

# POVERTY AND CONTRACEPTIVE USE IN RURAL MEXICO

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## 1 – Introduction

The use of contraceptive methods has proven of great importance in reducing fertility in Mexico during the past 20 years. For example, in the middle of the current decade the number of births avoided every year thanks to the use of contraceptive methods has been calculated, using the so-called *method of prevalence* (Bongaarts, 1985),<sup>1</sup> at almost 2.3 million (Table 1). In fact, contraception is a close determinant of fertility and greatly explains the decrease observed during the past 20 years (Table 2).

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1. With this procedure the difference between *potential fertility* and *observed fertility* can be obtained for a given period, the former being defined as the level of fertility in the reference period in the absence of contraceptive methods. The method uses aggregate data by specific age groups (a). Avoided births (AB) are equal to

$$AB_a = (PF_a - MFR_a) W_a$$

where PF is the level of potential fertility, so that  $PF_a = MFR_a / (1 - C_a(U_a))$ , with  $MFR_a$  the specific rate of marital fertility of age group a

$U_a$  the prevalence of contraceptive usage among married or cohabiting women of age group a

$W_a$  the number of women of age group a

$C_a$  the coefficient of elasticity as a function of sterility by age and level of efficiency of the use of contraceptive methods. In this exercise the coefficients proposed by Bongaarts are used.

Table 1  
Births avoided in Mexico through the use of contraceptive methods, 1995

Age	Contra- ceptive preva- lence	Age- specific fertility rate (%)	Potential fertility	Coeffi- cient	Female population (million)	Effects of fertility increase (‰)	Avoided births (thou- sand)
15-19	0.06	87.7	91.1	0.62	5.1	3	17.3
20-24	0.305	178.7	220.4	0.62	4.7	42	195.9
25-29	0.518	170.6	297.4	0.823	4.1	127	519.8
30-34	0.661	119.6	315.9	0.94	3.5	196	686.9
35-39	0.711	71.5	261.6	1.022	2.8	190	532.2
40-44	0.637	31.2	187.8	1.309	2.2	157	344.4
Total	--	--	--	--	--	--	2 296.4

Table 2  
Close determinants of fertility in Mexico, 1976, 1987 and 1995

Determinants	1976	1987	1995
Tgf	5.64	3.68	2.81
U	30.2	52.7	66.5
Cm	62.3	60.8	60.3
Cc	73.4	48.0	34.0
Ci	80.4	82.8	84.4
Ca	90.3	89.5	95.5

The adoption of family planning methods is on the rise in Mexico. In 1976, one out of every three married or cohabiting women in fertile age (15 to 49) regulated their fertility with some kind of contraceptive method.<sup>2</sup> This percentage increased in the following years at an annual rate between 2 and 3 percent: in 1987 the prevalence of contraceptives was estimated at 52.7%, and in 1995, two-thirds of the married or cohabiting women in fertile age used a family planning method to delay, space or limit births.

2. The use of contraceptives by married or cohabiting women is considered because they have a higher risk of becoming pregnant, given that they maintain an active sexual life.

In addition to a more extensive use of contraceptive methods, the proportion of married or cohabiting women who have never used contraception has diminished. For analytical purposes three categories of the female population will therefore be considered, i.e. women who used a contraceptive method at the time of the survey (current users); women who have used contraceptives in the past, but who are not using them at the time of the survey (ex-users); and women who have never used a contraceptive (non-users). The percentage of married or cohabiting women in the third category has considerably diminished between 1976 and 1995. In the 70s, more than half had never used a family planning method, while today the share is only 19.7%.

Nevertheless, while the use of methods for regulating fertility in the country is significantly increasing, important differences can still be observed among different population groups. Thus, women in urban areas with little formal education and those living in poverty use less contraceptives. The purpose of this paper is to analyze the practice of fertility regulation among women belonging to these types of households.

## **2 - Data source and methodology**

The data analyzed were collected through the National Family Planning Survey 1995 (NFPS-95) (*Encuesta Nacional de Planificación Familiar*, ENPF-1995). The National Population Council (*Consejo Nacional de Población*) conducted this survey from September to December of that year. The survey is based on a probability sample that provided sociodemographic information for the country as a whole and for each of the nine States: Chiapas, Mexico, Guanajuato, Guerrero, Hidalgo, Michoacán, Oaxaca, Puebla and Veracruz. The data collection instruments were composed of two questionnaires: one for the household survey, and another one directed to women from 15 to 54. Likewise, a community questionnaire was distributed in order to collect data on the community aspects of the households. In the NFPS-95 13,840 households were visited and 11,248 interviewed. It should be pointed out that in this survey the monolingual indigenous community was not interviewed.

On the other hand, households were classified according to degree of poverty through the use of a points model, the methodology of

which was developed by the Program for Education, Health and Food (Progresá). For the purpose of approaching poverty in a multi-dimensional way, extremely poor households were identified through a process that incorporated, in addition to family income, other indicators reflecting the complex relationships among the determining factors. These indicators are related to various areas of the social and economic condition of the household and include, among others, household composition and size, age, education, participation in the labour force, type of employment of family members, as well as household equipment.

The very concept of poverty is a relative notion, both in time and in the context of each society. Nevertheless, its definition is of great importance for the development of social policy strategies. Several methodologies have been proposed to measure and examine poverty, many of which are based on the specification of a level of income below which it is considered that people live in poverty. This level is not always defined on the basis of the same criteria. Sometimes a particular population group is focused upon, such as those considered to live in "extreme poverty", i.e. those households without the necessary income to satisfy their basic food requirements.

Thus, extreme poverty is calculated by comparing per capita family income with the price of the basic food basket and establishing a line of *extreme poverty*. In this way, households with an income below this line are considered to be extremely poor. In Mexico, at the end of 1995, the poverty line related to the so-called Standard Food Basket elaborated by COPLAMAR, corresponded to an average family income of 1,189 pesos (considering exclusively the monetary cash income of a family of 5.5 persons).

However, family income is not in itself the only factor that may be used to identify poor population segments. In fact, concentrating exclusively on family income may lead to the omission of situations in which, for example, due to their precarious socio-economic condition, families engage additional family members, such as children and youth, in income generating activities, thus raising the household income level. This has important consequences for developing the capacities and potentialities of the family members, such as children not attending school, which will place them in a more vulnerable social position in the future.

In the methodology used the socio-economic profile of each household is compared (based on the above mentioned indicators), taking into account the typical characteristics of families located above and below the extreme poverty line and analyzing which category they belong to. With this procedure it is then possible to classify the economic condition of each family and identify those that live in a state of extreme poverty.

Table 3  
Percentage distribution of characteristics  
of married or cohabiting fertile women  
according to poverty status. Mexico, 1995

Characteristics	Poor	Non-poor
<i>Age</i>		
15-19	7.1	4.8
20-24	13.6	18.2
25-29	21.4	18.1
30-34	22.3	20.5
35-39	15.5	17.0
40-44	11.1	11.5
45-49	9.0	9.9
<i>Parity</i>		
0	3.4	8.6
1	7.1	22.1
2	12.2	27.2
3	19.3	18.8
4 or more	58.1	23.3
<i>Educational level</i>		
None	17.8	4.4
Incomplete primary	37.6	16.0
Complete primary	29.1	24.8
7 and more years	15.5	54.8
<i>Place of residence</i>		
Urban	47.0	85.6
Rural	53.0	14.4
<i>Total</i>	29.3	70.3

The analysis is focused on married or cohabiting women in fertile age, distinguishing them according to their condition of extreme pov-

erty (throughout this paper they will be referred to as *poor and non-poor* women). Table 3 shows the general characteristics of this population. Although the poor women are only a little older than the non-poor women they have much higher parities, as indicated by the fact that 58% of them have four children or more born alive, as compared to 23.3% of the rest of the women. On the other hand, the proportion of poor women who have not finished primary school (six years) is more than double that observed among non-poor women, i.e. 55.4% and 20.4% respectively. Half of the poor women live in rural areas (defined in this paper as towns with less than 2,500 inhabitants), while only 14% of the non-poor reside in this type of community. In fact, poverty is more widespread in the rural areas, where 60% of married or cohabiting fertile women are members of households classified as extremely poor, while only 18% of urban women are in this condition.

### 3 - Use of contraceptive methods

Table 4  
Percentage distribution of married or cohabiting fertile women according to contraceptive methods used, poverty status and place of residence, 1995

Poverty status	Status of use of contraceptives		
	Current user	Ex-user	Non-user
<i>Poor</i>			
Rural	46.1	13.3	40.6
Urban	67.8	13.5	18.7
Total	56.3	13.4	30.3
<i>Non-poor</i>			
Rural	62.9	16.8	20.3
Urban	72.1	13.4	14.5
Total	70.8	13.9	15.3
<i>Total</i>			
Rural	52.8	14.7	32.6
Urban	71.3	13.4	15.3
Total	66.5	13.8	19.7

In 1995, the use of contraceptives by poor women reached 56.3%. In comparison, almost 71% of non-poor women used some method to regulate their fertility. With respect to women not using contraceptives (as proposed above, they may be called ex-users or non-users), the fact that 30% of the poor women have never had experience in the practice of contraception is prominent, while for the rest of the population this percentage is only 15% (Table 4).

The difference in the use of family planning methods depending on the poverty status is much more pronounced in rural than urban areas. Thus, in cities approximately 68% of the poor women use contraceptives, as compared to 72% of the non-poor. On the other hand, in the rural areas there is a very accentuated difference in contraceptive use between these two groups, i.e. 46% and 63% respectively.

In order to gain some insight into these differences the so-called *family planning demand* will be analyzed. This refers to the expressed desire of fertile married or cohabiting women to limit or space their pregnancies.<sup>3</sup> This leads us to suppose that this population group represents the *total demand for contraceptive methods* (Bertrand *et al.*, 1994). At the same time, the demand may be divided into demand for limiting pregnancies and demand for birth spacing, depending on the desire to have a new pregnancy.

It can therefore be considered that if a woman expresses her desire to limit or space births, but does not practice contraception, this is an *unmet demand*. On the contrary, if the woman uses contraceptives, the *demand* is *satisfied*.

### **3.1 – Demand for contraceptive methods and unmet demand**

In 1995, 80.8% of all fertile, married or cohabiting women demanded contraceptive methods (Table 5). Approximately 40% of them demanded methods of birth spacing.<sup>4</sup> Regarding unmet demand, i.e., the proportion of women who expressed a desire to regulate their fertility but were not using contraceptives, the figure was 17.6% in 1995,

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3. In defining the fertility status and desire for new pregnancy, the criteria established by Westoff and Ochoa (1991) were followed, as well as those of Westoff and Bankole (1996), in which consideration is given, among other things, to amenorrhoea and the time period before a new desired pregnancy.

4. These proportions are obtained from total contraceptive demand.

with unmet demand for birth spacing exceeding demand for birth limitation. Thus, 22.2% of women desiring to space their births were not using a contraceptive method, compared to only 14.3% of those who wanted to limit their pregnancies.

Table 5  
Family planning demand according to poverty status  
and place of residence, 1995

Residence/ Poverty status	Use of contraceptives		Unmet demand		No de- mand	In- fertil- ity	Method failure	Total
	Spacing	Limiting	Spacing	Limiting				
<i>Urban</i>	26.7	44.6	6.3	5.2	9.3	6.4	1.5	100
Poor	14.7	53.1	4.3	11.1	9.5	3.9	3.4	100
Non-poor	29.4	42.7	6.8	3.9	9.2	6.9	1.1	100
<i>Rural</i>	23.5	29.2	10.6	11.4	13.6	10.8	0.9	100
Poor	17.9	28.2	10.4	15.3	16.7	10.5	1.0	100
Non-poor	32.2	30.7	10.9	5.4	8.9	11.3	0.6	100
<i>Total</i>	25.9	40.7	7.4	6.8	10.4	7.4	1.4	100
Poor	16.4	39.9	7.6	13.3	13.3	7.4	2.1	100
Non-poor	29.8	41.0	7.4	4.1	9.2	7.6	1.0	100

On the other hand, it is observed that poor women made less demand for contraceptives than non-poor women (77.2% and 82.3% respectively). Nevertheless, it should be noted that among the extremely poor women, there is a very high proportion of couples who wish to postpone or definitively limit their pregnancies.

In an urban context, the level of demand for family planning is practically the same for both groups (83%). Although this percentage decreases among the rural poor and non-poor population, more than seven out of ten fertile married or cohabiting women living in extreme poverty reported not to have any intention of a new pregnancy.

As could be expected from the parity profile of poor women, 69% of their demand for family planning corresponded to the desire to definitively limit reproduction; in comparison, 55% of non-poor women desired limitation.



Preference for large families seems to have a relatively small effect on the different uses of contraceptive methods observed depending on women's poverty status. In fact, considering the ideal number of children desired by married or cohabiting mothers,<sup>5</sup> and focusing on an analysis of the reproductive preferences of women beginning their reproductive lives (without children or with only one),<sup>6</sup> it was found that among the married or cohabiting women without children born alive the size of the desired family is 2.3 children with 2.5 among those already having a child. Among poor women, these averages are 2.5 and 2.6, and for the non-poor 2.3 and 2.4. In other words, practically the same. Thus, the data relating to women of low parity shows a situation in which the ideal of a relatively small family size confirms the ideal framework of younger women in Mexico, regardless of their economic situation.

For these reasons, the more limited use of contraceptives among poor women seems to be mainly due to an unmet desire to regulate their fertility. In 1995, 17.6% of the total demand for family planning remained uncovered. In the case of poor women, this proportion reached 27% and for poor rural women 35.8%. Thus, the risk faced by poor women not to satisfy their expressed desire to postpone or avoid a pregnancy is practically twice as high as that of non-poor women.

From this we can deduce that there is a need to consider, in the analysis of the low use of contraceptives among poor married or cohabiting women, aspects related to information and access to contraceptive methods by the population.

### **3.2 - Socio-demographic characteristics and contraceptive use in rural areas**

It has been pointed out that unmet demand for contraceptives is higher in rural than urban areas. For this reason, in this section we shall

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5. The following question was asked of women without a child born alive: If you could choose exactly the number of children you would have during the rest of your life, how many would you have? Those women who already had one child were asked: If you were to return to the time when you had no children and could choose, how many children would you have?

6. The reproductive preference of women with two or more children is higher than that of women with a lower parity. This very probably reflects an *adjustment* in the ideal number with respect to the already reached parity.

study the socio-demographic characteristics of women living in rural areas and the use of contraceptives, restricting the analysis only to women demanding contraceptives. Based on the results of a multiple model, it is probable that a fertile, married or cohabiting woman who does not desire a pregnancy for a certain period of time or definitively is using a contraceptive method.<sup>7</sup>

The characteristics introduced simultaneously in the analysis are the following: age of the women, educational level, parity, relative poverty of the household. The categories used and the results of the multiple analysis are presented in Table 6. In addition to the individual characteristics of the women, a variable on access to contraceptives has been included in the model, i.e. the distance to a public health unit offering family planning services.<sup>8</sup>

For rural women not desiring a pregnancy, the probability of using contraceptives clearly increases with education, as indicated by the relative risks (expressed as odds ratios) of less than 1 for uneducated women, women not having completed primary school, and women having completed primary school, relative to those having completed at least one year of secondary school (0.31, 0.46 and 0.58 respectively).

The probability of using a method of family planning, on the other hand, is less among women with 0 or 1 parity in comparison to women

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7. The model in question is a logistic regression (Kleinbaum, 1994). This is adequate for the analysis of a dichotomic variable (0 or 1), as is the case of use or non-use of contraceptives among women who do not desire a pregnancy. In this case, the use of a contraceptive method is analyzed as a response category, i.e. as having satisfied the demand.

8. The analysis is based on 1995 data. As a follow-up of the National Family Planning Survey a field study was carried out in 1996 of family planning services for the rural population in the areas of the nine states visited in 1995 (Chiapas, Guanajuato, Guerrero, Hidalgo, México, Michoacán, Oaxaca, Puebla and Veracruz). The access data is derived from this field work and the population considered in this section is limited to the rural women of the nine states. The distance to the health unit is locally available information and the same for all the women in a given community, but should be considered in the analysis as a characteristic not pertaining to the individual. For this reason, a special processing routine has been employed that allows to control the condition (*svylogit* of the STATA package). The procedure allows for an analysis based on the sample design. On certain occasions, the observations are made at different levels, e.g. individual or local. In cases when the analysis is made without considering if there is a correlation among individuals of the same community, there is a tendency to over-estimate the significance of the variables and to under-estimate standard errors.

with a parity of 2 or more (there seems to be no significant difference in the risk measure for women with two or more children).

Table 6  
Relative risks (odds ratios) of the use of contraceptives  
for married or cohabiting fertile women with a demand for family planning.  
Rural areas of nine states, 1995

Characteristics of women	Odds ratio
<i>Age</i>	
15-24	0.80
25-34	REF
35-49	1.29
<i>Educational level</i>	
None	0.31
Incomplete primary	0.46
Complete primary	0.58
Secondary or more	REF
<i>Parity</i>	
0	0.04
1	0.61
2	REF
3	1.26
4 or more	1.05
<i>Poverty status</i>	
Non-poor	REF
Poor	0.34
<i>Access to contraceptives</i>	
Less than 5 km	REF
5 to 10 km	1.09
10 km or more	0.55

Even when all the above mentioned factors are being controlled, women living in extreme poverty risk using contraceptive methods three times less than non-poor women.

Concerning access to public health services, the risk of using a method is practically the same for women living less than 5 km from a unit with family planning services than for those living at a 5-10 km distance. Only when the closest unit is at a distance of 10 km (this is

the case for one out of ten fertile married or cohabiting women living in a rural area), the probability of using a contraceptive method decreases for women not desiring a pregnancy.<sup>9</sup>

These results indicate that access to contraceptive services is a relevant factor in unmet demand for family planning methods. Nevertheless, even when access is controlled, the association of certain social and demographic characteristics of the women with unmet demand for ways of regulating fertility is evident. It should be stressed that the condition of poverty is very important in the absence of contraceptive methods (more than 60% of married or cohabiting, fertile, rural women in this analysis are in this condition), as are a low educational level and low parity.

### **3.3 - Reasons for not using contraceptives**

In order to have more elements on which to base the analysis of the absence of contraceptive methods, the reasons expressed by the women themselves for not regulating their fertility, even when their desire is not to have more children, should be taken into account. Since unmet demand is higher in the rural areas, our analysis will be centred on this population group, especially extremely poor women (with data for urban women not using contraceptives presented for comparative purposes).<sup>10</sup>

In 1995, 19% of poor rural women not using contraceptives indicated that there was a *lack of information* regarding the different contraceptive methods available, and some also mentioned (although to a much lesser extent) *ignorance* of sources where information on *ways of using* the methods could be obtained, as one of the main reasons for not employing family planning in spite of their desire to postpone, space or limit their offspring. The proportion of rural women of low parity or living in extreme poverty giving these reasons is similar. On the contrary, only 8.8% of urban women with unmet demand reported this reason (Table 7).

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9. If instead of analyzing distance, travel time to the closest health unit with a contraceptive offer is considered, the results are very similar, i.e. the risk of using a method decreases after two hours of travel.

10. The analysis excludes pregnant women.

Table 7  
 Percentage distribution of poor, fertile, not pregnant,  
 married or cohabiting women with unmet demand for contraceptives,  
 according to reason for their non-use and place of residence, 1995

Reason for non-use	Urban	Rural
Limited knowledge	8.8	19.1
Partner opposition, religion	2.6	7.4
Collateral effects	31.7	42.7
Difficult to get pregnant	29.4	10.7
Other	27.5	20.1

This indicates that even when there is access to health units offering family planning services, there is a lack of information in rural areas concerning the use of contraceptive methods (characteristics or way of operation), which does not favour their use. This may also reflect a lack of attitude and *wider* action by the personnel in charge of these services in the sense that they should *come closer* to the population to inform them on means of regulating fertility, instead of waiting for their demand.

A much greater proportion (42.7%) of the rural poor state that they do not use contraceptives because of fear of collateral effects (including those perceived as affecting breast-feeding), while in urban areas this is the main reason given for not using contraceptives. From this type of cause it can be deduced that there is inadequate information regarding existing alternatives of contraceptive methods, the way they work and possible collateral effects. Although in Mexico information regarding family planning methods has been diffused widely, it should be pointed out that it is necessary to disseminate further profound knowledge of their *operative* aspects.

Generally, opposition to contraception for religious reasons by the partner or by women themselves has often been argued as relating to the non-use of contraceptives. It should be pointed out that in urban areas barely 3% of the women with unmet demand, and 7.4% of poor rural women, declare this as a reason for not using contraceptives. This indicates that the main aspects linked to the non-use of contraceptive methods can be found in the area of communication and counselling on the topic.

Nevertheless, communication and information on the subject should go beyond the use of contraceptives and include reproduction aspects. The reason for this can be seen in the proportion of women who do not desire pregnancy and do not use a method because they believe that they *do not get pregnant easily*. In the studied circumstances there is a high risk that fertile women who do not desire a pregnancy in the short term, initiate a gestation without knowing they are fertile (we should remember that in defining the population with a demand for contraceptives the presence of infertility is controlled).

#### 4 - Conclusions

The use of contraceptive methods is becoming more and more generalized in Mexico and has had an important impact on fertility changes. Nevertheless, women living in poverty have a total fertility rate of more than 5 children per woman, and in the case of poor, urban women, this level rises to 5.3 children, while non-poor women have a fertility of 2.6 children (Table 8).

Table 8  
Total fertility rate (children per woman), 1995

Poverty status	Rural	Urban	Total
Poor	5.30	4.75	5.08
Non-poor	2.72	2.58	2.60

The realization of the reproductive desires of women with greater social needs implies the satisfaction of a large demand for contraceptives in the more backward regions of Mexico, where the levels of fertility greatly surpass the national average and the vicious circle created between demographic backwardness and poverty demands drastic measures.

It should be pointed out that even when poor women use contraceptive methods, this practice is adopted relatively late in their reproductive lives. More than half of the users of family planning methods

living in extreme poverty have opted for a definitive contraceptive method, such as bilateral tube occlusion (Table 9). This situation, however, is reached once there is a high fertility level and 80% of the poor women who have been sterilized did so when they had four children or more. On the contrary, among the non-poor women this proportion is 47% (Table 10).

Table 9  
Percentage distribution of contraceptive users according to method used and poverty status

Method	Poor	Non-poor	Total
Pills	12.7	12.8	12.7
IUD	18.7	23.0	21.9
Bilateral tube occlusion	51.7	38.0	41.3
Vasectomy	0.1	1.2	0.9
Injections	4.1	4.8	4.6
Condoms and spermicides	3.3	5.6	5.1
Traditional methods	13.4	14.6	13.4
Total	100.0	100.0	100.0

Table 10  
Proportion of users of bilateral tube occlusion with four children or more, without previous use of another contraceptive method, according to poverty status

Poverty status	Women with 4 children or more	Women without previous use
Poor	80.3	56.8
Non-poor	46.9	25.2
Total	53.6	32.4

This comparatively high parity when contraceptive methods are used to limit fertility is mainly associated with a lack of opportunity to practice contraception in earlier stages in life. Thus 56.8% of poor women using tubal occlusion opted for this method without having

had any other previous experience in the use of contraceptives. This condition is much less frequent (25%) for non-poor mothers (Table 10).

From this overview further elements can be deduced that should be considered in order for the less favoured population to reach their reproductive ideals. Here it is necessary to point out that, regardless of the clear tendency for preferring smaller families, it is still fundamental to reinforce education and communication so that more couples recognize the advantages of a smaller family unit, with due respect for the rights and dignity of the individual. The benefits afforded by family planning are improved living conditions of the family as a whole, better maternal and infant health, and development of the couple, women and children. In this way, the processes can be supported continuously and the opportunities for education and participation in economic life, especially of women, widened.

A typical feature of the use of contraceptives in Mexico is the great importance accorded to the role of public health institutions as a place in which the population can be supplied with family planning methods. Today 71.1% of users resort to these sources for their contraceptives.

Starting with the change in the population policy of the Government of Mexico in 1973, official programmes for family planning have been created to help develop an efficient system of contraceptive distribution and the diffusion of new norms related to reproductive behaviour (birth intervals of longer duration, more appropriate age and range of ages for having the first child, and ideal number of children) (Potter *et al.*, 1986; Alba and Potter, 1986; Lerner and Quesnel, 1994).<sup>11</sup>

In the development of the distribution system and offer of contraceptive methods integrated in government health institutions (Alarcón *et al.*, 1985a), emphasis is placed on modern methods of family planning, especially those considered to be the most *efficient, with less collateral effects and greater continuity* (García Zebadua, 1985). Of all the contraceptives, the public preferred the IUD and tubal occlusion, methods which require *clinical* treatment.

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11. These norms are sustained by the health benefits of fertility regulation: "To promote in the population and the individual a wider knowledge of family planning, by moving from the simple concept of contraceptive protection to its identification as one of the fundamental actions in contraceptive promotion and protection of the health of the population, especially mothers and children." (Alarcón *et al.*, 1985a).



Although family planning services and contraceptives are offered free of charge by public health institutions and public health service infrastructures have been expanded, especially in the rural areas (Alarcón *et al.*, 1985b; Alba and Potter, 1986), and family planning services integrated into medical care services, especially primary care, the results show that, although all of these appear to be elements that favour a greater satisfaction of the demand for contraceptives, they are not sufficient to promote greater use by the poorer Mexican population segments.

It should be stressed that it is necessary to place greater emphasis on family planning services in order to make them more *proactive* in their information and diffusion strategies. This implies education, communication, promotion and a service addressing the early stages of the reproductive cycle of women and couples, promoting and informing about reversible methods and seeking to attend to the people without waiting for them to come and ask for help.

At the same time, it is necessary to improve the quality of family planning services in general, i.e. to facilitate an offer of contraceptive methods that would respond to the information, counselling and follow-up requirements of their use considering that there are important groups with great social needs but little experience in contraceptive practices.

The possibility of planning procreation, in the sense of seeking the best results and highest affective realization of the persons involved, is the most beneficial aspect of the use of contraceptive methods. For this service to help improve the well-being of both individuals and families is a task of the greatest importance from the perspective of personal development of the whole population.

## References

- ALARCÓN, F., CORREU, S., and MARTÍNEZ MANAUTOU, J. (1985a), "Operación del programa de planificación familiar en el medio urbano", in: J. Martínez Manautou and J. Giner (eds.), *Planificación familiar y demografía médica*, IMSS, México.
- ALARCÓN, F., CORREU, S., and MARTÍNEZ MANAUTOU, J. (1985b), "Atención primaria de la salud y planificación familiar en el medio rural",

- in: J. Martínez Manautou and J. Giner (eds.), *Planificación familiar y demografía médica*, IMSS, México.
- ALBA, F., and POTTER, J. (1986), "Población y desarrollo en México: una síntesis de la experiencia reciente", *Estudios Demográficos y Urbanos*, Vol. 1, No. 1.
- BERTRAND, J., MAGNANI, R., and KNOWLES, J. (1994), *Handbook of Indicators for Family Planning Program Evaluation*, The Evaluation Project.
- BONGAARTS, J. (1985), "A prevalence model for evaluating the fertility effects of family planning programmes", in: United Nations, *Studies to Enhance the Evaluation of Family Planning Programmes*, New York.
- GARCÍA ZEBADUA, A. (1985), "El proceso de programación", in: J. Martínez Manautou and J. Giner (eds.), *Planificación familiar y demografía médica*, IMSS, México.
- KLEINBAUM, D. (1994), *Logistic Regression*, Springer Verlag, New York.
- LERNER, S., and QUESNEL, A. (1994), "Instituciones y reproducción", in: F. Alba and G. Cabrera (eds.), *La población en el desarrollo contemporáneo de México*, COLMEX, México.
- POTTER, J., MOJARRO, O., and HERNÁNDEZ, D. (1986), "Influencias de los servicios de salud en la anticoncepción en México", in: *Memorias de la Tercera Reunión Nacional sobre la Investigación Demográfica en México*, Vol. 1, UNAM/SOMEDE, México.