

PROJECT AUTHORIZATION AMENDMENT

Country: Latin America and Caribbean-Regional

Project Title: Expansion and Improvement of Family Planning Programs: Project No. 936-3043

Pursuant to section 104 of the Foreign Assistance Act of 1961, as amended, the authorization dated August 9, 1985, for the centrally-funded project Expansion and Improvement of Family Planning Programs is hereby amended as follows:

1. New total Grant funding is \$39,000,000, of which \$2,000,000 are estimated to be buy-ins.
2. The final year of obligation is FY 1991.
3. The Project Assistance Completion date is December 31, 1993.
4. Para 4b: add the following: Subcontract or Subagreement pertains to a transaction between a Sub-Grantee and a source of services or goods in a cooperating country, not a Sub-Grant itself.

All other terms or references specified under the authorization of August 9, 1985 remain unchanged.



N.C. Brady
Senior Assistant Administrator
for Science and Technology
Date 7/10/87

Clearance: S&T/POP/FPSD:J Rogosch JR Date _____
S&T/POP:D Gillespie DR Date 7/8/87
S&T/POP:B Case h Date 7/2/87
S&T/PO:G Gower R Date 7/8/87
S&T:D Brennan DB Date 7/9/87
GC/CP:S Tisa h TEL Date 7/6/87

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

JUL 07 1987

ACTION MEMORANDUM FOR THE SENIOR ASSISTANT ADMINISTRATOR
FOR SCIENCE AND TECHNOLOGY

FROM: S&T/POP. Duff Gillespie *DG*

SUBJECT: Expansion and Improvement of Family Planning Programs
in Latin America and the Caribbean (936-3043)

Problem: Your approval is needed to 1) authorize a five-year extension of this project for expansion and improvement of family planning programs at an estimated total cost of \$27,000,000 and 2) approve the selection of the Western Hemisphere Region (WHR) of International Planned Parenthood Federation as the recipient of these funds.

Discussion: In May, 1987 S&T/POP received the attached unsolicited proposal from WHR to provide funding and technical, advisory, and commodity support to selected Family Planning Associations (FPAs) throughout Latin America. S&T/POP proposes to fund the proposed budget over the next five years, with minor line item changes, through a matching grant to WHR. We propose an in-cash cost sharing/matching grant where WHR will match 200% of A.I.D.'s contribution to the WHR New York office (approximately \$5.7 million), and 100% of A.I.D.'s contribution, (approximately \$21.3 million) to WHR affiliates.

Throughout the Western Hemisphere, private FPAs affiliated to the WHR have been the key to progress in family planning, and in most cases have been the most cost-efficient providers of family planning services and information. While we believe that LDC governments can and eventually will assume a good portion of the service burden, current public sector efforts in most Latin American countries fall far short of what is needed. Contraceptive prevalence surveys continue to indicate high unmet need for family planning services in countries surveyed. Concurrently, many FPAs in the Western Hemisphere are unable to generate sufficient local resources to achieve fiscal independence.

Project Description: During the next five years, WHR will provide technical, advisory and commodity services to selected Family Planning Associations (FPAs) throughout Latin America and the Caribbean. The five year program will expand community based distribution programs; increase family planning services through a network of private doctors (700); establish family planning services in collaboration with the public and private sector; establish family planning associations with private voluntary organizations; activate management information systems in FPAs; increase resource allocation to FPAs; carry out client surveys; provide technical and advisory assistance and evaluation assistance to member FPAs throughout the region.

As a result of this project, it is expected that an additional 2.8 million new clients will have received family planning information and services, 10 million clients will have been served, and participating FPAs will have strengthened management and family planning services in their respective communities. This project will give special assistance to FPAs not covered under USAID mission agreements, and the matching grant mechanism will assure that A.I.D. does not become the sole sustaining donor to WHR.

Our recommendation for the selection of the assistance recipient is based on: 1) our review of their unsolicited proposal; 2) the exclusive operational relationship held between WHR and its Latin American FPA affiliates; 3) the fact that WHR assistance in this project addresses total FPA programs within a long-term context (as opposed to discrete projects which could be implemented by a number of international family planning organizations); and 4) IPPF/WHR's exemplary performance as the grantee for the first two years of this project. WHR is a minority PVO.

The project has been reviewed favorably by S&T/POP and received verbal concurrence from LAC/DR/POP and from representatives in the field. The required Advice of Program Change has been forwarded to Congress. The waiting period expired June 11, 1987.

Evaluation: Mid-term and final evaluations of the new grant are planned. Although no formal evaluation was scheduled for the current two-year Matching Grant, evaluation requirements under the grant are designed to compile, correct and analyze service statistics from IPPF affiliates. The evaluation program is expected to conduct client surveys and evaluate technical meetings, collect profiles, set intermediate indicators in the workplans and analyze each subproject that relates to new acceptors and couple-year-protection outputs. At the beginning of each year, WHR submits a detailed workplan for all sub-grants with a rationale for how each activity will meet the service needs of a particular country or the region as a whole. These workplans are reviewed and cleared by S&T/POP, LAC/DR/P and the appropriate Mission representatives. All have been pleased with IPPF/WHR's performance.

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Recommendation: That you 1) sign the attached Project Authorization Amendment and 2) approve the selection of IPPF-Western Hemisphere as the recipient without consideration of other sources by signing below.

Approved *[Signature]*

Disapproved _____

Date 7/10/87

Attachments:

- 1. Project Authorization Amendment
- 2. Project Data Sheet
- 3. IPPF/WHR Proposal

Clearance: S&T/POP:BKennedy *BK* Date 7/1/87
 S&T/POP:JDumm *[Signature]* Date _____
 S&T/POP:BCase *[Signature]* Date 7/2/87
 GC/CP:STisa *TER* Date 7/6/87
 S&T/PO:GGower *[Signature]* Date 7/8/87
 S&T:DBrennan *[Signature]* Date 7/9/87

ST/POP/FPSD, CHabis/fsl:5/18/87:235-2458:3585Y



INTERNATIONAL PLANNED PARENTHOOD FEDERATION, WESTERN HEMISPHERE REGION, INC.
302 BROADWAY NEW YORK, NY 10010, USA TELEPHONE: 212-995-6800 CABLE ADDRESS: WHIPPE TELELEX: 520661
FEDERACION INTERNACIONAL DE PLANIFICACION DE LA FAMILIA, REGION DEL HEMISFERIO OCCIDENTAL, INC.

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5661
NC.

May 7, 1987

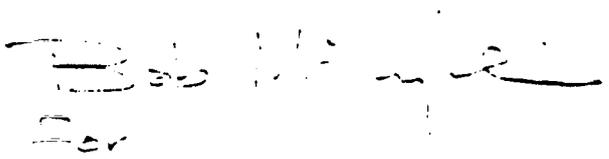
Mr. Charles Habis
Agency for International Development
ST/POP/FPSD
SA-18, Room 809
Washington, D.C. 20423

Dear Charles:

I am attaching a copy of our unsolicited proposal for a 5-year renewal of the Matching Grant (#DPE-3043-G-SS-5067-00), in the amount of \$27,000,000. Needless to say we stand ready to answer any questions you may have about this proposal, and to supply any additional information you may need in order to evaluate it.

Looking forward to hearing from you I am,

Sincerely yours,


Hernan Sanhueza, M.D.
Regional Director

A) INTRODUCTION: THE MATCHING GRANT THUS FAR

Based on the results of the first 5 quarters (4 or less at the field level), the Matching Grant has already succeeded in expanding and improving provision of family planning, as shown in the following table:

Comparison of FPA-wide NEW ACCEPTOR and CYP Results 1985-1986
(adjusted by length of each FPA's 1986 MG project)

COUNTRY	:Proj : :Start : :Date :	New Acceptors				Couple Years of Protection					
		1985	:Total	MG	Non-MG	: % :	1985	:Total	MG	Non-MG	: % :
Colombia*	:1/86 :	111,169	120,458	59,748	60,710	+6%	1,204,538	1,407,293	709,324	697,969	+17%
Brazil	:1/86 :	312,727	360,957	166,599	194,358	+15%	444,284	730,129	402,700	327,429	+64%
Mexico	:1/86 :	59,697	174,634	111,740	62,894	+193%	148,781	317,136	110,355	206,781	+113%
Peru	:5/86 :	35,948	60,275	24,763	35,512	+68%	88,241	142,621	28,000	114,621	+62%
Uruguay	:3/86 :	20,708	27,612	13,079	14,533	+33%	38,481	47,213	17,100	30,113	+23%
Chile	:4/86 :	305,324	NA	2,406	NA		1,074,189	NA	8,800	NA	
Trinidad	:4/86 :	1,647	1,806	706	1,100	+10%	13,686	10,964	6,300	4,664	-20%
TOTAL**	:	847,121	745,742	379,041	369,107	+38%	3,012,200	2,655,346	1,282,579	1,381,567	+37%

* New Acceptors Column excludes CSD
** % Change Columns exclude Chile

The same results are displayed graphically in attachment I, and it is easy to see that when the period of Matching Grant (MG) support in 1986 is compared with the same period of 1985, all six of the current sub-grantees for which comparable figures are available registered gains in the number of new family planning acceptors, and all but Trinidad and Tobago registered gains in couple-years of protection (CYP). Taken as a group, the 6 Family Planning Associations (FPAs) increased their new acceptors by 38%, and their CYP by 37%.

Apart from these quantitative achievements, the MG has led IPPF/WHR and its FPAs to re-examine traditional assumptions about how much FPAs should aspire to achieve in service provision, and how best to spend new resources. By 1985, after years of stagnant budgets, largely due to stagnant IPPF income worldwide, many FPAs in the Western Hemisphere had resigned themselves to a modest or even symbolic role in service provision, and were counting on the public sector to eventually become interested and

finish the job that FPAs could only start. Unfortunately, the public sector in this hemisphere has not always lived up to these high expectations, despite constant encouragement from FPAs. The MG has allowed at least eight FPAs to take matters into their own hands and to expand and improve their service programs with or without public sector involvement. It has encouraged them to take a fresh look at the state of family planning in their countries, and to seize program opportunities that had long been beyond their reach.

The MG has introduced new rigor into the relationship between WHR and its FPAs, reflected in better and more frequent reporting and supervision. This new rigor is beginning to affect the management of non-MG resources as well: the very frequency and detail of reporting and supervision under the MG are contributing to better WHR understanding of FPA activities that are not funded by the MG. Combined with the increased exchange of experience among FPAs, also made possible by the MG, this has led WHR and FPAs alike to question program strategies that had long been taken for granted, and to re-examine the alternatives.

In sum, the MG has become the leading edge of the WHR in service delivery, with direct and indirect effects not just on the services being provided by sub-grantees but also on the way the WHR and its affiliates view service options throughout the hemisphere.

B) THE PROGRAM STRATEGY, AND EXPECTED OUTCOMES

Having seen the potential of the MG during its first year, we have raised our ambitions beyond simple maintenance of the activities funded under the original grant. We now propose a 5-year renewal which we believe will change the basic program strategy of many FPAs in this hemisphere, and leave them in a stronger position to accelerate the long-term spread of family planning in their countries. The difference between a simple extension of the MG and the kind of renewal we have in mind will arise from the following new elements:

- 1) A new way of expressing the long-term service goal of FPAs: to set the stage for faster increases in contraceptive prevalence by lowering the Real Cost of Contraception (RCC), that varying combination of monetary and non-monetary costs which family planning clients are currently forced to pay. This restatement reflects our growing conviction that demand for contraception is already much higher than contraceptive prevalence in most parts of the hemisphere, and that real costs (e.g. high prices of contraceptives in pharmacies, long waits and unpleasant service in "free" government clinics, occasional stock-outs in FPA CBD posts) still constitute real barriers for potential users, and are probably responsible for much of the observed gap between expressed interest in

contraception and actual contraceptive practice. Starting with cost-effectiveness research in Colombia, funded by the World Bank, a computerized resource allocation model being developed with MG support, and Client Surveys in 10 countries, WHR will refine the concept of RCC, identify its most important components, and develop ways of estimating RCC at the national and local levels. Five countries will be chosen for more intensive work on RCC, from among the ten countries that will have Client Surveys (see #B6 below).

2) A new emphasis on identifying the factors which keep RCC high, by method and by provider, and on reaching an efficient and realistic division of labor among non-profit, public sector, and commercial providers which will lower RCC to more accessible levels. Since many of the factors presently contributing to high RCC lie beyond the direct reach of FPAs, this approach will lead inevitably to greater emphasis on collaborative projects with other organizations.

3) A shift toward areas, and groups, of lower income and lower contraceptive prevalence. While we had good reasons for giving preference to expansion of proven programs during the first two years, the fact is that some countries of our Region, or certain areas within those countries, are already relatively well served, as indicated by data from recent contraceptive prevalence surveys (CPS). Some other areas are not yet well served, but are in a position to increase prevalence more easily, based upon relatively low RCC. It makes sense to begin shifting our attention toward less favored areas, both among countries and within countries, where low income populations still face relatively high RCC. During the next five years we will be pressing FPAs to demonstrate that their services are reaching people who would probably not be practicing family planning otherwise. The Client Surveys will help us to reach conclusions about who is using FPA services, and why.

4) Special emphasis on three ways of providing FP at a discount: ways which allow FPAs to mobilize the resources of other organizations and thus to avoid the classic dilemma of either absorbing high recurring service costs or passing most of those costs on to clients who can ill afford them:

a) networks of Community Doctors and other health professionals offering FP services at modest prices, subsidized initially by FPAs but sustained in the long run by the communities they serve. There are promising examples of such networks in Mexico, Peru, Ecuador, and several other countries, and we are convinced that many other FPAs could find ways of motivating private MDs to provide FP at much less than the going rate. The regional meeting about Collaboration with Private Doctors, to be held this year, will allow us to evaluate our collective experience thus far and to design country-specific projects. During the next five years, the MG will support the creation of at least five new networks, involving at least 700 MDs and other health

professionals by the end of the period.

b) collaboration with public sector agencies, to identify existing bureaucratic and logistical barriers and to explore ways of using limited FPA inputs to help overcome them. The fact is that most public sector agencies charged with delivering family planning in this hemisphere are doing a poor job of it, and need help from more specialized and more flexible organizations in order to make better use of the tremendous human, physical and financial resources at their command. The WHR has a long history of effective collaboration with the public sector in countries like Chile, Costa Rica, and Brazil. What is needed is a fresh look at the opportunities in these and many other countries, and a realistic analysis of how FPAs can help the public sector improve its performance in FP programs. From 1988 to 1992 the MG will support major new FPA-public sector collaborative projects in at least four countries. A meeting in 1988 will set the stage for these projects by analyzing the strengths and weaknesses of existing efforts.

c) collaborative projects with other PVOs, especially those involved in primary health care and child survival and those serving males. We have some collective experience in this area (with the Red Cross in Chile, with labor unions in Peru, and with military health services in other countries), but far more could be done. The emphasis must be on reaching agreements that involve short-term support from FPAs, or support in the form of resources that are relatively inexpensive for FPAs (e.g. training, contraceptives). During the next five years the MG will support new FPA-PVO projects in six countries.

To successfully implement these new elements we will need to continue our investment in the modernization of FPA management, following up on the initial MIS activities scheduled for this year. The 15 FPAs that will receive hardware, software, and initial training later this year will require more specialized training during the next 5 years, and the modernization will be extended to 10 other FPAs as well. During this period we will also add telecommunications hardware and software to this network of FPAs, greatly facilitating the exchange of written material among FPAs, and accelerating the correspondence between FPAs and the New York office (many important documents still have to be sent back and forth by courier, because postal service is slow and unreliable). The resource allocation model presently being developed for Brazil, Colombia and Mexico will be implemented in an additional 10 FPAs, and will give FPA managers a new tool for reviewing current service programs. Finally, a part-time Management Consultant will be appointed to provide specialized management assistance to 3 FPAs per year, and to formulate specific recommendations for improvements in FPA management procedures.

The WHR has written regional standards and guidelines, which cover structural, administrative, financial, and program areas (see Attachment II). These are presently being extended and refined by the Board of Directors, with advice from the regional staff. The MG will contribute to this process in the form of a Medical Consultant, who will be appointed to advise the WHR and FPAs about how best to conciliate their needs to:

- a) offer a broad range of FP methods, with informed consent and freedom of choice
- b) reduce the recurring costs of FPA services without compromising medical safety.

Through client surveys to be conducted this year, four FPAs will be able to look at FP services through the eyes of their clients, identifying the direct and indirect costs perceived by clients, and will then be offered technical and financial assistance to make services more responsive to client needs and preferences. Six more FPAs will conduct such surveys with MG support during the next five years. The results of these ten surveys will be distributed to all FPAs in the Region, and discussed at our annual Regional Councils, so as to encourage all FPAs to offer truly client-oriented services.

Through analysis of monthly clinic reports from three FPAs, Clinic Profiles will be developed, in an attempt to identify key ratios (e.g. the number of new IUD acceptors vs. the number of IUD revisits) and other numerical indicators (e.g. acceptor trend data) that could be used to distinguish "normal" clinics from "problem" clinics, before the problems become entrenched. At first the Clinic Profiles will be tested retrospectively on clinics whose history is well documented, and then a prospective sample will be chosen to determine whether the profiles can serve as an early warning system for FPA managers. If so, they will be incorporated into the Clinic MIS which WHR is developing with support from the MacArthur Foundation, and offered to FPAs throughout the Region.

We will continue to support technical assistance among FPAs, based on observation of how family planning innovations have spread in this hemisphere:

- a) Most of what we would like all FPAs to do can be found already happening in at least one of the 47 FPAs in this Region.
 - b) It is easy for FPAs to get into a rut, and to settle for a simple repetition or slight expansion of last year's program.
 - c) Advice from abroad is often viewed with skepticism by FPAs, with some reason: much of it comes from people who have never managed an FPA, and who will not be around to help if their advice proves to have been unwise.
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d) Advice from another experienced FPA is harder to brush aside, which is why FPA managers listen closely to their peers.

e) Seeing an innovation is more impressive than hearing about it, as we have learned with CBD, CRS, use of mass media, and most recently collaboration with private MDs. In all of these cases, visits to the pioneering FPAs have been an important factor in the spread of the innovation to other FPAs.

Last but not least, the MG will continue to yield significant increases in family planning services, as measured by new acceptors (NAs) and couple-years of protection (CYP). The following table shows what we believe can be accomplished during the next five years in the 7 countries which already have MG sub-grants for service delivery: 2.8 million new acceptors, and 10 million CYP. This does not include the advances that will be registered in other countries, such as the four that will be chosen for new sub-grants in the next five years or the others that will benefit from the regional components of the MG.

Estimated New Acceptors Oct 1987 - Sept 1992
(in thousands)

COUNTRY	Actual		5 YEAR PROPOSAL TARGETS					1988-1992
	1986	1987	1988	1989	1990	1991	1992	Total
Brazil	166.6	221.4	236.9	251.1	263.7	276.9	290.7	1,319.2
Colombia	59.7	67.9	72.7	77.0	80.9	84.9	89.2	404.6
Mexico	111.7	112.4	123.6	136.0	148.2	161.6	176.1	745.6
Peru*	24.8	30.3	33.3	36.7	40.0	43.6	47.5	201.0
Uruguay*	13.1	14.8	15.5	16.3	17.1	18.0	18.9	85.9
Chile*	2.4	4.2	4.4	4.6	4.9	5.1	5.4	24.4
Trinidad*	.7	3.3	3.5	3.6	3.8	4.0	4.2	19.1
TOTAL	379.0	454.3	489.9	525.4	558.6	594.0	631.9	2,799.8

Estimated CYP Oct 1987 - Sept 1992
(in thousands)

COUNTRY	Actual		5 Year Proposal Targets					1988-1992
	1986	1987	1988	1989	1990	1991	1992	Total
Brazil	402.7	449.6	503.6	558.9	620.4	688.7	750.7	3,122.2
Colombia	709.3	773.1	858.2	952.6	1,047.8	1,152.6	1,267.9	5,279.1
Mexico	110.4	123.6	142.2	163.5	188.1	216.3	248.7	958.7
Peru*	28.0	33.6	38.6	44.4	51.1	58.8	67.6	260.5
Uruguay*	17.1	19.3	21.4	23.8	26.4	29.3	32.3	133.3
Chile*	8.8	15.4	17.1	19.0	21.1	23.4	25.7	106.2
Trinidad*	6.7	20.0	22.2	24.6	27.4	30.4	33.4	138.0
TOTAL	1,283.0	1,434.7	1,603.3	1,786.9	1,982.3	2,199.4	2,426.2	9,998.1

C) A FINANCIAL STRATEGY

Our financial goal for the next five years is to gradually reduce the annual level of MG support required. That, combined with increasingly stringent matching conditions, will ensure that by the end of the period MG resources will represent a substantially smaller portion of total resources, both at the FPA level and at the regional level. If it should then turn out that no further MG funding is available, the disruption to programs will be limited. The annual sequence we propose is as follows:

Matching Requirements
(ratio of ^{non-}Federal to ~~non-~~Federal)

FY	Annual Budget	FPA/Regional	New York
1986*	\$5.0M	1.0	2.0
1987*	7.0M	1.0	2.0
1988	6.3M	1.1	2.1
1989	5.8M	1.2	2.2
1990	5.4M	1.3	2.3
1991	4.9M	1.4	2.4
1992	4.6M	1.5	2.5
	<u>\$39.0M</u>		

↑
ratios
to be
used in
new
Grant

*Original Matching Grant.

To appreciate what this will mean in practical terms, consider that the Mexican FPA is receiving approximately \$1.1 million in MG support this year, which it will have to match with at least \$1.1 million of local and other non-Federal support. In 1992, when MEXFAM is scheduled to receive only \$850,000 in MG support, it will have to match that 1.5 to 1, that is with \$1.27 million in local and other non-Federal support. Proportionately, and in absolute terms, MEXFAM will have to be considerably less dependent upon the MG in 1992 than it is today.

How will the FPAs change in order to become less dependent upon the MG but more effective in family planning? Attachment III indicates that some will be able to meet the more stringent matching requirements simply by maintaining the dollar value of their present non-Federal income, as their MG support declines. Others may be pressed by the effect of devaluations (which reduce the dollar value of their local income) and will have to find new sources of non-Federal income. All of the FPAs, however, will have to make their programs more cost-effective, in order to meet the rising service targets with less MG funding.

There will be a gradual shift toward service delivery featuring lower cost per CYP, either through a more favorable mix of contraceptive methods or through measures which reduce recurring costs for the FPAs. Improvements in management information systems (MIS) will help FPA directors identify more cost-effective service programs. Through the MG, the FPAs will also be encouraged to explore the three collaborative approaches outlined in Section B4, above, which offer the long-term potential of multiplying FPA resources.

There is still room for clinical projects that manage to offset the costs of heavily subsidized services for the poor by offering some "middle class" services. The same goes for CBD programs using volunteer distributors, or distributors who receive very modest fees for their services. On the other hand, as MG resources become scarcer it will be increasingly difficult to justify support for traditional (high cost/high subsidy) clinical programs, or CBD programs based upon paid staff.

However cost-effective FPA programs may become over the next five years, they are not likely to overcome the long term financial dilemma for FPAs: how to increase self-sufficiency while serving people who cannot afford to pay the full cost of the services. If the CPS data are showing us that FPAs should concentrate on people who otherwise would not have access to family planning, we cannot hope to recover more than a fraction of the cost from those same people. This is especially true of voluntary sterilization and the IUD, two of the most effective methods but always expensive to provide. Consequently, MG subgrantees will be encouraged to recover costs, but their fee structures will be closely examined to make sure they do not constitute a barrier to the most needy.

D) PROPOSED ACTIVITIES, FY1988-FY1992

\$27,000,000

The promising results of the Matching Grant in 1986 were achieved at an annual expenditure of approximately \$4.5 million. In 1987, substantially better results are expected from a program costing from \$6.5 to \$7 million. Since the proposed 1988 budget is \$6.3 million, and since the annual budgets thereafter will steadily decline to \$4.6 million in 1992, what we are really proposing is to do progressively more with less and less. This fact makes it difficult for us to specify in advance exactly how we are going to achieve the projected year by year budget reductions in each activity described below. We are counting on the new program strategy outlined above, and on the cumulative effects of the MG in increasing the cost-effectiveness of FPA programs.

Recognizing that AID faces its own financial limitations, we should point out that our ability to achieve the service goals of the MG, and to implement the far-reaching program strategy described in Section B, depends upon simultaneously maintaining successful services begun in 1986 and 1987 while launching new, more cost-effective collaborative projects during the next five years. If the annual level of MG support to FPAs declines too rapidly, we believe the momentum for change will be lost. Similarly, if the MG is used to replace resources previously provided by AID Missions, or by other Cooperating Agencies, its net effect at the FPA level will be diminished.

Of the \$27 million requested for the next 5 years, 79% will be spent for sub-grants to FPAs, and an additional 5.4% for regional activities of direct benefit to FPAs.

1) Sub-Grants to FPAs

\$21,320,000

The following descriptions of sub-grants to FPAs are necessarily brief and tentative. Even the "big 3" FPAs (Brazil, Colombia, and Mexico) have only one full year of experience with MG projects, and are not yet in a position to make detailed plans for the next five years. All of the FPAs will be gradually losing MG support from 1988 to 1992, and will have to make hard decisions about how to cut costs year by year. Consequently, we have limited ourselves to analyzing the current MG activities of each FPA and indicating the changes we expect to see over the 5-year period.

The annual Work Plans of the MG, which we will present at least 30 days before the start of each Fiscal Year (our Work Plan for the first Fiscal Year of the renewal period will be presented by August 31, 1987), will include detailed descriptions of each sub-project, and specific targets for the next 12 months. Intermediate outputs will be identified, and quantified where possible.

a) BRAZIL (BEMFAM)

\$5,400,000

After a relatively slow start, BEMFAM's service results picked up nicely in the last two quarters of 1986, and the 1986 vs. 1985 comparison is very favorable, especially in terms of CYP. Referred sterilizations (referred by BEMFAM and performed by collaborating public agencies) accounted for about 70% of the net increase.

As revealed by the BEMFAM/Westinghouse Demographic and Health Survey (DHS) of 1986, contraceptive prevalence is already relatively high in Brazil, at 65%, despite the lack of an effective government program. Rather than wait for the government, the Brazilian people have found their own way, largely through pharmacy sales of oral contraceptives and informal provision of female sterilization by private doctors. Most of the clients have to pay the full market price for these methods, which is why there is a strong inverse relationship between the state by state prevalence rates and average per capita income in those states. Prevalence rates in the poorest states are in the 30s and 40s, and if we go below the state level we will find many counties with prevalence in the 20s. Given the sheer size of Brazil, and the number of such states and counties, the Brazilian population still without effective access to family planning is greater than the unserved population of most neighboring countries combined.

Furthermore, the method mix of Brazil's current prevalence is not what it should be. The heavy reliance on sterilization suggests that family planning is being used largely to terminate child bearing, rather than to space births. The result is earlier child bearing, and a higher rate of population growth (still about 2%) than would be the case if more temporary methods were available. The heavy use of orals is testimony to their low over-the-counter price, but includes many women (e.g. smokers and older women) who would be better off using another method. In short, the relatively high prevalence in Brazil is certainly good news, but the DHS also reveals the existence of large-scale needs, especially in poor areas, and distortions resulting from the limited availability of other methods.

Given the overall prevalence rate in Brazil, and the heavy concentration on just two methods, we expect BEMFAM to demonstrate that the projects it proposes for the next five years will reach areas, or populations, that are poorly served at the moment, and that the method mix offered will broaden the options available to low-income clients. We will also be looking for projects that do not generate heavy recurring costs for BEMFAM. Proposed training or IEC activities will be supported if they are directly related to services.

The proposed budget shows a 5-year total of \$5.4 million for Brazil, down significantly from the \$1.5 million per year allocated for the first two years of the MG. The proposed level of support should allow BEMFAM to continue statewide community-based programs in Brazil's Northeast (Piaui, Ceara, and Bahia) and in urban slums of the Southeast. Clinics of three types (Reference, Demonstration, and Support) will be maintained in those areas where the demand is sufficient to make them cost-effective. In other areas, collaborating private MDs will be enlisted to provide medical backup and to increase the geographical reach of BEMFAM's services.

b) COLOMBIA (PROFAMILIA)

\$6,400,000

The MG in Colombia was a tremendous success during 1986, yielding a 32% increase in sterilizations and significant increases in other areas. It coincided, unfortunately, with a decline of PROFAMILIA's commercial distribution program (not supported by the MG), due to factors beyond PROFAMILIA's control. For that reason the net increase in new acceptors and CYP from 1985 to 1986 did not fully reflect the success of the MG projects.

Given the initial success, we see no reason to change the current mix of voluntary sterilization, other clinical services, and CBD for the 1988-92 period. We recently discussed sterilization services with AVSC and PROFAMILIA representatives, and remain convinced that it is too early to expect those services to become self-sufficient. There are still too many Colombians for whom a partial subsidy is not enough: they can only afford sterilization if it is heavily subsidized, as it is in the MG projects. There is no other explanation for the 32% jump in sterilizations during the first year of MG support. From 1988 to 1992, PROFAMILIA will continue to provide low-cost sterilizations through :

- 1) Rural Mobile Programs
- 2) Urban Mobile Clinics
- 3) Hospitals and Private Clinics
- 4) PROFAMILIA clinics

MG funds will also be used to support 6 urban and 10 peripheral clinics, offering a full range of contraceptive methods. As the annual level of MG support gradually declines, however, supplementary income will have to be found for some of these clinics.

PROFAMILIA was the pioneer of community-based distribution in this hemisphere, and has accumulated a wealth of experience in managing large-scale CBD programs in urban

slums and remote rural areas. The MG will continue to support CBD programs in four of Colombia's most important cities: Bogota, Barranquilla, Cali, and Cartagena.

The current subgrant to PROFAMILIA includes some creative information and education in support of services, including posters and billboards which testify to PROFAMILIA's status as an FPA whose name means family planning to most Colombians. Unfortunately, this element will have to be sharply reduced starting in 1988, due to the much lower level of MG support.

The proposed 5-year budget includes \$6.4 million for Colombia, down significantly from the \$1.8 million which has been approved for the current year. Nevertheless, we are confident that PROFAMILIA will find ways of maintaining most of the sterilization, clinical, and CBD services presently being funded under the MG, and of increasing the total volume of services provided.

c) MEXICO (MEXFAM)

\$5,250,000

MEXFAM more than doubled its service provision from 1985 to 1986, and did so thanks largely to MG projects which promise to have modest recurring costs in the long run. MEXFAM activities, previously confined to 12 states, were extended to an additional 11 states. It would be hard to imagine a better start for the MG in Mexico.

We see no need for any change in program strategy, and believe that the "Medicos Comunitarios" project, already functioning well in a variety of different environments, deserves replication on a far wider scale. During the next five years, MEXFAM will increase from 90 to 300 the number of young Community Doctors it trains and helps to establish in poor communities. These doctors will receive some basic medical furniture and equipment from MEXFAM, together with contraceptives and a gradually declining guarantee of MEXFAM reimbursement for services to new family planning acceptors. MEXFAM also provides community promoters, who inform local residents about the Community Doctor, and distribute free coupons for family planning services. The doctors sign an agreement to provide family planning services at subsidized prices (fees for other services are set according to the local market), and are visited periodically by MEXFAM staff. Recent visitors to MEXFAM have been unanimous in their praise for this project, in which the FPA seems to have found just the right formula for motivating young doctors to offer family planning and other health services in poor communities, where they are really needed.

MEXFAM also works with two other categories of private MDs, in ways that deserve careful analysis: "Medicos Afiliados"

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and "Medicos Asociados". The Associated Doctors are already established in practice, so they need no income guarantee or start-up support from MEXFAM. The FPA provides training and contraceptives to help these doctors become efficient providers of family planning services and information. The Affiliated Doctors are an even more interesting category, because they were once salaried employees of MEXFAM, in the days when the FPA maintained a large and costly network of clinics. Now those same doctors are financially independent of MEXFAM, and have their own private clinics, but deliver even more family planning.

In fact, MEXFAM is engaged in challenging the traditional structure of FPAs, through a conscious effort to eliminate salaried positions. In service delivery, this has largely been accomplished, as MEXFAM's Director reports: "MEXFAM doctors who serve the public receive their fees directly from the clients or, in the case of clients who lack the resources, they are reimbursed by MEXFAM for each service delivered." This is an innovation which deserves careful evaluation, and possible replication by other FPAs.

MEXFAM has demonstrated considerable ingenuity and flexibility in collaborating with public sector providers, especially DIF. Public sector providers have vast human and physical resources at their disposal, but are often operating at a fraction of their capacity because of simple administrative or logistical problems that MEXFAM, thanks to its long experience in family planning, can help to solve. MEXFAM signs cooperative agreements with such agencies, usually on a state by state basis, and thus gains opportunities to help improve public sector services.

MEXFAM has also demonstrated a flair for innovative posters, pamphlets, and other audio-visual materials in support of its services. Its materials aimed at men are particularly creative, and are now used to promote a special male clinic in Mexico City.

In short, MEXFAM has made excellent use of MG resources thus far, and seems to be heading in exactly the cost-effective direction that we would like to encourage. We are proposing \$5.25 million for Mexico during the next 5 years, which will average slightly less than the \$1.1 million annual support at present. In 1988 and 1989, however, MG support will be somewhat higher, allowing MEXFAM to expand the "Medicos Comunitarios" project and collaborative projects with public sector agencies.

MEXFAM will continue to present its MG projects in geographical clusters, covering service networks in Mexico City, 8 other Mexican cities served mainly by public sector agencies, 6 cities served by "Medicos Comunitarios", 7 rural areas, and three areas served by medical school health programs. The FPA adapts itself to the needs and resources

of each area, using different mixes of clinical and CBD services. All contraceptive methods are available, with most sterilizations being performed by collaborating public agencies.

d) CHILE (APROFA)

\$850,000

The expansion of APROFA's collaboration with the Red Cross, now involving 35 Red Cross clinics, is very much in line with our desire to take advantage of other resources in Chile. Furthermore, everyone who has visited the clinics comes away impressed by the very high quality of service being provided, not just in family planning but in all areas of primary health care. Nevertheless, the volume of family planning provided in 1986 was modest, especially when compared to the services delivered the previous year by the Ministry of Health, with help from the FPA. During 1987 we will be evaluating the Chilean project to see whether the productivity of the Red Cross clinics in family planning can be increased or their recurring costs to APROFA decreased.

One possible solution would be to experiment with different procedures for follow-up visits: the current procedures require physical exams for routine follow-up visits, which limits the medical time available to see new acceptors or patients with specific complaints. Another possibility would be to experiment with different financial arrangements between APROFA and the Red Cross. At present APROFA pays the extra cost of the family planning services, including the salary of an APROFA nurse-midwife who works at each Red Cross clinic. Perhaps an agreement could be reached for the Red Cross to share in these expenses or to gradually assume them after the service is well established. If neither of these approaches proves to be possible (both would depend ultimately on Red Cross decisions), APROFA might be able to expand services through a group of young community doctors, or nurse-midwives, as in Mexico.

In any event, we know from preliminary 1986 data that the Ministry's family planning program lost ground last year, and it is no longer realistic to expect the public sector to take care of all family planning needs in Chile. Therefore it is increasingly important for the FPA to find additional partners, and new ways of delivering services.

We propose to provide gradually declining support to APROFA over the next five years to pursue these possibilities: an average of \$170,000 per year as compared with \$260,000 this year. If the Red Cross clinics become more productive during 1987, or if an alternative service opportunity is found, we are prepared to recommend an increase in the allocation for Chile.

e) GUATEMALA (APROFAM)

\$400,000

The need for training in voluntary sterilization is enormous throughout the hemisphere, and APROFAM is one of the very few Latin American organizations qualified to offer training in the three major sterilization techniques: vasectomy, laparoscopy, and mini-laparotomy. Although this training project was originally approved with Guatemalan doctors and nurses in mind, the Guatemalan Ministry of Health finally decided not to participate, and APROFAM went on to train 19 physicians (five of them foreign) and 6 nurses in 1986. This year, APROFAM will train 24 doctors and nurses sent by other Latin American FPAs, as well as numerous Guatemalan doctors and nurses. During the next five years there will no doubt be ample demand to fill the available training slots.

That being the case we would ordinarily propose full funding of this regional training course for the next 5 years, but it has been suggested that AVSC or the AID Mission in Guatemala might be willing to take over the cost of the training, or that other AID Missions could cover the costs of some foreign trainees. Assuming that will take some time to put together, and that other agencies may not have the budgetary resources to cover the full costs, we are requesting enough support to maintain the course at about two thirds of its current level (70 trainees per year, plus travel, plus equipment) in 1988, with declining support in subsequent years.

f) PERU (INPPARES)

\$1,200,000

INPPARES has done very well with its modest MG support, nearly doubling new acceptors and CYP in just 8 months of 1986. The FPA has expressed strong interest in expanding services further, both in Lima and in the outlying Departments, and we think they would make good use of additional MG support.

Some support for service expansion by INPPARES should be available from the bilateral project in Peru, but initial indications are that the Pathfinder funding will have to be divided among many different PVOs, and that support for INPPARES will be approximately \$90,000 for the year beginning July 1, 1987. That will certainly help, but will not come close to exploiting the full service potential of the FPA. All things considered, we have proposed a slightly higher level of annual MG support in Peru during the next 5 years. This will allow INPPARES to expand its current MG projects in Arequipa, Chiclayo, and Iquitos, and to establish a network of "Medicos Comunitarios" (the MG

Project Director of INPPARES will be visiting MEXFAM in June). Support for the model Patres Clinic will continue, and INPPARES will provide outreach services via large private companies in Lima. If any MG resources remain, they will be used to open new centers in Piura, Juliaca, Huanuco, Pucalpa, or Brena (a marginal area of Lima).

g) TRINIDAD AND TOBAGO (FPATT)

\$350,000

When FPATT proposed its original sterilization referral project, the premise was that a nurse-educator, by providing information to private doctors about the sterilization services of the FPA, could generate a substantial increase in the use of those services. The disappointing results of this very small project (there was no increase of sterilization acceptors in 1986) have led us to re-examine the premise, and we now understand that the lack of information about FPA services among private doctors was not a major limiting factor. Rather, there seems to be a need to provide more information directly to potential acceptors, to lower FPA service fees (the economy is now severely depressed), and to streamline the patient flow in the Association's two clinics.

The failure of the sterilization referral project, plus the appointment of a new Executive Director, has galvanized the FPA into corrective action. The reform of sterilization services is still being studied, but in February the Association published ads waiving all registration fees for new acceptors, and offering free condoms to men and women. The response was immediate: both the rate of new acceptors and the number of condoms distributed more than doubled when compared to the same period of 1985.

This has convinced the FPA that prices and publicity really do make a difference, and should lead to a much more creative use of MG funds. WHR staff will be working actively with the new Director and her staff this year, and will explore various new service possibilities, including a network of private MDs (because of the economic depression, many MDs are now underemployed, and presumably more open to such collaboration). A Client Survey will be carried out later this year, and that should help guide the FPA in reorganizing its services.

We propose a slight reduction of support in 1988 (\$90,000, as opposed to \$102,000 this year), tapering to \$50,000 in the fifth year.

h) URUGUAY (AUPFIRH)

\$400,000

AUPFIRH received limited MG support in 1986, and made very good use of it. This is indicated by their new acceptor and CYP figures, both well above 1985 levels. Even more important, MG support allowed the FPA to start working directly with Ministry of Health doctors, in the field, and this could be the start of a nation-wide collaboration, exactly the sort of approach we were suggesting in section B4b, above.

Even though Uruguay is not a high-priority country for AID, we think this is a low cost/high leverage opportunity that should not be ignored. We propose to slightly increase the level of support, to \$100,000 in 1988, and then gradually decline to \$60,000 in the 5th year. This should allow the FPA to expand its joint activities with the Ministry in the interior of Uruguay, and also to maintain community-based services of its own in the marginal areas around Montevideo.

i) OTHER FPAs

\$1,070,000

This is a residual category, but an important one. We are sure that the programs outlined above do not do justice to the 5-year opportunities in those eight countries, much less in the Western Hemisphere. In order to make the best possible use of MG funds over a 5-year period we think it is important to keep approximately 4% of MG funds in this flexible category of "other FPAs" so that when opportunities arise we are not then forced to cut back on existing projects (unless they are failing, in which case we should certainly regard the funds as available for re-allocation).

There are already potential candidates for these funds. Most important are the FPAs that carry out "client surveys" and will then need some help in making the changes that clients think are necessary. Next are some FPAs that have not yet benefitted from working with MG support (we are beginning to think that the process is as important as the funding, especially for FPAs that receive relatively small sub-grants). We hope to start working this year in Panama, on a small scale. We have requested AID approval of a male-oriented program there, involving community services offered by Volunteer Fire Departments and the Armed Forces, and vasectomy services offered directly by the FPA. We are optimistic about the potential of the MG to motivate other FPAs to expand and improve services, even some FPAs that have not changed their program strategy in years, and have been considered "difficult" FPAs.

There are other FPAs that are already receiving AID support, either through Cooperating Agencies or through a bilateral project, but still need additional funding to exploit the

service opportunities. During the next 5 years these FPAs are fully capable of coming up with project ideas for which no provision has been made. We would like to be able to follow up on some of these ideas in a modest way without having to request a formal amendment of the MG.

The FPA in Ecuador is a likely candidate, because its present support through a bilateral project will not cover a proposed expansion of its private MDs project. The new FPA in Belize wants to open two additional clinics that are not included in its bilateral project. The FPA in Paraguay wants to begin a major reformulation and expansion of its service program.

Last but not least there is Venezuela, where fertility remains high and where the new FPA needs all the help it can get. During the next five years we intend to raise again the possibility of MG support to that FPA.

For all of these reasons we have proposed \$250,000 in the Other FPAs category for 1988, tapering to \$170,000 in 1991 and 1992.

2) Regional Activities

\$1,470,000

a) COMMODITIES

\$560,000

FPAs have three main sources for the commodities they need to carry out their programs: IPPF, AID in-kind, and local purchase. IPPF/WHR tracks FPA consumption of commodities from all these sources through the Half-Year Report and the Annual Report which all grant-receiving FPAs must submit, in August and February. The forms used in these two reports (see Attachment IV) cover all commodities from all sources, and the use of contraceptives is broken down by type and brand.

In April of each year FPAs submit their Three-Year Plans (3YP), which include a forecast of use for each commodity. These FPA forecasts are analyzed by WHR staff in New York, and in June the Regional Board of Directors recommends IPPF commodities grants for the next three years. These recommendations are based on analysis of past consumption, new projects which will generate additional consumption, and estimated buffer stocks needed at the end of each year. The WHR recommendations are reviewed by the IPPF staff in London and approved (in whole or in part) by the IPPF Central Council in November. By that time WHR has received a more detailed FPA plan for the following calendar year, the Work Program and Budget (WPB), and is able to adjust its regional

recommendations accordingly.

In general the system works well, but it is subject to the accuracy and timeliness of FPA reporting about past consumption and present stocks, and FPA estimates of future consumption and commodities that will be received from other sources. Mid-course corrections are sometimes made, in the form of supplemental commodities grants above and beyond what was originally approved, and occasionally excess stocks in one FPA are transferred to another FPA.

A more profound problem, which the MG helps to address, is that the IPPF is simply not able to provide all the commodities needed by FPAs. IPPF commodities grants are paid from the same international budget that also funds IPPF cash grants for basic FPA program expenses, so inevitably there are compromises, and shortfalls, on both sides.

During the next five years, \$560,000 in MG funds will be reserved for the purchase of commodities needed by FPAs and not supplied by other donors (for 1987 the IPPF cut its commodities grants to many Associations). These funds will be used only for service-related cash commodities not available in-kind from AID, and for associated procurement, freight, and warehouse expenses. Actual purchasing and shipping will be done under contract with a purchasing agent, to be chosen through open bidding.

In addition to purchasing and distributing cash commodities, WHR will provide AID with written analyses of FPA needs for in-kind contraceptives, and will report semi-annually on FPA usage and stocks of those contraceptives. Attachment V contains our projections of 1988-1992 FPA needs for the four products currently provided in-kind by AID: Plain Condoms, Colored Condoms, Lo Femenal oral contraceptives, and CUT-380 IUDs.

As at present, the MG Project Supplies Officer and the Regional Supplies Coordinator will:

- a) Analyze FPA commodities reports and estimates
- b) Recommend amounts needed from IPPF and AID in-kind
- c) Identify key gaps that should be covered with MG cash commodities
- d) Provide on-site technical assistance to FPAs in the management of commodities, and verify that FPA reporting is accurate and that estimates of future needs are realistic

As described in the second year work plan of the MG, WHR has begun a major effort to modernize and standardize MIS at the FPA level.

1) Basic Hardware, Software, and Training

This year, 15 Latin American FPAs are scheduled to receive IBM-XT286-compatible computers, general purpose and specialized software, and training in their use for the management of service, commodities, and financial data. The training will be held in September, 1987, at one of three sites: the training center of ADC in Costa Rica, PROFAMILIA's training center in Colombia, or Research Triangle Institute in North Carolina. RFPs will be sent to these three centers in May.

During the two weeks of training, two staff members from each of the 15 FPAs will be exposed to:

a review of the IPPF Program Planning Budgetting and Reporting System (PPBR)

a basic introduction to computer installation and operation

instruction in the use of SuperProject Plus software, file maintenance software, and the computerized version of PPBR (written in Framework)

At the end of the training, participants will know how to install their IBM XT286-compatible, use SuperProject Plus to schedule project implementation, and track the financial and program aspects of FPA projects with computerized PPBR.

After the training, follow-up technical assistance will be provided through two visits to each FPA during FY1988, and consultants will be available for additional visits on short notice.

This same basic package of hardware, software, and training will be provided to 10 English-speaking FPAs in 1988.

2) Resource Allocation Model

The Associations of Brazil, Colombia, and Mexico will receive additional training in the use of a resource allocation model (RAM) being developed this year. This model, which builds on research carried out in Colombia with World Bank support, allows FPA managers to simulate changes in program objectives, family planning methods, delivery modes, and availability and prices of program resources. Discrepancies between resources required and those available will highlight the feasibility of

alternative scenarios and the particular resources constraining them.

The implementation of RAM requires extensive program and financial data from each FPA, and it will be extended to 10 more FPAs in 1988 and 1999.

3) Fund Accounting Systems

Beginning in 1989, we will start to link program outcome information with accounting information, to measure the accounting cost of FPA services and other activities. This will greatly facilitate financial analysis and reporting (by donor, by project, by clinic, etc.).

First the existing accounting systems (manual or automated) will be evaluated, to make sure they measure and report expenditures according to the program objectives of the FPA, and of each project. Once this is done, the FPAs will be trained in the use of fund accounting software. Ten FPAs will be selected for this evaluation and training in 1989, and five more in each of the next three years.

4) Telecommunications

In 1989 and 1990, 15 Associations will be provided with telecommunications hardware and software to use with their computers, so that text and data can be transmitted over telephone lines to New York and other FPAs. Depending on the quality of national telephone systems, this will be extended to additional FPAs in 1991.

By the end of the 5th year, 25 of the 35 grant-receiving FPAs of the WHR will have received the basic MIS package, and most will have received RAM and fund accounting as well. At least fifteen of the most important Associations and the New York office will be linked through a computer-based telecommunications network which will handle most of the written communications among them.

c) EVALUATION SUPPORT

\$335,000

Project Evaluation Officer

The MG Project Evaluation Officer is responsible for the compilation, correction, and analysis of service statistics received from the sub-grantees. The work also involves: monitoring the impact of MG-funded sub-projects on the FPA's service delivery program; providing technical assistance during field trips, to improve FPA target setting, accuracy and timeliness of reporting, and managerial use of evaluation data; and coordinating special research projects and meetings funded by the MG, as described below.

Client Surveys

Assuming that the four Client Surveys scheduled for this year prove useful, 6 more surveys will be carried out during the first two years of the renewal period, three in 1988 and three in 1989. In addition to revealing client likes and dislikes about FPA services, these surveys will identify determinants of client satisfaction that are within the control of the clinic administrator. Key variables such as travel time and costs, waiting time, physical discomfort or psychological stress, revisit/resupply requirements, and FPA fee structures will be examined with the goal of estimating the Real Cost of Contraception (RCC) at the FPA clinic. The surveys will also include questions (and information from other sources) designed to help estimate the RCC at alternative service locations, and may thus reveal program needs and opportunities beyond the improvement of existing FPA services.

Clinic Profiles

In three of these same 6 countries, we will attempt to develop Clinic Profiles, by examining clinic data and reports of previous years and looking for numerical indicators which preceded periods of greater or lesser productivity. The goal, as explained earlier, is to identify several indicators which can be built into a computerized clinic MIS (whose development is being funded by the MacArthur Foundation) and will collectively alert FPA managers to problems before they become chronic. We will examine service ratios, by month or by quarter, such as:

- 1) Family Planning visits to non-FP visits
- 2) IUDs inserted to IUD revisits
- 3) Sterilization counseling sessions to operations performed
- 4) Orals New Acceptors to revisits
- 5) CYP to total visits, by method
- 6) medical hours to consultations

We will also examine simple trend data, in an effort to identify patterns that mark the onset of clinic problems.

Project Outputs Related to Declining MG Support

During the period 1988 to 1992, annual MG support is scheduled to decline from \$6.3 Million to \$4.6 Million. This means that most subprojects will have a declining proportion of their costs financed by the MG. The annual MG

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evaluation will include an analysis for each subproject that relates New Acceptor and CYP outputs to the year's MG contribution, and to total subproject costs.

Meetings

There will be one technical meeting per year of FPA Evaluation Directors. The agenda for each meeting will cover one subject in detail, such as operations research, or client surveys, or evaluation of collaborative programs, and will provide time for other Cooperating Agencies, such as the Population Council, Development Associates, or Population Communication Services, to contribute.

Just as FPA and other representatives will be meeting later this year to analyze different ways of collaborating with private MDs, in 1988 we will hold an analogous meeting of FPA and public sector representatives to discuss various ways FPAs can help public agencies and vice versa.

Intermediate Indicators

Together with each FPA, intermediate indicators of project output will be set in each annual MG Work Plan. For service projects New Acceptors and CYP will remain as the final indicators, but there are numerous possible intermediate indicators, depending on the type of project:

CBD Projects

- New posts opened
- New distributors recruited and trained
- Average New Acceptors per post
- Client satisfaction

Clinical Projects

- Improved method mix
- Better patient flow
- lower average waiting time
- Client satisfaction

Private MD Projects

- New Doctors enrolled
- MD turnover
- contract compliance
- % FP visits of total visits
- financial self-sufficiency
- Client satisfaction

Public Sector and PVO Cooperative Projects

- New agreements signed
- Number of service sites involved
- Degree of FPA financial input required
- Client Satisfaction

d) TECHNICAL ASSISTANCE

\$165,000

The current MG supports "Technical Assistance Among FPAs", which has allowed FPA staff and volunteers to visit other Associations and to see projects and management procedures which could be adapted to their own environments. This kind of exchange among FPAs is hard to evaluate in the short run, beyond what is contained in the trip reports (some of which have been quite impressive). Still, we are getting lots of positive feedback from the FPAs, and we remain convinced that in many cases interaction among FPAs is the most efficient way for innovations to spread within the region.

We therefore propose to continue this kind of technical assistance, but at a lower level of funding (from \$50,000 in 1988 to \$20,000 in 1992), emphasizing exchanges directly related to program strategy and innovations in service delivery. At an average cost of \$2000 per trip, this will allow approximately 80 FPA representatives to visit other FPA programs during the 5-year period, most of them in the first three years.

3) Administration

\$2,590,000

We propose no major changes in the administration of the MG, except that gradual reductions in the amounts allocated for consultants, travel and per diem, and office equipment would offset the gradual increases in salaries and fringe benefits, so that the total cost of administration in the 5th year (534,000) would be only slightly more than the cost in 1988 (519,000).

The MG will continue with its current staff composition, which seems to have worked well:

Project Director
Project Officer
Project Accountant
Project Supplies Officer
Project Evaluation Officer
Project Secretary

The consultant item will be used rather differently, in response to the changing needs of the project. So far the consulting has been "in house", to pay for the time of other WHR staff who have helped the MG staff in New York and in the field. Now that the MG staff is more experienced, there is less need for day-to-day help from other WHR staff. What is needed now is more specialized advice in such areas as medical standards and procedures, and more detached advice about FPA management (staff structure and composition, salary policies, financial management, etc). Consequently, we intend to appoint a part-time Medical Consultant, and a Management Consultant, each of whom will devote approximately 50 days to the MG in

1988, and lesser amounts in succeeding years.

4) Indirect Costs .. \$1,620,000

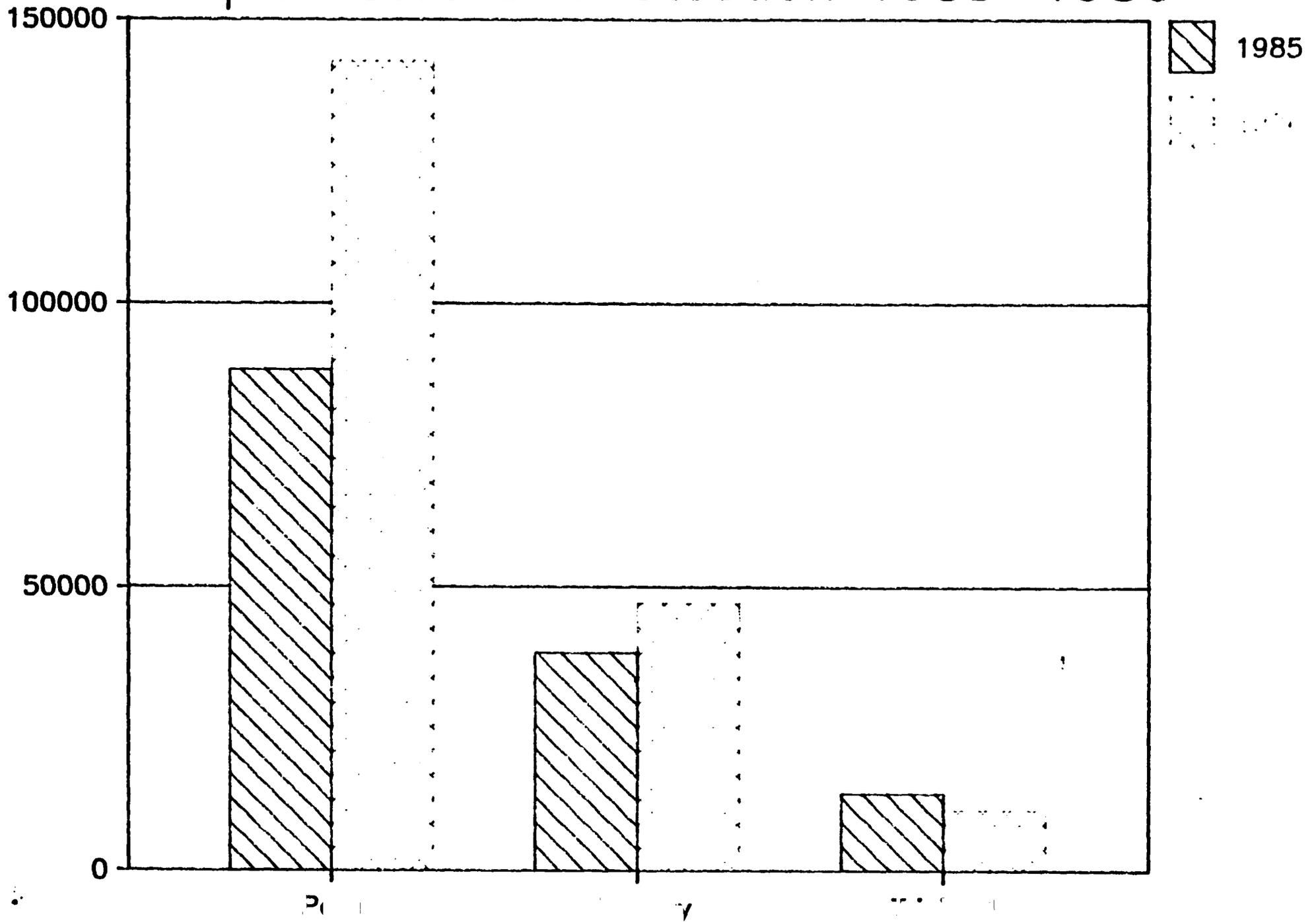
We estimate that indirect costs will amount to 75% of salaries and fringe benefits, including consultants, virtually the same as the estimated 76% in the current MG. Naturally these rates are subject to detailed analysis and approval by AID auditors.

A) BUDGET SUMMARY: FY1988 - FY1992

..	Budget in 9000s					TOTAL	% of GRAND TOTAL
	1988	1989	1990	1991	1992		
I. SUPPORT TO FPAs							
Brazil	1300	1190	1080	970	860	5400	20.0
Colombia	1500	1390	1280	1170	1060	6400	23.7
Mexico	1250	1150	1050	950	850	5250	19.4
Chile	190	180	170	160	150	850	3.2
Guatemala	100	90	80	70	60	400	1.5
Peru	260	250	240	230	220	1200	4.4
Trinidad&Tobago	90	80	70	60	50	350	1.3
Uruguay	100	90	80	70	60	400	1.5
Other FPAs	250	230	210	190	190	1070	4.0
SUB-TOTAL	5040	4650	4260	3870	3500	21320	79.0
II. REGIONAL ACTIVITIES							
Commodities	150	130	110	90	80	560	2.1
MIS	130	100	80	70	50	430	1.6
Evaluation	90	90	55	40	40	310	1.1
Technical Assistance	50	40	30	25	20	165	.6
SUB-TOTAL	420	360	275	225	190	1470	5.4
III. ADMINISTRATION							
a) Salaries/Fringes	309	331	362	396	432	1830	6.8
b) Consultants	100	80	60	50	40	280	1.2
c) Travel/Per Diem	100	90	80	70	60	400	1.5
d) Office Eqpt.	10	8	6	4	2	30	.1
SUB-TOTAL	519	509	508	520	534	2590	9.6
IV. INDIRECT COSTS	306.7	308.3	316.5	334.5	354	1620	6.0
V. GRAND TOTAL	6285.7	5827.3	5359.5	4949.5	4578	27000	100.0

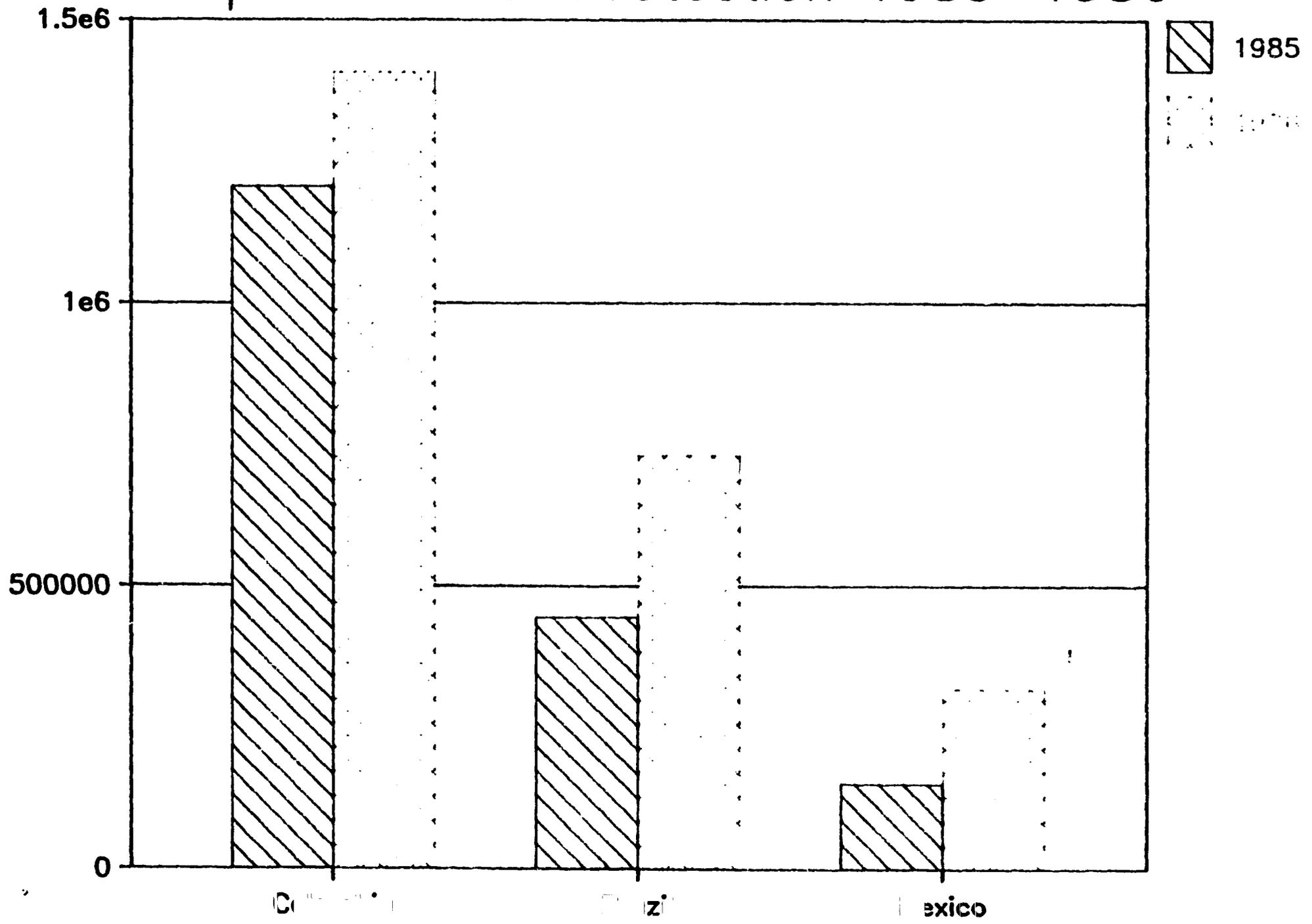
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Couple Years of Protection 1985-1986

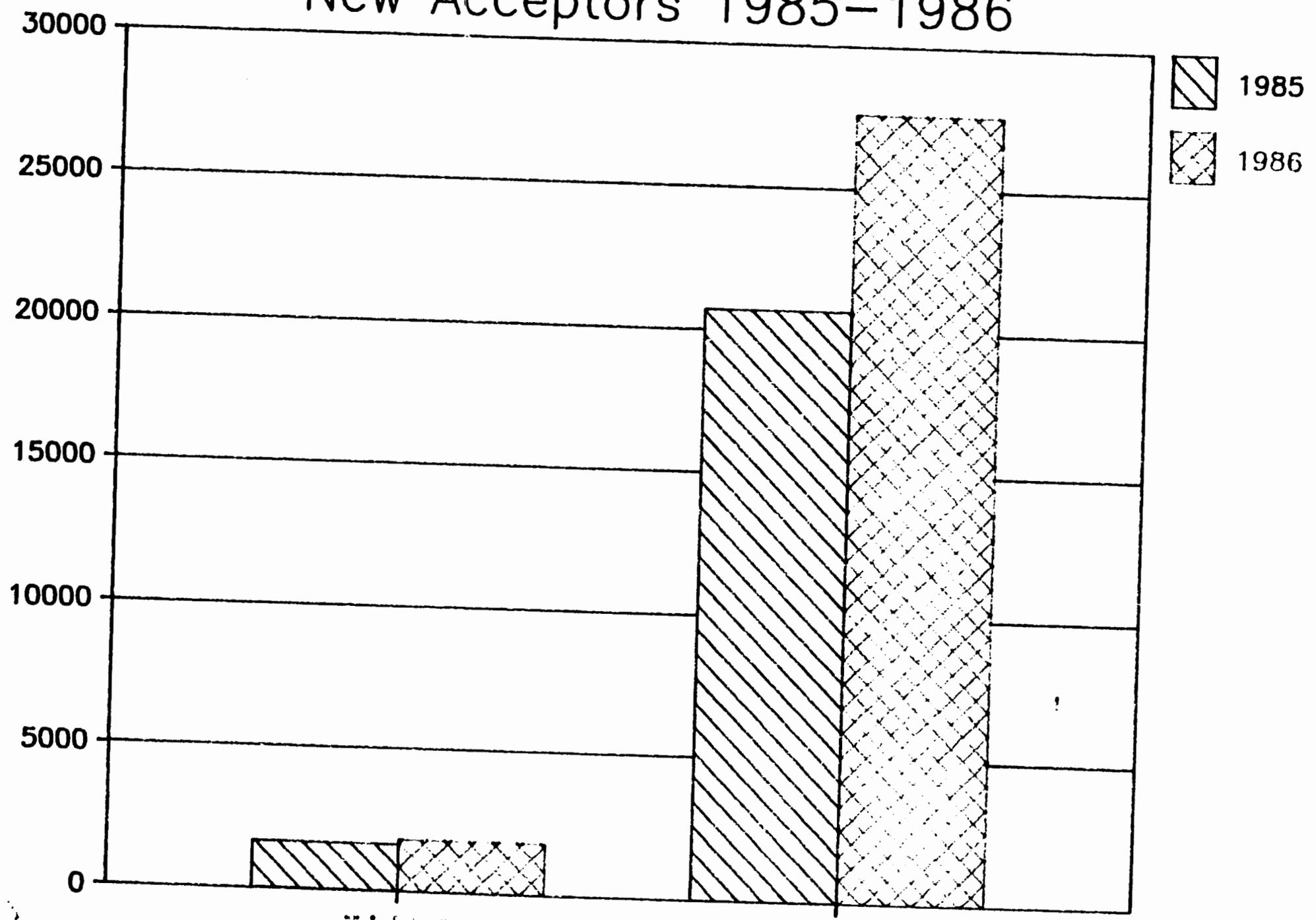


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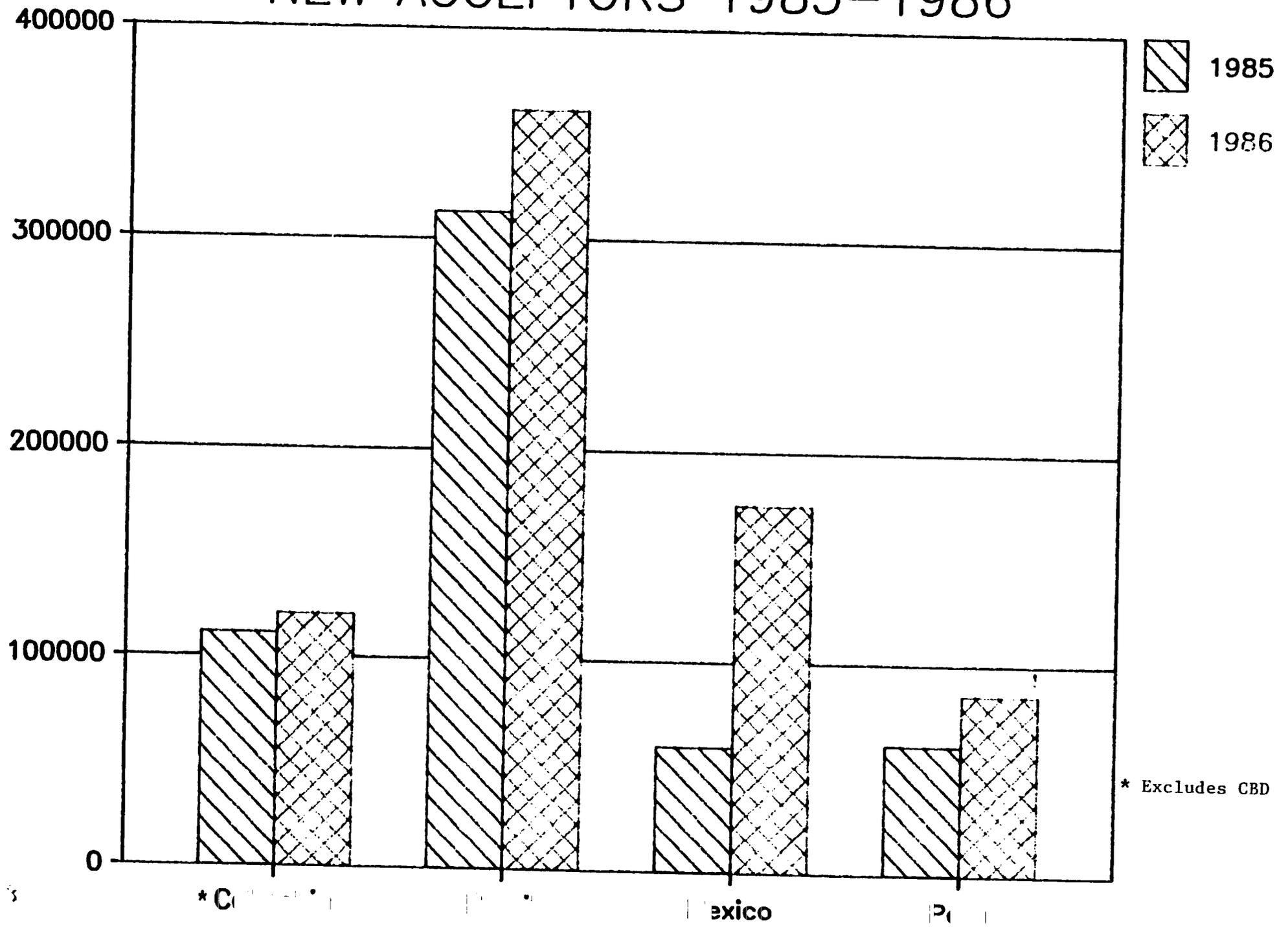
Couple Years of Protection 1985-1986



New Acceptors 1985-1986



NEW ACCEPTORS 1985-1986



MATCHING FUNDS FOR THE ASSOCIATIONS
WORKING WITH THE MATCHING GRANT PROJECT

PERIOD: JANUARY 1, DECEMBER 31, 1986

COUNTRIES	MATCHING GRANT	OTHER FEDERAL FUNDS	TOTAL	NON FEDERAL FUNDS
1- BRAZIL	1,780,079.97	883,104.47	2,663,184.44	2,752,901.36
2- COLOMBIA	1,737,386.00	1,355,567.35	3,092,953.35	3,538,211.58
3- MEXICO	1,149,146.02	233,079.72	1,382,225.74	1,133,833.03
4- ARGENTINA	54,811.00	.00	54,811.00	388,815.05
5- CHILE	100,513.76	43,999.56	144,513.32	622,954.15
6- GUATEMALA	20,436.62	1,970,907.05	1,991,343.67	1,052,607.39
7- PERU	103,528.30	154,455.34	257,983.64	347,767.53
8- TRINIDAD AND TOBAGO	30,504.16	94,604.17	125,108.33	515,490.28
9- URUGUAY	37,619.00	24,575.50	62,194.50	218,983.49
TOTAL	5,014,024.83	4,760,293.16	9,774,317.99	10,571,563.91

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ANNUAL REPORT

ATTACHMENT IV

ISSUES

Format "E1"

ASSOCIATION:

YEAR:

	ACTUAL Quantity	APPROVED BUDGET Quantity	VARIANCE between ACTUAL & BUDGET
/BRAND: T :			
Stock at 1 January			
2. Received/Requested through IPPF			
Received/Expected from other sources			
Issues to Association acceptors			
Issues to Other Agencies (please specify)			
Other Issues (incl losses, etc. : please specify)			
Stock at 31 December (Lines 1,2 and 3 less lines 4,5, and 6)			
BRAND: T :			
Stock at 1 January			
2. Received/Requested through IPPF			
Received/Expected from other sources			
Issues to Association acceptors			
Issues to Other Agencies (please specify)			
Other Issues (incl losses, etc.:please specify)			
Stock at 31 December (Lines 1, 2 and 3 less lines, 4,5 and 6)			

COMMENTS: Use a separate sheet of paper and attach it to Format "E1"

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THREE YEAR PLAN

CONTRACEPTIVES: NON IPPF SUPPLY

FORMAT "E1"

ASSOCIATION:

PART 2

CONTRACEPTIVE TYPE/BRAND (Unit)	SOURCE OF SUPPLY	ACTUAL 19 Quantity	APPROVED BUDGET 19 Quantity	FORECAST		
				19 Quantity	19 Quantity	19 Quantity

COMMENTS:

!

WORK PROGRAMME/BUDGET

CONTRACEPTIVES

FORMAT "E1"

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ASSOCIATION:

PART I

ACTUAL 19 Quantity	APPROVED BUDGET 19 Quantity	FORECAST 19 Quantity
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TYPE/BRAND: UNIT :			
1. Stock at 1 January			
2. Add Received/Requested through IPPF			
3. Add Received/Expected from other sources			
4. Less Issues to Association acceptors			
5. Less Issues to Other Agencies			
6. Less Other Issues (incl. losses, etc.)			
7. Stock at 31 December			
	8. Estimated Issues for year after "FORECAST" year		
TYPE/BRAND: UNIT :			
1. Stock at 1 January			
2. Add Received/Requested through IPPF			
3. Add Received/Expected from other sources			
4. Less Issues to Association acceptors			
5. Less Issues to Other Agencies			
6. Less Other Issues (incl. losses, etc.)			
7. Stock at 31 December			
	8. Estimated Issues for year after "FORECAST" year		

PROJECTED NEEDS FOR IN-KIND COMMODITIES, 1988-1992

PRODUCT: PLAIN CONCOMS

COUNTRY	1985 USAGE	1986 PROVIDED	1987 APPROVAL	1988	1989	1990	1991	1992
ANGUILLA		0	0	0	0	0	0	
ANTIGUA		0	0	0	0	0	0	
ARGENTINA		0	0	0	0	0	0	
ARUBA		0	0	0	0	0	0	
BAHAMAS		0	0	0	0	48,000	52,800	58,080
BARBADOS	0	30,000	34,000	92,400	101,640	111,904	122,934	135,288
BELIZE		48,000	0	0	0	0	0	
BOLIVIA		198,000	120,000	132,000	145,200	159,720	175,592	193,264
BRAZIL		0	0	0	0	0	0	
CFPA		6,000	0	0	0	0	0	
CHILE		0	0	0	0	0	0	
COLOMBIA		0	0	0	0	0	0	
COSTA RICA		0	0	0	0	0	0	
CURACAO		0	0	0	0	0	0	
DOMINICAN REPUBLIC		0	0	0	0	0	0	
DOMINICA		0	0	0	0	0	0	
ECUADOR		0	0	0	0	0	0	
GRENADA		198,000	198,000	0	0	217,800	239,580	263,532
GUATEMALA		0	0	0	0	0	0	
GUYANA		0	0	0	0	0	0	
HAITI		42,000	72,000	79,200	87,120	95,332	105,415	115,956
HONDURAS		0	0	0	0	0	0	
JAMAICA		240,000	248,000		0	0	382,800	422,184
MEXICO		0	0	0	0	0	0	
MONTSERRAT		0	0	0	0	0	0	
NICARAGUA		0	0	0	0	0	0	
PANAMA		0	0	0	0	0	0	
PARAGUAY		0	0	0	0	0	0	
PERU		1,491,600	1,998,000	678,000	1,338,000	1,410,000	1,475,000	1,554,000
ST. KITTS		0	0	0	0	0	0	
ST. LUCIA		0	0	0	0	0	0	
SURINAME		0	0	0	0	0	0	
ST. VINCENT		0	5,000	5,600	7,260	7,986	9,725	3,568
TRINIDAD & TOBAGO		168,000	108,000	198,000	234,000	246,000	258,000	270,000
URUGUAY		0	0	0	0	0	0	
VENEZUELA		0	0	0	0	0	0	
TOTAL		2,421,600	2,934,000	3,227,400	3,550,140	3,905,154	4,295,569	4,725,236

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PROJECTED NEEDS FOR IN-KIND COMMODITIES, 1988-1992

PRODUCT: COLORED CONDOMS

COUNTRY	1986 PROVIDED	1987 APPROVAL	1988	1989	1990	1991	1992
ANGUILLA	0	0	0	0	0	0	0
ANTIGUA	0	24,000	26,400	29,040	31,344	35,138	38,652
ARGENTINA	0	0	0	0	0	0	0
ARUBA	12,000	12,000	13,200	14,520	15,972	17,568	19,326
BAHAMAS	0	0	0	0	12,000	13,200	14,520
BARBADOS	12,000	0	0	0	12,000	13,200	14,520
BELIZE	48,000	0	0	0	0	0	0
BOLIVIA	156,000	122,000	134,200	147,620	162,332	178,520	196,482
BRAZIL	6,000,000	6,000,000	2,694,000	5,796,000	6,384,000	6,390,000	6,708,000
CFPA	6,000	0	0	0	0	0	0
CHILE	810,000	594,000	0	42,000	450,000	474,000	498,000
COLOMBIA	0	1,722,000	5,454,000	4,578,000	4,306,000	5,046,000	5,304,000
COSTA RICA	4,248,000	4,000,000	4,400,000	4,840,000	5,324,000	5,856,400	6,442,040
CURACAO	12,000	18,000	0	19,300	21,730	23,958	26,354
DOMINICAN REPUBLIC	0	0	0	0	0	0	0
DOMINICA	0	0	0	0	0	0	0
ECUADOR	222,000	150,000	0	165,000	181,500	199,550	219,515
EL SALVADOR	0	0	0	0	0	0	0
GUATEMALA	0	0	0	0	0	0	0
GUYANA	0	0	0	0	0	0	0
HAITI	198,000	72,000	79,200	37,120	35,332	105,415	115,357
HONDURAS	0	0	0	0	0	0	0
JAMAICA	0	0	0	0	0	0	0
MEXICO	0	0	0	0	0	0	0
MONTserrat	0	0	0	0	0	0	0
NICARAGUA	0	0	0	0	0	0	0
PANAMA	0	30,000	33,000	36,300	39,930	43,923	48,315
PARAGUAY	0	0	0	0	0	0	0
PERU	2,946,300	2,502,000	3,432,000	3,506,000	3,786,000	3,972,000	4,170,000
ST. KITTS	0	18,000	18,000	24,000	24,000	24,000	24,000
ST. LUCIA	30,700	138,000	90,000	108,000	114,000	120,000	126,000
SURINAME	0	18,000	19,300	21,730	23,958	26,354	28,339
ST. VINCENT	0	0	0	0	0	0	0
TRINIDAD & TOBAGO	198,000	120,000	330,000	343,000	366,000	402,000	442,000
URUGUAY	198,000	402,000	442,200	486,420	535,062	588,568	647,425
VENEZUELA	0	0	0	0	0	0	0
TOTAL	15,147,000	15,942,000	17,536,200	19,289,820	21,218,602	23,340,582	25,574,150

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PROJECTED NEEDS FOR IN-KIND COMMODITIES, 1988-1992

PRODUCT: LO FEMENAL

COUNTRY	1986 PROVIDED	1987 APPROVAL	1988	1989	1990	1991	1992
ANGUILLA	0		0	0	0	0	0
ANTIGUA	0		0	0	0	0	0
ARGENTINA	0		0	0	0	0	0
ARUBA	0	1,200	0	0	1,200	1,320	1,452
BAHAMAS	16,300	0	0	0	0	1,200	1,320
BARBADOS	0	0	0	0	0	0	0
BELIZE	5,000	4,800	5,500	7,260	7,986	8,785	9,563
BOLIVIA	0	7,200	7,920	8,712	9,533	10,542	11,536
BRAZIL	0	0	0	0	0	0	0
CFPA	1,200	0	0	0	0	0	0
CHILE	0	1,399,500	1,450,800	1,381,200	1,450,800	1,522,300	1,599,500
COLOMBIA	0	0	0	0	0	0	0
COSTA RICA	214,900	399,500	439,550	483,516	521,368	585,054	643,560
CURACAO	0	4,800	5,280	5,308	6,389	7,028	7,730
DOMINICAN REPUBLIC	0	0	0	0	0	0	0
DOMINICA	0	0	0	0	0	0	0
ECUADOR	0	30,000	33,000	36,300	39,930	43,923	48,315
GRENADA	3,500	2,400	0	0	2,400	2,540	2,304
GUATEMALA	0	0	0	0	0	0	0
GUYANA	0	0	0	0	0	0	0
HAITI	13,200	9,500	10,560	11,516	12,778	14,055	15,461
HONOLULU	0	0	0	0	0	0	0
JAMAICA	36,000	39,600	0	0	20,000	22,000	24,200
MEXICO	0	0	0	0	0	0	0
MONTserrat	0	0	0	0	0	0	0
NICARAGUA	0	0	0	0	0	0	0
PANAMA	0	0	0	0	0	0	0
PARAGUAY	0	0	0	0	0	0	0
PERU	0	0	199,200	159,600	168,000	176,400	184,800
ST. KITTS	3,597	0	0	0	0	0	0
ST. LUCIA	2,400	0	0	0	1,200	1,200	1,200
SURINAME	0	0	20,000	22,000	24,200	26,620	29,282
ST. VINCENT	0	0	0	0	0	0	0
TRINIDAD & TOBAGO	0	0	0	0	0	0	0
URUGUAY	0	0	0	0	0	0	0
VENEZUELA	0	0	0	0	0	0	0
TOTAL	297,597	2,398,800	2,638,680	2,902,548	3,192,303	3,512,083	3,863,291

PROJECTED NEEDS FOR IN-KIND COMMODITIES, 1988-1992

PRODUCT: CUT 380

COUNTRY	1986 PROVIDED	1987 APPROVAL	1988	1989	1990	1991	1992
ANGUILLA	0	0	0	0	0	0	0
ANTIGUA	200	200	220	242	256	293	322
ARGENTINA	17,000	0	0	0	0	0	0
ARUBA	200	0	200	220	242	256	293
BAHAMAS	500	0	0	400	440	484	532
BARBADOS	800	0	0	400	440	484	532
BELIZE	600	0	0	0	0	0	0
BOLIVIA	7,500	6,000	5,500	7,250	7,936	3,785	9,563
BRAZIL	220,000	0	0	12,500	50,300	63,300	66,000
CFPA	200	0	0	0	0	0	0
CHILE	92,000	102,200	294,400	298,500	313,400	329,300	345,600
COLOMBIA	70,000	100,000	135,200	116,300	122,300	128,300	135,400
COSTA RICA	4,000	4,000	4,400	4,340	5,324	5,356	5,442
CURACAO	1,500	2,000	2,200	2,420	2,562	2,928	3,221
DOMINICAN REPUBLIC	0	0	0	0	0	0	0
DOMINICA	0	0	0	0	0	0	0
ECUADOR	20,000	20,000	0	22,000	24,200	26,520	29,292
EL SALVADOR	0	0	0	0	0	0	0
GUATEMALA	0	0	0	0	0	0	0
GUYANA	0	0	0	0	0	0	0
HAITI	400	0	0	0	200	220	242
HONDURAS	0	0	0	0	0	0	0
JAMAICA	400	0	0	0	0	0	0
MEXICO	0	0	0	0	0	0	0
MONTSERRAT	0	0	0	0	0	0	0
NICARAGUA	0	0	0	0	0	0	0
PANAMA	0	0	0	0	0	0	0
PARAGUAY	0	0	0	0	0	0	0
PERU	1,000	50,000	97,200	101,800	106,800	112,200	117,300
ST. KITTS	0	0	0	0	0	0	0
ST. LUCIA	500	400	440	500	600	300	300
SURINAME	500	500	560	726	799	373	366
ST. VINCENT	400	0	0	200	220	242	266
TRINIDAD & TOBAGO	0	200	400	400	500	500	500
URUGUAY	3,500	27,000	37,000	26,300	28,200	29,500	31,000
VENEZUELA	0	0	0	0	0	0	0
TOTAL	441,800	312,600	558,920	596,308	675,179	711,357	748,362

Notes

- 1) Brazil - is not scheduled to receive CUT-380 since these are not approved as yet. The figures appearing on this table may have to be CUT-200. IPPF/WHR has kept some in the warehouse especially for this country.
- 2) Colombia - the figures approved for this year have to be confirmed by AID.
- 3) Peru - condom distribution has increased significantly and supplementary amounts will have to be sent this year to meet demand.
- 4) Trinidad - the annual report has not been received for 1986. Condom distribution may change.
- 5) Uruguay - condom distribution has increased beyond the initial projected amount for 1987. A supplemental shipment has been requested for current year.

Lo Gentrol is supplied instead of Lo Femenal . The amounts to be supplied are 280,000 cycles in 1987, 308,000 in 1988, 338,800 in 1989, 372,680 in 1990, 409,948 in 1991, and 450,943 in 1992.

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IPPF/WHR STANDARDS

**International Planned Parenthood Federation, Western Hemisphere Region, Inc.
New York, 1986**

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IPPF/WHR Standards

In 1983, volunteers in the Western Hemisphere began discussing the advantages of defining the standards under which the Region and its member associations conduct their work. Clarifying and formalizing standards, as they concluded, would serve both to measure performance and to set goals for future achievement.

The 1980s have witnessed the emergence of new financial stringencies for the cause of family planning and of a strong anti-family-planning movement. Yet the region's drive toward standards was self-initiated, and began before these pressures became evident. Nor did this drive reflect dissatisfaction with the current performance of the associations in the region, which have consistently upheld high standards, especially in the provision of medical services.

Indeed, the movement to define standards indicated the development in the region of a new sense of maturity. The standards are a testament to the associations' decades of experience and offer formal recognition of their commitment to quality. They also express a drive to test new possibilities.

In 1984, the Regional Council decided that standards should be reviewed under three headings, as follows:

- A working group was appointed consisting of the Regulations Committee and others under Chairman Stephanie Daly to consider standards in constitutions and bylaws.
- A working group was appointed under Chairman Deborah Mitton to consider program standards.
- A working group was appointed under Chairman Adrian Lajous to consider standards in management.

The standards were developed and refined through a participatory process that involved extensive discussions in the Regional Council and in the Board of Directors and repeated consultations with the associations. IPPF's International Office has also begun the process of formulating standards, and the regional review is being coordinated with that of the London office.

By 1986, the three working groups had produced standards which were endorsed by the associations in the Western Hemisphere. The Regional Council formally approved standards in constitutions and bylaws and in program at its meeting in 1985. Standards in management were drawn up in January, 1986, based on questionnaires completed by the associations and are to be submitted for the approval of the Regional Council at its meeting in October, 1986.

The three sets of standards are presented here. They do not constitute the last word on this subject. Indeed, we will continue in this region to review our standards, to improve them, to test their application in practice.

Jill W. Sheffield

Jill W. Sheffield

Chairman
The Board of Directors

Report of the Working Group
On Standards in Constitutions and Bylaws

PREAMBLE

The minimum requirement for associations to be eligible for membership in the International Planned Parenthood Federation (IPPF) is contained in the Schedule to the IPPF Act, 1977, and is that:

- they subscribe to the aims and policies of IPPF;
- they are not controlled by commercial interests;
- they do not discriminate with regard to race, creed, colour, political belief or sex.

The aims of the IPPF are set out in Section 2 of the IPPF Act, 1977, and its policies are contained in the IPPF Policy Compendium.

Not only is an association's constitution required to be scrutinized by the IPPF at the time when it becomes a member, but also all amendments to constitutions are required to be submitted to the IPPF for approval. At its first meeting, however, the working group had identified reasons why it was unsafe to assume that the constitutions of all members did in fact comply with those requirements, and this had been highlighted by a summary of the recommendations contained in the Management Assessments and Overall Program Evaluations for 1984 where 95 of 237 recommendations related to this area.

Also at its first meeting, the working group established a plan of action for the review of the constitutions of all the Region's members as well as those of the associations which are members of the Caribbean Family Planning Affiliation (CFPA). The latter were included because they are direct recipients of funding by the Western Hemisphere Region, and donors will be predictably concerned about their constitutions.

At its first meeting, the working group developed an outline for the review of the constitutions which formed the basis for the reviews which were subsequently conducted by a paralegal person.

At its second meeting, the working group reviewed the first seven reports received on the constitutions of members. On the basis of this review, the working group then developed categories into which the different constitutional standards could be placed. In developing these categories, the working group was fully conscious of the difficulty that associations might have in amending their constitutions in the circumstances obtaining in their respective countries and that requests for amendments should not be made lightly and should be kept to the minimum consistent with the objectives of this exercise. The four categories were:

- Essential provisions, in the sense that failure to include a provision in a constitution could, after all appropriate procedures had been observed, lead to loss of membership in the IPPF.

- Provisions deemed required to be implemented as soon as possible.
- Provisions to be implemented when convenient, e.g., when some other change was being effected.
- Provisions to be implemented at the discretion of the association.

At its third meeting, the working group reviewed the standards and categories previously identified. It also noted that the Central Executive Committee had discussed the issue of responsibilities of IPPF membership and in respect to constitutional issues had adopted the four standards and, with slight modification, the standards which the working group had allocated to these categories at its second meeting.

After discussion, the working group made certain amendments and approved the report produced at its second meeting. The result was the following set of standards for constitutions and bylaws.

ESSENTIAL PROVISIONS

(a) The prohibition against members, officers and directors deriving a profit by virtue of that status, both during the existence of an association and after its dissolution.

(b) The provision that an FPA is to be a membership organization.

(c) That there should be nothing in the constitution of an association inconsistent with the aims and policies of IPPF.

PROVISIONS TO BE IMPLEMENTED AS SOON AS POSSIBLE

(a) Membership in an association should not be unduly restricted (so that a wide membership is possible).

(b) Members should meet at least once a year.

(c) The full membership should appoint the members of the board of directors or of other decision-making bodies.

(d) Adequate notice should be provided for meetings of the members, of the board of directors or of other decision-making bodies.

(e) A provision is required substantially similar to IPPF Policy No. 3.5.3/01 (a) and (c) with respect to restrictions on payments to volunteers and on services provided by them.

(f) Members, volunteers, directors and officers should be prohibited from receiving loans from the association.

(g) In the event of the dissolution of the association, its assets should pass to a body or bodies with substantially similar objectives, or as local law requires.

PROVISIONS TO BE IMPLEMENTED WHEN CONVENIENT

(a) The association must not discriminate on grounds of race, creed, color, political belief or sex. Inclusion of this provision is highly recommended for new associations or where a new constitution is being prepared.

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(b) There should be rotation of the officers of the association.

(c) The accounts of the association should be audited annually by independent public accountants.

(d) Undue restrictions should not be applied to eligibility for membership on the board of directors or other decision-making bodies.

(e) If necessary, clarification should be made of the following:

(i) The size of the board of directors and of other decision-making bodies.

(ii) Qualifications for membership on the board of directors, and its powers, privileges and duties.

(iii) What constitutes a quorum and a majority of the votes.

(iv) Rules for the appointment of paid staff if not otherwise covered by local law.

(v) Terms of membership, including renewal and cessation whether by expulsion or otherwise.

**PROVISIONS TO BE IMPLEMENTED
AT THE ASSOCIATION'S DISCRETION**

(a) Membership on the board of directors and on other decision-making bodies should be on a rotation basis.

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(b) If membership requires approval of the board of directors, the vote needed should not be greater than a simple majority.

FURTHER CONSIDERATIONS

At its last meeting, the working group reviewed the model bylaws which had been prepared at its request, so that the model could be made available to associations requiring assistance in the drafting of amendments to their constitutions or in the preparation of new constitutions. Reservations were expressed over the fact that the model followed the standard language of bylaws for not-for-profit corporations in the United States. However, it was appreciated that the purpose of the model was to serve only as a guide to be adapted to local conditions as required.

Also at its last meeting, the working group accepted the recommendations made at its second meeting, as follows:

(1) There should be a new section in the analysis of three-year plans (known as the Red Book) dealing with compliance with constitutional standards and with responses to requests for compliance.

(2) The Regulations Committee should conduct an ongoing review of constitutions, responses to requests for compliance and reasons given for non-compliance. After a period of two years from the implementation of these standards, the Committee should reconsider the provisions listed in category II and decide whether any of them should be moved into categories I or III.

(3) Conclusions reached in the reviews of the constitutions currently being conducted should be sent to the associations concerned by the Regulations Committee and dialogue commenced with the associations as appropriate.

(4) The International Office and legal counsel should be kept fully informed on procedural matters and on the categories of the provisions as developed and their comments sought as appropriate.

At its earlier meetings, the working group had taken account of the following considerations:

(a) Some associations had paramount legal requirements such as those preserving a right to tax exemption for gifts to the associations.

(b) In some cases and at a given moment, it might be politically inopportune to amend a constitution.

(c) In some cases, further consideration had to be given to an association's policies and regulations when its constitution appeared to be inadequate.

The working group stated that there was no special significance in the words "constitution" and "bylaws". The recommendations being made referred to the formal documents constituting the associations and establishing their procedures however they were designated.



(d) It should be appreciated by all members that this was intended to be a positive, upgrading exercise enabling the Region to present a good image to donors by making sure that all members could stand up to external scrutiny of their constitutions and bylaws.

(e) It is apparent that non-compliance has sometimes been a result of lack of knowledge. The IPPF Policy Compendium has only recently become available in Spanish. A need was identified for ongoing education in IPPF's requirements.

Finally, the working group noted that legal procedures were often very slow and that associations had to be given sufficient time to effect needed amendments. It was further noted that after constitutions have been brought into full compliance with IPPF's requirements, further attention should be paid to implementation of constitutional provisions to make sure that the standards do not become a dead letter.

* * * * *

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Report of the Working Group
On Program Standards

PREAMBLE

In accordance with the Teheran Declaration and the World Population Plan of Action as approved in Bucharest and revised in Mexico City, the Western Hemisphere Region of the International Planned Parenthood Federation (IPPF/WHR) affirms that the goal of its member family planning associations (FPAs) is to ensure that all couples and individuals have the basic right of deciding freely and responsibly on the number and spacing of their children. For this purpose, the FPAs work to make family planning information, education and services available to all, and in this effort, they collaborate fully with governments and other private organizations.

ABSOLUTE STANDARDS

The following are Regional Standards that all member FPAs are obliged to maintain as members of the IPPF/WHR:

- A. All services provided by FPAs must be strictly voluntary, based on informed consent and offered without pressure or coercion.
- B. The services provided must be offered without discrimination for political or religious beliefs, race, ethnic group or socio-economic status.

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- C. Associations must develop, implement and review appropriate written standards to assure and maintain the quality of their services.
- D. The associations must preserve their status as not-for-profit entities, using all income to further their purposes and programs, and cannot be guided by commercial interests.

PROGRAMMATIC GUIDELINES

The following Regional Guidelines are strongly recommended to member FPAs to help them in implementing the four absolute standards. It is also recommended that each FPA formulate additional and more detailed programmatic standards in response to their own national needs.

A. Voluntary Services Based on Informed Consent

1. For the purpose of assuring freedom of choice, the services offered by FPAs should include a wide variety of medically approved family planning methods together with adequate information on these methods.
2. In cases of voluntary sterilization, FPAs must document the acceptors' informed consent in accordance with IPPF and World Health Organization (WHO) standards, and should keep the signed consent forms in their files.

B. Services without Discrimination

1. FPAs should undertake research on the unmet needs in family planning so as to identify the groups that are not being served by existing programs.
2. FPAs should make every effort to extend services as rapidly as possible to those couples and individuals whose needs are not being satisfied.

C. Services of High Quality

1. FPAs should make sure that the two principal programmatic components (information and services) function in close collaboration.
2. FPAs should ensure that volunteers and staff are adequately trained and motivated to carry out their respective programmatic roles.
3. FPAs should ensure that methods for controlling fertility conform to high standards of quality, effectiveness and safety, giving preference to those methods that are currently recommended by IPPF's International Medical Advisory Panel and the World Health Organization.
4. The services of FPAs should be made available through appropriate and practical channels, including primary health care programs,

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maternal and child health programs, specialized services, community-based programs and commercial channels. In all cases, FPAs should document the availability of adequate supervision and medical support.

5. FPAs should conduct research and evaluation to document the quality of services and their acceptability to users.

6. The FPAs' communications programs should inform people and motivate them to make use of existing family planning services, and should ensure that those entering the reproductive ages are informed about human reproduction and family planning.

7. FPAs should inform national leaders and decision-makers about the unmet needs for family planning and about the social and health benefits which better family planning information and services would bring to families and to the nation.

8. All information provided by FPAs should be as complete and accurate as possible.

D. Services That Are Not for Profit

1. The FPAs should make constant efforts to reduce their dependence on international donors by increasing their local income, and should avoid excessive dependence on one single donor, whether national or international.

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2. If FPAs charge for products or services, all income should be used to contribute to the work of the association.
3. All FPAs that receive project grants should try to include a realistic estimate of overhead costs in the project budget in order to avoid overloading the association's regular budget.

PERFORMANCE INDICATORS

The following are recommended to the FPAs as indicators that can be used to measure progress and efficiency in various specific aspects of their work:

1. Data from national surveys should be analyzed to measure the extent of unmet needs in family planning information and services and to measure trends in the use of and sources for contraception.
2. The total volume of contraceptive services provided can be measured by the number of new acceptors by method and by the number of couple-years of protection provided.
3. Service figures for FPAs can be compared with expenditures on those services-- taking into account inflation and services supported by the FPA working in conjunction with other organizations-- so as to measure trends in cost-effectiveness.

4. Local income of an FPA can be measured both in kind and in cash, while taking into account the economic conditions prevailing in the country, as a partial indicator of the self-sufficiency of the FPA and of its acceptance within the country.

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Report of the Working Group
On Management Standards and Guidelines

I. Management Standards

The Board of Directors

1. The Board of Directors establishes a clear role for the association, indicating for the FPA its objectives, mission and general areas of work.
2. The Board evaluates and approves general policies on operations and procedures, management and personnel.
3. The Board annually examines and approves the association's work program and budget and its three-year plan.
4. The Board reviews and approves financial reports, annual reports and other documents that provide information on the achievement of the association's objectives.
5. The Board ensures that its own regulations and procedures are followed as stated in the association's constitution.
6. The Board ensures that the Executive Director is professionally qualified to administer the association and its programs.
7. The Board formally delegates to the Executive Director the responsibility for implementing its policies, for directing and supervising the association's personnel and for administering the association's program and finances.

8. Periodically, the Board carries out a formal evaluation of the Executive Director's performance.

9. The Board of Directors ensures that each of its new members receives an orientation providing information-- and materials, where appropriate-- about the association and about the rights and responsibilities of Board members.

The Executive Director

10. The Executive Director ensures that each of the association's administrative units has clearly defined objectives stating the unit's goals and targets.

11. The Executive Director ensures that every staff member understands the association's role and mission and the objectives of his or her administrative unit.

12. The Executive Director ensures that each year a work program and budget and a three-year plan are prepared for the association in accordance with the guidelines provided by IPPF.

13. The Executive Director ensures that the annual work program and budget and the three-year plan are reviewed and approved by the association's Board of Directors

14. The Executive Director ensures that each administrative unit establishes a work plan that conforms to the association's work plan and budget.

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15. The Executive Director maintains the documentation that reports on the efforts of the association to achieve its objectives.

16. The Executive Director implements a staff system with clearly indicated channels of communication, lines of supervision and designated responsibilities.

17. The Executive Director participates with the Board of Directors in the establishment of policies and procedures for the management of the association.

18. The Executive Director accepts from the Board of Directors the formal delegation of responsibility for the administration of personnel policies, salary scales and procedures for dealing with the association's human resources.

19. The Executive Director ensures that formal evaluation of staff performance is carried out regularly and periodically.

20. The Executive Director ensures that each new staff member receives an orientation providing information-- and materials, as appropriate-- about the association and about the rights and responsibilities of staff members.

II. Management Guidelines

The Board of Directors

1. The Board of Directors makes sure that it has open communication with the Executive Director.

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2. The Board ensures that its members participate, as appropriate, in fund raising, public relations and representation in the community.

3. The Board ensures the periodic renewal of its own membership while maintaining continuity.

4. The Board ensures that the selection and appointment of its new members follow constitutional regulations.

The Executive Director

5. The Executive Director ensures that all appropriate staff participate in the development of work plans, three-year plans and annual reports.

6. The Executive Director establishes clear communication systems and opportunities for open discussion.

7. The Executive Director ensures that opportunities for advancement and professional development are open to all staff members.

8. The Executive Director ensures the existence and appropriate allocation of incentives to good performance.

9. The Executive Director ensures the codification of performance standards and makes sure that the standards are understood by supervisors and by those they supervise.

10. By action and example, the Executive Director stimulates a climate within the association of open communication, high motivation and general satisfaction.

11. The Executive Director ensures that the findings of evaluations are used as feedback for planning and programs.

12. The Executive Director ensures that staff assist the members of the Board of Directors to carry out their functions.

Note on Standards and Guidelines

During the deliberations of the Ad-Hoc Committee on Management Standards, it became evident to the Committee that a number of advisable managerial practices would be difficult to verify since their application depended to some extent on perceptions. This conclusion directed the Committee to divide its document into management standards and management guidelines. Standards are applicable to all associations. The guidelines are strongly recommended.

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