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MEXICO

PLAN OF OPERATIONS

DEVELOPMENT OF A MODEL ON MATERNAL AND CHILD HEALTH CARE FOR INDIGENOUS POPULATIONS

(TC-98-09-29-7)

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ABBREVIATIONS

IMIFAP	Mexican Institute for Research in Family and Population
INI	National Institute for Indigenous Population
JSF	Japan Special Fund
SEDESOL	Ministry of Social Development
SS	Ministry of Health

DEVELOPMENT OF A MODEL ON MATERNAL AND CHILD HEALTH CARE FOR INDIGENOUS POPULATIONS

(TC-98-09-29-7)

EXECUTIVE SUMMARY

REQUESTER:	Government of Mexico
BENEFICIARY AND EXECUTING AGENCIES:	Mexican Institute for Research in Family and Population (IMIFAP) with the support of National Institute for Indigenous Population (INI).
FINANCING:	IDB: (JSF) US$ 554,300.00 IMIFAP: US$ 50,000.00 Total: US$ 604,300.00
TERMS:	Execution period: 24 months Disbursement period: 30 months
ENVIRONMENTAL CLASSIFICATION:	The environmental committee made no comments nor requested any modifications to this proposal.
OBJECTIVES:	The general objective of this technical cooperation is the development, implementation and assessment of a combined model of modern and traditional health care, that could become an alternative health care service model for indigenous population. Once evaluated, it can serve as a model for nationwide action. The specific objectives are: (i) to design and evaluate a new model on maternal and child health care for indigenous populations; (ii) to improve the quality of the available health services as well as the management of the maternal and child health care services provision, in order to meet the particular needs of the indigenous population through the implementation of this health package; and (iii) to promote preventive health behaviors among indigenous people through community participation.
DESCRIPTION:	The activities that will be implemented to achieve the objectives of this proposal in the pilot communities involve the three following components: 1. **Component I. Design and implementation of pilot activities** (cost US$249,967.00), with two main activities: (i) Development and delivery of health packages. A basic health services package for maternal and child health care, balanced and based on the needs of indigenous populations, will be developed and implemented at health centers and hospitals; (ii) Development and

implementation of a communication strategy. An effective communication strategy will be designed, implemented and evaluated to promote education and prevention for maternal and child health.

2. **Component II. Establishment of an assessment system** (cost US$139,966.00), comprising three activities: (i) Health services assessment. The quality of health services will be investigated in pilot area communities through the combined health care model. (ii) Beneficiaries assessment.This investigation will identify indigenous people's perception about presently available health care services and the new model, as well as their health knowledge, behaviors and particular needs with respect to reproductive health. (iii) Development of an appropriate information management system. An information system will be developed to provide the information needed to monitor the combined health services' efficiency.
3. **Component III. Training of personnel** (cost US$164,367.00), including two main activities: (i) Training of health providers. Based on the results of the assessment, training for doctors, nurses, midwives and administrators will be provided at both community and hospital levels; (ii) Training of community leaders and health teams on traditional medicine. This activity will focus on promoting the participation of community leaders, bilingual health workers, and health teams in the practice of traditional medicine within a comprehensive combined health services model. The impact of this training activity will be monitored and evaluated.

BENEFITS: The following benefits to indigenous population expected to result from this technical cooperation are:

(i) Decrease in the maternal and child mortality-morbidity rates in the target communities.
(ii) Modifying attitudes towards and increasing health care knowledge among community members, increasing the population's capacity to responsibly communicate and prevent some illnesses.
(iii) Improvement of the quality of health care.
(iv) Increase in the demand for health care services following the modern and traditional medical attention approach.
(v) Provision of tools that facilitate the promotion and implementation of specific

health policies, directed towards providing medical attention to indigenous populations, that are culturally acceptable, efficient, equitable and cost-effective.

RISKS: Since this is the first time for IMIFAP and INI to be working together in the same project, there is the risk of taking uncoordinated actions of which both organizations are in charge. To minimize this risk and at the same time maximize the viability of the project, the participation of the Ministry of Health (SS) is considered of the utmost importance. For this same reason, a coordination committee made up of three representatives each belonging to one of the three participating organizations (IMIFAP, INI and SS) will be created to supervise the execution of the project. Another risk is that changes in the priorities of health care and/or health policies affecting the provision of services to these population groups. Nevertheless, since the execution of this project is planned for a period of two years, the possibility of these risks is very small.

THE BANK'S COUNTRY STRATEGY: The strategy of the Bank is aimed towards achieving sustained and equitable growth through economic stability and the consolidation of structural reforms in the social sectors. This proposal has been conceived following this strategy and the health care programs and policies of Mexico, as expressed in the country document pertaining to the sector. The Bank's operative strategy concerning the Health Care Sector in Mexico gives priority to those activities that provide basic coverage to the entire population through: (i) improvement in access to health care services and probably more decentralization of the medical services provided; (ii) improvement of present medical attention models in order to reach those sectors less attended in a more effective way; and (iii) revision of Social Security operations due to its role as provider of health care services. Among the areas of intervention of the Bank in the field of Nutrition and Health are: (a) definition of a minimum health package and modes for providing alternative health care services; (b) administrative decentralization and provision of state health care services; (c) strengthening marginal capacity and autonomy of medical units, particularly hospitals; (d) establishment of state-social security links; (e) increase in the participation of the private sector in financing and providing health care services; (f) separation of administrative authorities for the financing of health care services and the provision of these services; and (g) provision of more health

care services providers for the population to choose from. As for the Eight-Replenishment Mandate of the Bank, the document states that in general, indigenous groups are often among the poorest economic sectors of the population, and that projects directed towards these groups should strengthen their capacity to implement development programs that attend to their needs.

SPECIAL CONTRACTUAL CONDITIONS:

Prior to first disbursement: (i) IMIFAP will present a summary of the methodology manual that will be used to implement the project; (ii) IMIFAP will provide terms of reference for hiring consultants; (iii) IMIFAP with the support of INI must inform the Bank as to the communities chosen in each state for the development of the proposal and criteria used to select these communities.

CRITERION ON POVERTY IMPACT:

Due to the nature of the project and its design, this project complies with the criteria for reduction of poverty mentioned in paragraph 2.15 of the Eight Replenishment Mandate of the Bank, as more than 70% of the potential beneficiaries live in conditions of poverty.

I. BACKGROUND

A. General Information

1.1 In 1996, Mexico's health care expenditures amounted to US$12,562 million, equal to US$135.00 per capita which is equivalent to 4.4% of the GDP. The amount spent in health care by the private sector for that same year was 2% of the GDP, as compared to the 2.4% spent by the public sector. In 1996, the total population was approximately 93.2 million, 9.5% of which are indigenous; this is equivalent to a fourth of the indigenous population of this hemisphere.

1.2 The provision of services in the health care sector in Mexico is organized by the public sector, the private sector and the social security system. The coverage of the indigenous population is provided basically by the Ministry of Health, IMSS-Solidaridad and the National Institute for Indigenous Population. In 1995, 32.4% of the national total number of hospital beds belonged to the Ministry of Health, 2.24% to IMSS-Solidaridad and 0.02% to INI (16 hospital beds).

1.3 The health care sector in Mexico has faced constant and diverse structural and managerial changes. The characteristics of the health care model of the Ministry of Health of the present government is based essentially on: (i) Program for Extension of Health Care Coverage, (ii) Basic Health Care Services Package, (iii) Program for Reproductive Health Care and Family Planning, and (iv) Program for Prevention and Control of AIDS.

1.4 The problem of increase in health care costs, lack of adaptation of expenditures according to needs, as well as the problems related to a deficient coverage, are some of the elements that increase inequity, which is more evident in indigenous populations.

1.5 An extension of health care services to cover indigenous groups is being implemented at present. However, these interventions do not take into consideration traditional medicine, private medicine or community resources available in order to break cultural barriers or provide better comprehensive, efficient and quality health care services.

1.6 The collaborative incorporation of health care personnel into traditional medicine along with modern health care providers results in a better satisfaction of the health care needs of indigenous population, in a more cost-effective and culturally relevant way.

1.7 In the last decade the role of the government and of the private sector have been modified, and an opening towards promoting the participation of civil society and non-governmental organizations has begun. Mexico has experienced a continuous increase of civil

associations in which the participation of indigenous population to promote development is evident, through actions directed to the provision of basic services for these populations groups. The participation of civil society organizations represents an important potential to channel resources. Its purpose is to provide services to the most needy sectors with lower income, in new areas of investment. Through these new entities, activities could become more effective and efficient than those of the traditional sectors and they would thus contribute to increase equity and sustained development.

B. The Mexican Institute for Research in Family and Population (IMIFAP) and the National Institute for Indigenous Populations (INI)

1.8 IMIFAP is a non-governmental organization created in 1986, which evaluates, designs and applies programs in education, health care, and individual and community development. From its beginnings, IMIFAP has participated in programs for sexual health care and family education, AIDS prevention, improvement in the delivery of health care services, prevention of violence and community development in metropolitan poor, outlying areas. They have obtained financing from different foundations, embassies and international agencies. At present they are collaborating with projects from the Ministries (Secretarías) of Education and Health, and from the National System of Comprehensive Family Development, with the purpose of providing a better dissemination of operational models and programs that may in the future become institutionalized in communities to satisfy the needs of the beneficiaries.

1.9 The INI was created in 1948 as a decentralized public organization of the federal government, in charge of designing and implementing the governmental policy for indigenous populations in Mexico. In 1992, it became linked to the Ministry of Social Development (SEDESOL).

1.10 At present, INI assists indigenous populations spread over 23 states or provinces of the country, through 96 indigenous coordinating centers that are in turn coordinated by 21 state delegations and 12 sub-delegations. The activities of INI since its creation have been directed towards the study, research, consultancy, diffusion and training that allow the promotion of measures for improving life conditions of indigenous populations. This organization is in charge of the coordination of programs of other government offices aimed towards indigenous regions. At present INI has two hospitals, 15 radio stations, 3 training centers and 1,134 shelters that attend to the needs of 58,000 indigenous children. In 1994, INI had a national territorial coverage of 985 municipalities with 9,424 localities.

C. The Strategy of the Bank in Mexico

1.11 The strategy of the Bank is aimed towards achieving sustained and equitable growth, through economic stability and the consolidation of structural reforms in the social sectors. This proposal has been conceived following this strategy and the health care programs and policies in Mexico, as is expressed in the country document pertaining the sector.

1.12 The Bank's operative strategy concerning the Health Care Sector in Mexico, gives priority to those activities that provide minimum coverage to all the population through: (i) improvement in access to health care services and probably more decentralization of the provided medical services; (ii) improvement of present medical attention models in order to reach those areas with lower coverage in a more effective way; and (iii) revision of Social Security operations due to its role as provider of health care services.

1.13 Among the areas of intervention of the Bank in the field of Nutrition and Health are: (i) definition of a minimum health package and modes for providing alternative health care services; (ii) administrative decentralization and provision of health care state services; (iii) managerial strengthening and autonomy of medical units, particularly hospitals; (iv) establishment of state-social security links; (v) increase in the participation of the private sector in financing and providing health care services; (vi) separation of the administrative authorities between the financing of health care services and the provision of these services; and (vii) provision of more options for health care services providers for the population to choose from.

1.14 As for the Eight Replenishment Mandate of the Bank, the document states that in general, indigenous groups pertain to the poorest economic sectors, and that projects directed towards these groups should strengthen their capacity to implement development programs that attend to their needs.

1.15 This proposed T/C will design and test the tools needed to target the main causes of mortality and morbidity in mothers and their children under age 5 within indigenous populations. Its action will be mainly to prenatal and maternal illnesses, malnutrition, diseases preventable by vaccination, education for health care, sexually transmitted diseases and family planning. The project must be conceived following the government's health care policy and in agreement with other existing programs of primary health care services. The pilot areas will include indigenous communities in each one of the states of Yucatán, Oaxaca and Puebla. Three main levels of intervention will be carried out:

(i) Hospitals and primary health care units that provide combined modern and traditional health care services, and that are administered by INI in the three pilot states.

(ii) Community based services provided by IMIFAP in the selected locations.

(iii) Use of communication strategies to promote community participation in activities related to health care of the three pilot states.

II. OBJECTIVES AND DESCRIPTION

2.1 The general objective of the proposal is to develop, implement and assess a combined model of modern and traditional health care that could become an alternative health care service for indigenous populations. Once it is evaluated, this combined model can serve for a nationwide action with broader coverage.

2.2 The specific objectives of the proposal are: (i) To design and evaluate a sustainable model on maternal and child health care for indigenous populations; (ii) to improve the accessibility and quality of the health services, through the implementation of the health services package; and (iii) to promote preventive and promotional behaviors among indigenous people through community participation.

2.3 The project will reach these objectives through three components:

1. Component I for the design and implementation of pilot activities (Cost US$249,967.00)

2.4 **Development and delivery of health care packages**: A basic maternal and child health care package will be developed with the participation of combined modern and traditional providers, which will be used in community health care centers and hospitals. This package will include assessment of the nutritional status of mothers and children, immunization control and micronutrients supply, as well as the treatment of the most common diseases in children, pre and postnatal attention, high risk referrals, safe and clean child delivery, reproductive health care (AIDS control, family planning, sexually transmitted diseases, etc.). Managerial and financing mechanisms for the basic package will be developed making sure that they are culturally appropriate and ensure efficiency, sustainability and accountability. At the same time, repair and renewal jobs of health care centers included in the study must be made; in order to improve the quality of the medical attention provided.

2.5 For achieving these objectives, it will be required to hire consultants that contribute to the development of the health package and to its monitoring and assessment.

2.6 **Development and implementation of the communication strategy**: This activity will develop and implement an effective communication strategy for the promotion and prevention of maternal and child health care. The programs and materials will be produced in Spanish and indigenous languages, so the population may receive adequate and effective information. Local communication media, such as

radio, bulletins and community meetings, will be used to transmit messages. Communication programs will be developed on the basis of the evaluation of the beneficiaries that will be mentioned further on (paragraph 2.8). All the material produced will be tested before hand to assure its effectiveness. Consultants in planning, development and evaluation of projects are required.

2. Component II for the establishment of an assessment system (cost US$139,966.00)

2.7 **Health care services assessment**: This activity will investigate the quality of health care services provided to pilot area communities through the combined health care model. The methodology will be based on observational studies such as in-depth interviews of the providers of modern and traditional health care both in the community and hospitals. The results of the evaluation will compare the quality and availability of health care services before and after the intervention. At the end of the project, improvements will be presented to the health care providers and to the participants in the project, both orally and in writing.

2.8 **Beneficiaries assessment**: This activity will investigate indigenous people's perception of available health care services, as well as their health knowledge, behavior and particular needs with respect to reproductive health. The methodology to be used will focus on target groups, in-depth interviews and a small survey. The results of this assessment will compare the perception of quality and availability of health services before and after the intervention. At the end of the project, improvements will be presented to the participants of the project and to the providers of health care, both orally and in writing.

2.9 **Development of an appropriate information management system**: This activity will concentrate on the establishment of an information system to monitor the implementation of the comprehensive health care package and to evaluate the efficiency of the services. In order to establish this information system, basic information processing equipment such as computers and statistical programs are required. These will be installed both in INI and IMIFAP, and in selected health centers in three states. Consultants will be hired to train social workers in the application, management and design of formats to capture data.

3. Component III for the training of personnel (cost US$164,367.00)

2.10 **Health providers training**: Based on the results of the assessment described above (components I and II), training of health workers, including doctors, nurses, midwives and administrators will be provided at both hospitals and community health centers. The training program will focus on increasing the understanding of the health care workers on problems that affect indigenous populations,

in improving the state of maternal and child health care, in the perception of modern and traditional health systems and on the use of comprehensive methods of modern and traditional medical attention. The training material will be developed and distributed in workshops.

2.11 **Training of community leaders and traditional health teams**: This activity will focus on promoting the participation of community leaders, bilingual health workers and health teams in the combined traditional and modern health care service model. The training of this community-based health volunteers is directed towards providing and promoting maternal and child health care in indigenous populations of the target communities, and will help to bridge the cultural gaps between modern health providers and indigenous people. Workshops and community meetings will be held. The impact of this training activity will be monitored and evaluated.

III. EXECUTION, EVALUATION and COST

A. Execution

3.1 The execution will be 24 months with a total period of 30 months for disbursement. The execution will be in charge of the Mexican Institute for Research in Family and Population (IMIFAP) with the support of the National Institute for Indigenous Populations (INI) in the operational field. To guarantee the adequate execution of the proposal, a coordination committee will be constituted with IMIFAP, INI and the Ministry of Health (Secretaría de Salud). The IMIFAP will be responsible for the administration of resources from the contribution, and the submission of reports to the Bank. IMIFAP will provide the terms of reference for hiring consultants before the first disbursement, and will submit them for Bank=s approval.

3.2 Before the first disbursement, IMIFAP with the support of the INI must inform the Bank as to the communities chosen in each state for the development of the proposal and the criteria used to select these communities. The IMIFAP with the collaboration of the INI will determine the system of payments to be used, in agreement with the participating municipalities, both from health care personnel and members of the community. Before the first disbursement, the executing agency must present a summary of the methodology manual that will be used to implement the project to the Bank's satisfaction.

3.3 The INI will collaborate with IMIFAP in the development of personnel training strategies in health care in both medical attention schemes as well as the way in which this training will be given. It will also be in charge of preparing educational material and information bulletins to be used in the field of medical attention. The IMIFAP will in turn develop community personnel training strategies and the mechanisms that will be put in action

to provide this training. It will also be in charge of elaborating educational material and information bulletins to be used within the community.

B. Evaluation

3.4 The evaluation of the project will be made in three consecutive stages: the initial stage, the intermediate stage and the final stage. The evaluation will be made from the prospect of budget and disbursement, cost-efficiency and effectiveness of the interventions performed. At the end of the execution of the project, a final evaluation will be presented of the project=s achievements, the problems encountered during implementation, the mechanisms established for their control and correction, as well as a summary of the knowledge acquired.

3.5 Two semestral progress reports will be presented to the Bank's satisfaction including a detailed work plan, an assessment of the preliminary evaluation and a detailed assessment of the results. A first report will be presented six months after the first disbursement and the second one will be presented one year after the first disbursement. A final report will be presented and contain the global assessment of the study (economic, epidemiological, demographic and statistical). A report of the proposals and contributions made by community leaders and participants in the workshops and seminars will also be prepared and be included in this final report. The final report will be presented to the bank ten months after the last disbursement.

3.6 At the end of the first semester of execution, a financial report will be made, and at the end of the execution of the project an accountable financial report will be presented, duly audited by an independent consultancy company and previously authorized to the Bank's satisfaction.

C. Cost

CONSOLIDATED BUDGET
(IN US $)

BUDGET CATEGORY	IDB/JSF	COUNTERPART	%
Services Contracting	185,400.00		30.7
Training	164,367.00		27.2
Repair and Renewal of Health Centers	30,000.00		5.0
Equipment and materials	81,633.00		13.5
Other costs (travels, travel expenses, office support)	85,900.00	50,000.00	22.5
Contingencies	7,000.00		1.1
SUBTOTAL	554,300.00	50,000.00	
TOTAL	604,300.00		100.1

For more information on the costs of the proposal, see Annex I, Tables 1 and 2.

IV. BENEFITS AND RISKS

4.1 On the basis of the information gathered and its assessment, a maternal and child health care package following the modern and traditional medicine approach will be implemented. The following benefits to indigenous populations are expected to result from this technical cooperation:

(i) Decrease in the mortality-morbidity rates in the target communities in the maternal and child health care field.

(ii) Modification of knowledge and attitudes towards health care in the members of these communities, increasing the population's capacity to responsibly communicate and prevent some of the illnesses.

(iii) Improvement of quality of health care received.

(iv) Increase in the demand for health care services following the modern and traditional medical attention approach.

(v) Provision of elements that facilitate the promotion and implementation of specific health policies, directed towards providing medical attention to indigenous populations, that are culturally accepted, efficient, equitable and cost-effective.

4.2 The risks that have been identified are:

4.3 Since this is the first time that IMIFAP and INI work together in the same project, there is the risk of their being out of phase in those actions in which both organizations are in charge. To minimize this risk and at the same time maximize the viability of the project, the participation of the Ministry of Health is considered of utmost importance. For this same reason, a Consulting Committee made up of three representatives belonging to each one of the three participating organizations will be created, and its job will be to supervise the adequate execution of the project.

4.4 Another risk is that changes in the priorities of health care and/or health policies of the country may come about, affecting the provision of services to these population groups. Nevertheless, since the execution of this project is planned for a period of two years, the possibility of these risks is very small.

V. RECOMMENDATIONS

5.1 Lionel Y. Nicol, Chief of RE2/SO2 recommends the approval of this operation, and the authorization of funds from the Japan Special Fund to finance the costs of the project proposed and the approval of this Plan of Operations.

Lionel Y. Nicol, Chf/RE2/SO2 — 12/22/98 Date

VI. CERTIFICATION

6.1 I certify that resources up to US$554,300 are available in the Japan Special Fund to finance the activities described and budgeted in the present Plan of Operations.

Takeo Shinde, RE1/FSS — DEC. 22 '98 Date

VII. APPROVAL

Approved: Miguel E. Martínez, Manager
Regional Operations Department, 2 — 12/22/98 Date

PROPOSED BUDGET

Maternal and Child Health Care for Indigenous Populations

TABLE 1

Japan Special Fund					Counterpart
Category	Unit Price (d)	Number (e)	(d)x(e)	Subtotal	
Component 1. Design and Implementation	US$				
a. Health Package					
i. Preparation	15,000	1			
ii. Pilot implementation	50,000	1			
iii. Evaluation	15,000	1	**80,000**		
b. Communication Strategy (design, production, distribution and evaluation)	30,000	1	**30,000**	**110,000**	
Component 2. Assessment (information collection, processing and reporting)	US$				
i. Baseline	7,500	1			
ii. Post-intervention	7,500	1	**15,000**		
i. Beneficiary Assessment	7,500	1			
ii. Baseline	7,500	1	**15,000**		
iii. Post-intervention					
c. Information Management (5 computers, statistical programs and printers; 3 for the provinces and 2 for the Federal District)	30,000	1	**30,000**	**60,000**	
Component 3. Training for Health Providers	US$				
Workshops for Providers	1,150	20	**23,000**		
Seminars	400	20	**8,000**		
Workshops for Communities	200	100	**20,000**		
Training Materials (design, production, distribution)	10	2500	**25,000**	**76,000**	
SUB-TOTAL I				**246,000**	

TABLE 2

Japan Special Fund					Counterpart
Category	**Unit Price (d)**	**Number (e)**	**(d)x(e)**	**Subtotal**	
Consultants	US$				
General Coordinator	3,000	12 months	36,000		
Field Coordinator (3 for each province)	750 x 3	12 months	27,000		
Assessment and Research (Health Services and Beneficiaries)					
i. Pre-intervention	2,000 x 3	4 months	24,000		
ii. Post-intervention	2,000 x 3	4 months	24,000		
Information System	500 x 3	12 months	18,000		
Health Package	2,000	3 months	6,000		
Communication Strategy	3,000	8 months	24,000		
Training Specialists	2,000	12 months	24,000		
Bilingual Promoters	200	12 months	2,400	**185,400**	
Other Costs					
Air Travel Expenses for Consultant (domestic)	500 x 8	4,000 x 5	20,000		
Traveling Expenses (in provinces)	254	50	12,700		
Per diem for Consultant (in provinces)	1,330 x 8	10,640 x 5	53,200	**85,900**	
Repair and Renewal of Health Centers	10,000	3	30,000	**30,000**	
Administrative and Office Support					50,000*
Contingencies			7,000	**7,000**	
SUBTOTAL 2				**308,300**	50,000
SUBTOTAL (1 and 2)				**554,300**	
TOTAL				**604,300**	

All the expenses are based on national consultants
* This contribution is not in cash