PPC/CDIE/DI

PD-AAZ-029
ISN 60456

Presented to:

USAID/Honduras

TRIP REPORT

A STUDY OF COST ASSESSMENT, COST RECOVERY,
AND COST-EFFECTIVENESS
IN THE
ASOCIACION HONDURENA DE PLANIFICACION DE FAMILIA
(ASHONPLAFA)

8/29/88 - 9/22/88

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Under AID Contract Number PDC-1406-I-00-7113-00

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EXECUTIVE SUMMARY

This report is issued in accordance with the requirements of the United States Agency for International Development for performance of the designing of a private sector family planning project in Honduras.

The work upon which this presentation is based was performed in whole is in part under Contract Number PDC-1406-I-00-7113-00 between University Research Corporation and the U.S. Agency for International Development.

The Statement of Work Background and the Scope of Work for this consultant's participation in the design process are recapitulated within Chapter I, Introduction, and Chapter II, Methodology, rather than as an attachment because of the illegibility of the material as received via facsimile.

The tasks stipulated in the Scope of Work for the position of Program Specialist were carried out by Mr. Steven D. Orr, an independent consultant with University Research Corporation, who possesses more than fifteen years of field experience in family planning in Latin America and other regions of the world, with knowledge of project design, Couple Year Protection methodology, budget preparation, and FSI rating in Spanish of S-4+ R-4.

CONCLUSIONS and RECOMMENDATIONS

1. EXPAND THE COMMUNITY-BASED DISTRIBUTION DEPARTMENT:

   a. Immediately add a new position in the form of one Administrative Assistant to work in a support role to the CBD Director well in advance of the initiation of the new project.
   b. Add 15 new Promoters, resulting in 43 Promoters in the new project.
   c. Add one new Supervisor.
   d. Add 681 new Distribution Posts, resulting in 2,Ø64 posts in the new project.

2. TRAINING FOR COMMUNITY-BASED DISTRIBUTION and VOLUNTARY SURGICAL CONTRACEPTION PROMOTERS:

   a. Reestablish the system of Quarterly National Meetings for Promoters. Such meetings are an essential management mechanism for training in new information and for refresher training. It is through the process of these meetings that the Department sets objectives (Promoters set their local objectives in coordination with head office input). The process will be increasingly more important with the addition of new personnel in the new project.

   b. Quarterly National Meetings should serve as a training and refresher mechanism for the Voluntary Surgical Contraception Promoters, as well.

3. RADIO and TELEVISION PUBLICITY:

   ASHONPLAFA should develop a massive, long term, advertising campaign to educate the citizens of Honduras about their right to family planning services. The campaign should be coordinated with the campaigns emanating from Guatemala (APROFAM's) and El Salvador (ADS').

4. TRANSPORTATION:

   ASHONPLAFA should study the cost- and time-effectiveness of travel carried out via automobile by staff to San Pedro Sula and La Ceiba, as compared with the cost- and time-effectiveness of traveling by air to the two locations, using ASHONPLAFA-owned vehicles upon arrival.

5. PREVENTIVE MAINTENANCE and INCOME-GENERATION:

   ASHONPLAFA should study the concept of establishment of its own auto-repair shop. Such a shop could be oriented to the public for the sale of parts and performance of repairs, and could serve as ASHONPLAFA's in-house fleet repair shop.

6. EXPAND ASHONPLAFA's MARKETING CAPABILITY:

It is recommended that ASHONPLAFA study or employ outside consultancy to study exhaustively the development of a marketing strategy for the purposes of enchancing ASHONPLAFA's image among the public and for defusing the opposition's emphasis on ASHONPLAFA as a group of "asesinos" in Honduras. A formal marketing capability could provide ASHONPLAFA with a potential for cost-recovery and increased coverage.

7. VOLUNTARY SURGICAL CONTRACEPTION and INCOME GENERATION:

a. ASHONPLAFA should implement a clinic-rental/income-sharing project that combines two alternatives (described in Section 3) in order to provide the organization with an income-generation methodology that assures ASHONPLAFA of approximately L.11,000.00 yearly in income (once all six regional centers are in place).

b. With regard to the Scope of Work's Specific Task #2, Honduran law does not explicitly permit the paying of physicians on a per-procedure basis instead of on a salary basis. The law does mandate, however, that physicians work on the basis of a fixed number of hours (6) daily. The law is established and should not be contravened. Therefore, no recommendation as to the optimization of resources in this regard should be contemplated.

c. ASHONPLAFA should study the possibility of transferring more surgical procedures into ASHONPLAFA clinics out of the current arrangements with the Ministry of Health and with private physicians in contract clinics, as a potential cost-savings factor for the organization.

8. VOLUNTARY SURGICAL CONTRACEPTION EXPANSION INITIATIVES:

Following are steps that are recommended for ASHONPLAFA to take regarding expansion of the VSC effort:

a) increase the number of extant Promoters by four, adding one each in Trujillo, Olanchito, Yoro and La Esperanza;

b) employ three auxiliary nursing personnel in Tegucigalpa, San Pedro Sula and Choluteca, to support the Promoters in these three locations and thus free up the Promoters for straight promotional work;

c) provide transportation for the Promoter in Choluteca;

d) add at least five new projectors to the IEC Department's inventory, and obtain a stock of current topical films;

e) develop a mass advertising campaign, using the management methodology of subcontracting to a local publicity firm;

f) import as short-term consultants for mass advertising the key poeple in Guatemala's APROFAM and El Salvador's ADS (Asociación Demográfica Salvadoreña), e.g., María Cristina Rosales and/or Dora Elena Castillo, respectively;

g) establish a special category in the budget of the new project for payment of stipends, or reimbursements, to satisfied VSC users who would serve as promotional multipliers in their respective locations, under supervision of the VSC Promoter for the area.

And recommended to USAID/Honduras is a realignment of VSC objectives in the new project, as follows:

	1989	1990	1991	1992	1993	1989-1993 Total
ASHONPLAFA Regional Centers	3,000	5,000	6,500	8,000	10,000	32,500
Private Clinics	1,500	2,000	3,500	5,000	6,500	18,500
						51,000

9. ESTABLISH NEW OFFICES IN COMAYAGUA AND DANLI:

ASHONPLAFA should consider establishing sub-offices in the cities of Comayagua and Danli. Space in each city should be found and rented toward this end. This recommendation is made to provide ASHONPLAFA with the menchanism for image-enhancement in the communities and generation of income, as well as to provide personnel with a work place and to create a greater sense of ASHONPLAFA identification in the respective areas. The establishment of the sub-offices would provide a potential for income generation, a point-of-sales for contraceptives and other medicines, and for performance of citologies. There should be employed an individual for each office to serve as a secretary/receptionist/sales clerk. Each sub-office should be strategically located and should contain clinic space; thus rental of the space would permit the generation of income.

10. ASHONPLAFA-IHCAFE LINKAGE:

There is a strong potential for ASHONPLAFA to provide the Instituto Hondureño del Café (IHCAFE) and its large complement of personnel (approximately 450 individuals, including about 150 agriculture extensionists) with extensive training in family planning. As a result of initiatives undertaken during the period of this consultancy to provide ASHONPLAFA with an avenue of expansion in the rural areas of Honduras via IHCAFE's network, it is recommended that additional and continuing communication between the two organizations be maintained.

11. SHORT-TERM INTERMITTENT CONSULTANCY:

This consultant has learned over time that FPAs (and other organizations) in Latin America are chary regarding the assignment of USAID resident technical advisors to work inside the physical plant of the FPA. The lesson learned is that technical assistance is not only often desired or needed, but that it is best provided with a low profile in the form of multiple short-term TA visits over the long term by a professional in whom the FPA and USAID have confidence. I recommend that ASHONPLAFA and USAID consider this dynamic when developing the new project document.

1. INTRODUCTION

1.1. Study Purpose:

In August of 1988, USAID/Honduras contracted with the University Research Corporation, a Washington, D.C.-based research consultant firm, to carry out a technical assistance research study for the Honduran Family Planning Association (ASHONPLAFA), under Contract No. PDC-1406-I-00-7113-00. This study was to develop information leading to design of the follow-on project to the current ASHONPLAFA project. This document, produced by contractor's Program Specialist team member Steven D. Orr, working under the guidance of the USAID/Honduras Human Resources Development/Population Office, over approximately a three and one-half week period, was to assess the costs as well as the potential for cost-recovery, and to make recommendations as to how to increase coverage, cost-effectiveness and cost recovery in the Voluntary Surgical Sterilization and Community Based Distribution programs, as well as to assess the administrative structure of ASHONPLAFA for adequacy in implementing a large-scale family planning program in the follow-on project. This document presents the findings of the Program Specialist in accordance with the Scope of Work provided by USAID/Honduras and the University Research Corporation.

1.2. Background:

The Background provided in the Statement of Work is reproduced herein as appropriate to this document's purpose. Quote: Contraceptive prevalence in Honduras reached 41% in 1987. Prevalence in rural Honduras is 30%, urban areas have reached a coverage of 59%, while 63% of fertile-aged women in Tegucigalpa and San Pedro Sula use some method of contraception. The total fertility rate is considered high at 5.3 children per woman. Although Honduras has made impressive strides in expanding its family planning coverage, much more needs to be done in the next five years in order to reach 55% coverage by the year 1993 (Our Action Plan objective). It will be necessary to continue supporting family planning programs in Honduras, channeling the bulk of our population funds to the private sector.

The Ministry of Health has a small family planning component, but provides services to only 20% of the population. The Asociación Hondureña de Planificación de Familia (ASHONPLAFA), the private family planning association, on the other hand, provides more than 50% of women using contraceptives with services through the Community Based Distribution Program (CBD), the Medical/Clinical Services and Contraceptive Social Marketing (CSM) Program. Although impact data has been quite good, some of ASHONPLAFA's programs, such as the CBD and VSC programs have shown reduced rates of growth. Of more importance, however, is the increasing cost of ASHONPLAFA's programs. A recent financial study showed that annual costs per users have gone up at a rate of 30% since 1984. ASHONPLAFA needs technical assistance to expand both their

CBD and Médico Clínico program. Moreover, ASHONPLAFA needs help to be more efficient in its operations and generate more operating funds.

USAID is beginning a project design process for follow on to the current ASHONPLAFA project. The purpose of the project will be to increase contraceptive prevalence through the private sector. Support in the CBD, Médico Clínico and CSM programs of ASHONPLAFA will continue, with emphasis on cost-effectiveness and cost-recovery.

In addition to core support to ASHONPLAFA, this next project will assist the industrial sector in providing family planning services to their workers, sell contraceptives to ambulatory vendors at a nonsubsidized rate, and assist unemployed physicians in setting up clinics in marginal urban barrios to provide child survival/child spacing services to the communities. Unquote.

1.3. Organization of the Report:

The remainder of this report discusses the methodology employed in carrying out the study and presents the findings of the study. Chapter II describes the specific tasks of the study, the methodology employed, and definitions applicable to this study. Chapter III presents the study findings for the Voluntary Surgical Contraception Department of ASHONPLAFA and Chapter IV presents the study findings for the Community Based Distribution Department of ASHONPLAFA. The sections of both chapters discuss cost-assessment, the potential for cost-recovery, discussion on how to increase coverage, how to increase cost-effectiveness, and how to increase cost-recovery. Chapter V provides an Assessment of the Administration Department of ASHONPLAFA in terms of is structure and adequacy in implementing a large-scale follow-on family planning project, as well as an administrative recommendation vis-à-vis the Community-Based Distribution Department. Presentation of the Conclusions and Recommendations based on findings are presented in summary form at the outset of this document and are discussed in more detail in their respective chapters.

2. METHODOLOGY

2.1. Scope of Work:

The Scope of Work for the Program Specialist consultant is reproduced herein as appropriate to this section's purpose:

Objective As part of the Project Paper development team, the Mission requires the contractor to provide short-term technical assistance in the following areas:

Program Specialist: Specific Tasks

1. Assess costs as well as potential for cost-recovery of providing surgical contraception via the ASHONPLAFA clinics and the private clinics; make recommendations as to how to increase coverage, cost-effectiveness and cost-recovery accordingly.

2. Determine if paying physicians a per procedure basis instead of salaries is more efficient and make recommendations as to which route the new project should pursue in order to optimize resources.

3. Determine if ASHONPLAFA clinics can be rented out during the time that they are not being used for family planning services and estimate potential for generating funds. If rentals is a viable option, design a scheme for the rentals.

4. Assess costs of CBD Program as well as potential for cost recovery; make recommendations as to how to increase coverage, cost-effectiveness and cost-recovery.

5. Assess administrative structure for adequacy in implementing a large-scale family planning program.

6. Based on the assessments, recommendations and studies, described elsewhere, prepare a draft log frame, project description and technical analysis section for a follow-on project.

2.2. Study Procedures:

2.2.1. Review of Documents. A pre-trip initial review of materials took place following which there occurred a review of documents provided by USAID/Honduras, including previous evaluations, prevalence studies, and ASHONPLAFA quarterly reports. There was carried out an ongoing review of materials that surfaced during the course of the assignment, as well.

2.2.2. In-depth Interviews. Interviews were conducted during the two-week period of September 1, 1988 through September 9, 1988, with eleven Community-Based Distribution Promoters,

four Voluntary Surgical Contraception/IEC Promoters, four CBD Supervisors, two Regional Directors, ten CBD Post Distributors, and the Executive Director of ASHONPLAFA. During the remainder of the assignment, ad hoc interviews took place with various ASHONPLAFA supervisory personnel as a matter of routine. Interviews also took place in the form of briefings and other meetings with USAID/Honduras officials.

2.2.3. Site Visits. During the period September 2, 1988 through September 9, 1988, nine site visits took place at ASHONPLAFA staff locations in the cities of Tegucigalpa, Choluteca, Danlí, Juticalpa, La Ceiba, San Pedro Sula (twice), Santa Rosa de Copán, and Comayagua. In addition, ten CBD Posts were visited in the Departments of Paraíso, Olancho, Atlántida, Cortéz, and Comayagua.

2.3. Definitions:

In the interest of ensuring that there exist commonality of understanding regarding certain terms applicable to this report, following are definitions and citations for a select variety of terms having to do with the scope of work for this assignment:

COST-BENEFIT ANALYSIS:

A systematic technique for judging among alternative ways of trying to achieve the same or related objectives, frequently requiring use of a computer to handle the large quantity of data and equations involved. In effect it consists of quantifying and comparing the expected cost and benefit of each alternative and choosing the option whose cost-benefit ratio is smallest. Originally applied to water-resource development in the United States, cost-benefit analysis is now widely applied to virtually every kind of government spending.

- Dictionary of Business and Economics; Ammer, Christine & Ammer, Dean S.; The Free Press, New York, NY; 1984.

COST-EFFECTIVENESS:

Actual direct cost of a product compared with its standard cost; actual output compared with a budgeted output; time of performance compared with an anticipated time lapse. Quantitative effectiveness may be expressed as a percentage relation of the actual with the hoped-for. Without reference to such means of measurement, the word means little more than "quality." [p. 190]

- A Dictionary for Accountants; Kohler, Eric. L.; Prentice-Hall, Inc., Englewood Cliffs, N.J.; 1975.

COST-RECOVERY:

1. The cost recovery method, also known as the sunk-cost theory, is used in situations where recovery of cost is undeterminable or extremely questionable. The procedure is simply that all cost is recovered before any gain is recognized. Once all cost has been recovered, any other collections are recognized as revenue. The only expenses remaining to be charged against such revenue are those relating to the collection process.

   For example, if a company sells for $100 an item that cost $40, and receives no down payment, the first $20 collected, regardless of the year collected, would be considered recovery of one-half the cost. The next $20 collected would be recovery of the balance of the cost, regardless of the year collected. The remaining $60 (all gross profit) would be recognized as income when received. The only additional expenses that could be charged against the remaining $60 would be those directly related to the collection process.

   - Miller Comprehensive GAAP Guide, 1987

2. . . .recognizes that there are exceptional cases where receivable are collectible over an extended period of time and, because of the terms of the transactions or other conditions, there is no reasonable basis for estimating the degree of collectibility. When such circumstances exist, and as long as they exist, either the installment method or the cost recovery method of accounting may be used. (Under the cost recovery method, equal amounts of revenue and expense are recognized as collections are made until all costs have been recovered, postponing any recognition of profit until that time.)

   - Handbook of Accounting and Auditing; Burton, John C., Palmer, Russell E., and Kay, Robert S.; Warren, Gorham & Lamont, Boston & New York; 1981.

3. Cost Recovery Method. Under this method all proceeds received are deemed to apply to the carrying amount of the asset being conveyed to the buyer until carrying amount has been recovered; thereafter all proceeds are considered profit. This method is to be used when there is substantial uncertainty about whether the sale proceeds will be realized or whether there indeed will be any profit. [Ch. 7, p 34]

   - Handbook of Accounting and Auditing; Burton, John C., Palmer, Russell E., and Kay, Robert S.; Warren, Gorham & Lamont, Boston & New York; 1981.

4. a. Recover: To convert into cash or other current asset: said of all or part of the cost of a good or service, or operation, upon its sale or upon the recognition of its contri-

bution (as of depreciation) to production; to realize. [p. 399]

b. Recovery: The absorption of cost as the result of sale, use, or depreciation or other process of allocation; realization. [p. 399]

c. Cost Recovery: The recapture of cost through expense recognition; [p. 145] see cost absorption - The expensing of an added cost, such as freight, not passed on to a customer, replacement or repair under a guarantee of quality or period of performance. [p. 140]

- A Dictionary for Accountants; Kohler, Eric. L.; Prentice-Hall, Inc., Englewood Cliffs, N.J.; 1975.

COST-REDUCTION PROGRAM:

The employment of management devices in the performance of any necessary operation so that a maximum decrease in cost as compared with past cost or standard cost may be attained. Such devices include the search for cheaper materials, improved methods of production and inspection, and improved standards of quality and timing. [p. 146]

- A Dictionary for Accountants; Kohler, Eric. L.; Prentice-Hall, Inc., Englewood Cliffs, N.J.; 1975.

3. COST-EFFECTIVENESS OF THE VOLUNTARY SURGICAL CONTRACEPTION (STERILIZATION) DEPARTMENT IN ACHIEVING ITS OBJECTIVES

3.1. Cost Assessment:

A. The VSC Department's number of male and female sterilization cases for the period 1985-1988 (through August 31st) results thus:

	Módulo Teguc.	Módulo S.P.S.	Módulo Cholut.*	Private Clinics	GOH Hosps.	Number of Users
1985	1,090	1,117	n/a	984	2,592	5,783
1986	1,196	989	n/a	2,333	2,501	7,019
1987	1,424	1,267	n/a	3,385	2,213	8,289
1988	643	637	497	1,358	750	3,885
Totals:	4,353	4,010	497	8,060	8,056	24,976

* Commencing March, 1988.

B. The VSC Department's program effectiveness as compared to the USAID/Honduras 1985-1988 project description appears thus:

	USAID/H Projected Number of Users (ASHONPLAFA)	USAID/H Projected Number of Users (MOH)	USAID/H Projected Number of Users (Priv Clinics)	USAID/H Projected Number of Users (Total)	Current Total Number of Users
1985	3,000	5,000	2,000	10,000	5,783
1986	4,000	6,000	3,000	13,000	7,019
1987	5,000	7,000	4,000	16,000	8,289
1988	6,000	8,000	5,000	19,000	3,885
Totals:	18,000	26,000	14,000	58,000	24,976

Throughout the four years ASHONPLAFA in its <u>own clinics</u> has achieved 49% (8860 VSC users) of the objective of 18,000 through August 31, 1988. When prorated through 12/31/88, the rate of achievement is estimated at 54%, or 9749 VSC users.

The <u>MOH effort</u> throughout the four years has achieved 31% (8056 VSC users) of the objective of 26,000 through August 3, 1988. When prorated through 12/31/88, the rate of achievement is estimated at 32%, or 8,431 VSC users.

The <u>private clinic effort</u> during the same period has achieved 57.6% (8060 VSC users) of the objective of 14,000 through August 31, 1988. When prorated through

12/31/88, the rate of achievement is estimated at 62%, or 8739 VSC users.

The overall effort during this four-year period has resulted in achievement of 43% (24,976 VSC users) of the objective of 58,000 through August 31, 1988. When prorated through 12/31/88, the rate of overall achievement is estimated at 46%, or 26,919 VSC users. (However, the total number of VSC users is predicted to decline in the second half of 1988 due to the strength of opposition to ASHONPLAFA's efforts in the nation.)

C. The cost to ASHONPLAFA for performance of a surgical procedure in ASHONPLAFA's own clinics (in Lempiras) is as follows:

	Supplies	Personnel	General	Total Cost
Tegucigalpa	33.81	51.50	8.00	93.91
San Pedro Sula	33.71	46.50	8.00	88.21
Choluteca	33.70	51.30	8.00	93.00

In private contract clinics the minimal cost per pat to ASHONPLAFA is L.120.00, an amount reimbursed by ASHONPLAFA for each case. In ASHONPLAFA-owned clinic there is maintained a sliding fee scale for VSC pati of scarce economic resources. The maximum amount ch for a procedure is L.30.00, in both the private clinics and the ASHONPLAFA clinics.

D. The total cost per user figure in the Voluntary Surgical Contraception effort of ASHONPLAFA for the four-year period through August 31, 1988, in the ASHONPLAFA clinics, the private clinics, and the government hospitals is estimated as follows (in Lempiras):

	BUDGET	COST	NUMBER OF USERS	VSC COST PER USER
1985	1,126,203	643,514.54	5,783	111.28
1986	908,380	732,113.69	7,019	104.31
1987	1,343,390	1,095,710.69	8,289	132.19
1988	977,214	583,573.89	3,885	150.21
Totals:	4,355,187	3,054,912.81	24,976	124.50 (Avg)

Couple the fact that the 1988 figures are through August 31st with the strength of opposition being experienced by ASHONPLAFA during this second half of 1988. By December 31, 1988, likely, there will exist a marked decrease in number of users correlated with a relatively high cost-per-user figure.

The above data were compiled with the assistance of the ASHONPLAFA Department of Administration regarding budget

and cost data in the Voluntary Surgical Contraception program for the years 1985 through 1988 (through August 31st). The information is included in Appendix #1. Data regarding income generated during the period was not available at the time of production of this report.

E. The Scope of Work for this assignment cites a recent financial study as showing that annual costs per users have gone up at a rate of 30% since 1984. The study, "Analysis of the Financial Situation - Cash Flow Projections for the Period 1989-1994," produced by Price Waterhouse, indicates an average "Cost Couple Year Protection (AVG)" of 29.4% in Appendix III. This figure is misleading in the first place because cost of CYP is not equal to cost per user. Second, in the Expenses section of the study there is indicated a rate of growth of 5.6% for the expense category of Medical Contraceptive Services. This is not a highly significant rate of growth for expenses in the area of Voluntary Surgical Contraception.

3.2 Potential for Cost-Recovery:

The Voluntary Surgical Contraception Department has proposed two viable possibilities for the generation of income that involve the maximum utilization of extant ASHONPLAFA clinic facilities. Each is discussed below. They are followed by conclusive statements, then recommendations.

1) Rental of Unused ASHONPLAFA Clinic Space:

The first alternative concerns itself with rental of clinic space in the three present ASHONPLAFA centers in Tegucigalpa, San Pedro Sula and Choluteca, in the three planned centers La Ceiba, Juticalpa and Santa Rosa. The scheme would contemplate the rental of unused clinic space after 3:00 p.m. on regular work days, to gynecologists and general practitioners, at the following recommended monthly rates, deriving the potential annual sum of L.16,200 in income generated on behalf of ASHONPLAFA:

Tegucigalpa	L.300.00	
San Pedro Sula	250.00	
Choluteca	200.00	
La Ceiba	200.00	
Juticalpa	200.00	
Santa Rosa	200.00	

	L.1,350.00	per month
	x 12	months

	L.16,200.00	per year
	=========	

At these rates, a physician-client would be allowed access to ASHONPLAFA's equipment and certain supplies, but would be

responsible for his/her personnel (receptionist) and paperwork costs. The type of acceptable medical practice would entail gynecology, prenatal care, pediatrics, and general medicine. If this alternative were to be made a reality, physician-clients would be solicited through newspaper advertisements and professional contacts. Arrangements with physician-clients would be done through formal contractual procedures.

It would be necessary to establish a strong system of control for income, as well as a supplies inventory monitoring system.

2) Income-Sharing with Physician-Clients:

The second proposed alternative for income generation in the VSC Department concerns itself with contractual agreements with physicians, using an income-sharing formula based on fixed percentages. In this system, gynecologists and general practitioners would work in unused ASHONPLAFA clinics after 3:00 p.m. on regular work days. The amount a physician would earn from income generated as fee-for-service is set at 60%, with ASHONPLAFA realizing the remaining 40%. The monthly income derivable for consultations is suggested thus:

	Consulting Fee	x	Visits per Day	x	Nbr of Days per Month	=	Monthly Income Generated
Tegucigalpa	L.10		10		20	=	L.2,000
San Pedro Sula	10		10		20	=	2,000
Choluteca	10		8		20	=	1,600
La Ceiba	10		8		20	=	1,600
Juticalpa	10		8		20	=	1,600
Santa Rosa	10		8		20	=	1,600
							L.10,400

Using the 60% - 40% formula, the physicians would earn L.6,240 and ASHONPLAFA would earn L.4,160. Importantly, a strong system of control of income and daily cash reports would need be established.

3) Conclusion:

The arguments concerning rental of unused clinic space are pro and con. There is a difficulty in finding physicians as clients who might rent ASHONPLAFA clinic space. Nowhere in the country would established physicians contemplate doing so; only recently graduated physicians could. A mitigating negative factor, in addition, is the location of the ASHONPLAFA clinics in Tegucigalpa, San Pedro Sula and Choluteca: none of these centers is in an urbanized location favorable to necessarily potentially large numbers of patients. In Santa Rosa, La Ceiba and Juticalpa, on the contrary, each site is within 3 blocks to 2

kilometers from downtown centers, and bus transportation is convenient to all three locations. In Tegucigalpa, it has been suggested, the best location for ASHONPLAFA to have a clinic site is in Comayaguela, where the market place and abundant transportation exist.

The above factors being evident, let's take a look at the differences in income-generation potentiality for ASHONPLAFA, given the two alternatives developed. If we assume, in alternative #1, that ASHONPLAFA will be unable to rent clinic space to physician-clients in the Tegucigalpa, Choluteca and San Pedro Sula centers, then the generatable amount is L.1,350/month minus L.750 = L.600 x 12 months = L.7,200. If we compare this to alternative #2, wherein ASHONPLAFA stands to earn 40% of income in the annual amount of L.4,160, then ASHONPLAFA still stands to generate more income through rentals - L.3,140 more - than through income-sharing with physicians.

The logical conclusion to the question of renting unused clinic space (in the six centers, once all are open) is for ASHONPLAFA to formalize both alternatives with an eye to maximizing the potential for generating income in the Voluntary Surgical Contraception Department. Thus, ASHONPLAFA could conceivably generate L.11,360 annually through the receipt of L.7,200 in rentals plus L.4,160 in percentage income-sharing.

4) Recommendations:

a. ASHONPLAFA should implement a clinic-rental/income-sharing project that combines Alternatives #1 and #2, above, in order to provide the organization with an income-generation methodology that assures ASHONPLAFA of approximately L.11,000.00 yearly in income (once all six regional centers are in place).

b. With regard to the Scope of Work's Specific Task #2, Honduran law does not explicitly permit the paying of physicians on a per-procedure basis instead of on a salary basis. The law does mandate, however, that physicians work on the basis of a fixed number of hours (6) daily, per employed location. The law is established and should not be contravened. Therefore, no recommendation as to the optimization of resources in this regard should be contemplated. See Appendix #2, "Reglamento de la Ley del Estatuto del Médico Empleado."

3.3 <u>How to Increase Coverage</u>:

Interviews with ASHONPLAFA personnel throughout the country indicate that, similar to the Community-Based Distribution program, the best and simplest way to increase coverage in the Voluntary Surgical Contraception program is by increasing the number of users. There exists a variety of ideas for implementing increased coverage in the Voluntary Surgical Contraceptive program, all of which have varying applicability to the rest of

ASHONPLAFA's programs. Among these ideas are 1) radio and television publicity, 2) establishment of additional ASHONPLAFA office-clinic sites, 3) expansion of inter-institutional relationships, 4) expansion of ASHONPLAFA's marketing capability, and 5) expansion of the VSC promotional effort. These five topics are set forth as in the Conclusions and Recommendations section and are discussed in detail as follows:

1) Radio and television publicity: Promoters interviewed in the CBD and VSC programs express unanimity in their belief that ASHONPLAFA needs to promote itself more aggressively and vigorously via radio spots, talk shows, news releases, and dialogues. ASHONPLAFA has a product to sell which is, surprisingly, not family planning or birth control or maternal-infant care or public health or anything else; rather what ASHONPLAFA has to sell is ASHONPLAFA. Give ASHONPLAFA a positive image in Honduras and the subject areas will fall into place. The need is greatest in the sense of combating religious negativism and popular ignorance. This is the case in most of the country. In the western part of Honduras, however, there is a different - or additional - dynamic at work: There is no major problem vis-à-vis religious opposition in the Departments of Ocutepeque, Copán, Santa Barbara and Lempira, according to the ASHONPLAFA VSC and CBD Promoters assigned to this region. Opposition exists, but not to the degree that one would expect in this otherwise traditional part of Honduras. On the contrary, with the high degree of publicity emanating from Guatemala (APROFAM's) and El Salvador (Asociación Demográfica Salvadoreña's), the job of the VSC and CBD Promoters in these Honduras Departments is made that much easier. The Promoters are strong on the need for publicity, particularly Honduran - ASHONPLAFA - publicity. They would like to see ASHONPLAFA complementing APROFAM and ADS in their corner of the world, via television channel 5 and the radio. These Promoters admire what APROFAM and ADS are doing, and feel that ASHONPLAFA could fill an important publicity vacuum in this region.

   In the Comayagua area the religious opposition to ASHONPLAFA is seemingly the strongest, even to the point of condemnation - by name - of one of the Promoters by a priest during Sunday sermons. Nevertheless, the VSC and CBD Promoters here are unified in their desire for greater radio and television publicity by ASHONPLAFA.

   In the Danlí area, where religious-bureaucratic opposition is very strong, the same demand for ASHONPLAFA to mount massive publicity via radio and television is heard from the local Promoters.

   In La Ceiba, no less so, there is expressed a strong need for ASHONPLAFA to mount massive publicity on radio and television. This is particularly significant since outreach efforts by the ASHONPLAFA Promoters here encompasses difficult to reach areas such as the Mosquitia region and the islands, and it is felt

here that mass media advertising and promotion would go a long way toward assisting the Promoters in their work and getting the message out to isolated people.

2) Establish additional ASHONPLAFA office-clinic sites. Again in western Honduras, because a woman can obtain a sterilization (and medications) more economically (approximately 30% less) in Chiquimula, Guatemala and in El Salvador, ASHONPLAFA's own VSC program suffers financially, even though a woman might be able to obtain the service free under ASHONPLAFA's sliding fee scale within Honduras. This phenomenon is described as being neither a "cost issue" nor an "information issue"; rather, women are known to avail themselves of service in one of the other countries because of embarrassment locally. Still, the VSC climate is described as positive, with the influence from APROFAM and ADS helping considerably in Santa Rosa's Hospital del Occidente. The Ministry of Health is a problem for ASHONPLAFA personnel in terms of a lack of follow-through on agreements, but the majority of physicians are, nevertheless, pro-ASHONPLAFA. The VSC Promoter in this sector believes that there is justification for ASHONPLAFA to establish a small sterilization clinic in Ocutepeque.

In the San Pedro Sula area there is an expressed need to expand VSC coverage by turning private-clinic activities into income generators by establishing small ASHONPLAFA-owned clinic sites in surrounding areas. In line with the concept that the best and simplest way to increase cost-effectiveness is to increase the number of users, San Pedro Sula echoes the demand for massive publicity campaigns on radio and television along with a small increase in the number of qualified VSC Promoters.

In Comayagua the Promoters here are desirous of the establishment of a local ASHONPLAFA office in Comayagua, for the purposes of image-enhancement in the community and generation of income for ASHONPLAFA, as well as to provide them with a work place and greater sense of ASHONPLAFA identification in the area. These four individuals see the office (not a Regional Office, but a sub-center) in terms of the potential for income generation, as a point-of-sales for contraceptives and other medicines, and for performance of cytologies (the current system in Comayagua delays cytologies reports from 6 to 12 months - this is hardly conducive to the effective management of cases). While establishment of a sub-office in Comayagua would require the employment of a person to serve as a secretary/receptionist/sales clerk, it is felt that, if the sub-office were strategically located and contained clinic space, then rental of that space would permit the generation of income in that area.

In the Danli area there is a similarly expressed desire for establishment of a small office. Again, the purposes of image-enhancement in the community and generation of income for ASHONPLAFA, as well as provision of a work place for the

ASHONPLAFA employees, and a greater sense of ASHONPLAFA identification in the area, are reasons given for this desire.

In La Ceiba (as in Juticalpa and Santa Rosa) there is expressed a high level of positive anticipation by the ASHONPLAFA CBD and VSC Promoters in terms of the planned establishment of Regional Offices.

3) Expand Inter-institutional Relationships. The list of institutions that might potentially collaborate with ASHONPLAFA is, perhaps, long. As to what level there might exist collaboration is beyond the purview of this report. However, because of this consultant's recent experience (July, 1988) working as a representative of Development Associates inside the Instituto Hondureño del Café, I was able to bring together the Executive Director of ASHONPLAFA and the General Manager of IHCAFE in a preliminary strategy planning meeting. The result of the meeting appears positive for greater involvement of the two organizations in terms of spreading family planning information and education, and setting up a referral network within IHCAFE for CBD and VSC follow-up. At the Promoters' level, the idea of a working relationship with the Instituto Hondureño del Café is seen favorably. With regard to interinstitutional training in general, there was heard from Promoters the cautionary note that ASHONPLAFA should increase such activity but not at cost to ASHONPLAFA, that institutions should be charged for training as an income-generator for ASHONPLAFA.

4) Expand ASHONPLAFA's Marketing Capability.

In line with the expressed need for ASHONPLAFA to become more vigorously active in the area of mass media publicity via television and radio, there is a strongly expressed need for ASHONPLAFA to become more active in marketing strategies. There already exists a large distribution network within ASHONPLAFA to be tapped for the purpose of the marketing of other products. Many Promoters envision ASHONPLAFA marketing student supplies, feminine hygiene products, clothing, oral rehydration therapy salts, and other articles, all in the name of and clearly identifying ASHONPLAFA. For ASHONPLAFA to contemplate marketing consumer products bearing ASHONPLAFA's logo means that ASHONPLAFA would have to set up a repackaging department or subcontract the job. There will be a cost attached, whichever system might be developed.

5) Expand the VSC Promotional Effort.

Inquiries throughout the VSC Department in Tegucigalpa and in the field have surfaced a number of areas that need expansion. These areas are viewed as important and by their inclusion in the new project, it is felt, the following changes will be appropriate and will enhance the VSC Department's cost-effectiveness and cost-recovery efforts. The areas of concern are: a) increase the number of extant Promoters by four,

adding one each in Trujillo, Olanchito, Yoro and La Esperanza (or Mercala) b) employ three auxiliary nursing personnel in Tegucigalpa, San Pedro Sula and Choluteca, to support the Promoters in these three locations and thus free up the Promoters for straight promotional work; c) provide transportation for the Promoter in Choluteca; d) add at least five new projectors to the IEC Department's inventory, and obtain a stock of current topical films; e) develop a mass advertising campaign, using the management methodology of subcontracting to a local publicity firm; f) import as short-term consultants for mass advertising the key people in Guatemala's APROFAM and El Salvador's ADS (Asociación Demográfica Salvadoreña), e.g., María Cristina Rosales and/or Dora Elena Castillo, respectively; g) establish a special category in the budget of the new project for payment of stipends, or reimbursements, to satisfied VSC users who would serve as promotional multipliers in their respective locations, under supervision of the VSC Promoter for the area.

3.4 How to Increase Cost-Effectiveness:

When we define cost-effectiveness as a percentage relation of the actual with hoped-for, there is necessitated a review of ASHONPLAFA's performance in the area of Voluntary Surgical Contraception.

For the period 1985 - 1988 (through August 31st), as tabulated in section 3.1, above, we find that ASHONPLAFA carried out 8,860 sterilizations in its own clinics, 8,056 sterilizations in the government hospitals, and 8,060 sterilizations in the private clinics, for a total of 24,976 sterilizations performed in the current project. The overall rate of achievement is indicated to be 43% through 8/31/88, and is prorated through 12/31/88 at 46%. Of the three programs, the most effective mode is the private clinics, the second most effective is ASHONPLAFA's own clinics, and the least effective program is in the government hospitals.

With the current expansion, however, (e.g., opening up of the Santa Rosa, La Ceiba and Juticalpa Regional Offices), there exists a potential for the ASHONPLAFA clinic program to overcome the private clinic program, moving the latter to second place, and leaving the government hospital program still in third place.

If we eliminate the government hospital program and charge ASHONPLAFA with full responsibility for the Voluntary Surgical Contraception effort in the new project, then assign more realistic objectives based on experience in the current project, we would be fielding a more cost-effective program. In addition, with full control being maintained by ASHONPLAFA, the VSC program would be more accountable, more manageable, more successful, and more easily monitored by USAID/Honduras.

The assignment of 58,000 sterilizations in the current project was somewhat overambitious, it now appears. Suggested in the new project is a realignment of objectives, as follows:

	1989	1990	1991	1992	1993	1989-1993 Total
ASHONPLAFA Regional Centers	3,000	5,000	6,500	8,000	10,000	32,500
Private Clinics	1,500	2,000	3,500	5,000	6,500	18,500
						51,000

The political fallout of turning over the full VSC responsibility in Honduras to ASHONPLAFA could be offset by the contracting of USAID/Honduras funds to a small VSC project directly to the Ministry of Health, setting an objective of between 5,000 - 10,000 sterilizations for the period 1989 - 1993. Thus, ASHONPLAFA would not be held accountable for the government program, the government program would be directly accountable to USAID/Honduras, and USAID could monitor the program directly. Current circumstances in Honduras indicate that the government VSC effort is no smashing success, but they did perform 8,056 sterilizations during 1985 - 1988, achieving 32% of their objective for the period.

3.5 How to Increase Cost-Recovery:

The foregoing discussion leads now to a concept not heretofore discussed. This concept deals with the saving of costs by transferring more surgical procedures into ASHONPLAFA clinics out of the current arrangements with the Ministry of Health (and perhaps even with private physicians in contract clinics.) Various important factors would have to be determined, first, of course. For example: a) an estimate of what the shift of procedure sites vs. increased number of procedures would result in; b) physicians would have to be contracted for specific blocks of time (minimum of 2 hours per day); c) at least 40 procedures would need to be done per month at each center to justify the action; d) what would the rate of reduction of reliance on private physicians be?

While the concept of saving costs in this fashion might find itself offset by a negative political fallout, particularly from the Ministry of Health point of view, the idea merits further study by ASHONPLAFA, nevertheless.

4. COST-EFFECTIVENESS OF THE COMMUNITY-BASED DISTRIBUTION DEPARTMENT IN ACHIEVING ITS OBJECTIVES

4.1 Cost Assessment:

A. The cost-per-user figure in the Community-Based Distribution effort of ASHONPLAFA for the four-year period through August 31, 1988, is estimated as follows (in Lempiras):

	Number of Users	Total Budget	Total Expenses	Cost per User
1985	45,781	1,086,289.00	806,394.05	17.59
1986	45,173	1,041,713.18	767,567.61	16.99
1987	47,820	1,205,300.00	1,326,377.85	27.74
1988	49,544	1,258,337.00	407,964.18	8.23
Totals:	188,318	4,591,639.18	3,308,303.69	17.64 (Avg)

(These data were compiled with the assistance of the ASHONPLAFA Department of Administration regarding budget and cost data in the Community-Based Distribution program for the years 1985 through 1988 (through August 31st). The information is included in Appendix #1. Data regarding income generated during the period was not available at the time of production of this report.)

The 1988 figure of 49,544 is through June. If we were to prorate through December 31, 1988, the resulting number would be 99,088 users for the year. However, ASHONPLAFA is predicting that, in reality, there will be achieved the number of 52,000 users for 1988. This statement is based on the strength of religious opposition being experienced by ASHONPLAFA during this second half of 1988, as well as on other factors discussed below.

B. Methodological Obstacles in Fulfillment of Objectives:

The Community-Based Distribution Department is faced with a number of methodological obstacles that portend to restrain the already valiently vigorous effort of the Department through June of this year. Among the obstacles are these:

a) An increase in prices of contraceptives as of July 1, 1988; it is apparent that this obstacle is being overcome by time in the marketplace.

b) The provision of contraceptives gratis in public health locations.

c) In the San Pedro Sula area, where the CBD effort has been strong in certain factories, Social Security is

now providing free contraceptives under its funding from Family Planning International Assistance, thus cutting severely into ASHONPLAFA's income-generation effort in that sector.

d) The supply of Emko foam has run out and replacement supplies have not yet reached ASHONPLAFA.

e) The supply of Femenal pills received in late 1986 carried an expiration date of August, 1988, so this product has been retired from the ASHONPLAFA pipeline and replaced by Microgynon.

f) Changes in two Promoter positions and one Supervisor position have cost the department time in finding replacements and in training the new personnel.

g) Recently, ASHONPLAFA has mandated heavy budget reductions in travel and per diem expenses, in promotional activities expenses, in educational materials expenses, and in courses for Distributors. Also, the CBD Department has been restricted budgetarily from continuing its essential ongoing training and management activity of national quarterly meetings of Promoters (only one has been carried out nationally this year, while two regional meetings have been held).

4.2 Potential for Cost-Recovery

As discussed in Section 3 of this report (Cost-Effectiveness of the Voluntary Surgical Contraception Department in Achieving Its Objectives) there was set forth discussion concerning expansion of ASHONPLAFA's marketing capability. To iterate: In line with the expressed need for ASHONPLAFA to become more vigorously active in the area of mass media publicity via television and radio, there is a strongly expressed need for ASHONPLAFA to become more active in marketing strategies. There already exists a large distribution network within ASHONPLAFA to be tapped for the purpose of the marketing of other products. Many Promotors envision ASHONPLAFA marketing student supplies, feminine hygiene products, clothing, oral rehydration therapy salts, and other articles, all in the name of and clearly identifying ASHONPLAFA. For ASHONPLAFA to contemplate marketing consumer products bearing ASHONPLAFA's logo means that ASHONPLAFA would have to set up a repackaging department or subcontract the job. There will be a cost attached, whichever system might be developed.

If ASHONPLAFA were to contemplate an expanded marketing capability, making full use of the already well-developed national network of 1,383 distribution posts, as well as commercial distribution networks in Honduras, then there is no doubt that the marketing of the name "ASHONPLAFA" on a massive scale could be accomplished. The cost of mounting such an effort

cannot be stated in the purview of this document. But if ASHONPLAFA markets, say, a ballpoint pen carrying the ASHONPLAFA logo and the phrase "Vela por el bienestar de la familia hondureña," or other wording, and it costs ASHONPLAFA L.0.50 to make the article while it sells for L.1.00, the 100% markup would be a decent piece of change for ASHONPLAFA. The organization would have to make some hard decisions about what to market, how to market the product, what investments to make, what contractual arrangement to make in the community, how to monitor the packaging, repackaging, sales, income generated, supply and resupply logistics, and possible personnel costs.

Again, the details of this concept are outside the purview of this report, so the recommendation is that ASHONPLAFA study or employ outside consultancy to study the matter exhaustively.

4.3 How to Increase Coverage

Add 10 - 15 new Promoters to the Community-Based Distribution Department. While it will be up to the Director of the Department to make the appropriate placement decisions, it is worth echoing the strong plea of the Comayagua group of CBD and VSC Promoters that a CBD (also VSC) Promoter be placed in either La Esperanza or Mercala. Both locations are too remote from Comayagua for them to receive the type and frequency of attention that are expressed as needed, but are near enough each other that a Promoter could cover both locations relatively easily.

Concommitant with the addition of as many as 15 new Promoters, there should be added a new supervisory position to round out the Department. The current ratio of Promoters to Distributors is 3:28, or 1 Supervisor per 9 Promotors; the new configuration should result in a ratio of 4:43, or 1 Supervisor per 11 Promotors.

In line with the recommendations for the addition of 10 - 15 new Promoters and one new Supervisor, there follows the recommendation that ASHONPLAFA create a new position of Administrative Assistant. This recommendation is discussed fully in Section 5 ("Assessment of the ASHONPLAFA Administration Department for Adequacy in Implementing a Large-Scale Family Planning Program").

The foregoing three paragraphs address the matter of expansion of the CBD Department as an appropriate management methodology for increasing coverage. There should then follow expansion in the number of Distribution Posts, reaching a total of 2,064. The following tables provide data leading to this conclusion:

Year	No. of Supervisors	No. of Promoters	No. of Distributors	No. of Users
1985	3	26	1,148	45,781
1986	3	26	1,233	45,173
1987	3	27	1,315	47,820
1988	3	28	1,383	49,544*
				188,318

Through 6/30/88.

Data on the ratio of Promoters to Distributors, and on the average number of distribution posts per Promoter follow:

Year	Ratio of Proms:Dists	Average # of Dist. Posts per Promoter
1985	26:1,148	44.15
1986	26:1,233	47.42
1987	27:1,315	48.70
1988	28:1,383	49.39

With 43 promoters, and an average of 48 Distribution Posts per Promoter, the number of new Distribution Posts that ASHONPLAFA should add, following the addition of 15 new Promoters and one Supervisor, is 681. This results in the expanded CBD program at a total of 2,064 Distribution Posts. All factors considered, then, the CBD program could target expanded coverage of 78,432 users in the first year of the new project.

4.4 How to Increase Cost-Effectiveness

The preceding discussion implies considerable investment of money to permit the Community-Based Distribution program expand on a large scale. The singularly best way to increase the cost-effectiveness of the program is to increase the number of users. A case has been made for the program to conceivably achieve the number of as many as 78,432 users (38 users per post times 2,064 posts) in the first year subsequent to expansion in personnel.

In the second year, if the ratio of 43 Promoters to 2064 Distribution Posts, resulting in an average of 48 posts per Promoter, is increased to, say, 55 posts per Promoter, resulting in a total of 2,365 posts, the program could see its number of users increased to just under 90,000.

In years three through five of the project, the number of users could level off at somewhere between 80,000 and 100,000.

4.5 How to Increase Cost-Recovery

There aren't many methodologies for generating income in Community-Based Distribution programs short of selling contraceptives and instituting price increases. However, if ASHONPLAFA implements a full-scale marketing program, as discussed earlier, then there could be created ample opportunity for the CBD program to recover increasingly larger amounts of its costs.

5. ASSESSMENT OF THE ASHONPLAFA ADMINISTRATION DEPARTMENT FOR ADEQUACY IN IMPLEMENTING A LARGE-SCALE FAMILY PLANNING PROGRAM

Indications from the Administrator of ASHONPLAFA, Lic. German Serrato are that expansion of the department would depend entirely on the design of the new project for ASHONPLAFA. He cites the management study currently being undertaken by Price Waterhouse as impinging importantly on this question. Inquiries made of Region III Director Nathan Bonilla and Region II Director E. Robert López surfaced the shared opinion that ASHONPLAFA is administratively capable of implementing expansion of the family planning program.

Within the Community-Based Distribution program there exists no doubt that administrative expansion will be necessary in the new project. The expansion should take place in the form of one administrative assistant to work in a support role to the CBD Director, Sra. Nelly Funez. Justification for such a position exists in the current project. Presently, Sra. Funez has no-one available to absorb her administrative functions, thus restricting her time available for program planning, implementation and on-site supervision. Considering the recommendation for expansion of the CBD program to include approximately 15 new Promoters in the new project, Sra. Funez' role as CBD Director will definitely require administrative support within the department. Wisdom dictates that the position of Administrative Assistant be funded and designed by ASHONPLAFA now, and that an appropriately qualified individual be employed as rapidly as possible in anticipation of the new project, so as to be able to assist Sr. Funez to assume smoothly her responsibilities at the time of the new project expansion. It will be particularly important to have the Administrative Assistant in place before new project implementation because Sra. Funez is expected to have expanded responsibilities for new and refresher training, site fulfillment, on-site attention, and other management actions.

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