guardians at the same time. This nonprofit began as one pilot center in Mexico City, providing a range of sexual health services to youth. In 1983, CORA refocused on research, training, advising, and materials development on adolescent sexual health. During this time, CORA continued providing services and developing innovative programs such as youth community theatre on pertinent sexual health topics.<sup>28</sup>

Although USAID was not directly funding the rapid expansion of family planning programming that occurred in the wake of the 1974 population policy, many cooperating agencies (CAs) used USAID funding to conduct population-related activities in Mexico with the tacit approval of the Mexican government. These activities included both training and contraceptive donations. In 1977, several U.S.-based CAs accepted significant increases in USAID funding to expand population activities in Mexico (as well as Brazil and Colombia), and a full-time population representative was assigned to the U.S. embassy in Mexico. Despite initial U.S. embassy fears that family planning was too controversial a subject, the population representative worked closely with the Mexican family planning leadership without reprisals from opposition groups. In order to minimize the risk of controversy, a senior-level population committee, chaired by the

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<sup>25</sup> Reartes & Freyermuth, 2011.

<sup>26</sup> Freyermuth Enciso, G. La política de planificación familiar en México. CIESAS Sureste; 1996.

<sup>27</sup> Santos Preciado JI. La salud de adolescentes: cambio de paradigma de un enfoque de daños a la salud al de estilos de vida sana. *Salud Pública de México*. 2003. 45(suppl 1):S5-S7.

<sup>28</sup> Monroy de Velasco A. 1984. C.O.R.A.: una experiencia Latinoamericana de integrar la orientación sexual en la atención de la salud de los adolescentes. *Salud Sexualidad y Adolescencia: Guía Práctica para Integrar la Orientación Sexual en la Atención de Salud a los Adolescentes*. México: Centro de Orientación para Adolescentes; 1984:1-20.

deputy chief of mission of the embassy, was formed to oversee population activities. By the late 1970s, the USAID mission was coordinating the work of over 20 CAs.<sup>29</sup>

CONAPO developed two major programs in the late 1970s, one on sexuality education and one on family planning. In 1976, 1978, and 1979, Mexico conducted large-scale national surveys on contraceptive prevalence and fertility; this was an unprecedented level of research activity for the region and reflected the immense importance given to demographic concerns in the country at that time. The government's National Family Planning Coordinating Agency, headed by a prominent researcher, was another important actor.<sup>30</sup>

One of the key factors contributing to the success of the Mexican program, as well as the programs in Brazil and Colombia, was that these countries all focused on strengthening their family planning programs during a period of robust support for family planning in the 1970s and early 1980s. The strong international interest in family planning in the 1970s and 1980s supported and nurtured Mexico's efforts. In the 1980s and 1990s attention began to shift to HIV/AIDs and safe motherhood in the region and globally.

## **CONSOLIDATION AND PHASE-OUT OF USAID (1981-2000)**

Consolidation of the program was well under way by the early 1980s, by which time the Mexican program was seen as a leader in the region. During the decade from 1976 to 1987, demographic and contraceptive use indicators changed radically in Mexico; average family size decreased from 4.5 to 3.8 children. Modern contraceptive method use increased dramatically, from 23.3 percent of MWRA to 44.6 percent in 1987.<sup>31</sup> Observers note that social norms around ideal family size and use of contraception also changed enormously.

In 1984, the prescient national family planning program (already highly successful) reorganized its program focus to include initiatives often recommended to developing countries in the current decade. The program:

- initiated services for youth;
- expanded rural services;
- promoted permanent methods, IUDs and injectables; and
- integrated family planning into primary health services.

USAID's population activities increased markedly in the country in the latter part of the 1980s. The program supported both the public sector family planning program in the key areas described above and private sector programs. Throughout the 1980s and 1990s, USAID contributed extensively to the Mexican family planning program by sending many Mexican officials, private sector managers, and doctors to the U.S. for short-term training. Mexican

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<sup>29</sup> Bowers & Danart, 2005.

<sup>30</sup> Reartes & Freyermuth, 2011.

<sup>31</sup> United Nations Department of Economic and Social Affairs, Population Division (UN). *World Contraceptive Use 2012*. New York, NY: UN; 2012.

institutions became training centers for family planning providers and leaders from other Latin American countries. Continuing to work through its CAs, USAID supported the expansion of NGOs and ensured that the government family planning program had an ample supply of contraceptives.

Strong inter-institutional collaboration has been a hallmark of the Mexican family planning program since the formation of CONAPO, although this was not easy to attain. In 1988, a new coordinating entity was formed, the Inter-Institutional Group for Family Planning, comprised of seven government entities and four large NGOs. This group attempted to coordinate work among the different agencies and began to develop state-level strategies separate from those at the national level. Furthermore, intersectoral work, especially with the education secretariat, ensured that accurate sexuality education was included in curricula at all levels of the educational system.

The Mexico program became one of the largest and most successful USAID-funded population programs worldwide by the late 1980s.<sup>32</sup> The latter part of the 1980s witnessed a large investment from USAID and coincided with a fully consolidated program at the national level. By 1989, USAID was funding over 20 CAs in Mexico that collectively were involved in over 50 population projects and were providing direct funding to 12 local NGOs.<sup>33</sup>

In 1989, the USAID mission in Mexico began discussions about how to ensure a successful phase-out of USAID assistance. When initial talks regarding phase-out began, the government was largely in agreement. In 1992, an agreement outlining a phased graduation process was signed. Some highlights of the agreement were that USAID would provide \$50 million dollars in support for the Mexican population program over five or six additional years, with annual contributions declining towards the end of the period. The Mexican government agreed to match that contribution with a gradually increasing level of resources.<sup>34</sup>

During the period from 1992 to 1999, USAID provided support in a variety of areas including: increasing access to public services; assistance in developing and implementing information, education, and communication (IEC) activities; and capacity building for managers and health care providers. This included training over 68,000 providers in service delivery norms and over 26,700 in counseling. In addition, CONAPO received technical assistance in a major mass media campaign, “Planifica, es cuestion de querer” (Planning your family, it’s a matter of wanting to). USAID also provided support for the development of over 14 million copies of 280 different communications materials.<sup>35</sup>

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<sup>32</sup> Bowers & Danart, 2005.

<sup>33</sup> Ibid.

<sup>34</sup> Ibid.

<sup>35</sup> USAID/Mexico. *Population, Family Planning and Reproductive Health Program 1992-1999*. Washington, DC: Population Reference Bureau; 2002.

Assistance in ensuring reproductive health supplies included continued commodity donations and technical assistance in logistics and supply chain management, but little assistance in procurement.<sup>36</sup>

The large private sector groups (FEMAP<sup>37</sup> and MEXFAM) were not as comfortable with the proposed graduation. Although both NGOs had been discussing sustainability strategies for some time, they both ran large programs that received substantial funding and contraceptive donations from USAID. They were thus at high risk of losing their principal revenue stream with no replacement in sight, and according to some local observers, initial discussions with USAID were somewhat contentious. A plan was developed to increase their sustainability (along with that of other large IPPF member associations). Through USAID's Transition Project, FEMAP and MEXFAM received increased levels of support and technical assistance to achieve sustainability in the period prior to graduation in 1999. This included using social marketing approaches for promoting products and services, diversifying the range of services provided, creating income-generation activities and strengthening management information systems.

For the private sector, the phase out from contraceptive procurement occurred between 1992 and 1998. The initial steps included training and technical assistance in supply chain management and subsequent phase out of all procurement and logistics support. Since MEXFAM was still receiving some USAID contraceptives and also had IPPF-donated contraceptives, it was able to fill specific gaps in contraceptives for the government programs during the initial phase.<sup>38</sup>

A USAID-funded evaluation<sup>39</sup> of the Mexico phase-out plan identified three principal strengths. First, the program reflected the priorities of the Mexican institutions. Second, it improved management capacity and led to increased donor support during the phase-out period. A third strength of the program was the strong IEC component that led to increased demand for contraception. The evaluation of the phase-out plan also pointed to several areas for improvement. First, due to donations from USAID and other donors, the government did not need to procure contraceptives during the phase-out period, so the Mexican institutions had not developed the capacity to do so. Further complicating the situation, during the phase-out, no assistance was provided to the states in forecasting and procurement strategies. In addition, the special programs for adolescents, rural, and indigenous populations, which began in the middle of the phase-out, had not been institutionalized and were discontinued.<sup>40</sup>

The public sector's graduation from USAID funding was widely hailed as a success for the country. By 1999, the Mexican government had assumed responsibility for the acquisition of contraceptives and management of its own programs. The United Nations Population Fund (UNFPA) assisted with some donated commodities during the first years, but the government

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<sup>36</sup> Alkenbrack S, Shepherd C. *Lessons Learned From Phaseout of Donor Support in a National Family Planning Program: the Case Of Mexico*. Washington, DC: The Policy Project; 2004.

<sup>37</sup> The Federación Mexicana de Salud y Desarrollo Comunitario, (FEMAP, Mexican Federation of Private Health and Community Development Associations) is a network of organizations based in Ciudad Juarez, Mexico that was one of the nonprofit pioneers in Mexico.

<sup>38</sup> Alkenbrack & Shepherd, 2004.

<sup>39</sup> Ibid.

<sup>40</sup> Ibid.

bore the major responsibility for procurement. As can be seen in table 1, MCPR continued to grow during the final years of phase-out and immediately after graduation, increasing more than 10 percentage points (between 1997 and 2003, the MCPR increased from 56.2 to 69.3).

The shift to a broader focus on sexual and reproductive health (SRH) as a human right began in Mexico in the early 1990s. Local observers note that there was some initial tension between the population community and the groups more interested in a broader approach to family planning and reproductive health. By the mid-1990s, these two groups were working together to shift the country's public and private sectors to a broader SRH focus.

## **POST-CONSOLIDATION/GRADUATION (2000-PRESENT)**

Many of the programmatic investments made during the phase-out period provided ongoing benefits to the program in the early 2000s. In addition to the carry-over of stock, the intensive systems development and capacity-building of the late 1990s provided the FP program with a solid foundation in the first years post phase-out. The government and private sector institutions that made up the family planning movement in Mexico were solid and had a number of leaders who had been trained by USAID projects. At the time of the phase-out in 1999, the Mexican family planning program was considered by many observers to be one of the strongest in Latin America.

Nonetheless, the family planning program faced many challenges in the aftermath of USAID's phase-out of assistance. The 1998 decentralization of health services to the states resulted in most of the health budget being turned over to the states. By 1999, states were responsible for managing over 70 percent of their health care budget. The Federal Health Secretariat retained control over the development of norms and policies. Resources for enforcing these policies were not available at the federal level. The states were responsible for nearly all aspects of training and program implementation.

In 2000, after 70 years of virtually unchallenged rule, the Partido Revolucionario Institucional (PRI, Institutional Revolutionary Party) lost power to the Partido de Acción Nacional (PAN, National Action Party), which governed until 2012. While still supportive of FP, the government had other priorities according to informants in the family planning movement. Globally, interest in family planning also waned as the HIV epidemic and the safe motherhood initiative became more central as health priorities.

External donor funding for a relatively wealthy country like Mexico became increasingly difficult to obtain in the 2000s. Observers note that those donors willing to fund sexual and reproductive health activities were more interested in innovation on the more cutting-edge aspects of reproductive health (new technologies, integration with HIV prevention and other health services, emergency contraception) and less likely to fund family planning service provision to the general population, expecting that domestic funding should cover those ongoing costs.

## FAMILY PLANNING AND THE HEALTH SYSTEM

### *Policies, Leadership, and Governance*

Mexico had pronatalist economic development policies dating from 1934, and the first General Law of Population promulgated in 1947 included language about the importance of population growth for development.<sup>41</sup> By the early 1970s, influential actors in the FP movement (many trained by USAID) began to hold sway with the Mexican government.<sup>42</sup> The Mexican Constitution was amended in 1972 to provide for “the right of every person to an informed, responsible and free decision about the number and spacing of their children” (Article 4). In addition, the General Health Law states that “family planning is a priority” (Article 27:12). It also mandates the provision of family planning information in both Spanish and indigenous languages (this last only in the indigenous areas). CONAPO was established to research and formulate population policies, and the Secretaría de Salud (SSA, Health Secretariat) was responsible for policy implementation.<sup>43</sup>

Mexico’s 1974 Population Policy was the most progressive in the region at the time, and the central government ensured its implementation throughout the country. Even before it was signed into law, the major institutions began to implement some of the policy’s mandates. In 1977, the National Family Planning Plan was approved, establishing specific goals and targets for family planning.

After the International Conference on Population and Development (ICPD) in 1994, the National Population Policy was updated with a broader vision of sexual and reproductive health as its centerpiece. This progressive policy states that the government “should contribute to [ensuring] that the Mexican population enjoys a satisfactory, healthy and risk-free sexual and reproductive life with complete respect for rights and liberty in decision making.”<sup>44</sup>

This post-ICPD approach was a welcome change for the women’s movement in Mexico, which hitherto had viewed the family planning community’s demographic motivations with suspicion. The demographic rationale of the Mexican family planning movement in the 1970s and 1980s with its rhetoric of “population control” did not resonate well with some feminist groups, whose leaders’ attitudes had been forged in the anti-imperialist left in Latin America. Feminist critiques pointed out that population control strategies did not include efforts to empower women and that most methods were provider-controlled. Feminists expressed concerns that the safety of contraceptive methods had not been fully assessed. The post-ICPD focus on human rights as a cornerstone for improved access to family planning and reproductive health united family planners and the women’s movement, which then began a slow process of coalition-building.

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<sup>41</sup> Nagel, 1978.

<sup>42</sup> Bowers & Danart, 2005.

<sup>43</sup> Freyermuth, 1996

<sup>44</sup> Ibid.

In the 2000s Mexican reproductive health and rights advocates organized to hold the government accountable for its commitments to providing SRH care. Mexican civil society ensures health rights in a variety of ways. A number of government and nongovernmental entities monitor adherence to health policies and publish their results. In efforts to be more transparent and accountable, the public sector health institutions have put much of their data online, including information on spending and coverage.

In the years after USAID phased out its support, the efforts of advocates have gone beyond monitoring existing commitments to changing policy related to sexual and reproductive health. A coalition of feminists, rights advocates, and the population community worked together to develop and pass legislation in 2007 decriminalizing abortion in Mexico City. Abortion is now available free-of-charge in government clinics there, although it remains highly restricted in other states.

### *Service Delivery*

In 2004, the Mexican health system identified universal health coverage as a principal goal of the Mexican health system. The four principal public institutions responsible for that coverage, and how family planning is included in the services they provide, are discussed below.

**Secretaría de Salud (SSA, Secretariat of Health)** — The SSA is responsible for governance of the health sector, including developing and implementing the norms and regulations for the entire health system. The SSA is responsible for 31 priority programs, the health information system, reporting, accountability, and most commodities purchases. When the government began a process of decentralization in the 1990s, the SSA’s role diminished as functions were transferred to state governments. However, in recent years some functions have been returned to the central SSA. The SSA coordinates an inter-institutional program for family planning, establishes FP norms, and is also the principal agency responsible for procurement of contraceptives at the federal level.<sup>45</sup> As can be seen in figure 2, 24.3 percent of sexually active women obtain their contraceptives from the SSA. The SSA also has a mandate to provide free or low-cost health care to anyone not covered through other agencies in the health system or who cannot afford health care from the private sector. The SSA runs the Seguro Popular, which provides health services to the poorest sectors of the population through a variety of external providers (an additional 7.9 percent of users reported obtaining contraceptives through the Seguro Popular).

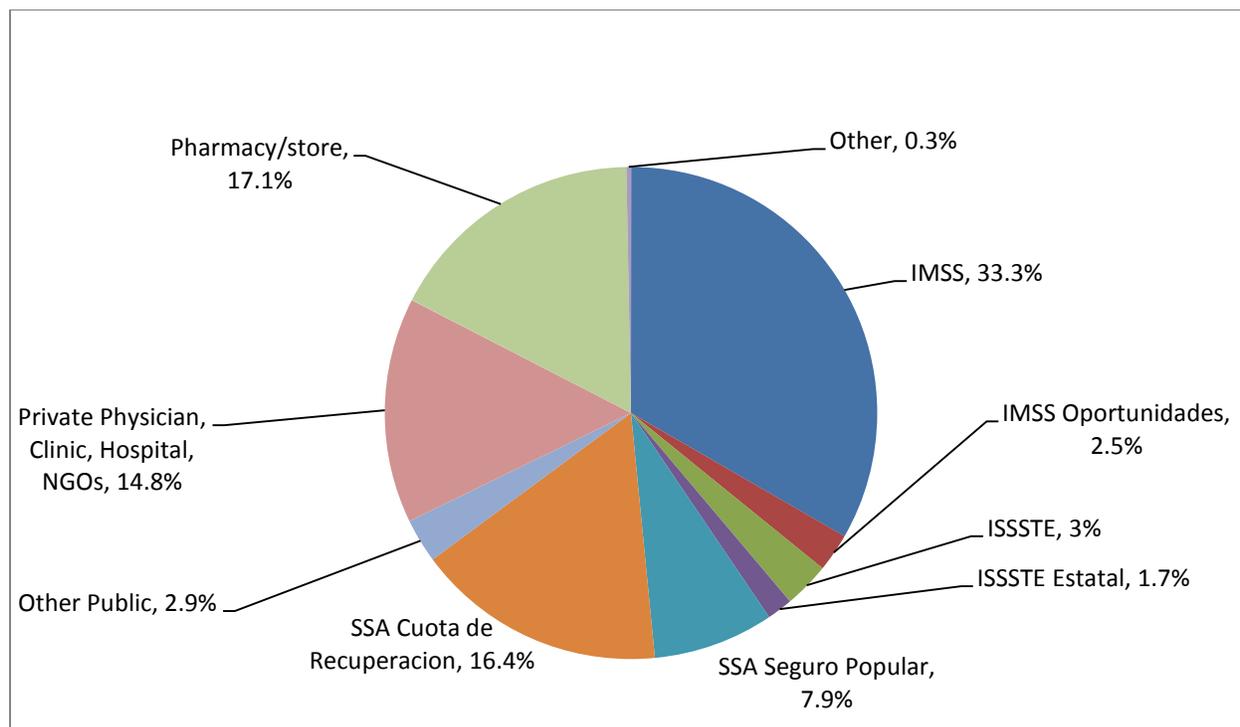
**Instituto Mexicano de Seguro Social (IMSS, Mexican Social Security Institute)** — The IMSS provides health coverage to non-governmental, formal sector workers. The IMSS is the largest provider of FP services; 33.3 percent of users report obtaining their contraception from IMSS services.

**IMSS-Oportunidades (IMSS Opportunity, formerly IMSS/Solidaridad)** — The IMSS provides services to the poorest sectors of Mexican society through its IMSS-Oportunidades

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<sup>45</sup> Instituto Nacional de las Mujeres. *Monitoreo de la Atención a las Mujeres en Servicios Públicos de Sector Salud*. Mexica City, Mexico: Centro de Investigaciones y Estudios Superiores en Antropología Social; 2011.

program. IMSS-Oportunidades provides conditional cash transfers to poor families that meet specific conditions. The conditions of the program are complex and include the use of prenatal and delivery care, as well as several infant and child-related services. Family planning is included in the program as a free service and providers are required to offer FP, but FP is not a condition for receiving transfers. Figure 2 shows that the IMSS Oportunidades program provides only 2.5 percent of users with contraceptive services.



Source: ENADID, 2009.

**Figure 2: Method source (Mexico, 2009).**

**Instituto de Salud, Seguridad Social y Servicios para Trabajadores Estatales (ISSSTE, Institute of Health, Social Security and Services for State Workers)** — As its name implies, the ISSSTE provides health coverage and administers social security benefits for government workers. This agency provides contraceptives to only 4.7 percent of all users.

In addition to the four institutions of the health system described above, the Sistema Nacional para el Desarrollo Integral de la Familia (SNDIF, National System for Integral Family Development) also provides information and education through the Family Planning and Reproductive Health Program. It covers the contraceptive needs of 3.7 percent of women in union. In addition, the armed forces, the national petroleum agency (PEMEX) and all governmental and parastatal agencies include family planning as part of the health services offered.

The public health system (SSA, IMSS, ISSSTE, others) provides free contraceptives to 67.7 percent of sexually active women who use contraception. The nonprofit sector (NGOs such as

MEXFAM and FEMAP) and small private physicians' clinics provide 14.8 percent, while pharmacies provide contraceptives for 17.1 percent of users.

In the most socio-economically deprived states (Chiapas, Guerrero, and Oaxaca) the public sector provides approximately three-quarters of users (76.3 percent) with contraceptives while the private sector provides the remainder. In the states with the lowest rates of poverty (Baja California, Coahuila, the Federal District, Nueva Leon) the public sector provides only 58.3 percent of the population with contraceptives and 41.7 percent obtain them from the private sector.<sup>46</sup>

State health institutions have provided integrated reproductive health services for adolescents aged 15-19 since 1995. A law passed in 2009 ensured that such services to youth are free in Mexico City. The SSA, IMSS, and IMSS-O all provide integrated reproductive health services for youth. Services for youth are provided both as part of the standard health services and through specialized programs. The SSA, for example, has a specialized program for youth sexual and reproductive health. The IMSS has JUVENIMSS and Rural Care Centers for adolescents (CARA) that provide integrated health services to young people. The norms for the SSA and the IMSS-O require that services for adolescents meet standards related to privacy. A 2012 evaluation found that slightly over half of the service delivery points had specialized spaces, there were few visual aids and those were predominantly related to HIV/AIDS. However, most of the staff had received special training in youth-friendly services.<sup>47</sup> The greatest gaps in adolescent sexual and reproductive health (ASRH) services exist in the rural and indigenous areas.

There are a number of strong NGOs working in Mexico on family planning and sexual and reproductive health. USAID's principal partners in the early days of the family planning movement (FEMAP and MEXFAM) remain active. FEMAP continues to provide services through its affiliated clinics in the U.S. border region, sometimes contracting with local governments to provide services for the public health sector. MEXFAM not only provides services, but has also maintains its role as an incubator for new ideas and is an advocate for sexual and reproductive rights.

### *FP Workforce*

USAID's investments in training professionals, especially in the 1970s, strengthened the capacity and leadership that created arguably the strongest public family planning program in the Latin American region. As the home of some of the most respected universities in the region, and with strong medical and public health faculties, Mexico has a large pool of qualified professionals to draw from in order to maintain its leadership.

The well-respected National Autonomous University of Mexico (UNAM) and other training institutes produce a substantial supply of the general practitioners who are key to public sector family planning services for the disadvantaged. In fact, Mexico produces more general

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<sup>46</sup> CONAPO. *La Situación Demográfica de México 2000-2010, México*. Mexico City, Mexico: CONAPO; 2011.

<sup>47</sup> Reartes & Freyermuth, 2012.

practitioners than the system can employ. Nearly one-third (31 percent) of medical school graduates cannot find a job in their field, particularly if they are not specialized. There are also reports that few doctors want to go to the poor areas where need is highest. Demand outstrips supply for gynecologists and nurses.<sup>48</sup> Despite existing challenges, in comparison to other countries in the region, Mexico has a relatively strong system of human resources for health and supply of trained staff for family planning.

As a priority area, family planning service provision remains a part of the in-service training system. However, as with much else in Mexico, this varies by state, with the poorer, highly indigenous states doing worse in in-service training programs.

### *Information Systems*

The Mexican health system has a strong track record in information systems and research. However, the fact that so many separate, large institutions are involved in health service provision makes for a complicated information system. The Sistema Nacional de Información en Salud (SINAIS, Integrated Health Statistics System) must collect information from both the social security (IMSS, ISSSTE) and social protection sectors (IMSS-O and SSA). Each of these institutions collects information on its own services which is in turn compiled by the General Directorate for Information Systems (DGIS) and entered into the SINAIS, the national health information system.

Mexico's health statistics and government data on the utilization of health services are available online for use by researchers and advocates. The databases for the census and other major surveys are available for download.

Research is important in Mexico, and there are numerous governmental and private agencies that carry out research related to family planning, sexual and reproductive health, and gender issues. CONAPO was the leader in research on family planning and reproductive health for many years, but has relinquished many of its functions to other agencies. The National Institute for Statistics and Geography conducts and disseminates the ENADID survey. These surveys were conducted every three years through 2009. The National Survey of Health and Nutrition conducted in 2010 and 2012 contains some variables related to reproductive health, including contraceptive use. The survey uses different age ranges and definitions than the ENADID, so it is of limited use for trend analysis and international comparisons.

### *Commodities and Medical Supplies*

Reproductive health supplies are addressed in detail in the Mexican program of action for family planning, which aims to guarantee adequate budgets for supplies, improve procurement, and ensure broader method availability. Mexico's national List of Essential Medications includes oral

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<sup>48</sup> Nigenda G, Ruiz JA, Bejarano R. 2005. Educational and labor wastage of doctors in Mexico: towards the construction of a common methodology. *Human Resources for Health*. 2005. 3(1):3.

contraceptives, injectables, and implants. Mexico has been procuring most of its contraceptive supplies since its graduation from USAID funding in 1999. While there were numerous difficulties in the early years after graduation, most have been overcome. A major problem in the early years (late 1990s and most of the 2000s) was the fact that most of the health budget went to the states, which then had to procure their own supplies. In the more recent past, greater responsibility for the procurement of essential medicines has been assigned to the federal-level Health Secretariat as state level purchasing was inconsistent and resulted in persistent stock-outs.

The major Mexican NGOs (MEXFAM and FEMAP) purchase commodities through the private commercial market. MEXFAM also uses a donation from IPPF to pay for commodities obtained through IPPF.

### *Contraceptive Security*

The Mexican government experienced problems in procuring and supplying contraceptives immediately after its phase-out from USAID funding. UNFPA provided some donated contraceptives and assisted with procurement during that time. It continues to provide support in specific instances although the government is largely self-sufficient in terms of all procurement activities. The central health secretariat purchases reproductive health supplies in both the national and international markets, with some purchases from UNFPA. In addition, some states purchase additional supplies directly from the pharmaceutical companies.

Contraceptive security is a challenge for the Mexican government, but one that has been taken very seriously. As is the case elsewhere in Latin America, issues of procurement mechanisms, price fluctuations and suppliers' lack of consistently available products are impediments to continuous supply of contraceptives. The government has made efforts to strengthen forecasting and supply chain management.

Mexico's size is a factor in its ability to negotiate favorable deals with suppliers. Most of the large pharmaceutical companies have distributors in Mexico and the Mexican government is an attractive client due to its size.

### *Financing*

The Mexican government has an historically strong commitment to health and social programs. Social spending in Mexico has continued to increase through both the PRI and PAN governments (from 4.5 percent of GDP in the 1970s to 6.2 percent in 2012).<sup>49</sup> Although it remains an official priority program, the actual amount of spending for maternal and neonatal health and family planning declined slightly from 2003 to 2009.<sup>50</sup>

Mexico operates the largest social protection programs in the region; the IMSS Oportunidades program and the SSA's Seguro Popular program provide services to the poorest sectors of the

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<sup>49</sup> World Bank. *Health Expenditure as Percentage of GDP*. Washington, DC: World Bank; 2013.

<sup>50</sup> Instituto Nacional de las Mujeres, 2011.

population. The World Bank attributes some of the decline in extreme poverty rates in recent years to the effects of these two programs.<sup>51</sup>

The IMSS-Oportunidades program provides free family planning counseling, but family planning is not a condition for receiving cash transfers, and states have promoted family planning to greater or lesser extents within the program.<sup>52</sup> Several evaluations of the IMSS-Oportunidades program have found mixed results regarding the effect of this program on contraceptive use. Studies of IMSS-Oportunidades, conducted in 2000, found increased contraceptive use for women who had been in the program two years.<sup>53</sup> However, in later studies, Oportunidades was not found to have an effect on either contraceptive use or fertility.<sup>54</sup> These differing results may have been due to program changes. As mentioned above, family planning was more actively promoted in the late 1990s, which may have magnified the effect of the cash transfers.

The private sector NGOs have managed to sustain their programs largely through the sale of services to users or to the government. While FEMAP is not as large as when it received USAID funding, it still operates 29 clinics, including two hospitals. FEMAP obtains revenues primarily through the sales of services and social marketing of contraceptives. The platform and technical capacity for providing these services sustainably was developed in the years when USAID supported technical assistance to strengthen the organization. The sale of services to the government has been an important source of support for FEMAP. Since 2006, it has had contracts with the SSA's *Seguro Popular* to cover the health care needs of this extremely poor segment of the population. FEMAP also receives some funding from private sources.

MEXFAM has also relied heavily on user fees to remain sustainable through services provided in its 30 centers serving over 6000 communities. It has a diversified funding base and attracts donor funding for its work in HIV, youth, advocacy and transparency and accountability. Interestingly, MEXFAM is one of the few NGOs in reproductive health in Latin America that receives significant funding from local philanthropists on a regular basis. It has benefitted from several generous donations and also conducts a large annual fundraising event attended by wealthy donors in Mexico City. This has been made possible by an active and committed group of high-net-worth individuals on the MEXFAM board who support the organization through their own donations and by fundraising among their friends and acquaintances.

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<sup>51</sup> World Bank, 2013.

<sup>52</sup> Reartes & Freyermuth, 2011.

<sup>53</sup> Gutiérrez JP, Bautista S, Gertler P, Hernandez Avila M, Bertozzi S. Impacto de *Oportunidades* en la Morbilidad y el Estado de Salud de la Población Beneficiaria y en la Utilización de los Servicios de Salud. In Evaluación Externa de Impacto del Programa Oportunidades 2004, Tomo 2: Salud, ed. Bernardo Hernández Prado and Mauricio Hernández Avila. Cuernavaca: INSP; 2005. 17-74; Steklov G, Winters P, Todd J, Regalia F. *Demographic Externalities from Poverty Programs in Developing Countries: Experimental Evidence from Latin America* [Department of Economics Working Paper Series No 2006-1]. Washington DC: American University; 2006.

<sup>54</sup> Feldman BS, Zaslavsky AM, Ezzati M, Peterson KE, Mitchell M., 2009. Contraceptive use, birth spacing, and autonomy: an analysis of the *Oportunidades* program in rural Mexico. *Stud Fam Plann.* 2009. 40(1):51-62.

## LOOKING TO THE FUTURE

### *Challenges*

As of 2014, Mexico had provided consistent family planning services to its population for over 10 years with minimal support from international donors. Nonetheless, it still has challenges to overcome in order to reach its own ambitious goals in terms of contraceptive prevalence, equity and universality.

### *Universal Access to Sexual and Reproductive Health*

Serious inequities remain in terms of poverty, health, and fertility in Mexico, with women in the largely indigenous states of Chiapas, Guerrero, and Oaxaca having higher unmet need than the rest of the population. The institutions of the Mexican health system are actively working to mitigate the significant barriers to access faced by these remote populations. Barriers include both the indirect economic costs of obtaining services (transportation, child care, etc.) and a variety of cultural factors. The indigenous peoples of Mexico commonly express distrust of government (sometimes violently) and often reject health services that are not adapted to their cultures. The health system in the indigenous states is beginning efforts to provide culturally-appropriate health services. This effort faces the challenge of providing such services to highly dispersed populations living in numerous small communities.<sup>55</sup>

### *Adolescent Sexual and Reproductive Health*

Unmet need remains high among adolescents in Mexico; 36 percent of young women aged 15–19 are sexually active, do not want a pregnancy and are not using contraception.<sup>56</sup> Although both the public and private sectors have programs for adolescents, the adolescent birth rate has not decreased and has in fact shown a slight increase.<sup>57</sup> There is a need for expanded and effective adolescent sexual and reproductive health promotion and more accessible services for young people.

### *Noncommunicable Diseases*

A large proportion of Mexico's population is living longer and succumbing to the illnesses of upper middle income countries. The health system is facing increased pressure to shift resources in order to address noncommunicable and chronic illnesses, such as cancer, diabetes, and obesity. It will be important that these vital but expensive initiatives not affect programs for maternal health and family planning.

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<sup>55</sup> Reartes & Freyermuth, 2011.

<sup>56</sup> CONAPO, 2011.

<sup>57</sup> ECLAC, 2012.

## CONCLUSIONS

Mexico is an important family planning success story in the region and the world. Since its earliest inception, the Mexican family planning program has been a vital component of the social and health sector in Mexico. Visionary Mexican leaders created an enduring system of legislation, policy frameworks and regulations that ensure that family planning remains an integral part of the health system today.

USAID was an important partner to the Mexican family planning leaders for several decades, finding creative ways to support the leadership in what they wanted to accomplish. This support, and the commitment of Mexico's leaders, helped create a truly ground-breaking program that helped shape the family planning movement in Latin America. While based initially on demographic and economic arguments, the Mexican family planning policy was later framed in terms of rights and equity. The program also values and incorporates sound research, evidence-based programming and respect for evaluation.

There is a high demand for family planning in modern Mexico. The health system promotes integrated family planning and strong watchdog groups help ensure standards of quality and coverage. In the future, it will be important that the public health system maintains its expenditures in services such as family planning, especially for the poor, the indigenous, and adolescents while also addressing the needs of an aging and economically developing population.



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