

UNCLASSIFIED

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
Washington, D. C. 20523

PERU

PROJECT PAPER

PVO FAMILY PLANNING SERVICE EXPANSION

AID/LAC/P-546

Project Number: 527-0335

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE
 A = Add
 C = Change
 D = Delete
 Amendment Number _____

DOCUMENT CODE
 3

2. COUNTRY/ENTITY
 PERU

3. PROJECT NUMBER
 527-0335

4. BUREAU/OFFICE
 LAC [05]

5. PROJECT TITLE (maximum 40 characters)
 PVO Family Planning Service Expansion

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)
 MM DD YY
 09 21 90

7. ESTIMATED DATE OF OBLIGATION
 (Under "B" below, enter 1, 2, 3, or 4)
 A. Initial FY [89] B. Quarter [4] C. Final FY [89]

8. COSTS (\$000 OR EQUIVALENT \$) =

A. FUNDING SOURCE	FIRST FY 89			LIFE OF PROJECT 2/		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	1,203	1,014,302	2,217,302			
(Grant)	(1,203)	(1,014,302)	(2,217,302)	()	()	()
(Loan)	()	()	()	()	()	()
Other U.S. 1.						
Other U.S. 2.						
Host Country		1/				
Other Donor(s)						
TOTALS	1,203	1,014,302	2,217,302			

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT 2/	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) PN	480	440				2,217,302			
(2)									
(3)									
(4)									
TOTALS						2,217,302			

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)
 460 450

11. SECONDARY PURPOSE CODE
 440

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	B. Amount	BWV	BU	PVON
	2,217,302		2,000,000	2,217,302

13. PROJECT PURPOSE (maximum 480 characters)

To maximize the availability of all family planning methods to women and men who wish to use them by increasing the capacity of the private voluntary sector to deliver long-lasting contraceptive methods while maintaining support for temporary supply methods and natural family planning.

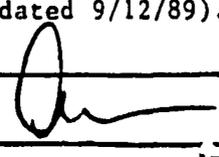
14. SCHEDULED EVALUATIONS
 Interim MM YY MM YY Final MM YY
 05 90

15. SOURCE/ORIGIN OF GOODS AND SERVICES
 500 941 Local Other (Specify) Peru

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)

1/ See Annex I Exhibit E, Justification for Waiver of 25% contribution requirement.

2/ Based upon an evaluation of PRISMA's performance in Year 1, Mission will determine whether PRISMA will continue to implement the project or if an alternate modality is required for Years 2 thru 4 (See STATE 290998 dated 9/12/89).
 CM FA

17. APPROVED BY
 Signature: 
 Title: Mission Director

Date Signed MM DD YY
 10/12/89

18. DATE DOCUMENT RECEIVED IN AID/M, OR FOR AID/M DOCUMENTS, DATE OF DISTRIBUTION
 MM DD YY

PROJECT AUTHORIZATION

Name of Country: Peru
Name of Project: Private Voluntary Family Planning Services Expansion
Number of Project: 527-0335

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Private Voluntary Family Planning Services Project ("Project") for the Proyectos en Informatica, Salud, Medicina y Agricultura ("PRISMA") in Peru involving planned obligations of not to exceed Two Million Two Hundred Seventeen Thousand Three Hundred and Two United States Dollars (\$2,217,302) in grant funds ("Grant") over a one year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the Project. The planned life of the Project is twelve months from the date of initial obligation.

2. The Project consists of a Cooperative Agreement with PRISMA (the "Implementing Agency"), a Peruvian private voluntary organization ("PVO") registered with A.I.D., to support activities to strengthen the capability of the private voluntary sector to deliver family planning supplies and services to Peruvian men and women who wish to use them. This is the first phase of a projected four-year effort to provide institutional strengthening support to the participating organizations, promote the delivery of long-lasting contraceptive methods (intrauterine devices, implants, and voluntary surgical contraception) and provide support for temporary supply methods (pills, condoms, and spermicides) and natural family planning, and extend family planning coverage in rural areas through PVO-public sector collaboration.

3. The Cooperative Agreement, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and delegations of authority, shall be subject to the following essential terms, covenants, and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

a. Source and Origin of Commodities and Nationality of Services.

Commodities financed by A.I.D. under the Cooperative Agreement shall have their source and origin in Peru or in the United States, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of

commodities or services financed under the Cooperative Agreement shall have Peru or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Cooperative Agreement shall be financed only on flag vessels of the United States, except as A.I.D. may otherwise agree in writing.

b. Condition.

Prior to the hiring of key personnel under the Project, A.I.D. shall approve, in writing, such personnel, including the Administrative/Management Specialist, Accountant/Analyst, and Logistics/Statistics Coordinator.

c. Covenant.

The Implementing Agency agrees that none of the funds made available under the Cooperative Agreement for family planning activities will be used to finance any costs relating to:

- i. the performance of abortion or involuntary sterilization as a method of family planning;
- ii. the motivation or coercion of any person to undergo abortion or involuntary sterilization;
- iii. biomedical research which relates, in whole or in part, to methods of, or the performance of, abortion or involuntary sterilization as a method of family planning;
- iv. the active promotion of abortion or involuntary sterilization as a method of family planning; or
- v. the procurement of any equipment or materials for the purpose of abortion or involuntary sterilization.

4. The A.I.D. requirement for Operational Program Cooperative Agreements ("OPCAs"), that a minimum of at least twenty-five percent of total project costs be contributed from non-U.S. government sources, is hereby waived, the justification for which is included as an Annex to the Project Paper.

September 22, 1989



Craig G. Buck
Mission Director

Drafted by: HR/POP:JBurdick B
Cleared by: HR/POP:GNichtawitz GN
PPD:CKassebaum CK
PPD/PDO:LJackson LJ
PPD/PROG:EVarillas EV
CONT:PKramer PK
RLA:ANewton AN
DD:ASilva AS

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- Exhibit C: GOVERNMENT OF PERU CONCURRENCE
- Exhibit D: ENVIRONMENTAL THRESHOLD DECISION
- Exhibit E: JUSTIFICATION FOR WAIVER OF 25 PERCENT CONTRIBUTION REQUIREMENT
- Exhibit F: JUSTIFICATION OF NONCOMPETITIVE AWARD

ANNEX II

- Exhibit A: LOGICAL FRAMEWORK
- Exhibit B: ILLUSTRATIVE LIST OF COMMODITIES
- Exhibit C: CONSOLIDATED PROJECT BUDGET BY INPUTS, PROJECT YEARS, AND PROJECT COMPONENTS
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- Exhibit A: REVIEW OF PRIVATE SECTOR FAMILY PLANNING PROJECT (527-0269)
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LIST OF ABBREVIATIONS AND ACRONYMS

A.I.D.	Agency for International Development
A.I.D./W	AID Headquarters Office in Washington, DC
AMIDEP	Asociacion Multidisciplinaria de Investigacion y Docencia en Poblacion, (Lima-based population PVO specializing in communication research)
APRA	American Popular Revolutionary Alliance
APROPO	Apoyo a Programas en Poblacion, (Lima-based family planning PVO currently implementing the CSM Project)
APROSAMI	Asociacion de Profesionales para la Promocion de la Salud Materno-Infantil, (Lima-based family planning PVO)
ARDN	Agricultural, Rural Development, and Nutrition Account (of Development Assistance appropriation)
ATLF	Asociacion de Trabajo Laico Familiar, (Lima-based natural family planning PVO)
AVSC	Association for Voluntary Surgical Contraception
BA	Births Averted
CA	Cooperating Agency (Grantee in AID/W centrally funded projects)
CBD	Community Based Distribution
CDSS	Country Development Strategy Statement
CE	Coordinating Entity (of family planning PVOs)
CEDPA	Center for Development and Population Activities
CENPROF	Centro Nor-Peruano de Capacitacion y Promocion Familiar, (Trujillo-based family planning PVO)
CN	Congressional Notification
CNP	Peruvian National Population Council
CPT	Commodity Procurement Table
CSA	Child Survival Action Project (527-0285)
CSM	Contraceptive Social Marketing
CYP	Contraception Year of Protection
DHS	Demographic and Health Survey
ENSSA	National Health and Nutrition Survey (1984)
EOP	End of Project
FAA	Foreign Assistance Act
FAO	Food and Agricultural Organization (U.N. Agency)
FPIA	Family Planning International Assistance
FY	Fiscal Year
GDP	Gross Domestic Product
GFR	General Fertility Rate
GOP	Government of Peru
GTZ	German Technical Assistance Agency
HSA	Health Sector Analysis (1984)
IEC	Information, Education, and Communication
INANDEP	Instituto Andino de Estudios en Desarrollo y Poblacion, (Lima-based population research PVO)

INOPAL Operations Research in Family Planning for Latin America Project, (AID/W centrally funded project implemented by the Population Council)

INPPARES Instituto Peruano de Paternidad Responsable (Lima-based family planning PVO)

IPPF International Planned Parenthood Federation

IPSS Peruvian Institute of Social Security

IRR Internal Rate of Return

IUD Intrauterine Device

JHPIEGO Johns Hopkins Program for International Education in Gynecology and Obstetrics

LOP Life of Project

MIS Management Information System

MOH Ministry of Health

MSH Management Sciences for Health

MWFA Married Woman of Fertile Age

NFP Natural Family Planning

O/HR Office of Human Resources

ORS Oral Rehydration Salts

OYB Operating Year Budget

PACD Project Assistance Completion Date

PCA Peruvian Coordinating Agency

PCFP Private Commercial Family Planning Project (527-0326)

PD&S Program Development and Support Project (527-0000)

PDV Present Discounted Value

PID Project Identification Document

PIO/C Project Implementation Order/Commodities

PIO/T Project Implementation Order/Technical Services

PLANIFAM Proyecto Planificacion Familiar (Cusco-based family planning PVO)

PNPF Peruvian National Family Planning Program

PP Project Paper

PRICOR Operations Research in Primary Health Care (AID/W centrally-funded project implemented by Center for Human Services)

PRISMA Proyectos en Informatica, Salud, Medicina y Agricultura, (Lima-based development PVO)

PROFAMILIA Promocion de Labores Educativas y Asistenciales en Favor de la Salud, (Lima-based health and family planning PVO)

PSC Personal Services Contract(or)

PVFP Private Voluntary Family Planning Services Expansion Project (527-0335)

PVO Private Voluntary Organization

PY Project Year

SMISSA Servicio Medico Materno Infantil San Alfonso (Lima-based health and family planning PVO)

SPF Private Sector Family Planning Project (527-0269)

STD Sexually Transmitted Disease

TA	Technical Assistance
TAG	Technical Advisory Group
TDY	Temporary Duty
TN	Technical Notification
UNFPA	United Nations Fund for Population Activities
USAID	A.I.D. Mission to Peru
USAID/Peru	A.I.D. Mission to Peru
USDH	U. S. Direct Hire
VSC	Voluntary Surgical Contraception
WFA	Women of Fertile Age
WFS	World Fertility Survey

GLOSSARY

Contraceptive method mix: The different family planning methods being used and the relative contribution of each method to total contraceptive prevalence.

Contraceptive prevalence: The proportion of women of reproductive age who are using some method of family planning.

Instituto Marcelino: A Lima-based family planning PVO.

Interval contraceptive procedure: The application of a contraceptive method (usually IUD or voluntary surgical contraception) between pregnancies or after the termination of the last pregnancy, but not within the post-partum period.

Long-lasting contraceptive methods: Refers primarily to IUDs, contraceptive implants, and voluntary surgical contraception. A single application of the method confers long-term protection against pregnancy (at least 5 years for an IUD, 3 years for an implant, and life-time protection for surgical contraception).

Natural family planning: Various forms of periodic abstinence in which the couple avoids intercourse in the days immediately preceding, during, and following ovulation. These are the only contraceptive methods approved by the Catholic Church.

Post-partum contraceptive procedure: The application of a contraceptive method (usually IUD or voluntary surgical contraception) within the first five days following a birth, or during the woman's hospitalization stay.

Pueblo joven: Squatter slums found in the periphery of urban areas. Many of the residents of these slums are recent emigrants from rural areas.

Temporary supply contraceptive methods: Refers to pills and barrier methods (condoms and spermicides). Users of these methods require a constant supply of the method throughout the period of use (13 cycles of pills per year, approximately 100 condoms per year, etc.).

Traditional contraceptive methods: Refers to folk methods and others such as withdrawal and some forms of periodic abstinence. These methods generally are less effective in preventing pregnancy than modern methods such as pills, IUDs, etc.

Vecinos Peru: A Peruvian development PVO, affiliated with World Neighbors, specializing in agricultural innovations and community development. Under a subgrant from the INOPAL project, Vecinos Peru successfully implemented after-hours family planning clinics in MOH hospitals in Ayacucho, Huanta, and Huancavelica. This model is proposed for expanding rural family planning coverage under the present Project.

I. SUMMARY AND RECOMMENDATIONS.

A. Recommendations.

1. Funding.

It is recommended that \$2,217,302 in grant funds be authorized to finance an Operational Cooperative Agreement (OPCA) with Proyectos en Informatica, Salud, Medicina y Agricultura (PRISMA) for the first year of the Private Voluntary Family Planning Services Expansion (PVFP) Project, which has a Life of Project (LOP) of one year from the date of initial obligation. This is the first phase of a four-year project of the same name. This Project Paper presents the full four-year project, with the first, year-long phase clearly set out within (and contributing to) the total effort.

2. Geographic Code.

The Project Authorization should specify that, except as A.I.D. may otherwise agree in writing:

- a. goods and services financed by A.I.D. under this Project shall have their source and origin in A.I.D. Geographic Code 000 (U.S.) or Peru; and
- b. ocean shipping financed by A.I.D. under this Project shall be only on flag vessels of the United States.

3. Determination of National Interest for Obligation.

Pursuant to Section 123(e) of the Foreign Assistance Act (FAA), A.I.D. has determined that it is in the national interest to continue support to PVO activities; the Mission Director is, thus, authorized to obligate funds to PRISMA, a PVO supported by A.I.D. funds on August 2, 1989, the date that Peru entered into 620(q) sanctions.

4. Waiver.

The justification for the Mission Director's waiver of the requirement that a minimum of twenty-five percent of total project costs be contributed from non-U.S. Government sources is included as Annex I, Exhibit E.

5. Sole Source Award.

By LIMA 10729, a cable requesting PID approval, USAID informed the Acting Assistant Administrator for the Latin American and Caribbean Bureau of its intention to obligate in excess of \$2 million to PRISMA, a duly-registered local PVO. By STATE 290998, AID/W

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approved the PID and instructed USAID to submit justification of noncompetitive award in writing to the Regional Contracting Officer (RCO) in Quito. Approval of the justification was given by the RCO on September 21, 1989, and is included in Annex I, Exhibit F.

B. Summary Project Description and Financial Plan.

1. Project Description.

The project goal is to improve the quality of life for Peruvian families through increased access to the means to achieve the desired number and spacing of their children. The project purpose is to maximize the availability of family planning services to women and men who wish to use them by strengthening the capacity and improving the performance of the private voluntary sector to deliver quality and efficient services, focusing on long-lasting contraceptive methods, and maintaining support for temporary supply methods and natural family planning methods.

Six family planning service delivery private voluntary organizations (PVOs) will be the major participants in the Private Voluntary Family Planning Service Expansion (PVFP) Project. They include:

- Asociacion de Trabajo Laico Familiar (ATLF),
- Asociacion de Profesionales para la Promocion de la Salud Materno-Infantil (APROSAMI),
- Centro Nor-Peruano de Capacitacion y Promocion Familiar (GENPROF),
- Instituto Peruano de Paternidad Responsable (INPPARES),
- Promocion de Labores Educativas y Asistenciales en Favor de la Salud (PROFAMILIA), and
- Proyecto Planificacion Familiar (PLANIFAM).

Other Peruvian PVOs will be invited to participate in specific activities, such as training, research, and production of educational materials production, and may include non-family planning development agencies which wish to collaborate with the public sector to offer family planning services. Project support may also be extended to a PVO coordinating body, when and if such an entity begins to function.

The objectives of the project are:

- (a) to strengthen the capacity of selected PVOs to deliver family planning services (institution building),
- (b) to improve the availability of long-lasting contraceptive methods,
- (c) to maintain support for temporary supply methods and natural family planning, and
- (d) to enhance rural family planning coverage through PVO-public sector collaboration.

Increased capacity to deliver family planning services. The project will strengthen institutional management of the six primary PVOs through the introduction, acquisition, and application of management systems and skills. One of the first project activities will be to develop and install a standardized management information system (MIS) for tracking staffing and resource allocations, logistics (commodities), and service statistics.

Participating PVOs will be assisted to identify administrative and program costs, both direct (program) and indirect (capital, administrative, and support), and to analyze and use that information to determine cost-effectiveness ratios and other financial indicators. The data for these analyses will be provided by the MIS, and the indicators produced will be used for institution and program planning, monitoring, and evaluation.

The project will strengthen the PVOs' ability to utilize market analyses for the family planning services and methods they offer to enable them to increase the productivity of existing services, adjust the fees they charge, and expand into new geographical areas, income levels, and/or contraceptive methods. The project also will assist the participating PVOs to acquire skills required to undertake income-generating activities: specifically, to increase local in-kind and cash donations, and to undertake profit-making activities.

Availability of long-lasting contraceptive methods. PVOs will receive technical assistance to improve the utilization of their existing clinical capacity to provide long-lasting methods. This will include adding new services, increasing community outreach efforts, and better integration with non-clinic, community-based distribution programs. The rotating medical post system will be expanded in some peripheral urban areas of the countries, both by increasing the frequency of operation from twice a month to weekly in those posts already operating at peak output and by opening new post locations in underserved areas. Community workers (volunteers) will be trained to screen their clients for reproductive risk using such MOH criteria as age, parity, and previous obstetric problems, and to refer high-risk women to medical posts and/or clinics for intrauterine devices (IUDs) or voluntary surgical contraception (VSC).

As clinic programs expand their capacity to provide long-lasting contraceptive methods, project support will increase for this element and will decrease for the existing support of salary subsidies for CBD personnel (e.g., supervisors) during Project Year 1. By the end of Project Year 2, such salary subsidies shall be eliminated. Project-funded contraceptive commodities will continue throughout the entire four years of the project.

Maintenance of support for temporary supply methods and natural family planning. Given the importance of providing the full range of legally acceptable contraceptive choices to prospective and continuing users, the project will continue commodity donations of temporary supply methods to all the participating family planning PVOs. Institutional strengthening assistance will also be provided to a PVO specializing in natural family planning. A key element in this project will be to assist the PVOs in cost recovery and income generation, so that they can begin to purchase their own temporary contraceptive supplies locally from Peruvian manufacturers. (CSM products will be promoted as part of the interface between this project and the Private Commercial Family Planning Project (527-0326)).

Rural coverage through PVO-public sector collaboration. In rural areas where family planning services are underutilized or nonexistent, project funds will be provided for PVOs to enter into agreements with MOH departmental health units and hospital directors to provide family planning services. These services will be provided at public sector hospital outpatient clinics in the afternoons when normal clinic activities cease. The MOH (or IPSS) will provide the facility, equipment, and contraceptive supplies. The PVO will contract and train staff, including a midwife, nurse auxiliary, receptionist, and statistical clerk. Depending on local conditions, these staff may be either MOH personnel or may be drawn from the private sector. (This collaborative approach to service delivery has been tried with considerable success under an A.I.D.-funded operations research project of INOPAL (The Population Council) with Vecinos Peru, a PVO affiliated with World Neighbors.)

2. Project Description for Year One.

Project Year One will test the capabilities of the Implementing Agency and will validate the viability of the proposed approach. Funds and contraceptive commodities will be provided to continue existing PVO operations with minimal expansion.

Among the principal objectives for PY 1 are the following:

- a. develop and implement a logistics/service statistics system;
- b. conduct cost and market studies;
- c. conduct institutional financial audits of the participating PVOs;
- d. prepare administrative and financial procedures and manuals; and
- e. evaluate the performance of the Implementing Agency and the implementation modality tested in the Year One, and authorize the remainder of the project with modifications in project goals and methodology, as necessary.

3. Financial Plan.

A summary of total project costs by component follows in Table 1. While this PP provides the estimated costs for a full four-year activity, the Mission will obligating and authorizing only the first year, pending evaluation of PRISMA performance during the last quarter of the first year.

TABLE 1.
ANNUAL AND TOTAL PROJECT COSTS, BY PROJECT COMPONENT
(US\$000)

<u>Project Component</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Life of Project</u>
A. PROGRAM COSTS	<u>1,840</u>	<u>1,667</u>	<u>1,492</u>	<u>1,294</u>	<u>6,293</u>
1. PVO Instit. Support	<u>710</u>	<u>600</u>	<u>550</u>	<u>456</u>	<u>2,316</u>
- APROSAMI	210	180	165	131	686
- ATLF	40	35	35	30	140
- CENPROF	60	50	45	35	190
- INPPARES	140	110	105	90	445
- PLANIFAM	110	95	85	70	360
(Cusco)	(65)	(55)	(50)	(40)	(210)
(Puno)	(45)	(40)	(35)	(30)	(150)
- PROFAMILIA	150	130	115	100	495
(Lima)	(95)	(90)	(85)	(70)	(340)
(Huancayo)	(55)	(40)	(30)	(30)	(155)
2. Technical Assistance	<u>60</u>	<u>125</u>	<u>150</u>	<u>125</u>	<u>460</u>
- IEC	0	25	20	10	50
- Training	0	25	35	25	85
- Research	60	50	50	50	135
- Other	0	25	45	40	110
3. Contraceptive Commod.	<u>1,070</u>	<u>942</u>	<u>792</u>	<u>713</u>	<u>3,517</u>
B. ADMINISTRATIVE COSTS	<u>351</u>	<u>258</u>	<u>298</u>	<u>253</u>	<u>1,160</u>
1. Wages and Benefits	88	87	87	87	349
2. Office Expenses	23	23	23	23	92
3. Vehicle Costs	13	6	6	6	31
4. Local Travel	27	27	27	27	108
5. Evaluation	20	0	40	50	110
6. Audits	70	60	60	60	250
7. USAID Monitoring	110	55	55	0	220
C. OVERHEAD	27	30	30	30	117
D. CONTINGENCIES	0	70	70	45	185
TOTAL PROJECT	2,218	2,025	1,890	1,622	7,755

4. Budget Elements.

Program Costs include those elements of direct benefit to the participating PVOs, including institutional support for program operations, technical assistance, and contraceptive commodities.

PVO Institutional Support. The bulk of PVO support in the first year will go to improvements and modifications of urban-based programs. Some funding will be applied to opening after-hours family planning programs in public-sector facilities in rural areas. Depending on need, project funds may be used for staff salaries, purchasing local equipment, in-country training, etc. It is anticipated that as the PVOs generate more income, decreasing percentages of their recurring costs, especially in urban areas, will be underwritten by project funds. By the last year, approximately 40 percent of the A.I.D. project-funded PVO institutional support will be applied to rural programs.

Technical Assistance. During Year One, technical assistance will be limited to two technical studies of service delivery costs and marketing/pricing of commodities and services. The successful implementation of these studies and a commodity logistics system with the participating PVOs will be the central criteria against which PRISMA will be evaluated, in determining whether to negotiate a new Cooperative Agreement with PRISMA or to seek a new obligating mechanism for Project Years 2-4. These studies will also serve as a basis for the operations and direction for the remaining three years of the project.

During years 2-4 technical assistance funds will be available to contract for short-term technical assistance of both a general (information, education, communications, and research) and specialized nature to supplement the Implementing Agency team. Depending on availability and specialized needs, buy-in's to centrally funded projects may be used. In light of the unique implementation difficulties in Peru (hyperinflation, socio-political sensitivities, and bureaucratic bottlenecks), the availability of local talent, and desire to integrate women into all facets of project implementation, preference will be given to Peruvian sources and women professionals.

Contraceptive Commodities. While the implementing agency will be responsible for estimating, calling forward, receiving, storing, and distributing contraceptives to participating PVOs and monitoring their use, the actual procurement will be undertaken by A.I.D. The implementing agency will authorize USAID to issue a PIO/C to access the central AID/W purchasing contract. Commodity handling costs are also included under this line item.

Administrative Costs are comprised of all personnel and administrative inputs directly and exclusively dedicated to this project, many of which also will directly benefit the participating PVOs. All of these costs cease at the end of the Project. They include wages and benefits of advisors and staff hired by the Implementing Agency, office expenses incurred by the Implementing Agency, local travel and vehicle costs for Project staff, evaluations and audits of both the Implementing Agency and the participating PVOs, and funding of USAID Project monitoring.

For the first year of the Project, the following personnel inputs are required for the Implementing Agency: Team Leader (part-time only); Administrative/Management Specialist; Logistics/Statistics Coordinator; Accountant/Analyst (equivalent to CPA); Accounting Assistant; Secretary (2); and Driver/Messenger. For the succeeding three years, a Program/ Evaluation Specialist is added and either he/she or the Administrative Specialist becomes the Team Leader (prior part-time input dropped).

Other direct inputs are legal assistance (retainer), insurance, rental of space and selected equipment, maintenance contracts, and all other normal and usual administrative costs. All of these costs are exclusive to the support of the Project and can be readily verified.

Evaluations. Two evaluations shall be undertaken during the term of the project. A threshold assessment, starting in Month 8, will concentrate on the success of PRISMA's efforts as the implementing agent; a favorable finding will lead to negotiation of a new cooperative agreement and authorization of the remaining three years of the project (with modifications, as necessary). A final project evaluation will be held at the end of Year 4.

Audits. Annual audits (of PRISMA and the participating PVOs) will be conducted in accordance with A.I.D. policies. Funds are provided to contract out the independent, certified audits and to bring in external evaluators.

USAID Monitoring. Through execution of a PIO/T, the implementing agency will authorize USAID to contract directly for a project monitor, using project funding. During Year One, the project will defray 100 percent of these costs; a future determination will be made as to the need for a project monitor in subsequent years and method of financing that position.

Overhead. Overhead, or indirect costs of program support, has been developed by an analysis of the monthly input of all PRISMA core personnel having a recurring input. This input, for most, will decline over the first year, reaching a minimum level required to

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monitor assistance to the PVOs and financial reporting during the remaining three project years. Included in overhead also are those core administrative expenses related to core personnel inputs. These costs are minimal and not expected to exceed US\$1,000 annually. Overhead will be reimbursed based upon monthly billings from PRISMA in local currency.

Contingencies. Contingencies are allowed for adjustments to PVO institutional support starting in Year 2.

5. Recurrent Costs and Other Financial Issues.

Recurrent costs are incremental expenditures associated with activities that must be made on a regular basis during the Project to achieve objectives, and after the Project to sustain accomplishments and continue activities. During the life of the project, USAID and the six participating PVOs will be financing recurrent costs. These recurrent costs will not add to the regular budgets of the PVOs during the life of the project; however, the Institutional Support and Audit costs financed by the Project will become additional costs to the PVOs after the end of the planned duration of USAID assistance. Program recurrent costs for PRISMA will terminate with the end of the project.

Under the "Program Costs", the principal financial expenditure categories (See Financial Tables) that cover recurrent costs fall under: PVO Institutional Support (administrative and project costs); Technical Assistance (Institutional Development); Contraceptives (plus freight and handling); Project Management, USAID Coordination, evaluation and audit. Recurrent costs can be identified for each component.

The costs of PRISMA management for the Project are all in excess of their current budget and can be clearly identified as costs directly related to their role as "Project Manager". The only costs which will continue after their role ends, are those for the Annual Audit, required for PVO annual re-registration. It is expected that by the end of this project that other resources will be forthcoming to continue the funding of these Annual Audits.

The recurrent costs for the six participating PVOs will continue and will expand somewhat in relation to their institutional share of the over-all private family planning efforts expansion. These costs will be partially financed during the life of the project, at increasing amounts, as project financing decreases. This financing will be provided by revenues from the sale of contraceptives and other income-generating activities.

The Technical Assistance inputs, administrative management training from PRISMA, and financial management skills imparted from the

Audits and Financial Management Reviews, will prepare the PVOs to be more cost-effective in providing family planning services to the private sector. The net effect will be the containment of recurrent costs at levels reasonably related to their family planning program objectives.

TABLE 2
PROJECTED OBLIGATIONS AND EXPENDITURES OF PROJECT FUNDS
BY FISCAL YEAR (FY) IN U.S.\$ 000

U.S. FISCAL YEAR (Project Year)	FY 89	FY 90 (PY1)	FY 91 (PY2)	FY 92 (PY3)	FY 93 (PY4)	TOTAL
1. Beginning of Year Balance	-	2,200	1,882	1,857	1,604	-
2. Obligations	2,218	1,900	2,000	1,637	-	7,755
3. Expenditures	18	2,218	2,025	1,890	1,604	7,755
4. End of Year Balance	2,200	1,882	1,857	1,604	-	-

C. Summary Findings of Project Analyses.

The USAID/Peru Project Development Committee has reviewed the analyses and other documentation for this project and has concluded that the project is environmentally, socially, financially, and economically sound, is technically and administratively feasible, and is ready for implementation.

D. Project Checklists.

The project meets all applicable statutory criteria. Appropriate checklists are included in Annex I.

E. AID/Washington (A.I.D./W) Concerns and Project Design Issues.

Several issues were raised during the A.I.D./W review of the Project Identification Document (PID) for this project on April 13, 1989. Annex II contains the initial PID review cable, Mission responses thereto, and the final PID approval telegram. USAID/Peru's response to these issues is summarized in this section and further discussed throughout the Project Paper (PP). During project development, additional project design issues were identified and resolved; such additional issues have also been addressed in this section and throughout the PP.

1. Management and Implementation Arrangements.

Review of implementation options. Three implementation options were considered during the design process, including: (i) A.I.D. direct grants to the PVOs; (ii) buy-ins to A.I.D./W centrally funded projects; and (iii) a Cooperative Agreement with a local non-family planning private voluntary organization (PVO). For the reasons described below, the third option, a Cooperative Agreement with a local PVO, was selected.

1. Direct Grants to PVOs.

The project contemplates core institutional funding for up to six separate family planning PVOs, and funding for separate project sub-grants or contracts for PVO-public sector collaboration and group activities (training, logistics, research, information, education, and communication, etc.). This will include the six core PVOs, as well as other family planning PVOs not receiving institutional support under this project.

Managing the project as direct grants to the participants would require six separate grants for institutional funding, separate project grants for PVO-public sector collaboration (each clinic budget totalling approximately \$7,000 yearly), and separate mechanisms for funding group activities. In addition, all recipients, including those not receiving institutional support, would need to be registered directly with A.I.D. The management burden on the Mission imposed by such arrangements would be incommensurate with the project funding levels and, in view of staffing constraints, would exceed USAID/Peru's managerial capacity.

Subsequent to the PID review, A.I.D./W issued guidance recommending that field missions deal directly with PVOs rather than coordinating assistance through umbrella organizations. USAID/Peru reviewed the recommendations and determined that there are instances in which the grouping of PVOs with a common interest is appropriate, such as in the present project. Furthermore, this project differs from the umbrella organizations reviewed by the LAC Bureau in that the Implementing Agency was not created for the purpose of coordinating the recipient PVOs and that the purpose of the Project is not to enhance the sustainability of the Implementing Agency. This is consistent with the new policy as stated in the guidance cable: "The umbrella group chosen should be self-sufficient and have a track record for managing micro-grants. The funding would not be used primarily for institution building or strengthening (of the umbrella) but rather to fund PVO activities."

ii. Buy-ins to Centrally Funded Projects.

This option was carefully considered during the design process, as it presents the advantage of quickly tapping into an existing organizational capacity. However, the buy-in arrangement limits direct Mission participation in the project. As the central agreement takes precedence over a mission's request for information, there are serious constraints to the degree of detail of financial reporting which the mission may require of the implementing entity. Additionally, each centrally funded project has an authorization which does not necessarily coincide with a four-year life of project term; indeed, the mandates of current central activities do not match the specific (and in some cases unique) needs of the project.

The Mission concluded that the project would have a greater chance for long-term success and sustainability of certain activities, if it were administered by a Peruvian entity. A local PVO, which was existing under the same constraints and in the same economic environment as the target beneficiary PVOs, could more effectively develop and convey financial and administrative management and logistic systems improvements. Furthermore, the lower salary costs and overhead rates involved with a Peruvian PVO would permit a greater proportion of project funding to be channeled to the recipient agencies.

iii. Cooperative Agreement with a Peruvian PVO.

Implementing the project via a cooperative agreement with a local PVO will facilitate Mission oversight and participation and permit a greater proportion of Project funding to be channeled to the recipient agencies. The project design team made a careful search of potential candidates, which needed to satisfy the following criteria:

- not a family planning service delivery organization (so as not to be seen as a competitor by the local family planning PVOs);
- previous experience with USAID/Peru Mission disbursement and reporting requirements;
- strong background and experience in a related development field; and
- previous collaborative relationship with the public sector.

Three potential candidates were identified: Vecinos Peru, APROPO, and Asociacion Benefica PRISMA. PRISMA was chosen as the strongest of the three, for its administrative/managerial capabilities, its linkages with the Ministry of Health both centrally and at the departmental level

throughout the country, its experience in working with Mission reporting requirements, and its experience in primary health care and P.L. 480 food distribution.

While PRISMA has a good record in managing and accounting for resources under other A.I.D. programs, concern was expressed about its capacity to take on another large and complex project without negatively affecting its other projects. Questions of its experience in specific family planning activities were also raised. As a result, authorization is given for a one-year, initial activity which could be extended, based on this PP, to a full four-year term.

During the first project year, PRISMA will serve as pass-through to ensure needed bridge funding for six family planning PVOs, thereby allowing uninterrupted provision of services to 260,000 Peruvians. It will also be responsible for ordering, storing, distributing, and monitoring contraceptive commodities (18-month supply) and commission two technical studies on marketing/pricing of commodities and costing of services. PRISMA's performance will be evaluated in Month 8 to determine if the cooperative agreement is the most effective manner of coordinating PVO support in Years 2, 3, and 4. Authorization of the remaining life of project (as described in this PP) and/or any modifications to this PP will be contingent upon the positive findings of this evaluation.

Impact of Peru continuing under sanctions. There is a strong possibility that due to debt arrearages, Peru will continue under Section 620(q) and Brooke-Alexander Amendment sanctions for the remainder of Fiscal Year (FY) 1989. Therefore, the Mission has requested and received the A.I.D. Administrator's determination, under Section 123(e) of the FAA, that obligations to PRISMA for this project is in the national interest. As a PVO registered with A.I.D. since 1986 and as an organization that has received A.I.D. funding for population related activities (Milpo Mining Project, the Risk Project, and Ninos Journal), PRISMA is eligible to receive A.I.D. funding under a Section 123(e) determination.

Roles and responsibilities of the implementing agency. The implementing agency will:

- (i) administer sub-grants to the participating family planning PVOs;
- (ii) recruit long- and short-term technical advisors;
- (iii) coordinate group activities, including identifying and contracting local vendors and services outlets;
- (iv) provide technical assistance;

- (v) finalize and implement a computerized integrated logistics and services statistics system; and
- (vi) be responsible for ordering, storing, and distributing contraceptive commodities to family planning PVOs.

Specifically, as indicated above, in Project Year 1, PRISMA will serve as the funding pass-through for six service delivery PVOs, will be responsible for the supply and accountability of contraceptives, will undertake two studies, and will commence implementation of these study recommendations.

USAID believes that based on its past performance, PRISMA is well-qualified to carry out these functions. However, given the enormous challenges posed by the four-year project, the Mission wishes to test PRISMA's capacity before committing resources beyond Year One. PRISMA has a large and qualified full-time staff and a technical oversight committee. Its financial infrastructure is oriented to Mission reporting requirements; it has worked successfully on projects totaling approximately \$500,000 annually. Project managers have extensive experience administering complex financial tracking programs under the hyperinflationary conditions of Peru. Additionally, PRISMA's experience in logistics and commodities includes its current participation in the Mission's Food for Development Program (under P.L. 480, Title II), in which it oversees the distribution of 16,000 metric tons of food commodities annually for the Ministry of Health's maternal and child health (MCH) food/nutrition program.

Types, amounts, and method of implementation of buy-in's to centrally funded projects. A relatively modest amount of project funds may be used for buy-ins to A.I.D./W centrally funded projects periodically during the life of the project for specialized activities, possibly including such areas as operations research, management information training and assistance, and logistics. We do not now foresee general, short-term technical assistance being provided through such buy-in's; our strategy is to rely on Peruvian talent, as much as possible. However, buy-in's of a highly technical, specialized nature may be identified for one or more participating PVOs to respond to discrete problems during implementation; once such technical assistance needs are identified, PRISMA will request the Mission, in writing, to obtain the required services; the Mission, in turn, will prepare a PIO/T for the buy-in and send it to A.I.D./W for action.

Mission policy on using personal services contractor (PSC) as project coordinator/monitor. The U.S. direct hire (USDH) Population Officer will serve as the Project Manager. The PSC who will be hired competitively with project funds to facilitate and monitor implementation will be the project monitor. The Project Monitor will be based primarily in PRISMA's offices.

He/she will report directly to the USDH Project Manager. This arrangement is, in the opinion of the Regional Legal Advisor, in keeping with the General Counsel's July 28, 1989, memorandum establishing guidelines on funding PSCs with A.I.D. project resources.

2. Adequacy of USAID/Peru OYB Population Funds.

Rationale for using Child Survival funds for family planning activities. Given the size and complexity of the population problem in Peru, as well as the obvious linkages between high fertility, abortion rates, and maternal and infant mortality, USAID/Peru has allocated both Population and Child Survival account funds to support the achievements of program objectives in the family planning sector. For the foreseeable future, since public sector family planning activities are included within the Child Survival Action Project (CSAP), such public sector activities will be funded principally by Child Survival funds; private sector activities (both commercial and voluntary) will be funded from the Population account.

Funding public sector family planning activities under the CSAP is justified on the grounds that improving birth spacing and reducing the number of high-risk pregnancies can have a significant impact on child survival. CSAP funds for the public sector program will be supplemented by the use of Population funds in the present project to support PVO-public sector collaboration in the form of after-hours family planning clinics in Ministry of Health (MOH) and Social Security (IPSS) installations.

Population account OYB funding levels. The Mission plans to accommodate both this project (including contraceptive requirements unforeseen when the initial PID was submitted) and the Private Commercial Sector Family Planning Project (527-0326) within current and projected Population account availabilities by (a) deferring the private commercial project to FY 1990 and (b) scaling back the project described in this PP from \$8.322 million to \$7.755 million. The following table presents the funding requirements and sources:

TABLE 3.
POPULATION ACCOUNT REQUIREMENTS AND SOURCES
FY 1989 - FY 1992
(in \$ 000)

Project No. Project Title (Life-of-Project Amount)	FY 1989	FY 1990	FY 1991	FY 1992
527-0000 Program Development and Support	98	100	100	108
527-0230 Contraceptive Social Marketing (\$4,100)	25	-	-	-
527-0326 Private Commercial Sector Family Planning (\$1,900)	-	300	500	600
527-0335 Private Voluntary Family Planning Service Expansion (\$7,755)	2,218	1,900	2,000	1,637
Total, Population Account	2,341	2,300	2,600	2,345

Sources of Funding:

OYB (Actual Budget Allowances or Approved Planning Levels)	2,238	2,300	2,300	2,300
Deob/Reob (from PD&S and Integrated Health/ Family Planning Projects)FP)	103	-	-	-
Starting FY 1991, with no functional accounts, transfer from straight- lined FY 1990 ARDN levels (made possible by deob/reob's in FY 1989)	-	-	300	45

Donations by other donors. In the past, A.I.D. provided some 75 percent of all population assistance to Peru. With the approval in late 1988 of a \$5 million project by the United Nations Fund for Population Activities (UNFPA) to the MOH, that percentage has declined. Nevertheless, A.I.D. remains almost the sole donor for private sector population activities. Recently, the German

Technical Assistance Agency (GTZ) funded a project to expand delivery of intrauterine devices (IUD) in Cuzco province. None of the other international donors have mounted large-scale family planning service delivery projects.

3. Sustainability of PVO Operations.

Long-term financial sustainability is a goal of this project, although the Mission recognizes that self-sufficiency is impossible in four years. The project will further the sustainability goal in four ways:

- (a) developing long-term institutional plans for the core participating PVOs;
- (b) calculating annual financial targets for each PVO receiving institutional support;
- (c) applying management indicators such as cash flow and management reporting systems, and logistics and service statistics systems; and
- (d) promoting cost recovery and income-generating activities.

Sustainability of PVO program operations is an important goal in and of itself and becomes more urgent in light of decreasing availability of OYB funds in the USAID population account and decreased emphasis on Latin America within A.I.D./W centrally-funded population projects. While sustainability ultimately depends on larger economic factors and clients' ability to pay, the economic and financial analyses performed as part of the development of this project suggest that significant income could be generated through the sale of donated commodities, which account for more than half of the direct institutional support provided to the PVOs.

4. Compliance of Sterilization Activities with Peruvian Law.

All voluntary surgical contraception (VSC) activities conducted under this project will not only follow A.I.D. requirements but will also be fully consistent with Peruvian laws and norms. MOH norms permit voluntary sterilization (male and female) in the case of high reproductive risk, which is specified by such health criteria as maternal age, parity, poor obstetric history, and acute and chronic health conditions. Compliance with these legal requirements will be fostered by development of counseling norms and procedures (including mandatory "waiting" periods) and close monitoring of centrally funded VSC projects. As suggested in the PID review cable, client satisfaction surveys (through a special module to be included in the next Demographic and Health Survey (DHS II) in 1991), will be used to test such compliance.

F. Contributors to the Project Paper.

Contributors to the Project Paper are listed in Annex II, Exhibit D.

II. BACKGROUND.

A. Country Setting.

1. Social and Economic Conditions.

Since the mid-1970s, economic development in Peru has stagnated, and future prospects for improvement are poor unless adverse population trends can be reversed. While fertility rates fell by 23 percent in less than 10 years (1977-1986), the national total fertility rate is still 4.1 births per woman (1986 Demographic and Health Survey (DHS)), and the annual population growth rate stands at about 2.6 percent. As a result, Peru adds nearly 600,000 people to its population each year. The current population of nearly 22 million has doubled in the years since the 1961 census. As another consequence of high fertility rates, a disproportionately large part of the population is under 15 years of age and therefore dependent on the relatively small numbers of economically productive adults.

Population growth in the cities is further increased by migration from rural to urban areas, where social services and economic opportunities cannot keep pace with the needs. Urban areas have been growing at a rate twice as fast as rural areas. The Lima metropolitan area, where nearly one third of all Peruvians live, has grown by almost 1,000 percent since 1940 and now contains some 7 million people.

Rapid urbanization has progressed through the 1980s. At present, almost two of every three Peruvians live in cities of 20,000 or more inhabitants. By the year 2000, three out of every four Peruvians will live in large cities, giving Peru a population distribution pattern similar to developed, industrialized countries.

This trend has major implications for development work in Peru. On the one hand, concentrating efforts in the cities has the potential of reaching the greatest number of people with a relatively lower expenditure of resources. On the other hand, if efforts are not made to promote agricultural and rural development, the countryside will become increasingly impoverished and susceptible to politically destabilizing influences; the rush to the cities will continue unabated, and the current urban crisis will intensify.

For two decades, Peru has experienced destabilizing political turbulence and socio-economic crises. More recently, it has begun to suffer the effects of an active and growing terrorist movement and drug trafficking. During the military dictatorship of the 1970s widespread economic and socio-political changes were effected, including massive land reform. These changes modified the structure and ownership of productive resources and greatly increased the role of the state in the economy.

In 1980, Peru elected a democratic government that set out to reverse the statist oriented policies of the 1970s. The world recession of the early 1980s led to a sharp drop in prices of Peru's major traditional exports. This, combined with unprecedented and widespread climatic distortions and inappropriate monetary and fiscal policies, precipitated increased inflation and rapid deterioration of the economy. Two terrorist groups, the Sendero Luminoso and Movimiento Revolucionario Tupac Amaru, as well as drug traffickers, have destroyed normal peaceful living conditions in many parts of the country and have contributed to a deteriorating economic situation.

The American Popular Revolutionary Alliance (APRA) Government, elected in 1985, was the first democratically elected government to succeed another in forty years. It instituted a heterodox program to control inflation and stimulate demand by freezing prices, declaring sharp wage increases, reducing interest rates, restricting imports, controlling exchange rates, and limiting external debt payments. This stimulated domestic demand and achieved an impressive, but temporary, supply response, while sharply reducing the inflation rate. An almost unprecedented 8.5 percent real gross domestic product (GDP) growth rate was achieved in 1986, inflation was cut in half from 163 percent in 1985 to 78 percent in 1986, and real wages rose 18 percent in 1986.

The effects of this growth strategy were short-lived. Net international reserves fell, exports and capital flows declined, and the central government deficit rose from 2.3 percent of GDP in 1985 to 5.3 percent in 1986. Beginning with an abortive attempt to nationalize the private banks and finance companies in July, 1987, the economic gains of 1985-1986 have suffered a complete reversal. Inflation rates rose to 114 percent in 1987 and 1,722 percent in 1988; and the GDP rose by 9.3 percent and 7.3 percent in 1986 and 1987, respectively, and declined by 8.5 percent in 1988.

Sufficient basic goods and social services to sustain even a minimal standard of living for a large proportion of the population are not available from either the private or public sector. Peru is one of only three Latin American countries whose average food consumption per person is less than 90 percent of the Food and Agricultural Organization (FAO) standard; it is estimated that 38 percent of all children under five are chronically malnourished. Although education for ages 6-14 is available to 84 percent of the population, drop-out rates exceed 50 percent for the first three grades. Housing is insufficient and inadequate. Less than half of the urban population has access to potable water, and only 30 percent of the population has access to electricity.

High fertility rates lead to high maternal and child morbidity and mortality rates. Infant mortality rates have declined from 97 deaths per 1,000 live births in 1972-1977 (1977 World Fertility Study (WFS)) to 76 deaths in 1981-1986 (1986 DHS). Nevertheless, Peru still has one of the highest infant mortality rates in Latin America, almost twice as high as Colombia and almost four times higher than Chile. Infant mortality rates vary widely by geographic region and socio-economic status: from 34 in metropolitan Lima to 110 in the Sierra, and from 22 among women with post-high school education to 124 among women with no formal education.

Rapid population growth has a direct effect on per capita income; it also strains already weak health and educational systems. Because the population is increasing so rapidly, public facilities face increasing numbers of new clients each year. In particular, rapid population growth affects health systems because obstetrics (mainly deliveries, pregnancy problems, and abortion complications) account for half of all hospital admissions. The school systems also suffer from the combination of static or declining budgets and rapidly increasing numbers of school age children.

2. Government of Peru Population Policy.

Efforts to develop a national population policy began under the military government with the formulation of "population policy guidelines" in the mid-1970s. These guidelines had no specific demographic, health, or programmatic targets and offered only a broad orientation for the population sector. As such, their effectiveness was limited. The preceding Government of President Belaunde created the National Population Council (CNP) in 1980 to assist the public and private sectors to follow the guidelines.

In July, 1985 the Government of Peru (GOP) took a major step in population policy with the passage of the National Population Law, Legislative Decree No. 346. Among other things, this law guarantees couples the basic human right to freely determine the number and spacing of their children, and establishes that the State shall promote responsible parenthood as a development and health priority. The Law recognizes all voluntary contraceptive methods with the express and explicit exception of sterilization.

Under the Government of President Alan Garcia, and largely as a result of his personal commitment and leadership, population matters have taken center stage in many aspects of development planning and services delivery. In late 1986, President Garcia called for a national development strategy which would include the establishment of operational policies and demographic goals specifically aimed at reducing the population growth rate.

A Presidential Population Commission, charged with developing a national population strategy, was formed in early 1987. The Commission completed its work in mid-1987 and recommended a comprehensive approach to solving Peru's population problem. Their recommendations included intensified work in education, service delivery, research, and public information. The Council of Ministers and the President approved the Commission's action plan, entitled "National Population Program 1987-1990".

The broad demographic target in the National Population Program calls for a reduction of the total fertility rate from 4.3 births per woman in 1985 to 2.5 births per woman in the year 2000. To accomplish this fertility reduction, it will be necessary to increase the total prevalence of family planning and to increase the relative use of more effective, modern contraceptive methods.

Specifically, the Government plan calls for increasing contraceptive prevalence from 28 percent of women of reproductive age in 1986 to 42 percent in the year 2000. For women in union, this would mean a prevalence rate of 60-70 percent by the year 2000. According to method mix targets developed by the Social Security Institute (IPSS), use of traditional methods would decline from 50 percent to 10 percent of all contraceptive use, and long-lasting methods (IUDs and VSC) would rise from 29 percent of all contraceptive use to 60 percent.

The National Population Program created a National Family Planning Program (PNPF) under the direction of the Ministry of Health (MOH) which is responsible for coordinating the efforts of both the public (MOH, IPSS, and Armed Forces) and private (commercial and voluntary) sectors. Sector coverage rates were established by the PNPF by department and contraceptive method.

Originally, the National Population Program called for the public sector to cover 90 percent of all contraceptive users by the year 2000. These targets have been scaled back considerably and, for 1989, reflect the general market segmentation revealed in the 1986 DHS:

- 53 percent of modern method users should be served by the public sector,
- 20 percent by the private voluntary (PVO) sector, and
- 27 percent by the private commercial sector.

The Government targets also reflect the expectations that changes in the contraceptive method mix will include larger proportions of modern methods such as pills, IUDs, and VSC.

3. Family Planning Availability.

Public Sector: Ministry of Health (MOH). The percentage of the total population designated to receive health care through the MOH

is 58 percent. However, only 26 percent of the total population actually receives such services, leaving 32 percent of the population without access to modern medical care. MOH services are delivered through a network of 2,700 health posts, 700 health centers, 125 hospitals, and 10 national institutes.

At the lowest level of the MOH system, the health posts are responsible for health promotion and preventive community-based health care activities, as well as some curative and emergency care. Health posts are generally staffed by a health auxiliary and (in some cases) a nurse or midwife. They serve a population within a ten kilometer radius, approximately 3,000 inhabitants in rural areas and 5,000 in urban areas. Under the MOH norms, health post personnel are authorized to distribute barrier methods (condoms and spermicides), may prescribe hormonal contraceptives (orals and injectables) if staffed with a nurse or midwife, and may even insert IUDs if staffed by more than a paramedic.

Health centers are located in the district or provincial capitals and offer both preventive and curative health care. They are usually staffed with nurses, health auxiliaries, technicians and/or a physician (where available). There are also two levels of health centers: Level Two does not have beds, while Level One health centers may have six to eight beds. Health centers generally serve the population within a ten kilometer radius, as well as the referrals from the health posts in their jurisdictions. The size of the population covered is approximately 35,000. Under the MOH norms, health centers are authorized to apply all reversible contraceptive methods and to refer patients with high reproductive risk to hospitals for surgical procedures.

Hospitals exist at the provincial, departmental, and national level and provide preventive, curative, and rehabilitative services, with emphasis on curative care. Hospitals have seven departments, including surgery and obstetrics/gynecology, and also refer patients to the national institutes. Under the MOH norms, hospitals are authorized to apply all contraceptive methods, including voluntary surgical contraception for cases of high reproductive health risk.

The MOH Family Planning Director serves as the Director of the National Family Planning Program. He is assisted by expatriate and Peruvian advisors and by departmental family planning coordinators. The MOH prepares a yearly action plan for family planning, including departmental targets for new and continuing users by contraceptive method, commodities, and budget support needed. A service statistics system is being implemented to track program performance and feed into operational planning goals.

Public Sector: Peruvian Institute of Social Security (IPSS). The IPSS is legally mandated to cover all private and public (including parastatal) sector salaried workers as well as cooperative members. The self-employed may join voluntarily. In 1984, a law expanded dependent coverage to include not only maternity care and children under 1, but also some services for children ages 1 to 14. More recently, IPSS has been mandated to extend coverage to farmers' groups, mothers' clubs, rural cooperatives, housewives, and children up to age 18. The IPSS target population now includes 720,000 women of reproductive age. The percentage of the total population considered to be covered by IPSS now totals more than 28 percent, or some 6 million beneficiaries, although actual coverage is probably considerably lower.

The IPSS delivers medical services via a six-tiered system that as of 1987 includes 26 hospitals (at national, regional, and zonal levels), 48 polyclinics, 212 medical posts, and 100 factory posts. Family planning services are provided at hospital outpatient clinics and polyclinics. The IPSS national family planning program director is assisted by a small central level staff and regional family planning coordinators. Yearly operational family planning targets, commodities, and budgetary requirements have been projected since 1987, and a service statistics system has been operational since that year.

The Private Voluntary Sector. PVO family planning activities in Peru date back to the mid-1960s. Some of the earliest PVOs included the Christian Family Movement, the Peruvian Association for Family Protection (the first Peruvian affiliate of the International Planned Parenthood Federation (IPPF)), and the Instituto Marcelino. In 1973, the pro-natalist military government closed all family planning PVOs, except the Instituto Marcelino and those supported by Catholic authorities.

The family planning PVO sector was reactivated in the late 1970s and early 1980s. An institutional analysis conducted in 1985 for the Private Sector Family Planning Project (527-0269) identified 17 agencies in the sector, including:

- 10 involved in service provision,
- 2 specializing in training family planning workers and medical personnel,
- 2 involved in research,
- 1 involved in information, education, and communication,
- 1 preparing to launch a major social marketing (CSM) effort, and
- 1 involved in policy development.

Family planning service delivery PVOs offer contraceptive services and commodities through a variety of outlets, including community-based distribution (CBD), fixed and rotating location clinics and medical posts, and commercial marketing. Most receive donated commodities, usually from A.I.D. sources, and distribute them free of charge or at nominal prices. Some also pass on contraceptive commodities to other outlets, including community centers and private physicians, for subsequent distribution. Thus, the quantity of commodities distributed by the PVOs is considerably greater than their share of the end-user market. For example, in 1988, INPPARES distributed almost 57,000 IUDs, of which 73 percent were delivered to other distribution outlets.

Private Commercial Sector. The private commercial health sector in Peru consists of more than 3,500 registered pharmacies, several thousand private practice physicians, and several hundred private clinics and hospitals. It is oriented predominantly to outpatient care, accounting for only 18 percent of all hospital beds and four percent of primary health care facilities, but fully three-fourths of all pharmaceutical sales. The 1984 Health and Nutrition Survey (ENNSA) found that as many as two-thirds of the residents of major urban areas routinely consult private physicians for their outpatient health care needs.

Included in the private commercial sector are third party payment plans. In 1984, the private sector accounted for 34 percent of all health sector expenditures. Health insurance and employer and provider plans accounted for 15 percent of the non-pharmaceutical expenditures in the private health sector. These plans do not provide medical care directly, but instead contract with private individual and/or group practices for health services.

B. Status of Family Planning Utilization in Peru.

1. Contraceptive Prevalence and Method Mix.

Contraceptive prevalence was minimal in the 1960s; as late as 1969, only 36 percent of women in union of reproductive age had knowledge of any form of modern contraception. By 1986, nearly 90 percent of all women of reproductive age knew of at least one modern method. Increasing contraceptive knowledge has been accompanied by increasing contraceptive use.

Overall, contraceptive prevalence has risen considerably over the past ten years, although total prevalence and use of modern methods still lag behind other countries in Latin America, such as Brazil and Colombia. However, Peru compares favorably with some countries in the Andean region (Ecuador and Bolivia) in terms of total contraceptive prevalence.

In 1986, contraceptive prevalence was measured at 28 percent of all women of reproductive age (46 percent of women in union of reproductive age), and it appears to be rising by about 2 percent per year. Current contraceptive practice is about equally divided between modern, effective methods and less effective, traditional methods. Traditional methods provide only about half the contraceptive protection of the most efficient methods (IUDs, implants, and sterilization). Half of all contraceptive prevalence in Peru, therefore, is of limited effectiveness and has limited impact on fertility. Among modern methods, the pill, IUD, and female sterilization are the most popular. Each accounts for about 30 percent of total modern use, while barrier methods (spermicides and condoms) comprise the remaining 10 percent.

Peruvian contraceptive practice is remarkable in several regards. First, Peru shows one of the highest rates of IUD use anywhere in the world, both in absolute and in relative terms. Second, the use of female sterilization is almost as high as pills or IUDs, despite the legal limitation on access to that procedure. (As mentioned earlier, by law, sterilization is permitted only to avert high-risk pregnancies.)

The high use of less effective, traditional methods coupled with the strong demand for IUDs and female sterilization suggests that more women would like to use modern methods, but are forced to use traditional ones because they do not know where to obtain modern methods or because they are not available. Many women have received disinformation or have unfounded health fears about the safety of modern methods, indicating the need for better information and education about contraceptives as well as improved accessibility.

2. Contraceptive Market Segmentation.

While there is no single definitive study of contraceptive market segmentation in Peru, available data consistently suggest that the public sector serves approximately half of all modern method users, followed by the private commercial sector, and then the private voluntary sector. The 1986 DHS included questions on source of current method, but interpretation of the results has been confounded by lack of precision in the questionnaire and in the response categories used.

The DHS found that 53 percent of modern method users were served by the public sector, 39 percent by the private commercial sector, and 8 percent by the private voluntary sector. (These results are based on recoding of ambiguous responses; in the original publication, the PVO sector was credited with only 2 percent of total modern method users.) The wording of the DHS questionnaire probably led to an overestimate of the proportion of users receiving pills and other

supply methods from private physicians and underestimated the users supplied by pharmacies. However, the public vs. private sector disaggregation is probably valid.

A survey of marginal areas of Arequipa, Chiclayo, Cuzco, Piura, and Trujillo conducted by the Private Sector Family Planning (SPF) Project in 1988 produced similar results. The relative contributions of the public and private sectors were basically unchanged (52 percent public sector and 48 percent private sector for all modern methods; 67 percent public sector and 33 percent private sector for IUDs). The five-city survey did not distinguish between private physicians and PVOs, so the PVO sector contribution could not be disaggregated. However, better information on use of pharmacies was obtained than in the 1986 DHS; the pharmacy contribution of non-IUD modern methods was 55 percent and of all modern methods was 27 percent (versus approximately 7 percent of all modern methods in the DHS).

The individual user of contraception probably regards family planning as another health service: contraceptive supplies and services are provided primarily through normal health outlets --- pharmacies, physicians' offices, clinics, and health centers. Therefore, the segmentation of the contraceptive market should follow the segmentation of the health care market, with use of public and private outlets determined by contraceptive method, income, perceived quality of care, and proximity to service providers.

The use of public and private sector health outlets is affected both by the availability of the outlets and characteristics of the user. Many families use both public and private health facilities, depending on the nature of the health condition, the age of the user, and other factors.

Availability is a function of both service providers and facilities. Physicians are divided almost equally between the public and private sectors, but only 18 percent of the hospital beds in Peru are found in the private sector. Therefore, we should find that health cases requiring hospitalization show higher public sector usage rates, while outpatient care should show higher private sector participation.

This is confirmed by the findings of the 1984 National Health and Nutrition Survey (ENNSA); for example, 23 percent of the women receiving prenatal care used private physicians or clinics, but only 15 percent of the institutional births were attended in the private sector. Similarly, 68 percent of the women using female sterilization received their method from the public sector, as did

57 percent of the IUD users, but only 46 percent of pill users (1986 DHS). Sterilization and IUD insertion require clinical facilities, but a pill prescription does not.

Use of health or family planning service providers is also governed by the user's ability to pay. According to the USAID-commissioned Health Sector Analysis (HSA), in 1984:

- the private sector provided coverage to 21 percent of the population,
- the public sector provided coverage for 47 percent, and
- an estimated 32 percent of the population had no access to modern health services.

The inability of large segments of the population to pay commercial sector prices for contraceptive services and commodities and the inability of the public sector to serve all of the economically needy underscore the importance of A.I.D. assistance to the private voluntary sector. However, PVOs cannot depend on A.I.D. or other foreign donor subsidies indefinitely.

The purpose of the PVFP project will be to continue institutional, financial support to a select group of PVOs; while providing technical assistance to improve their management systems and income generation abilities to a point where they are more economically sustainable. It is unlikely, however, that they will become completely self-sufficient by the end of this or any other assistance project.

3. Unmet Demand for Contraceptives.

Unmet demand for contraceptives in Peru is among the highest in the world. For more than a decade, Peruvian women have had and, continue to have, more children than they wanted. As early as 1981, average ideal family size was already fewer than three children, or about 1.5 fewer children than 1986 total fertility levels. Over one-third of all births occurring in the last three years before the 1986 DHS were reported to be "unwanted", because the woman did not wish to have any more children.

The rate of unwanted pregnancies is even higher, as many are terminated by clandestine abortions. Recent studies estimate that in urban areas as many as half of all pregnancies are terminated by abortion; Government statistics demonstrate that abortion complications are the fourth leading cause of hospital admissions in Peru.

There are many operational definitions of unmet demand for contraception. At a minimum, it would include all sexually active, fecundable women who do not wish to become pregnant and are not

using any contraceptive method. To these could be added pregnant and post-partum women who do/did not wish the pregnancy and were not using contraception when it occurred.

Using this definition, Peru ranks first among five Latin American countries in terms of unmet need for contraception: 29 percent of women in union, including 9 percent who wish to space their next pregnancy and 20 percent who want no more births, or nearly 900,000 women between the ages of 15 and 49 can be classified as having an unmet need. If we add those sexually active unmarried women who do not contracept and do not wish to become pregnant, and current contraceptive users whose methods are inappropriate for their fertility intentions (e.g., women who want no more births and use ineffective contraceptive methods), the total unmet demand for contraception is even greater.

C. Constraints to Improved Family Planning in Peru.

1. Political and Social Considerations.

Destabilizing factors. Peru is currently undergoing its most severe instability in decades, fostered by inconsistent economic policies and an ever-increasing presence of destabilizing guerrilla groups. The problems faced by the GOP in its attempts to promote urban and rural development are exacerbated by rapid population growth. Peru's current population of nearly 22 million is largely urban and is concentrated along the coast. The population growth rate is about 2.6 percent, with urban Peru growing twice as fast as rural Peru. If these trends continue, Peru's population will double within 30 years, with over 75 percent of its people living in urban areas.

This has important implications for family planning service delivery. On the positive side, since the overwhelming proportion of private commercial sector delivery occurs in urban areas, the increasingly large proportion of the urban population will enhance the economies of scale and market opportunities which could further attract private commercial sector involvement. On the negative side, it will become increasingly difficult to service the rural population, thereby augmenting the flight to the cities and its resulting socio-political destabilization.

Relatively less effective public sector. The relatively weak performance of the public sector underscores the importance and rationale for the private sector development efforts foreseen under the PVFP Project. The public family planning service delivery infrastructure suffers from lack of trained medical personnel,

management capability, and staff continuity. Government policies have increased the burden on health facilities by increasing the eligible population (e.g., extended IPSS coverage to all housewives, the population in the Andean Trapezoid, and to market cooperative members) without significantly raising health sector budget levels.

Family planning services feel the pressure of this additional burden, as the limited number of medical personnel must attend greater numbers of clients with decreasing budgets and support. Management capabilities are lacking at all levels, resulting in delays in patient processing, weak logistic systems, poor planning, budgeting and programming, and inadequate use of statistics.

The inefficiencies in the public sector have already led increasing numbers of Peruvians to depend on the private voluntary sector for family planning services and supplies, attracted by low (subsidized) prices and the PVOs' reputations for quality services. A significant portion of current and potential PVO users have enough disposable income to contribute to the cost of the services and supplies they receive from the PVOs, but not enough to pay commercial sector prices. The ideal market for family planning PVOs is precisely that segment of the population which cannot afford the commercial sector, but which can pay a portion of their family planning costs.

Legal and regulatory constraints. The most immediate constraints affecting design of PVFP are restrictions on dispensing of commodities by non-medical personnel. In practice, these constraints have had little impact on program functioning with donated commodities, but could pose an obstacle in the future when the PVOs begin to purchase IUDs and pills locally, since under government regulations pharmaceutical manufacturers can sell only to registered pharmacies, physicians, and medical establishments.

A second legal constraint is the prohibition of voluntary sterilization solely for contraceptive purposes. MOH norms permit voluntary sterilization (male and female) only for high reproductive risk, which is specified by such health criteria as maternal age, parity, poor obstetric history, and acute and chronic health conditions. Most of the men and women wishing to opt for this method satisfy the MOH criteria for high reproductive risk.

Socio-cultural constraints to family planning service delivery. The vast social, cultural, and geographic differences existing in Peru constitute a difficult constraint in designing strategies for family planning service delivery. Conservative medical professionals and influential community leaders often side with Catholic Church

hierarchy in opposing modern methods of family planning. It is unusual to find half of the couples practicing family planning to be using traditional methods in a Latin American country, as is the case in Peru. Deeply ingrained misconceptions about specific methods make the transition from traditional methods to modern ones difficult.

Continuing leadership commitment. The upcoming presidential election (scheduled for 1990) may reduce public statements and other indications of commitment to family planning due to the sensitivity of the issue. A new administration may sharply reduce its overall commitment to family planning; worse, it may also reduce the ability of the private sector to function.

2. Financial and Economic Considerations.

Economic chaos. The current instability faced by Peru poses a difficult constraint to the successful implementation of any project. The hyperinflation during the past year (August 1988 to August 1989) was 5,950 percent, with hyperinflation since January 1989 running at an annualized rate of 7,000 percent. Real wages have dropped substantially, by about 50 percent; the Lima employment index has been declining an average of 5 percent on a monthly basis, since September, 1988. The gross domestic product declined by 8.5 percent in 1988, with a further decline of 15 percent foreseen for 1989. Public budgets have become totally inadequate; prices and contracts have had to be renegotiated; public sector strikes have become a common occurrence, and key GOP officials have left government service.

Private sector credit outstanding in real terms was cut by more than half by inflation and credit limitations, bringing on a severe recession and a very poor business environment. Government policies towards private business have been inconsistent, with reversals and mixed signals in policies of pricing, nationalization, and import/export restrictions. Real exchange rates are extremely unstable and are often harmful to exporters. Industrial production has slowed, as have exports of raw materials. The GOP has distanced itself from the entire international financial community, including the IMF, IBRD, IDB, and commercial banks.

Impacts on the private voluntary sector. Business confidence --- and the confidence in the Government to weather the economic maelstrom --- has fallen to very low levels. Industrial corporations and other entities are seriously re-examining the feasibility of continuing work (and the compensation and benefits

packages of their employees) in this environment. Wyeth Pharmaceuticals, for example, has pulled manufacturing operations out of Peru, although some of their products will continue to be marketed.

To tackle the economic crisis, the GOP has imposed increasingly stringent import restrictions, both on raw materials and on finished products. Pills and spermicides are manufactured locally, but with imported raw materials; condoms and IUDs must be imported. There is some speculation that supplies of locally manufactured contraceptives might experience sporadic shortages in the future (especially, with the anticipated stimulation of demand), although no shortage exists as of August 1989. In this context, the continued supply of donated commodities becomes even more critical, as does the ability of the PVOs to assume more responsibility for projecting their future needs and exercising better control of their logistics.

High rates of unemployment and underemployment have reached the middle and upper classes, and hyperinflation has eroded their purchasing power. At the same time that real disposable income has declined, the cost of medical insurance has increased sharply. Employers have reduced coverage or have increased employee co-payment fees.

Should the economic decline continue, the demand for low- or no-cost family planning services and commodities may increase more than is currently projected, as greater numbers of the middle class are priced out of the commercial market. These displaced middle-class clients, already accustomed to paying for goods and services, would probably be willing to continue to pay, albeit at a lower level, for family planning, thereby improving income generation for the PVOs.

3. Gender Considerations.

Lack of gender-disaggregated data. Information on men's knowledge, attitudes, and practice of family planning is extremely limited; contraceptive prevalence surveys typically have used only female respondents. This focus is appropriate from the demographic perspective of direct impacts on fertility, and at least one study has shown that when husbands and wives are interviewed separately, they agree as to what (if any) family planning method is being practiced. However, in order to raise contraceptive prevalence and to increase the availability of under-utilized methods, especially condoms and vasectomy, the male perspective should be surveyed.

Male opposition to family planning. It has been suggested that the man's consent may be necessary for the woman to adopt family planning. In Peru, spousal opposition to contraception does not

appear to be an important explicit factor in a woman's non-use of family planning. In the 1986 DHS, only 1.2 percent of the women who had discontinued family planning and 8.7 percent of the women exposed to unwanted pregnancy and not using contraception cited the opposition of their spouse as the principal reason for not using family planning. However, men report the same health fears about contraceptive methods as women.

Male's refusal to cooperate; lack of male-oriented family planning programs. Of the various contraceptive methods available, one (NFP) requires the man's cooperation and three (withdrawal, condom, vasectomy) are used by the man rather than by the woman. The two modern male methods show the lowest prevalence rates: condoms (0.7%) and vasectomy (less than 0.01%). Condoms appear to be used more in pre- and extra-marital relationships, and usage rates may be under-estimated in the standard prevalence survey. Vasectomy, on the other hand, has never been promoted, is generally unavailable except for a few private sector outlets, and is virtually unused in Peru; only one case was reported in the 1986 DHS survey.

Socio-cultural stereotypes may lead potential vasectomy providers to conclude that the method is unacceptable to Peruvian men and therefore not worth promoting; the resulting lack of information and availability prevents potential users from learning about and adopting vasectomy. Countries such as Brazil and Colombia, where vasectomy has been strongly promoted by clinical programs oriented to men, now show significant acceptance of the method.

Women's participation in management and training opportunities. It appears that among the professional service providers (physicians) and program managers, the proportion of women is less than their proportion of the population. Gender-disaggregated data on program managers, physicians, distributors, service receivers, participants, beneficiaries, etc. have been collected as part of the institutional and social analyses for this project. Gender-disaggregated training targets have been developed on the basis of these findings.

D. Other Donor Activities.

A.I.D. provides approximately \$2.5 million in bilateral population assistance to Peru annually, plus another \$1 to \$2 million each year in central population funds, which in the past represented some 75 percent of all international donor population assistance. With the approval in late 1988 of a \$5 million project by the United Nations Fund for Population Activities (UNFPA) to the MOH, that percentage has declined. Recently, the German Technical Assistance Agency (GTZ) funded a project to expand delivery of IUDs in Cuzco province.

A.I.D. continues to be the only large-scale donor for the private voluntary sector. None of the other international donors have mounted large-scale family planning service delivery projects. From time to time, individual PVOs receive donations from foundations, pharmaceutical companies, etc., but with the exception of IPPF assistance to INPPARES, these donations are seldom substantial or long-term.

E. USAID/Peru and A.I.D. Policies and Strategies.

1. USAID/Peru Population Sector Strategy.

USAID/Peru's strategy for the population sector is outlined in the 1988 update of the Country Development Strategy Statement (CDSS). It identifies rapid population growth as a serious impediment to Peru's long-term economic development objectives. It also stresses the health implications of high fertility for women and children.

As stated in the CDSS, the Mission's approach to the population sector is to assist the public sector, through the Ministry of Health (MOH) and the Peruvian Social Security Institute (IPSS), and the private voluntary sector to provide family planning services and to stimulate private commercial markets in family planning products and services. The strategy responds to the existing unmet demand for family planning by increasing service delivery capabilities throughout the population sector and thereby increase users' access to those services.

In order to respond more effectively to the demands and expressed needs of men and women, the USAID Population Strategy divides the population of current and potential users of family planning methods into three operational categories. These are defined by the individual's reproductive intentions for him or herself, rather than by any arbitrary criteria such as age or socio-economic status. They include:

- those who already have all the children they want and therefore wish to have no more children;
- those who wish to postpone a first or subsequent birth; and
- those who would use contraceptives on an occasional basis (e.g., to avoid sexually transmitted diseases (STDs)).

Data from the 1986 DHS indicate that 64 percent of women in union of reproductive age do not wish to have any more children. This finding has been corroborated by other smaller-scale surveys. The

unmet demand generated by limiters for long-lasting methods cannot be met entirely by the public sector, whose facilities are already over-loaded with maternity cases and medical emergencies.

Therefore, the USAID strategy for public-sector assistance includes support for developing more efficient service delivery paradigms, such as post-partum procedures and those performed after treatment for abortion complications (post-abortion procedures). In the short-term, the demand for interval procedures (not linked to a birth) must be handled largely by the private sector, including both commercial providers and PVOs.

The private voluntary sector will play a central role for those who wish to have no more children and those who wish to postpone births as well. USAID's short-term strategy is to enhance the capacity of the PVO sector to provide interval (non-birth related) delivery of long-lasting methods. USAID's long-term strategy is to increase the private commercial sector share of commodities and services for those who wish to postpone births.

2. A.I.D. Population Policy.

The underlying principles of U.S. assistance for family planning are voluntarism and informed choice. A.I.D. seeks to (a) enhance the freedom of individuals in developing countries to choose voluntarily the number and spacing of their children, and (b) offer a range of family planning methods and information about those methods. As one component of a complete family planning program, PVFP will increase information and availability of all contraceptive methods, especially those whose demand currently exceeds the available supply. Individual market decisions as to whether or not to purchase these methods will ensure the voluntary nature of the program.

F. Relationship of this Project to Other A.I.D.-Financed Projects.

1. Private Sector Family Planning Project (527-0264).

Project history. The Private Sector Family Planning Project was designed as one element of a three-part strategy to support family planning services in Peru. The other two initiatives included a public sector project (Integrated Health and Family Planning (527-0230) and its planned follow-on for the MOH) and a commercial sector project (Contraceptive Social Marketing, launched in 1984).

This PVO initiative also was designed to respond to the slow and poor results experienced in the public sector. The rationale was to

capitalize on the purported greater effectiveness, flexibility, innovation, and agility of the private sector agencies to meet the demand for family planning services. It was, however, recognized that the numerous, diverse family planning PVOs were not altogether prepared to meet the challenge, and that to attain the goals of this initiative, these groups needed coordination and institutional strengthening.

All PVOs which had received or were then receiving A.I.D. funding (either directly from USAID projects or indirectly from centrally funded Cooperating Agencies (CAs)) were included in the initiative. While these entities could account for funds received and had at least rudimentary systems, staff, and infrastructure to begin the task, none (except INPPARES, the IPPF affiliate) had had access to a steady flow of technical assistance (TA) and funding essential in the development of comprehensive management systems and service provider capabilities.

The project concept. As performance problems were attributed to the start/stop nature of multiple CA funding, sporadic TA, and administrative delays, the new project offered all PVOs the ongoing TA and funding needed to develop institutional capabilities. The PP's institutional analysis of each PVO provided some baseline measures of institutional characteristics and family planning users. Funding and TA were to be provided to all PVOs during Project Year (PY) 1. The first assessment of each institution's progress as measured against its own baseline was scheduled after PY 1. Those unwilling or unable to develop efficient management systems would cease to receive A.I.D. financial support.

The Private Sector project also sought to develop the ability of the private sector to determine its policy needs (through research) and articulate them to the GOP. Additionally, it was (a) to foster cooperation and coordination among PVOs to maximize use of existing resources, and (b) to encourage increased financial independence through training in income generation.

Outputs. Under its institution building component, the Private Sector project was to develop PVO objectives and work plans, improve accounting systems, develop evaluation plans, utilize a comprehensive logistical support system, and implement a standardized statistical data collection and reporting system. Of the 16 items on the illustrative list of technical assistance and training topics, 11 referred to management systems. However, as the only quantitative output measures specified in the PP related to services expansion (explicit measures/outputs of institution building were not specified), service delivery expansion and IEC activities received the bulk of resources.

In the population policy component, the project included research studies on policy topics and institutional development of private research agencies (AMIDEP and INANDEP) and the CNP. The project was (a) to underwrite seminars/conferences for opinion leaders, and (b) to publish and distribute books, monographs, studies, and a regular policy bulletin (for policy-makers). The PP also called for changes in population laws affecting private sector family planning agencies.

The PP conceptualized the inter-agency coordination component to promote PVO intercommunication and cooperation on issues of common interest and to reduce duplication of services. Outputs included the establishment of a Peruvian Coordinating Agency (PCA) and the increased ability of PVOs to become more financially independent.

Project accomplishments. The project began operations on October 1, 1986, as Apoyo al Sector Privado en Planificación Familiar (SPF) and inaugurated its Lima headquarters later that month. The four-person core team was contracted by January 1, 1987, and eventually expanded to seven support staff and eleven technical staff (one part-time), including an executive director, an administration/program director, two program officers, a program assistant, a finance director, a financial supervisor, an accountant, an IEC director, an IEC assistant, and a logistics coordinator.

Table 1 of Annex III summarizes relative resource allocation by project component during the first 20 months of the project. While it was not possible to assign dollar values to staff days, consultant days, and workshops, the table clearly shows that the greatest share of project resources were directed at services delivery: 45 percent of the SPF professional staff time allocated to PVOs, 58 percent of the consultant days allocated to PVOs, 82 percent of the subgrants, and 13 percent of the workshops. Inter-agency coordination received the smallest allocation of project resources, followed by population policy. This closely follows the resource allocation stipulated in the PP.

All PVOs identified in the PP (except SMISSA and Marcelino-Lima) received subgrant support; 63,800 new contraceptive users were attributed to this new service delivery. All PVOs identified in the PP participated in at least one workshop, with the three major service providers (APROSAMI, PROFAMILIA, and INPPARES) participating in all workshops. Some 164 individuals representing 33 institutions throughout Peru were trained in the workshops.

A study of current population policy and law was commissioned; at the request of (and on the behalf of) the PVOs, SPF advocated liberalization of the voluntary sterilization laws. Finally, the executive directors of the PVOs met at SPF on a monthly basis. Through the zonification sub-project, the three largest service providers in Lima coordinated their programs to reduce duplication.

Table 2 of Annex III, Exhibit A presents a comparison of achieved output indicators to targets set in the PP. Project outputs are basically congruent with the quantitative measures specified in the PP. However, these measures are insufficient to assess progress in all components --- especially that of institutional strengthening; the benchmarks bias project activities away from that central feature and towards services expansion.

Difficulties encountered. The PP recognized --- but underestimated --- the enormous management burden that the project and the many PVO beneficiaries would impose on the Population Division; foreseen staff requirements were inadequate for monitoring and coordination. The limitation of competition to the three CAs already registered in Peru (only one submitted a proposal) and the obligation constraints created by Section 620(q) and Brooke-Alexander sanctions combined to yield a hastily executed cooperative agreement. Early on, it became evident that the agreement was not sufficiently detailed to avoid differences of opinion on implementation and reporting.

The decision to leave some design details "open" (to be resolved by the awardee) led to ambiguous or internally inconsistent goals within the PP. The Mission request for in-depth financial reporting, which was greater than that required by A.I.D./W activities, created tensions with the CA. These difficulties were exacerbated by high project administrative costs, and their increasing burden as the overall Population account declined.

While the original FP contained the essential components for a successful PVO family planning initiative, a mid-term evaluation concluded that some components and subcomponents had inappropriate output measures and were inappropriately prioritized by the CA in its operational plan. The evaluation recommended a more detailed look at the project, once the Mission had defined an overall family planning strategy. The Mission subsequently decided to terminate the cooperative agreement two years earlier than planned and design/implement a new PVO project.

2. Contraceptive Social Marketing.

USAID/Peru will be concluding a five-year project in contraceptive social marketing (CSM) in February 1990. The activity promotes locally produced brands of pills and spermicides and targets younger users in lower-middle and upper-lower income groups. While there were no formal linkages between the CSM and SPF projects, APROPO (the implementing agency for CSM) participated in the monthly meetings of PVO executive directors held at SPF and in the discussions to form a coordinating entity of Peruvian family planning PVOs.

Some of the achievements of the CSM Project have directly benefitted PVOs. For example, APROPO obtained MOH approval to sell donated contraceptive commodities at a profit, thereby opening the way for PVOs to charge higher prices for the supplies they provide. The mass media promotion of pills and spermicides may have increased demand for those methods and the promoted brands among women served by PVOs and has demonstrated the willingness of some PVO clients to pay higher prices than are currently being charged. Several CBD programs reported anecdotally that users of the A.I.D.-donated pills were requesting the CSM brand, even if it meant paying a much higher price. By generating their own income through the sales of contraceptives, the PVOs not only become more economically self-sufficient, but they achieve greater freedom in selecting the products they wish to carry.

3. Private Commercial Family Planning Project.

USAID/Peru will inaugurate a three-year Private Commercial Family Planning Project (PCFP) in 1990 as a follow-on to the CSM Project. PCFP will consolidate the advances made in commercial marketing of pills and spermicides and will offer limited support to motivate the inclusion of family planning services and supplies in health insurance and employer plans. While PCFP will work with the for-profit sector and PVFP with the private voluntary sector, there are several linkages between the two projects.

It is anticipated that as a result of PVFP Project activities, the PVOs will develop a stronger market or business-oriented approach, including better cost recovery and income generation plans. As the PVOs increase the prices charged for services and supplies -- especially in urban community based distribution (CBD) of temporary supply methods, they will begin to compete for some of the same markets served by the commercial sector, namely the upper-lower and lower-middle classes.

During the life PCFP, USAID/Peru will continue to provide commodity support for urban CBD. A.I.D. regulations require that all donated commodities be purchased centrally. Therefore, PVFP cannot use project funds to purchase CSM brands. However, it is hoped that as the PVOs recover more of their operating costs through contraceptive sales, they will begin using some of this income to purchase local CSM brands, thereby adding to point-of-purchase outlets and contributing to PCFP Project success.

Additionally, some PVOs may enter into contractual arrangements with employers and/or health insurance companies to provide services, such as training, supervision, or family planning services. For

example, INPPARES has an on-going project to provide family planning services to industry. In the past, these services have been heavily subsidized (employers have given "donations" instead of paying fees for the services provided). Under the PVFP Project, INPPARES will be encouraged to charge fees for industrial services rendered.

Under the Milpo pilot project, two PVOs (PRISMA and Instituto Marcelino) were contracted to provide training and supervision for company staff. These contractual arrangements will be continued under the APROPO mines project. All PVOs will be encouraged to develop some additional source of income.

4. A.I.D./W Centrally Funded Population Activities.

Throughout the years, various CAs have provided funds to PVOs to carry out such family planning activities as training, research, and service delivery, in accordance with the mandates of their respective A.I.D./W centrally funded projects. Mission involvement with these activities has been limited primarily to approving project design. Since early 1988, however, the Mission has taken a more active role in targeting and coordinating CA assistance to conform with USAID's family planning strategy.

The Population Division maintains a listing of all CA projects and updates it every six months. Current levels of total CA funding are approximately \$1.5 to \$2.0 million per year (from 1985-1988, 17 CAs funded 45 projects with 30 PVOs). The Mission has actively encouraged CAs to work in Peru and offered SPF collaboration and assistance to coordinate and supervise their projects.

Among the service delivery and training projects that have assisted and complemented Mission population activities, the most valuable CA effort has been that of the Population Council/INOPAL Project. The operations research performed by INOPAL subprojects has produced findings that have resulted in better and more cost effective PVO service delivery. The impact of this work has been enhanced by the presence of in-country staff who, in addition to their research, have provided valuable technical assistance. Another important source of assistance has been JHPIEGO, which helped the MOH to develop and implement the high-risk norms for surgical contraception.

5. Child Survival Action Project.

USAID/Peru family planning activities in the public sector (MOH and IPSS) are financed through the Child Survival Action (CSA) Project. There are both implicit and explicit linkages between the PVFP and CSA Projects. First, as director of the National Family Planning Program, the MOH is charged with coordinating all family planning

activities in Peru, including those in the private sector. Private voluntary sector contributions to overall contraceptive prevalence, new user targets, and contraceptive commodities are included in the annual targets for the National Family Planning Program.

The model proposed in the PVFP Project to expand family planning coverage in rural areas will require direct linkages with the CSA Project. Specifically, PVFP will provide financial support for PVOs to operate after-hours family planning clinics in public sector (MOH and IPSS) hospitals and health centers. Equipment and commodities for these clinic sessions would be provided by the CSA Project, and the PVOs would receive PVFP funds to hire and train personnel, who may or may not be MOH/IPSS staff.

G. Lessons Learned from On-Going and Recent A.I.D.-Financed Projects.

In the design of the PVFP Project, USAID has been guided by the experience of previous interventions in the family planning sector. These lessons learned are provided, immediately below.

Avoid a complex, complicated design. An overly broad or extensive scope of work, either in terms of number of activities or in terms of number of participating agencies, results in unnecessary complications, over-extension of personnel, and lack of coordination. Future projects, especially those funded and monitored directly by the Mission, should be more limited in scope and more narrowly targeted.

Use of local talent. Whenever possible and feasible, host country nationals and in-country personnel should be employed. This includes the implementing agency, consultants for short- and long-term technical assistance, and specialized agencies for training and research, etc. Use of local resources strengthens the providers as well as recipients of assistance, lowers administrative and support costs, and maximizes the funds available for project activities.

Clear definition of Mission's role. Before project agreements are finalized, the Mission and implementing agency must clearly define, in writing, the role that the Mission will play in project implementation. The Mission must select the obligating mechanism (cooperative agreement, contract, operational program grant, etc.) appropriate to this role. The project agreement, regardless of obligating mechanism, should carefully and clearly specify:

- a. the lines of authority and roles of all participating agencies and individuals;

- b. the number and qualifications of all staff to be hired under the project; the Mission should reserve the right to interview candidates for all professional positions, check their references, and give approval on the final selections; and
- c. the reporting requirements should include internal quarterly program (technical) and financial reports, as well as complete and detailed semi-annual program and financial reports.

Use of a steering committee. Mission-funded projects with more than one participating agency should include a project steering committee or technical advisory group with representatives from the Mission, the implementing agency, and the participating agencies. Depending on the subject matter, the committee might also include public sector representation. Specifications of the role of the steering committee, frequency of meetings, and other operational details should be included in the project agreement.

H. Project Rationale and Strategy.

The USAID/Peru family planning policy supports the expansion of contraceptive prevalence and the increased use of more effective contraceptive methods in order to assist Peruvian families to have the number and spacing of the children they want. Given the constraints of the public sector and the worsening economic situation, this project is needed to support and strengthen the private voluntary sector to deliver family planning services and supplies to lower-income women and men and to assist the public sector expand family planning coverage in unserved or underserved rural areas.

This project will support and strengthen the PVOs as integral institutions, capable of internally coordinating their various programmatic activities in a more effective and cost efficient manner and capable of internally generating larger portions of their institutional budgets. The skills and infrastructure introduced by this project will continue to serve the PVOs in developing increasing self-sufficiency even after the project ends.

Institutional strengthening will be accomplished through the development of appropriate management structures and procedures within the participating PVOs. Once the appropriate management systems are implemented and functioning well, a concentrated effort will be made to increase the cost effectiveness of the PVOs' service delivery components.

The project will also improve cost recovery by assisting the PVOs to establish realistic user fees. Price elasticity studies will be conducted to set prices and establish mechanisms to adjust for inflation. Sliding fees or other pricing procedures will guarantee equity --- that poorer clients will still be able to afford PVO services. Income-generating activities will be introduced as appropriate in the form of cash and in-kind donations from local Peruvian individuals and organizations and profit-making ventures. This element of institutional development will contribute directly to self-sufficiency by transferring part of the subsidy burden from international donors to local sources of funding.

Operating funds will be provided for services delivery during the process of institutional development. In keeping with A.I.D. policy of freedom of choice, assistance will be provided for all methods of contraception. However, emphasis will be given to increasing the availability of those under-utilized methods identified in the USAID/Peru family planning strategy, namely long-lasting methods (IUDs and VSC; implants may also be introduced). Accordingly, financial support for urban CBD programs will be reduced over time to donation of commodities, and technical assistance will be provided to make urban CBD programs self-sufficient.

Limited funds will be provided for services expansion. In keeping with USAID/Peru's strategy to increase access in rural areas, these funds will be reserved for rural expansion, beginning with PVO-public sector collaboration. Local PVOs will operate after-hours family planning clinics in public hospitals and/or health centers. Once an after-hours clinic is functioning (and if community demand is demonstrated), rural CBD programs may be established.

Institutional support will be limited to no more than six family planning PVOs. Technical assistance, commodity support, and training will be offered to all family planning service delivery PVOs. Whenever possible, contracts to provide training, production of educational materials, and research will be awarded to Peruvian family planning PVOs. Grants to operate after-hours family planning clinics in public sector facilities will be made to PVOs already operating in the area, including non-family planning PVOs which wish to add family planning to their other development activities.

In summary, this Project will consolidate the advances achieved through more than a decade of donor support to the Peruvian private voluntary family planning sector. Through enhanced management and programmatic capacities and improved economic self-sufficiency, the participating PVOs will expand their abilities to deliver long-lasting contraceptive methods, while maintaining education in and delivery of temporary supply methods and natural family planning, and will assist the MOH to expand family planning coverage to more remote rural areas where it is badly needed.

III. DETAILED PROJECT DESCRIPTION.

A. Project Goal and Purpose.

The Project goal is to improve the quality of life for Peruvian families through increased access to the means to achieve the desired number and spacing of their children. The Project purpose is to maximize the availability of all family planning methods to women and men who wish to use them by increasing the capacity of the private voluntary sector to deliver long-lasting contraceptive methods while maintaining support for temporary supply methods and natural family planning.

B. End-of-Project Status Indicators.

The objectives of the project are (1) to increase the capacity of selected PVOs to delivery family planning services (institution building); (2) to improve the availability of long-lasting contraceptive methods; (3) to maintain support for temporary supply methods and natural family planning; and (4) to enhance rural family planning coverage through PVO-public sector collaboration.

1. Increased Capacity to Deliver Family Planning Services.

Institution building is a crucial prerequisite to increasing the availability of cost effective services and information and to providing family planning services to more users. By the end of the project, the participating agencies will have reduced the unit costs of services delivered so that they will be able to increase the number of users served at present donor funding levels or reduce the international donor support required to maintain the current level of users served. This is reflected in indicators presented immediately below.

Improved Administrative Systems. By the end of the project (EOP), all six participating PVOs will have developed and implemented:

- strategic plans,
- annual operational plans and financial objectives, and
- management information systems.

Improved Cost Effectiveness. By EOP, participating PVOs will have improved operational efficiency, reduced costs, and improved cost efficiency. Costs per service delivered will vary by contraceptive method, service delivery outlet, and geographic region. Following

the completion of the technical studies in PY 1, numerical targets for use of installed capacity in both full-service clinics and rotating posts will be specified for PY 2, 3, and 4.

- for urban areas: (a) full-service clinics, and
(b) rotating posts; and
- for rural areas: (a) full-service clinics, and
(b) rotating posts.

Enhanced Financial Self-Sufficiency. Financial sustainability will be encouraged by increasing locally generated revenues, principally through cost recovery (fees for services and supplies) and income generation (sales of other services, commodities, local donations, etc.). By EOP, urban CBD programs will be self-sufficient, except for donated commodities. In addition, after the completion of the technical studies in PY 1, numerical self-sufficiency targets will be established for PY 2, 3, and 4 for:

- urban clinics,
- urban rotating posts, and
- rural programs (in non-public sector installations).

2. Availability of Long-Lasting Contraceptive Methods.

Installed Capacity. During PY 1, numerical (percentage) targets will be established for increasing PVO capacity to delivery IUDs and VSC and for increasing the portion of the PVOs' operating budgets dedicated to delivery of long-lasting methods.

Long-Lasting Contraceptive Method Users Served. Following the trends observed between 1987-1988, the number of acceptors of IUDs and VSC served directly by the PVOs will increase by 35 percent per year. The proportion of IUD and VSC acceptors over all acceptors in urban areas will increase by 20 percent per year. These levels take into consideration current Peruvian law and MOH norms which allow VSC only for men and women at high health risk.

3. Increased Rural Coverage:

After-hours family planning clinics will be opened in 30 public sector hospitals and/or health centers, of which 10 will be operated by the MOH or IPSS before the project terminates. Four rural CBD programs will be established. As a result of project activities, rural contraceptive prevalence will increase by 2 percent per year, and modern method use will increase to 75 percent of all contraceptive use.

4. Gender Considerations.

The numbers of women in management and other professional positions will be increased as a result of project activities. To correct historical imbalances, at least 67 percent of new hires in professional/management positions will be women. Participation of women in management training courses will be equal to their representation in the PVOs' work force or 50 percent of all management trainees, whichever is greater.

More men will be recruited as CBD distributors and supervisors. Twenty percent of all new CBD distributors trained will be men. Since the restructuring of urban CBD programs may include reducing the numbers of supervisors, no numerical targets for male supervisors will be stipulated. However, programmatic activities aimed at promoting male methods will be encouraged to recruit male supervisors.

C. Project Components.

1. Participating Agencies.

Six family planning service delivery PVOs will be the major participants in the PVFP project.

Asociacion de Trabajo Laico Familiar (ATLF). Recognized by the Episcopate of the Catholic Church, this agency offers laboratory services in reproductive health and promotes only natural family planning methods. It receives funding from the Church, UNFPA, and from A.I.D. through both the SPF project and centrally funded CAs. ATLF operates in Lima and the surrounding areas.

Asociacion de Profesionales para la Promocion de la Salud Materno-Infantil (APROSAMI). Clinic-based with an extensive CBD program, this agency previously received support from Family Planning International Assistance (FPIA) for five years. It is now being almost totally funded by the SPF project. APROSAMI participates in the SPF-funded Lima zonification project. It offers family planning services in Lima and operates a hotline for adolescents in Arequipa.

Centro Nor-Peruano de Capacitacion y Promocion Familiar (CENPROF). Based in Trujillo, CENPROF provides clinical and CBD services. CENPROF currently receives institutional funding from SPF and CAs.

Instituto Peruano de Paternidad Responsable (INPPARES). INPPARES is the Peruvian affiliate of International Planned Parenthood Federation (IPPF). It offers training and services through both clinical and CBD operations. INPPARES participated in an operations

research project with the Population Council/INOPAL Project that has been adopted by SPF as the model for rotating medical posts. INPPARES has received four services subgrants from SPF and participates in the Lima zonification project. It operates a nationwide network of family planning service outlets.

Promocion de Labores Educativas y Asistenciales en Favor de la Salud (PROFAMILIA). This PVO offers family planning and other health services through a network of four clinical modules and CBD programs. PROFAMILIA has received three subgrants from SPF, including two to work outside of Lima (in Tingo Maria and Huancayo) which have now terminated, and participates in the Lima zonification project.

Proyecto Planificacion Familiar (PLANIFAM). This agency offers CBD and clinic-based family planning services in the city of Cusco and the surrounding peri-urban area. It has recently extended its CBD program to rural parts of Puno department. PLANIFAM is supported by funding from the SPF project and a CA (CEDPA).

Other Peruvian PVOs will be invited to participate in specific activities, such as training, research, and production of educational materials production. These may include PVOs involved in non-family planning development activities which wish to collaborate with the public sector to offer family planning services. Project support may also be extended to a PVO coordinating body, when and if such an entity begins to function.

2. Institutional Strengthening.

This component will strengthen the management of the six primary PVOs through the introduction, acquisition, and application of management systems and skills.

Institutional Management Structures. Institutional management structures will be strengthened through:

- (1) the introduction of personnel management systems,
 - (2) the establishment of organizational structures and staffing levels and compositions that are adequate to support the institutions' mission and programs, and
 - (3) the expansion of the role of the Boards of Directors.
- Participating PVOs will develop annual and multi-year objectives and work plans for their institutions as a whole, integrating programmatic activities financed by project funds, CAs, and other funding sources.

Most of the participating PVOs have experienced rapid growth in the size and extent of their program activities through infusions of funding from a variety of donors, principally SPF and CAs. While

the number, geographic coverage, and size of individual programs have expanded rapidly, there has not been a commensurate expansion or adjustment in their organizational structures. Essentially, most PVOs remain under the personal control of their executive directors, and expansion has meant more tasks for existing personnel rather than additional staff.

The project will assist the PVOs to develop balanced organizational structures, with proper division of responsibilities among newly organized management levels. The first step will be to assess the individual PVOs to determine the adequacy of their staffing for administration and support activities. Project funds will be available to hire and train managerial, supervisory, and support staff where needed. With the exception of new rural projects, additional service delivery personnel will not be paid with funds from this component: staff intended exclusively for service expansion must be hired through savings from cost reductions or with income generated through the project.

Tasks will be clarified and responsibilities will be delegated to ensure the maximum utility of the staff. Decentralization will be emphasized. Management tasks will be distributed in a more efficient manner through delegation of authority for decision-making. The type of specialized training and TA provided to each PVO will vary with its staffing composition and other characteristics.

Training in supervision techniques will be offered for both supervisors of management staff and supervisors of service providers. Selective supervision using performance feedback will be emphasized. Specialized techniques will be developed to address specific program problems identified through the management information system.

The project will address personnel policy as a critical element of management systems, especially to reduce turn-over. Staff turn-over reduces cost-effectiveness through lowered productivity and high recruitment and retraining costs. The project will assist participating PVOs to implement formal personnel management systems and to develop written personnel policy manuals that include job descriptions, supervisory lines of command, salary ranges and evaluation and advancement criteria, vacation and leaves, and grounds for termination of employment.

Finally, the project will assist the PVOs in expanding the role of their Boards of Directors. It will provide specialized training for members of the Boards of Directors. Technical assistance will also be provided in community resource development, oversight responsibilities, policy guidance, setting short- and long-term

institutional and program objectives, and approval of capital and operating budgets.

Measurement and Control of Administrative and Program Effectiveness. Improved ability to measure and control administrative and program effectiveness will be achieved via the development, installation, and use of a standardized management information system (MIS) for tracking staffing, resource allocations, logistics (commodities), and service statistics. This MIS will be used for reporting production levels to management, boards of directors, and donors, and for performing analyses of resource use. Accounting systems, logistical support systems, service statistics systems, and evaluation plans will be developed and implemented. The MIS will have a central core that is common to all the participating PVOs and specialized individual subsystems. It will contain information on institutional and program inputs, processes, and outputs. The project will assist the PVOs to determine the structure and content of the MIS and will provide individualized TA to each PVO in using information generated by the MIS for planning, supervision, and evaluation.

The MIS will be organized to track staff and resource allocations, logistics, and service statistics. Depending on the size of the PVO, two or more managerial staff will be trained in its use; at least one staff member from the administrative staff (e.g., accounting) and one staff member from the program staff (e.g., program coordinator). These staff will be responsible for training their subordinates in data collection techniques.

The first priority of the project will be to develop and implement the standardized logistics/service statistics component. This will include commodity inventory, distribution, and sales tracking. These procedures will be standardized across all PVOs receiving A.I.D. commodities and across all donors. The logistics system will permit the institution to maintain overall inventory control and to disaggregate resources by program or funding donor.

The production component (service statistics) of the MIS will include both standardized and individualized measures, since not all PVOs offer the same services and contraceptive methods via the same delivery modalities. CBD programs will track contraceptives disbursed to distributors, numbers of sales, and revenues received. User characteristics will not be routinely collected from CBD programs. Clinical programs have a greater wealth of user information. Clinic client visits will be registered by type of service provided, fees paid, etc. Data collection procedures will build on work already underway and systems already in place in the PVOs. For example, the INOPAL operations research projects have developed several computerized databases that could be adapted for wider application.

In terms of resource allocation, each PVO receiving project institutional support will automate its payroll and accounting systems. Efforts will be made to standardize the accounting procedures used by all donors (project and CAs) so that the same MIS can produce all financial reports.

End-users of the MIS will be program supervisors, managers, and senior-level administrators. They will be involved at all stages of MIS development and implementation, first to design the indicators to be produced and then to be trained in the use of cost and performance data to make management decisions. They will learn to set standards and evaluate performance.

Indicators will include gross production measures (new users, medical consultations, revisits, income generated from fees, etc.), coverage measures (program prevalence, prevalence increase, etc.), quality measures (continuation rates, patient flow, etc.), and efficiency measures (cost effectiveness, etc.). The project will teach end users to utilize these indicators to provide performance-based feedback to service personnel, identify bottlenecks and operational problems, prepare budgets, and design new programs.

Identification of Program and Administrative Costs. Participating PVOs will be assisted to identify administrative and program costs, both direct (program) and indirect (capital, administrative, and support), and to analyze and use that information to determine cost-effectiveness ratios and other financial indicators. The data for these analyses will be provided by the MIS, and the indicators produced will be used for institution and program planning, monitoring, and evaluation. Participating PVOs will develop annual and multi-year operating and capital expense budgets.

Few family planning PVOs know how much it costs to operate their institution as a whole or the costs associated with their administrative, capital, or program components. This stems largely from the fact that most programmatic activities are funded by discrete donors and are not integrated into an overall action plan. The financial statements prepared by the PVOs reflect this project-based, rather than institution-based, orientation. Staff have insufficient time and support to prepare financial statements for the institution as a whole. As a result, administrators lack the documentation necessary to evaluate the financial condition of their institutions.

This subcomponent of the project addresses the need to identify and analyze costs for the institution as a whole as well as its many parts. This will be accomplished by establishing a comprehensive, institution-wide accounting system that permits PVOs to meet external reporting requirements and to meet their own internal

reporting requirements as well. Using data prepared by the MIS, the fund accounting system will generate the level of subsidy (cost minus price) for each unit of output. The system will also permit the PVO to prepare financial statements and annual reports that reflect the true financial condition of the institution to support solicitation efforts for local and international donor funding.

PVOs will then accumulate better historical data with which to make realistic budget projections to support clearly articulated institutional and project goals and objectives. The elaboration of capital and operating budgets will permit them to design short- and long-term strategies for increasing program outreach and levels of self-sufficiency.

The accounting system will also identify capital, support, and other indirect costs, establishing a base for allocating a fair share of these costs to the direct costs associated with each service delivery project. This will assist them in negotiating overhead rates with their international and other donors.

Family Planning Market Analysis. This subcomponent of the project will strengthen the PVOs' ability to conduct market analyses for the family planning services and methods they offer, in terms of unmet need, users' and potential users' preferences for methods, ability to pay, etc. For existing programs, these analyses will ensure that current users are being well-served and paying appropriate prices for services and supplies received. Prior to program expansion, market studies will be conducted to determine which market segment should be addressed, and pricing and delivery strategies. This will enable the PVOs to raise production of existing services, adjust the fees they charge, and expand into new geographical areas, income levels, and/or contraceptive methods.

The target market for the PVOs are lower income groups which require subsidized commodities and services. Most of the PVOs have attempted to reach these groups by locating clinic outlets and CBD programs in outlying, poorer areas (pueblos jóvenes) and charging token fees. However, not all PVO clinics are located in poor areas, and not all clients require complete subsidies. Furthermore, the PVOs lack information as to the size of their markets, both in terms of population size and in terms of unmet need.

The first activity will be to assist the PVOs to determine the size of their markets. While official census information for the pueblos jóvenes is either lacking (because the pueblo was formed after the last census was taken) or out of date, useful population data are often available from indigenous community organizations. Similarly, there is little reliable information on unmet need for contraception for the individual PVO service areas. However, data are available

from the 1986 DHS. The project will assist the PVOs to estimate the size of their target populations and design the most efficient service strategy to serve those targets.

Once the market segment to be targeted by the PVO is identified, the project will assist the PVO to determine the nature of community preferences and other factors which may influence contraceptive use. Many of the existing programs have been operating for several years in the same locations and will be able to develop this community profile from service statistics. Others have recently begun service delivery or are considering expanding to new geographical areas and have little information to guide them. The project will assist the PVOs to review existing data sources (such as the DHS) and, only when needed, to collect new data.

The third activity will be to determine fair prices and price policies (e.g., sliding scales) for goods and services. Available data suggest that at least the three major service providers in Lima (APROSAMI, INPPARES, and PROFAMILIA) should increase user fees. The extent to which fees can be raised without pricing the services beyond the target community's ability to pay, will be examined in price elasticity studies to be conducted in the communities served by the PVOs. By project end, all participating PVOs will have introduced or raised client fees. Clients who cannot pay any fee will still be served by the PVOs, but the major responsibility of serving the poorest of the poor belongs to the MOH.

Increased Local (Peruvian) Support. Reducing costs and increasing fees will reduce the per user subsidy that PVOs require to provide family planning services, but in most, if not all cases will be insufficient to achieve full economic self-sufficiency. While international donor support will be continued through the LOP and probably beyond, the final output of the institutional strengthening component will be to increase the level of subsidy funding from local sources.

This subcomponent will assist the participating PVOs to acquire skills required to undertake income-generating activities, specifically:

- to increase local in-kind and cash donations, and
- to undertake profit-making activities.

Where appropriate, PVOs will begin or expand income generation activities, the profits from which will be reinvested in capital expenditures, staffing, or program operating expenses.

Many PVOs already solicit local donations. For example, in 1987, PROFAMILIA raised \$153,500 to support its non-family planning health services. INPPARES' 42 neighborhood posts in Lima are housed in facilities provided by the communities.

As a first step to broaden solicitation of local donations, the PVOs will specify their current and future capital and operating budget needs, using outputs of the MIS. With this information, the PVOs will be better able to prepare funding appeals for individual and corporate donors. These appeals will offer in-kind and cash options and choices regarding the use of the donation, and exploit the tax incentives for donations made to philanthropic institutions. As required by law, the PVOs annual report will list all donations received, donors, and the use to which these donations were put. These annual reports will then be used for future fund raising to show potential donors that their donations (i) are needed, (ii) contribute to specific institutional objectives, and (iii) and will be accounted for.

The project will also introduce profit-making activities into the family planning PVOs to further increase their levels of self-sufficiency. Peruvian law permits agencies registered as non-profit to produce profits so long as the income generated is reinvested in the agency and not distributed among its members.

Profit-making activities will be introduced only after the other institutional development outputs have been achieved. The project will assist the PVOs to identify their marketable skills and products, markets, and prices. Second, the project will assist in the development of business plans that clearly specify the product or service to be sold, the market, start-up costs, and cash flow projections. Small amounts of capital venture funds may be provided by the project and/or assistance solicited from CAs (e.g., the Enterprise Project).

3. Improve the Availability of Long-Lasting Contraceptive Methods.

Increasing the availability of long-lasting contraceptive methods will be facilitated by reducing USAID/Peru funds allocated for PVO institutional support of urban CBD programs. Project support of salary subsidies for CBD personnel (e.g., supervisors) will be reduced during Project Year (PY) 1 and eliminated by the end of PY 2. Project-funded commodity donations will continue throughout the life of the project. USAID funds freed up from urban CBD will in large part be applied to clinical program operations.

PVOs will receive technical assistance to improve the utilization of existing clinical capacity. This may result in adding new services, carrying out community outreach efforts, and better integration with CBD workers. The rotating medical post system will be expanded in peripheral urban areas, both by increasing the frequency of functioning from twice a month to weekly in those posts already

operating at peak output and by opening new post locations in underserved areas. Results from operations research projects on effective catchment areas of rotating posts will be used to assist in determining the locations of the new posts.

Community workers (volunteers) will be motivated to make more referrals for IUDs and VSC counseling. Depending on the results of price elasticity and market studies, the user fees for IUDs will be raised, with a portion of the increase going to the worker making the referral. CBD promoters will also be trained to screen their clients for reproductive risk using such MOH criteria as age, parity, and previous obstetric problems, and to refer high risk women to medical posts and/or clinics for IUD or VSC.

4. Maintenance of Support for Temporary Supply Methods and Natural Family Planning.

In keeping with A.I.D. commitment to offer the full range of legally permitted contraceptive methods to prospective family planning users, the project will continue commodity donations of temporary supply methods to all family planning PVOs and will provide institutional strengthening assistance for a PVO specializing in natural family planning. Continuity of support for temporary supply methods beyond the LOP will be enhanced by assisting the PVOs in cost recovery and income generation, so that they can begin to purchase their contraceptive commodities locally from Peruvian manufacturers. (CSM products will be promoted as part of the interface between this project and the PCFP Project.)

5. Rural Coverage Through PVO-Public Sector Collaboration.

Expanded rural coverage through PVO-public sector collaboration will follow the model developed by Vecinos Peru in their operations research project in Ayacucho, Huanta, and Huancavelica. It consists of entering into an agreement with the MOH Departmental health unit and the hospital director to provide family planning services in the hospital outpatient clinic in the afternoons when normal activities are closed.

In this model, the MOH (or IPSS) will provide the facility, equipment, and contraceptive supplies. The PVO will contract and train staff, including a midwife, nurse auxiliary, receptionist, and statistical clerk. Depending on local conditions, these staff may be either MOH personnel or from the private sector. In the three departments where the model was tested, in the first year of operations, new family acceptors increased by 200 percent to 700 percent over the baseline period.

The after-hours clinics were especially popular with men, who were unwilling to attend in the mornings, when family planning shared waiting and examination rooms with gynecology and obstetrics. Acceptance of all methods increased in the experimental sessions, but temporary supply methods --- especially condoms (due to the higher numbers of male clients) --- showed the largest increases. These results suggest that it might be worthwhile to open rural CBD programs once the after-hours hospital clinics become well-established, so that users of temporary supply methods can receive resupply in their own communities.

These rural CBD programs would not be expected to become self-sufficient, but they would employ such cost containment measures as using the hospital family planning clinic as a supply and supervision point rather than employing separate supervisors to circulate among the CBD workers. Adopting this approach implies that USAID is willing to underwrite recurrent costs in this sector for the foreseeable future, or at least until economic conditions improve.

6. Enhanced Intra-Sectoral Cooperation.

This project component is contingent on the creation of a professional organization which will unite the various members of the private sector family planning community in the pursuit of goals of mutual benefit. Creating and maintaining an organization requires effort on the part of its members and requires that the potential benefits be larger than the costs. It is probably the case that most of the PVOs have failed to see the benefits of inter-agency coordination, and that this attitude accurately reflects reality rather than shortsightedness on their part. Furthermore, this distorted reality is in part due to the way A.I.D. and other donors have operated for many years.

Taken as a group, except for size, there is little to distinguish one PVO from another. All offer more or less the same products (temporary, principally female, contraceptive methods), all recruit from the same population (women of reproductive age who are unable or unwilling to pay commercial prices for family planning services), most do not charge more than token payments for services, few apply client fees to program operations, and most are nearly totally underwritten by international donors. Sheltered from the need to be financially self-supporting, even to the extent of purchasing commodities, these family planning PVOs have not had to deal with the kind of market forces that have led other professionals to band together. Indeed, it has been said that the family planning PVOs tend to view one another as competitors. However, they compete not for markets or profits or even users, but for increasingly scarce donor funds.

As the PVOs become increasingly independent of donor support, they will also become increasingly susceptible to market pressures. At that point, the benefits of joining together to promote their common interests should also become more apparent. This project component will offer limited support to an indigenous coordinating entity, if and when it begins to function. The project will not be responsible for creating this body.

The coordinating entity (CE) will be formed at the initiative of the family planning PVOs. It will likely include a General Assembly which will elect a smaller Board of Directors, whose members will include representatives from the General Assembly and possibly representatives of other private sector, non-family planning agencies (e.g., industrialists, community leaders, etc.). The Board of Directors will meet regularly and frequently and appoint standing and ad hoc committees.

If requested and approved, the project will provide limited technical assistance and funding to the CE for developing and implementing annual work plans and hiring staff. Activities that may be supported by the project include, but will not be limited to:

- use of mass media for population and family planning education;
- lobbying to reduce restrictions on access to and delivery of all family planning methods;
- setting standards for training and services delivery;
- bulk purchasing of local or imported contraceptives and other supplies; obtaining customs clearances; developing, testing, and printing IEC materials, etc.;
- coordinating training, supervision, etc.; and
- developing new markets for family planning and related services.

7. Gender Considerations.

Wherever appropriate, project input and output data will be disaggregated by sex. As a minimum, PVOs will maintain gender disaggregated personnel rosters, including both volunteer and paid staff. PVO directors will be encouraged to increase the numbers of women in management and other professional positions and to encourage women's participation in management training courses. CBD program directors will be encouraged to recruit male CBD distributors and supervisors. User data are already implicitly gender disaggregated (e.g., IUD and tubal ligation acceptors are necessarily women, and vasectomy acceptors are necessarily men), but small point-of-purchase surveys of acceptors of pills, condoms, and spermicides will be conducted to evaluate the participation of men and women in these methods (i.e., how many men purchase pills and how many women purchase condoms for their partners).

Sample surveys will be encouraged to include male respondents, although it will often be necessary to limit them to small, well-defined groups to keep costs down (since male interviewers should be used to interview men, including equal representations of men and women in survey samples would double the costs). Specific IEC promotions will be targeted to men, based on identified knowledge, attitudes, and practice.

D. First Phase: Project Description for Year One.

As described earlier, authorization is given for the first year of this four-year project, with authorization for the final three years contingent on year one performance and results. This section describes the expected outcomes of PY 1.

As stated earlier, the overall objectives of the Project are (1) to increase the capacity of selected PVOs to delivery family planning services (institution building); (2) to improve the availability of long-lasting contraceptive methods; (3) to maintain support for temporary supply methods and natural family planning; and (4) to enhance rural family planning coverage through PVO-public sector collaboration.

1. Increased Capacity to Deliver Family Planning Services.

By the end of PY 1, the participating agencies will have developed and implemented the administrative systems that will enable them to take steps to reduce the unit costs of services delivered. This is reflected in indicators presented immediately below.

Improved Administrative Systems. By the end of PY 1, all six participating PVOs will have developed and implemented:

- strategic plans,
- annual operational plans and financial objectives for PY 2,
- logistics/service statistics systems, and
- uniform management and accounting systems.

Improved Cost Effectiveness. By the end of PY 1, participating PVOs will have the information they need to calculate service delivery costs and begin steps to improve cost efficiency. The basis for these determinations will be the results of:

- institutional financial audits,
- technical study 1 (cost analysis), and
- reduction in salary subsidies to urban CBD programs.

Enhanced Financial Self-Sufficiency. Financial sustainability will be encouraged by increasing locally generated revenues, principally through cost recovery and income generation. By the end of PY 1, the participating PVOs will be able to set pricing policies and

self-sufficiency targets based on the results of:

- technical study 2 (market study),
- zonification of the rest of the country.

2. Availability of Long-Lasting Contraceptive Methods.

Installed Capacity. During PY 1, numerical (percentage) targets will be established for increasing PVO capacity to delivery IUDs and VSC and for increasing the portion of the PVOs' operating budgets dedicated to delivery of long-lasting methods.

Long-Lasting Contraceptive Method Users Served. Following the trends observed between 1987-1988, the number of acceptors of IUDs and VSC served directly by the PVOs will increase by 35 percent per year. The proportion of IUD and VSC acceptors over all acceptors in urban areas will increase by 20 percent per year.

3. Maintenance of Support for Temporary Supply Methods and Natural Family Planning.

Institutional funding and contraceptive commodities will be provided to the PVOs to continue offering these methods. A phase-out of the importation of vaginal foaming tablets, to be replaced with local purchase of CSM products will be initiated.

4. Increased Rural Coverage.

The project is not expected to open any after-hours family planning clinics in public sector facilities during PY 1. CA funding of such activities will be encouraged.

5. Gender Considerations.

No large-scale hiring or management training activities are anticipated for PY 1. As part of their administrative review, the PVOs will compile sex-disaggregated personnel rosters which will form a baseline for future hiring, training, and promotion.

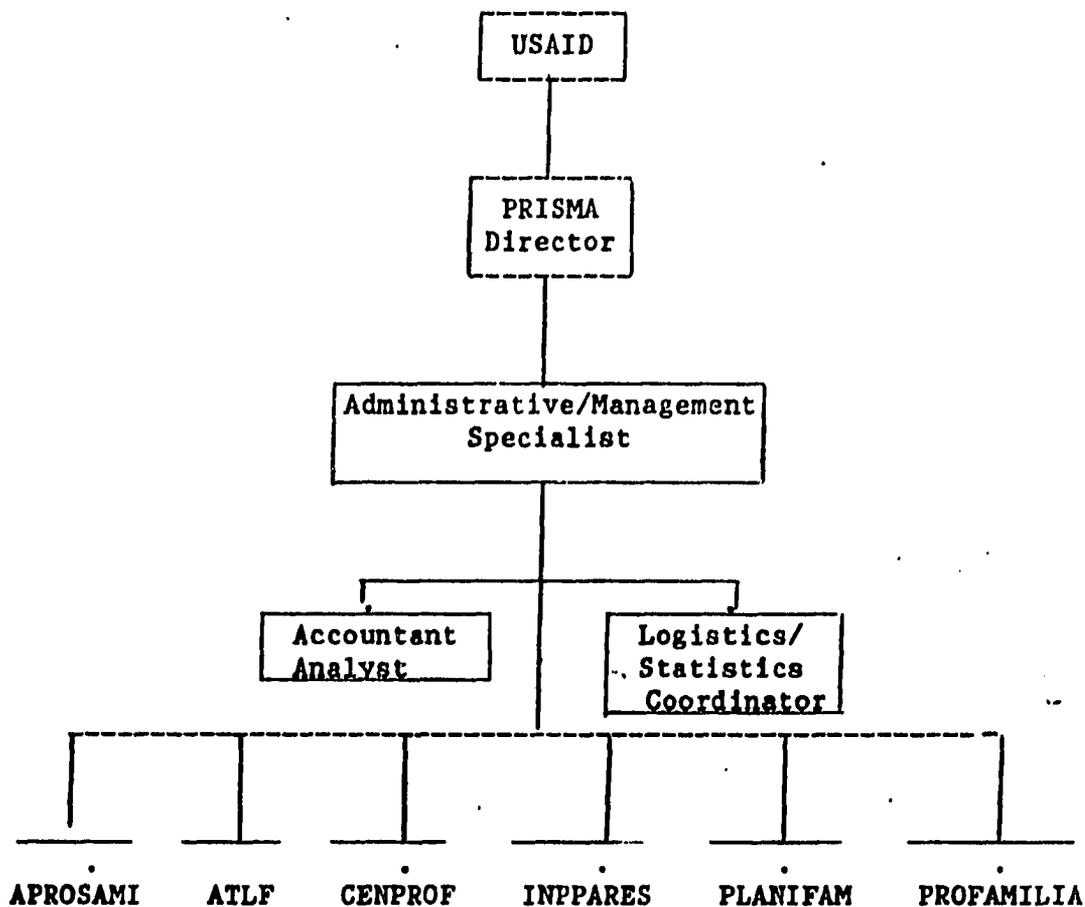
PVOs will be encouraged to recruit more men as CBD distributors and supervisors. Twenty percent of all new CBD distributors trained will be men. Programmatic activities aimed at promoting male methods will be encouraged to recruit male supervisors.

IV. IMPLEMENTATION PLAN.

A. Administrative and Monitoring Arrangements.

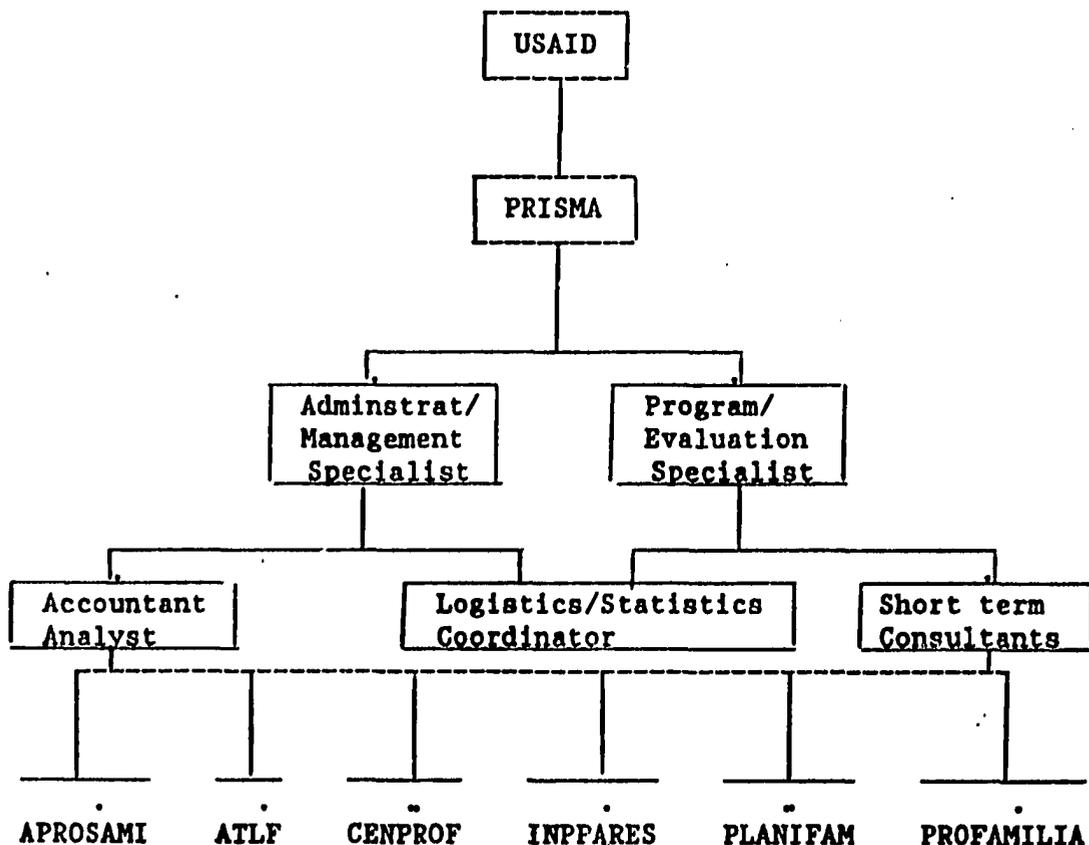
The anticipated organizational structure for implementing the project is depicted in Figure 1, below, which illustrates the basic lines of communication and responsibility for PY 1.

FIGURE 1.
PROJECT ORGANIZATIONAL STRUCTURE: PY 1



The expanded organizational structure for implementing the project in Pys 2, 3, and 4 is depicted in Figure 2, below.

FIGURE 2.
PROJECT ORGANIZATIONAL STRUCTURE: Pys 2-4



1. Overview.

USAID/Peru will obligate and implement the project through an initial one-year cooperative agreement with a Peruvian non-profit organization, Proyectos en Informatica, Salud, Medicina y Agricultura ("PRISMA" or "Implementing Agency"), which may be extended to an additional three years if the results of the first-year evaluation of PRISMA's work are favorable. Planned funding to the PVOs selected to participate in this project, for group activities, and for buy-ins to A.I.D./W centrally funded projects, will be channeled through the cooperative agreement.

Funding will be obligated for Project Year One during September 1989. Depending on future authorization of the remaining three years of the project, future obligations will be made in the three subsequent FYs.

The Implementing Agency will authorize USAID to issue PIO/Ts for (a) buy-ins, (b) for direct contracting of USAID monitoring staff, and (c) for direct contracting of audit and project evaluation services; it will also authorize USAID to issue PIO/C for the AIDS/W central procurement of contraceptive commodities under the project. Such funds will be contained within the cooperative agreement.

2. Implementing Agency.

The Regional Contracting Officer will sign a cooperative agreement with the Implementing Agency, PRISMA, which will obligate grant funds and establish the main project implementing relationships between PRISMA and USAID/Peru; the agreement will clearly set out the substantive involvement of A.I.D. during the implementation of the project. The Project Director of the Implementing Agency will report directly to the Population Division, Office of Human Resources, at USAID/Peru.

Responsibilities of the Implementing Agency. During Project Year One, for which initial authorization and obligation of the project is made, the major responsibilities of the Implementing Agency will be to:

- i. negotiate and sign sub-agreements with PVOs for institutional funding;
- ii. commission and supervise two technical studies related to service delivery costs and pricing policies and begin to implement the recommendations of such studies with the participating PVOs;
- iii. procure equipment and commodities needed by the Implementing Agency itself and the PVOs and assist the Mission in preparing the contraceptive procurement tables (CPT) for all qualified PVOs, including those not otherwise participating in the project; be responsible for receiving, storing, and distributing contraceptive commodities to qualified PVOs, and monitor distribution of contraceptives to users;
- iv. insure adequate project planning and start-up of activities;
- v. oversee disbursement of funds for specific activities in-country (e.g., technical studies and other assistance);
- vi. monitor all project-related activities; and
- vii. participate in a threshold evaluation (beginning in Month 8) and in a first year financial audit (and resultant financial reviews) as required by USAID.

During the remaining term of the cooperative agreement, if the Mission determines to extend such agreement, the major responsibilities of the Implementing Agency shall be amended to:

- provide long-term training and technical assistance in administration and program management to the participating PVOs in order to achieve the goals of the project and which are responsive to the needs of the agencies;
- arrange for short-term training and TA by local and international consultants;
- identify specialized assistance needs which can be addressed by buy-ins to A.I.D./W centrally-funded projects and assist the Mission in preparing the documentation for the requisite PIO/Ts;
- monitor all activities and evaluate project progress annually with the participating agencies; and
- participate in one major mid-term evaluation and financial audits as required by USAID; participate in the preparations for the 1991 Demographic and Health Survey which will serve as a major component of the mid-term evaluation; and participate in the final evaluation.

Implementing Agency Team. During PY 1, the Implementing Agency will field a 7-person team led by the agency's director, who will dedicate 50 percent of her time to this effort. She will be the counterpart of the USAID Project Manager and will be responsible for directing day-to-day project activities. She will also be the authorized representative of the Implementing Agency for purposes of the project. Other key personnel will be an Administrative/Management Specialist, an Accountant Analyst, and a Logistics/Statistics Coordinator. They will be supported by an Accounting Assistant, two secretaries, and a driver/messenger. One of the secretaries will be available half time to the Project Monitor.

In PY 2, the project team will be augmented by a Program/ Evaluation Specialist. These four key personnel will serve for the remainder of the project. The Implementing Agency will supply appropriate administrative back-up from its own staff. During the last quarter of PY 1, a determination will be made as to who will act as team leader for the subsequent 3 years. Either the Administrative Specialist or the Program Specialist will also serve as Team Leader.

Team Leader. This position is critical to the success of the project and maintenance of good relations with the PVOs with which the project will collaborate. He/she will be the primary representative of the Implementing Agency and will assume full-time project responsibilities within 30 days of the signed agreement. In addition to his/her technical responsibilities, the management responsibilities of the Leader will include:

- coordinating planning, training, TA, commodity, and other requirements with the participating agencies;

- developing and negotiating sub-agreements with the participating agencies;
- developing an in-country list of Peruvian technical assistance and training resources;
- coordinating and managing technical assistance and training needs;
- supervising all Implementing Agency personnel working under the project;
- overseeing the administration of sub-agreement funds;
- facilitating collaboration between the participating agencies;
- monitoring project progress;
- communicating regularly with the USAID Project Monitor;
- fulfilling all A.I.D. reporting requirements; and
- participating in project threshold and final evaluations, as required by USAID/Peru.

Administrative/Management Specialist. This individual may be either a Peruvian national or an expatriate. Previous experience in family planning is not required. He/she should have extensive private sector management expertise in Latin American contexts and previous experience working with private voluntary organizations. The Administrative/Management Specialist will be responsible for strengthening the management and financial capabilities of the participating PVOs and will be provided by the Implementing Agency for the entire life of the project. The responsibilities of the Administrative/Management Specialist will include:

- providing technical assistance and training to the participating agencies in setting up and implementing management systems, including personnel, legal, supervisory, procurement, inventory, and logistical support;
- identifying management technical assistance and training needs of the participating agencies and providing the necessary resources to meet those needs;
- assisting with the coordination of the participating agencies through the development of job description, personnel evaluations, and staff development;
- providing technical assistance to the participating agencies in developing income generating capabilities, including expansion of resource base;
- actively participating as a trainer or lecturer in in-country management training programs and board of directors training;
- implementing strategic planning and other project activities with PVO management staff and boards of directors;
- assisting in the identification and training of any replacement; and
- participating in the final evaluation.

Program/Evaluation Specialist. This individual may be either a Peruvian national or an expatriate. He/she should have extensive experience in family planning program management in Latin America, especially in clinical operations and community outreach. At the same time, he/she should not be strongly identified with any one of the participating PVOs. The Program/Evaluation Specialist will be responsible for providing technical assistance and training in those aspects of program operations that deal directly with service delivery and outreach and will be provided by the Implementing Agency for the entire life of the project. The responsibilities of the Program/Evaluation Specialist will include:

- providing technical assistance and training to the PVOs in developing and implementing program management systems, including projection of commodity needs, inventory and logistics control, service delivery personnel needs, and service statistics and production measures;
- assisting the PVOs in developing and implementing systems to identify and monitor costs and to develop more cost-effective service delivery activities;
- providing technical assistance to the PVOs in setting pricing and price adjustment policies;
- participating in the design and evaluation of market and price elasticity studies;
- providing technical assistance and training to the PVOs to develop income generation and/or cost recovery plans to phase out USAID salary subsidies to urban CBD programs, including the development of new activities for CBD distributor and promoters, such as identification of high reproductive risk;
- assisting the PVOs to identify new service delivery and income generation activities, such as voluntary surgical contraception, reproductive health, etc.;
- actively participating as a trainer or lecturer in in-country program training programs;
- assisting in the identification and training of any replacement; and
- participating in the final evaluations

Logistics/Statistics Coordinator. This individual should be a Peruvian national resident in Peru. He/she should have at least 3 years of experience in evaluation and/or research of family planning service delivery and in training and supervising evaluation staff, supervisors, and field staff. The Logistics/Statistics Coordinator will be responsible for implementing the management information system (MIS) in the PVOs and will monitor operations research projects funded by the project. The responsibilities of the Logistics/Statistics Coordinator will include:

- assisting the Administrative and Program specialists in implementing systems developed by the project in the participating PVOs, training PVO staff in their use, and monitoring their performance;
- supervising all aspects of project data collection, including timeliness, completeness, and quality control;
- preparing quantitative progress reports;
- coordinating service statistics and production reports of the PVOs, including effectiveness and efficiency indicators, commodities distribution, and inventory;
- assisting the Program/Evaluation Specialist in preparing projections of commodities needs of the participating PVOs and in coordinating project commodity requests with the Peruvian National Family Planning Program;
- providing technical assistance to operations research projects funded by the project and liaison with A.I.D./W centrally-funded projects in research and evaluation of family planning services delivery in the PVO sector;
- actively participating as a trainer or lecturer in in-country supervision and evaluation programs;
- assisting in the identification and training of any replacement; and
- participating in the final evaluation.

The above staff will each have counterparts within the PVOs, with whom they will work closely and directly. These activities will be carried out with the prior approval of the PVO executive directors.

Accountant Analyst. This position should be filled with a Peruvian national with accounting and logistics experience, perhaps a certified public accountant. He/she will provide administrative back-up to the senior project staff. The responsibilities of the Accountant Analyst will include:

- participating in the preparation of administrative reports for USAID, including collecting the required financial and logistics information from the participating PVOs and monitoring it for completeness and accuracy;
- tracking financial disbursements and logistics flow, including liaison with the MOH and Peruvian customs; and
- maintaining project financial records and prepare the financial statements and reports of the Implementing Agency.

3. USAID Project Monitoring.

The Population Division of the Office of Human Resources (O/HR) will have responsibility within USAID for managing the project. The Chief of the Population Division will serve as the Project Manager and will be responsible for the administrative approval of all project inputs and for overall project monitoring and coordination.

The Project Manager will be assisted by a personal services contract (PSC) Project Monitor with funds provided under the Cooperative Agreement for the first year of the Project. Contingent upon determination by USAID, this position may be continued in Years 2 through 4, with funding source to be determined later. The Project Monitor will have his/her primary offices at PRISMA though USAID will provide limited space on an occasional basis. He/she will work exclusively on this project. The threshold evaluation will recommend whether or not to extend the Project Monitor's position to years 2-4 of the Project.

The major responsibility of the Project Monitor will be to assist the Implementing Agency in carrying out its responsibilities under the cooperative agreement (including ensuring compliance with project objectives and A.I.D. procedures), to be the point of day-to-day contact between USAID and the Implementing Agency and between USAID and the subgrant recipients, to help PRISMA prepare quarterly status reports, annual work plans and activities requiring USAID approval, and to help USAID analyze such.

Additionally, the Project Monitor will assist in planning and implementing the threshold evaluation of the Implementing Agency performance, commencing in Month 8 of Year One. S/he shall also ensure that financial audits and reviews of the Implementing Agency and subgrant recipients --- and implementation of recommendations related thereto --- are undertaken.

To the extent that the cooperative agreement and/or project is extended to its full four-year term and the threshold evaluation recommends extending the position of the Project Monitor, he/she will also plan and assist in implementing the final (end of project) evaluation. The Project Monitor position will be competed; he/she will have an educational and/or experiential background in program administration and family planning.

The Project Manager shall be assisted:

- in contracting and procurement actions, by the Regional Contracting Officer (located in Quito) and the Mission's Executive Office;
- in legal interpretations, by the Regional Legal Officer (in Quito),
- in financial matters, by the Office of the Controller;
- in evaluation, donor coordination, and project design/implementation activities by the Program Office (including the Project Development Officer);
- in training activities, by the Training and Social Development Division within O/HR; and
- in logistics matters by the Executive Office.

These Mission (or regional) resources shall be supplemented by A.I.D./W backstop staff in the Office of Development Resources in the Bureau for Latin America and the Caribbean (LAC/DR), various offices within the Bureau for Science and Technology (S&T), and the Office of Data Management and the Office of Contracts and Commodity Procurement in the Management Services Bureau.

4. Technical Advisory Group.

The Implementing Agency and the Mission shall jointly establish a Technical Advisory Group (TAG) composed of approximately seven experts in population, family planning, and institutional development. These experts may be Peruvian or expatriates; all will be resident in Peru. From time to time, visiting experts may be asked to join the TAG on a temporary basis.

The purpose of the TAG shall be to advise the Implementing Agency and Project Monitor on technical issues relating to the design, implementation, and evaluation of the project activities. The project participants and the Mission may independently request assistance of the TAG or of its individual members. Project funds may be used to pay consulting fees to TAG members for requests for technical assistance requiring more than one hour and for paying travel and per diem in Lima for TAG members living outside of Lima.

B. Implementation Plan.

1. Implementation Strategy.

During the first quarter of PY 1 bridge funding to the six PVOs will be initiated in accordance with on-going operational plans prepared under the predecessor SPF project. During the second and third months, project staff and PVOs will meet to negotiate new budgets for the subsequent quarter based on revised operational plans prepared by the PVOs. During the last quarter of PY 1 the PVOs and project Staff will develop operational plans for the following year. Year Two budgets will be established and approved at that time.

During the last quarter of each subsequent PY, operational plans and budgets will be reviewed and adjusted according to accomplishments and/or economic/political considerations that may have an impact on project activities.

2. Project Start-up Activities.

The first project year will consist of a one month start-up phase from signing of the Cooperative Agreement o/a September 22, 1989 through October 22, 1989. The following activities are expected to

be completed or initiated during the start up phase of the Project;

- a. Budgets for PVO bridge institutional support will be processed to initiate funding and avoid cash flow problems.
- b. PY 1 staff will be identified and hired, including the Administrative/Management Specialist, Accountant Analyst, Logistics/Statistics Coordinator, and support staff.
- c. PIO/Ts will be prepared and a Personal Services Contracts signed to hire the Project Monitor and secretary.
- d. In coordination with the USAID Controller's Office, a Scope of Work for the PVO institutional financial audits will be drafted, reviewed, and revised as necessary.
- e. A contraceptive order (PIO/C) will be prepared based on results of the inventory.

3. Schedule of Activities, by Project Year.

Project Year (PY) 1. The first project year will test the capabilities of the Implementing Agency to implement the project and will validate the viability of the proposed approach. Generally, Year One will continue existing PVO services and operations (with minimal expansion) and will ensure continued availability of contraceptive commodities. User targets will be expanded by a maximum of 3 percent across the board (to adjust for population growth of women of reproductive age). Service expansion will be limited to targets of opportunity in the rural sector.

a. Overall Objectives for PY 1.

Overall objectives for PY 1 include the following:

- i. develop a uniform and integrated logistics/service statistics system and implement it in all PVOs receiving A.I.D. commodities;
- ii. conduct cost and market studies;
- iii. conduct institutional financial audits of all six participating PVOs;
- iv. review and refine strategic plans;
- v. analyze and design an appropriate zonification strategy for the entire country, including a reexamination and possible modification of the Lima zonification strategy;
- vi. prepare administrative and financial procedures and manuals to be followed by the project and the recipient PVOs;
- vii. commence roll-back of salary subsidies to urban CBD;

- viii. evaluate the progress of individual PVOs toward meeting institutional development objectives to determine whether they should continue in the project;
- ix. evaluate the performance of the Implementing Agency and the implementation modality tested in the Year One, and authorize the remainder of the project with modifications in project goals and methodology, as necessary.

The threshold evaluation of the Implementing Agency will include, but not be limited to, successful design and implementation of the integrated logistics/service statistics system and completion of the institutional financial audits and two technical studies. Authorization of the remaining three years of the project will be made contingent on the findings of the threshold evaluation of the Implementing Agency and affirmation of the methodological approach.

b. Monthly Schedule of Activities for PY 1.

Month 2:

- A Request For Proposal (RFP) will be issued to local firms soliciting bids for the PVO institutional financial audits. Three weeks will be provided for submission of proposals. The proposals will be evaluated by a committee composed of the USAID Project Monitor, a representative from the USAID Controllers Office, the Project Team Leader, the Administration/Financial Specialist and the Financial Analyst (CPA). Following negotiations with the firm providing the best proposal, the contract will be awarded for the Audits. Three months will be allowed for completion of assigned work.
- The Logistics/Statistics Coordinator will begin to work with the PVOs on an inventory of contraceptive stocks and projected commodity needs for the next 18 months.
- PVO second quarter budgets will be reviewed and adjusted as required and according to availability of funds.
- Work will be initiated with PVOs on the logistics and service statistics systems.

Month 3:

- The first order of contraceptives will be prepared, based on results of the inventory.
- Scopes of work will be developed by the Administrative/Financial Specialist for the Technical Studies 1 and 2 (Service Costs Study and Market/Pricing Study) for review and approval by USAID.

Month 4:

- Requests For Proposals (RFP) will be issued for Technical Studies 1 and 2. Three weeks will be allowed for submission of bids. The proposals will be evaluated by a committee including the USAID Project Monitor, a representative from the USAID Controllers Office, the Project Team Leader, the Administrative Specialist, and the Logistics Coordinator.
- Subgrants for the 3rd quarter will be reviewed with the PVOs and modified as required.

Month 5:

- Institutional financial audits will be completed. With TA from the Administrative Specialist and Financial Analyst, the PVOs will initiate the remedial steps recommended by the auditors.
- USAID will begin the process of contracting for the evaluation of PRISMA scheduled for Month Eight. A two-person team is anticipated; the individuals may be US, TCN, or local, as determined by qualifications and availability.

Month 6:

- Computerized integrated logistics/service statistics systems will be installed in all 6 participating PVOs.
- Fourth quarter subgrants will be reviewed and finalized.

Month 7:

- Work will continue with PVOs on the revisions of financial systems recommended in the financial audits.
- Plans will be finalized by USAID for the evaluation of PRISMA.

Month 8:

- PRISMA's performance in completing the activities assigned during the first seven months of the Project will be evaluated. This evaluation will require an estimated of three weeks of field work and one week to prepare a report.

Month 9

- The Project Team and the USAID management staff will jointly evaluate PVO service delivery, assessing quantitative and qualitative aspects of activities. A questionnaire will be designed for this purpose.

- Technical Studies 1 and 2 will be completed. Meetings will be held with the PVOs to share findings, discuss implications and establish plans for implementation of results.
- The results of the evaluation of PRISMA will be presented to USAID.

Month 10:

- The Project will continue to assist the PVOs to develop and prepare the subsequent year's operational plans and budgets.
- Based on the results of the PRISMA evaluation, USAID will make a determination as to the future implementation of the Project.

Months 11 and 12:

- Work initiated with PVOs based on results of audits and studies will be continued by Project staff.
- USAID will complete preparations for the follow-on plan.

Project Year 2. Based on the threshold evaluation of the performance of the Implementing Agency, the remainder of the four-year project may be authorized and a new cooperative agreement negotiated (or another implementation modality selected). PY 2 activities will focus on the initiation of income generating and cost recovery elements.

Overall objectives for PY 2 include the following:

- i. evaluate one-year operational plans and modify long-term plans;
- ii. establish institutional goals for cost recovery and income generation, including numerical utilization and self-sufficiency targets;
- iii. complete phase-out of salary subsidies to urban CBD;
- iv. commence and/or continue cost recovery and income generation for clinical services;
- v. initiate procurement of QSM commodities with non-A.I.D. donated income;
- vi. open/continue rural after-hours clinics and CBD programs;
- vii. develop and implement a uniform management and accounting system in all PVOs receiving project institutional support;
- viii. establish uniform pricing/salary policies in Lima, including sliding scales;
- ix. develop new methodology for user targets; and
- x. evaluate progress of individual PVOs toward meeting institutional development objectives to determine whether they should continue in the project.

Project Year 3. During the third year, increasingly greater resources will be concentrated on PVO self-sufficiency. A major focus will be on cost efficiency of their operations. Overall objectives for PY 3 include:

- i. evaluate institutional targets and modify plans as appropriate;
- ii. achieve utilization and self-sufficiency targets in urban full-service clinics; commence roll-back of subsidies to rotating posts;
- iii. extend uniform pricing and salary policies to other urban areas;
- iv. open/continue after-hours rural clinics and rural CBD programs;
- v. develop and expand other marketing and commercial schemes;
- vii. expand user targets; develop cost efficiency targets;
- viii. evaluate progress of individual PVOs toward meeting institutional development objectives to determine whether they should continue in the project; and
- ix. conduct a mid-term evaluation of the project, modifying goals, end of project status, output indicators (and benchmarks), and methodology, as necessary.

Project Year 4. The fourth year of the project will consolidate the gains in made earlier in institutional strengthening. Overall objectives include:

- i. evaluate performance and modify institutional plans;
- ii. increase percent of institutional budgets from non-A.I.D. sources;
- iii. achieve utilization and self-sufficiency targets for rotating medical posts;
- iv. open/continue after-hours rural clinics and rural CBD programs;
- v. set and achieve targets for local procurement of contraceptive commodities (CSM products) with non-A.I.D. income;
- vi. expand user targets; increase cost efficiency;
- vi. conduct the end-of-project evaluation.

C. Procurement Plan.

1. Technical Assistance.

Technical assistance (TA) will be provided by project staff and short-term consultants contracted by the Implementing Agency on behalf of the participating PVOs.

Funding for project staff is included under the "Project Office" line item of the cooperative agreement. During Year One, it will

finance a Project Team Leader, an Administrative/Management Specialist, an Accountant Analyst, a Logistics/Statistics Coordinator, an Accounting Assistant, two secretaries, and a Driver/Messenger. The Team Leader's position will be discontinued after Year One, and a Program/Evaluation Specialist will be added to the staff during the first half of Year Two.

Funding for short-term consultants is included in the cooperative agreement and is separate from the institutional support provided directly to PVOs, as subgrants. (While the "Technical Assistance" line item in the cooperative agreement provides general consulting services, the implementing agency may, with concurrence from the Mission, stipulate that short-term consultancies required by only one PVO be paid by that PVO from within its subgrant.)

Prior to issuing a contract for technical services, the Implementing Agency (PRISMA) will prepare a detailed scope of work and solicit proposals; final selection will be subject to USAID review and approval. Preference will be accorded to local procurement of such short-term technical services from Peruvians or expatriates resident in Peru; in consonance with women in development goals, preference will also be accorded to female professionals. The Implementing Agency may also wish to access A.I.D./W centrally funded activities; in such an instance, the Implementing Agency will authorize USAID to issue a funded PIO/T, utilizing funds made available under the cooperative agreement.

2. Institutional Support.

Institutional support in the form of pass-through funding will be provided to each of the six participating family planning PVOs. Annual project subgrants will be negotiated individually between each participating PVO and the Implementing Agency, with the participation of and subject to final approval by USAID. Prior to beginning negotiations, each participating PVO will prepare an annual institutional budget and projected quarterly cash flow, listing all expenditures and all sources of income. Depending on the PVO's needs, project funds may be used to help cover recurrent operating costs (but on a declining basis) and/or capital expenses.

Budgets will be prepared in local currency (intis) and include adjustments for expected inflation. Different inflation indices may be used for different budget categories; for example, salaries and benefits may show a lower inflation rate than office and medical supplies. It is essential that these inflation projections be incorporated into the initial budget estimates, as --- during the last few years --- local inti costs have risen faster than devaluation of the currency against the dollar. Since the project's total dollar budget is fixed, once the year is underway, it will be

almost impossible to effect additional adjustments in the local currency budgets, if inflation outstrips devaluation.

While it is impossible to predict hyperinflation (or inflation) rates with any degree of security or absolute certainty, project will have to make estimates based on the best information available and the considered judgment of management and financial professionals who have experienced the Peruvian economic reality first hand. The annual budget exercise will help promote better management practices and avoid the person-hours that were wasted under the previous practice of calculating quarterly budget adjustments. PVO directors will be ultimately responsible for their own shortfalls and will have to compensate for them in a normal business fashion: by raising prices, cutting expenses, or securing other revenue sources or enhancements.

Funding advances and liquidations between USAID and the Implementing Agency and between the Implementing Agency and the recipient PVOs will follow the standard practices specified by the USAID Controller's office. Quarterly cash flows will be prepared in advance of each project year and reviewed and approved by USAID. The first quarter's anticipated cash flow will be advanced at the beginning of the year and accounts liquidated on a monthly basis. Subsequent estimated quarterly cash flows will be modified on the basis of the experience of previous months and anticipated expenses.

3. Project Management and Support Services.

USAID Management Team. Day-to-day project operations will be supervised by a Project Monitor who will report to the Project Manager. The Project Manager will be a USDH, in this case, the USAID Population Officer. At the request of the Implementing Agency, USAID will prepare a PIO/T to hire a PSC Project Monitor. Initial authorization for this position will be for one year, in keeping with the one-year Project authorization.

The Project Monitor position will be advertised locally and internationally in both English-language and Spanish newspapers. US citizens, Peruvian nationals, and TCNs will be eligible to apply. Candidates should be experienced in PVO family planning program operations and A.I.D. procedures, familiar with the Peruvian context, and fluent in both Spanish and English (FS 3 in non-native language). The job announcement will appear before October 1, 1989, and final selection will be made by December 1.

Evaluations and Audits. All short-term consultants required for evaluations and audits under the Project will be selected by the Implementing Agency and/or USAID and paid with funds obligated under the Cooperative Agreement. A case-by-case determination will be

made as to which consultants will be hired directly by the Implementing Agency and which by USAID (under appropriate PIO/Ts).

4. Commodities.

For Project Year One, immediately upon the signing of the cooperative agreement, the Implementing Agency will authorize USAID to issue a funded PIO/C to buy into A.I.D./W central procurement of contraceptive commodities. The amount of the funding (\$1,003,000) will be stipulated in the cooperative agreement and is based on contraceptive needs for an 18-month period. On a quarterly basis, the Implementing Agency will call forward various commodities, as needed by the PVOs participating in the project.

The Implementing Agency is responsible for storing, distributing, and monitoring the use of such commodities. Project funds have been budgeted for customs clearance, storage, and handling. The project will finalize and implement a tracking system for commodities (the logistics/service statistics system) during PY 1. With prior approval from USAID, the Implementing Agency may directly assume the tasks of customs clearance, storage, and distribution to the PVOs, or it may subcontract for these services locally.

D. Supervision Plan.

The Project will utilize a 3-tiered supervision plan, from USAID to the Project Team Leader, the Team Leader to Project staff, and Project staff to the PVOs. Communication will be facilitated by regularly-scheduled meetings of the project staff (biweekly), between the Project Monitor and the Team Leader (monthly), and of the Coordinating Committee (quarterly).

During PY 1, the Implementing Agency will prepare and submit to USAID written technical progress reports, on a monthly basis and as discrete project phases (e.g., technical studies) are completed.

E. Monitoring and Evaluation Plan.

Monitoring Project effectiveness will include the collection of information on selected impact indicators as well as Project inputs and outputs. As much as possible, data collection efforts will be integrated into on-going project activities to reduce costs, minimize disruption, and institutionalize the methodology of self-evaluation. Instruments and procedures will be designed by project staff with assistance from USAID and external consultants.

Monitoring and evaluation activities during PY 1 will concentrate on the development of appropriate indicators and instruments and the

collection of baseline data. This will include, but not be limited to, the institutional financial audits, the logistics/service statistics and management information systems, and the technical studies (cost and market studies).

Numerical targets (e.g., utilization of fixed capacity, income generated, self-sufficiency, etc.) will be established for each participating PVO during the first quarter of PY 2 and monitored on a quarterly basis. The data used to construct these indicators will be provided by the routine service statistics and financial reports collected by the PVOs. As the computerized information systems are phased in and become operational, the collection of data should become more reliable and timely.

An external evaluation of the Implementing Agency will be commissioned by USAID for month 8 of PY 1. The results of this evaluation will be used to determine whether a new Cooperative Agreement should be negotiated and/or what modifications to the Project approach should be made prior to authorizing the final three years of the Project. The evaluation will include, but not be limited to, successful design and implementation of the integrated logistics/service statistics system and completion of the institutional financial audits and two technical studies. Data sources will include routine reports produced by the PVOs and the Project, results of the institutional financial audits and the technical studies, and site visits and interviews with USAID, Project, and PVO staff.

A final evaluation of the impact of project activities on PVO services delivery will be commissioned by USAID. Secondary sources (e.g., 1984 Health Sector Analysis, 1986 DHS) and information collected during PY 1 will provide baseline data. Process data will be provided by routine PVO and project reports.

The project Logistics/Statistics Coordinator will have primary responsibility for ensuring the quality of the data reported by the PVOs, with assistance from the Administrative/Management and Program/Evaluation specialists. In addition, a new Demographic and Health Survey, tentatively scheduled for 1991, will provide information on the impact of PVO services delivery on contraceptive prevalence and fertility. Project staff will assist in the design and analysis of the survey. Care will be taken to overcome the shortcomings of previous surveys, especially in terms of correctly identifying where family planning users obtain their contraceptives.

F. Financial Reviews and Audits.

Audits and Financial Management Reviews will play a dual role for this Project. In addition to the traditional function of

verification of fiscal propriety and compliance with the terms of the Agreement, these inputs will provide technical assistance to PRISMA and the implementing PVOs. This technical assistance will help in the design and implementation of financial reporting systems that control advances given to PRISMA by USAID and the subsequent advances by PRISMA to the PVOs. This will assure that one of the principal objectives of the project, the development of financial and administrative maturity by PRISMA and the PVOs, will be met by the end of the first year of the project.

The first level of audits, that contracted by PRISMA and approved by USAID, will be performed progressively throughout the first year. This audit function will impart technical assistance while providing compliance for the PVOs annual audit requirements. The same type of audit assistance for PRISMA will assure that their financial reporting systems are in tune with the overall project needs.

Additionally, USAID will contract for Financial Management Reviews to complement the technical assistance provided through audit. These reviews will be strongly oriented towards the more specific needs and demands of A.I.D regulations.

Project financial and compliance audits required by A.I.D. regulations will be requested from RIG/A/T as per their established procedures concerning non-federal audits. These will be performed for the first year's activities and near the end of PY 4.

The PVOs will be expected to continue the audits from their own resources in compliance with the annual re-registration provision of A.I.D. The results of these annual certified audits will be used to guide the initial training courses for PVO management and will be an integral part of on-going project monitoring and evaluation. For example, evaluation of progress made toward self-sufficiency will be based, in part, on the results of the annual certified audit. Smaller, subproject audits will continue to be carried out in accordance with donor requirements.

During the first half of PY 1, the Implementing Agency, with the assistance of the USAID Population Division and the Controller's Office, will prepare administrative and financial procedures and manuals to be followed by the project and the recipient PVOs. These materials will include, but not be limited to:

- norms and procedures for the preparation of monthly and annual financial statements;
- payroll control and disbursements, including time sheets and other supporting documentation;
- minimal procedures for procurement and control of purchased and donated commodities;
- preparation of short-, medium-, and long-term budgets; and
- preparation and revision of organizational procedures and manuals.

The Implementing Agency will be responsible for orienting and supervising the PVOs in the use of these materials. To this end, it will contract local specialized services, such as an accounting firm, to assist in the preparation of the materials and the instruction and supervision of the PVOs in their use.

G. Disbursement Procedures.

1. **Methods of Financing Foreign Exchange Costs**

USAID will assume responsibility for disbursing funds for some of the foreign exchange costs under the Project. These include commodities, but not domestic transportation and handling costs. These commodity foreign exchange costs will be disbursed by A.I.D./W and charged to the Project through advices of charge (AOC). USAID coordination costs will be earmarked through a PIO/T, at the request of PRISMA, and contracted through a direct PSC and paid directly by USAID. Evaluations will also be contracted and paid by USAID, upon written requests of PRISMA, and/or cosigning PIO type document.

With prior AID approval (through PIL type document), PRISMA will contract for their annual audit and the PVOs and systems and procedures assistance. As is the current custom, payment will be made in US dollars. Payment will either be made by PRISMA or upon request by PRISMA directly by AID on their behalf. This will be reviewed during implementation and will be dependent on the economic situation and the GOP's policy on dollar accounts.

Project audits will be contracted through the non-federal audit mechanism established by RIG/A/T. The PIO/T and Contract will be executed by the USAID. Payment terms will be negotiated by the EXO or RCO, as appropriate in their contracting negotiations. Financial Management Reviews will be confirmed and contracted through co-signed PIO/Ts and contracts executed directly by USAID/Peru.

2. **Methods of Financing Local Currency Costs**

PVO institutional support, technical studies, technical assistance and project management costs will all be defined and approved by AID through the PIL procedure. Funds will be provided on an advance basis, based upon monthly approved cash flow projections, covering basic cash needs. The advances will be liquidated by monthly billings from PRISMA. Assuming PRISMA continues to monitor and control USAID funds adequately as under their current projects, the Mission will perform or, if appropriate, contract accounting firms to perform on USAID's behalf (from the financial review line item) post review of vouchers at the implementing offices. If during the audits on financial reviews it is determined that the systems are no longer adequate, USAID will require all supporting documents until

action is taken to resolve problem areas.

PVO institutional support advances will be in turn advanced by PRISMA, based upon each PVO's basic cash needs for each thirty days operations. The PVO will submit monthly reports of expenditures to PRISMA clearing their advances; and, PRISMA will consolidate these submissions in a reporting format, approved by USAID, which will serve to clear their advances from USAID.

PRISMA will use the same basic financial reporting system for the six PVOs as has been used by PRISMA in reporting to USAID under its other current projects. The system is adequate in the informational sense but its effectiveness will depend upon refinements needed in the PVO's basic accounting systems. These refinements will be provided by PRISMA with assistance from the financial consultants chosen for systems and procedures installation.

Technical assistance and technical studies will be approved by the PIL procedure for PRISMA contracting and monitoring. USAID will provide advances as needed. The process will be the same as explained above.

Project management costs of PRISMA will be approved by USAID as follows: an annual cash flow projection of administrative costs will be developed presenting monthly cash requirements; quarterly requirements will be presented to USAID as the basis for monthly advances of cash requirements. Monthly advance liquidations presented to USAID will be made after the bank statements have been received and accounts reconciled by PRISMA. These advance clearances will be made on or before the fifteenth day following the end of the reporting month. Overhead will be reimbursed based upon monthly billings from PRISMA in local currency.

V. PROJECT ANALYSES.

A. Institutional Analyses for Six Family Planning PVOs.

In-depth analyses of the six family planning PVOs which will be central participants in this PVO umbrella group project were conducted by a multi-disciplinary team of experienced Peruvian professionals. The detailed scopes of work for the team were prepared by an expatriate family planning specialist and an American management expert. In addition, the six PVOs and PRISMA participated in a strategic planning workshop held by a consultant from the A.I.D./W centrally funded Family Planning Management Training Program. Materials prepared as part of the workshop were made available for the institutional analyses.

A more extensive discussion of the findings of the consultants is found in annex V to this document. Below is a summary of the findings.

1. Administrative and Management Analysis.

The PVOs were evaluated according to the following scale:

- Group A: Good strategy and a strong organization.
Characteristics of an excellent organization.
- Group B: Poor strategy and a strong organizations.
Characterized by resistance to change and lack of strategic planning.
- Group C: Good strategy and a weak organization.
Characterized by over dependence on a central executive, obsessed with growth, and overly opportunistic to short-lived environmental changes.
- Group D: Poor strategy and a weak organization.
Characterized by a lack of problem-oriented thinking, defensive posture, and lack of consistency.

Individual Assessments

APROSAMI. APROSAMI is a level D organization. It suffers both from a limited market strategy and an under-developed organizational capacity. Problems of personnel motivation and development negatively impact on its progress. In addition, APROSAMI views family planning as a part of maternal-child health, rather than the institution's principle purpose. With a better marketing strategy, APROSAMI could improve to level C; with a better organizational structure and capacity, it could evolve into level B.

ATLF. ATLF is a level D organization. Its exclusive emphasis on natural family planning constitutes a severe strategic marketing barrier. The most logical path for ATLF would be to consolidate its organizational capabilities, evolving into a level B organization.

CENPROF. CENPROF is classified as a type D organization due to lack of internal consistency in its institutional goals. It has evolved as far as it has, more as a function of donor requirements on its subprojects than because of any institutional strategy or decisions. CENPROF senior management appears defensive.

INPPARES. INPPARES is a typical level B organization, due primarily to an insufficient marketing strategy. INPPARES's managers confuse bureaucracy with production; they focus on internal form rather than orienting the institution to the external market. In order to develop into a level A organization, INPPARES must overcome its weak marketing strategy, which up to now has not permitted it to improve its income generation.

PLANIFAM. PLANIFAM is classified as a type B organization due to the charisma and values of its executive director. Given its inherent institutional fragility, PLANIFAM runs the risk of regressing to level D.

PROFAMILIA. PROFAMILIA is a typical level C organization, due to its indefatigable executive director, whose personality is one and the same as the institution's. Its marketing strategy has succeeded in diversifying its donor base. As an institution, PROFAMILIA lacks organizational cohesion. If it could improve its organizational capacities, it could advance to level B or even level A.

2. Financial and Accounting Analysis.

This analysis focused on three areas: organizational structure and management; purchasing and inventory; and personnel policies and procedures.

Organizational Structure and Management.

Organizational and Procedural Manuals. All of the PVOs lack updated organizational manuals, and their organizational charts do not reflect their real structures. Procedural manuals are not specified in sufficient detail, and some PVOs show incompatible personnel functions due to the lack of procedural manuals.

Annual Budgets and Cash Flow. Only INPPARES and PROFAMILIA prepare institutional budgets. ATLF, APROSAMI, CENPROF, and PLANIFAM have never prepared global budgets. With the exception of INPPARES, none of the PVOs appear to have prepared cash flow projections.

Financial Statements. Three of the PVOs (APROSAMI, INPPARES, and PROFAMILIA) prepare annual institutional balance sheets. The other three (ATLF, CENPROF, PLANIFAM) do not. Accounting activities are limited to subproject financial reports for donors. Accounting systems are generally not computerized. ATLF and PLANIFAM do not

have computers, and the other PVOs lack adequate accounting software. None of the PVOs liquidates expenses on time, as stipulated in their subcontracts.

Institutional Audits. Only INPPARES conducts independent institutional audits. Individual subprojects are examined by their respective donors.

Purchasing and Inventory.

None of the PVOs routinely solicits bids. Four of the PVOs (APROSAMI, ATLF, INPPARES, and PROFAMILIA) prepare purchase orders; CENPROF and PLANIFAM do not. Three of the PVOs (APROSAMI, ATLF, and PLANIFAM) do not properly document receipt of purchased supplies and equipment. Two PVOs (ATLF, PLANIFAM) do not have a system of inventory control; the remaining PVOs have appropriate systems of internal control, but they could be improved. Only two PVOs (APROSAMI, INPPARES) carry insurance policies; the other PVOs (ATLF, CENPROF, PLANIFAM, and PROFAMILIA) do not.

Personnel Policies and Procedures.

Two PVOs (CENPROF and PLANIFAM) maintain personnel on fixed-term contracts. By law, these employees have acquired employment stability despite their contractual status. None of the six PVOs maintains signed time sheets for employees paid with subproject funds. Three PVOs (ATLF, CENPROF, and PROFAMILIA) classify full-time staff as independent professionals. These employees are subject to withholdings and benefits assigned by law.

3. Programmatic Analysis.

The programmatic analysis focused on five aspects of service delivery: (a) physical facilities; (b) medical equipment and furnishings; (c) service delivery personnel; (d) productivity and cost recovery; and (e) patient flow.

Physical Facilities.

Clinics generally present at least the minimum physical requisites for IUD insertion in terms of space, illumination, utilities, and cleanliness. Some problems were noted in the surgical facilities being readied to offer voluntary surgical contraception. The rotating posts reflect the conditions of the communities in which they are located. Those located in community facilities tend to be better constructed and sometimes have electricity, water, and bathrooms. Those located in promoters' homes, especially in the pueblos jovenes, are poorly constructed and lack electricity, water, and bathrooms. Minimal but adequate privacy is ensured by placing screens or curtains around the patient examination area.

Medical Equipment and Furnishings.

Clinical facilities, both clinics and rotating posts, are generally equipped with at least the minimum necessary for carrying out gynecological examinations and inserting IUDs. PLANIFAM/Cusco needs a few basic equipment items to bring its clinic up to the norm. The ATLF field installations could be equipped with electrocautery equipment so that they can provide that service locally and thus provide another potential source of income for the institution.

Four PVOs either are planning to open facilities for voluntary surgical contraception (VSC) or could open a surgical facility with minimal modifications of their current physical plant. They include APROSAMI, GENPROF, INPPARES, and PROFAMILIA. At the moment, none of them possesses the necessary equipment to deal with emergency complications such as cardiac or respiratory arrest. These deficiencies will be brought to the attention of the appropriate CAs (AVSC and JHPIEGO) before the facilities are opened.

Service Delivery Personnel.

In general, service delivery personnel showed reasonable familiarity with institutional philosophy, but almost total unawareness of service delivery targets or goals. With the exception of ATLF (which offers exclusively NFP), service delivery staff were knowledgeable about modern contraceptive methods.

Productivity and Cost Recovery.

Utilization of Installed Capacity. Clinic utilization rates ranged from 76 percent (INPPARES) to 16 percent (PROFAMILIA clinic). Two clinics (PROFAMILIA and PLANIFAM) should consider cost saving measures. The PROFAMILIA clinic should be moved to a location closer to its outreach program.

Post utilization rates ranged from 99 percent (INPPARES) to 35 percent (PLANIFAM). INPPARES should consider expansion of post capacity, preferably by increasing frequency from the present two sessions a month to weekly sessions. PLANIFAM should consider reducing post capacity, perhaps by reducing the number of biweekly posts or by relocating them. APROSAMI, ATLF, and GENPROF should improve their promotion efforts.

Cost Recovery. Cost recovery is the ratio of income to operating expenses. The ratio can be improved by reducing costs and/or increasing income. Since none of the PVOs have accurate cost information available, the results of the cost recovery analysis are preliminary at best and must be validated by further study.

Most PVOs charge more for a service delivered in their clinic than for the same service delivered at a rotating post. However, there is little consistency from one agency to another, and it could not be determined how much clients were actually paying. Cost recovery varies widely by PVO, with clinics recovering more of their costs than rotating posts. Clinic rates range from a theoretical high of 84 percent (CENPROF) to a low of 6 percent (PLANIFAM), and all of the posts average below 10 percent.

Potential for Self-Sufficiency. At the present time, none of the PVOs is anywhere near self-sufficiency. It is not clear how much better the situation would be if utilization rates were higher. It appears that with appropriate cost containment and high productivity, clinic facilities can approach self-sufficiency through patient fees. Market studies are needed to determine how high the fees can be set.

Posts are inherently more expensive to operate than clinics and can never reasonably expect to become self-sufficient through patient fees. Post programs must strive to achieve higher productivity and greater installed capacity to attain better economies of scale. Even in the best programs, rotating posts will require external operating subsidies, either from donors or from PVO income-generating activities.

Patient Flow.

Given the suboptimal utilization rates in clinic facilities, observed patient waiting time was generally within reasonable limits. Similarly, the post sessions that were observed did not present major problems in patient flow. Formal evaluations of patient flow do not appear warranted at this time.

4. Commodities and Logistics Analysis.

This analysis is based on commodity shipments from each PVO central warehouse to distribution outlets for the calendar years 1988 and 1989. Commodities delivered to users were not recorded. This is the only standard measure that could be applied to all PVOs.

General Conclusions.

INPPARES showed the greatest movement of commodities, accounting for 87 percent of the IUDs, 73 percent of the pills, and 67 percent of the condoms moved in 1988. With the exception of vaginal foaming tablets, total movement of all contraceptive methods decreased from 1987 to 1988, although the agencies reported serving more family planning users. This net decline may reflect overstocking in 1987 and a subsequent decrease in inventories in 1988.

Significant quantities of contraceptives were delivered to non-PVO service outlets, including other institutions and the commercial sector. Totals range from 65 percent of all IUDs moved in 1988 to 15 percent of all pills moved in 1988. These do not include commodities originally delivered to PVO clinical and CBD outlets which may have been subsequently marketed.

The study also revealed a number of deficiencies in management of commodities and logistics that were common to all PVOs. They included the following:

- at the level of the central warehouse, none of the PVOs maintain systematic reports of the movement of contraceptives, although all keep records in one form or another;
- none of the PVOs validate their service statistics (users served, commodities distributed to users) against the warehouse shipments;
- the official reports published by the PVOs do not coincide with the information obtained from the warehouses; and
- all PVOs need technical assistance to develop, install, and maintain adequate logistics control norms and procedures.

Individual Findings.

APROSAMI maintains a card file in its warehouse which records warehouse movement. Due to overstocking, in some months, the quantity of outdated commodities returned to the warehouse exceeded the amount sent out. During 1987-1988, APROSAMI sent commodities to Arequipa, Cajatambo, Huacho, and Piura.

CENPROF registers warehouse shipments separately for supervisors, posts, and physician offices. Balance sheets for supervisors and physician offices are prepared separately by a controller. CENPROF's IUD "marketing" and CBD activities extend as far as the city of Tumbes.

INPPARES maintains a computerized logistics system, but the data are not cleaned and are therefore unusable. The warehouse also maintains manually derived annual totals of commodities moved. In addition to its central warehouse, INPPARES stocks 14 regional warehouses: Arequipa, Ayacucho, Cajamarca, Callao, Chiclayo, Chimbote, Ica, Ilo, Iquitos, Juliaca, Moquegua, Piura, Tacna, and Tumbes.

PLANIFAM's central warehouse is too small to store its inventory, commodities received are transferred immediately to storerooms located in each of its five service outlets. Each storeroom keeps its own records, and there is no feedback or consolidation at the central level. Shipments to Puno are recorded in Cusco.

PROFAMILIA. Due to PROFAMILIA's recent move, it appears that some of the warehouse records have been lost or misplaced. The warehouse figures often differ substantially from the official reports; sales and shipments to provincial programs are entered under the Lima CBD program. During 1987-1988, PROFAMILIA shipped commodities to Canete, Huancayo, Mala, and Tingo Maria.

B. Institutional Analysis of PRISMA.

1. Background.

Proyectos en Informatica, Salud, Medicina y Agricultura (PRISMA), the Implementing Agency, was legally constituted in Peru as a charitable association in April 1986. It was registered in the Lima Public Registry for Registered Associations in Peru on June 5, 1986, and is also registered with the Ministry of Health, the National Planning Institute, and the Ministry of Economy and Finance as a tax-exempt organization to which donations are tax deductible. PRISMA was granted a certificate of eligibility as a registered foreign PVO by USAID/Peru on November 3, 1986.

PRISMA is administered by an Executive Director, an Administrative Director, and a predominantly Peruvian Board of Directors. PRISMA currently employs 23 professional staff, principally physicians, four technical personnel, and almost 50 auxiliary personnel.

PRISMA works with urban and rural poor populations to foster their participation in, and benefit from, modern technology in the areas of medicine, public health, agriculture, and information systems. During 1988, PRISMA executed a total budget of \$756,400 among its A.I.D.-related projects. Its current A.I.D.-related budget to be administered during 1989 is \$533,800, plus \$5,977,025 worth of food commodities under Project 527-0323 - Integrated Food, Nutrition and Child Survival: A Joint Effort Between a PVO and the MOH.

PRISMA also receives funds from foundations, other donors, and Peruvian organizations, including the following:

Milpo Mining Company. Along with Instituto Marcelino, PRISMA has a contract with the Milpo Mining Company to provide training and supervision in family planning/maternal child health care.

University of Arizona Veterinary Department. In conjunction with the Universidad Peruano Cayetano Heredia, PRISMA is participating in a study of Cryptosporidium, which causes diarrhea in young children. PRISMA is responsible for managing the grant and for collecting field data and specimens.

World Health Organization (WIO). PRISMA has a grant from the Safe Motherhood Program to identify women who have experienced illegal abortions, establish a profile of those at risk of future abortions, and design interventions for this risk group.

International Foundation for Science. PRISMA has a grant to conduct a study on the use of vaccination to prevent porcine Cysticercosis. This project is being carried out in coordination with the San Marcos School of Veterinary Medicine.

2. USAID In-House Management Review.

PRISMA's first overall A.I.D. management review is scheduled for the end of 1989 by the Regional Inspector General/Honduras Office. A preliminary assessment was conducted by the USAID/Peru Population Division during April, 1986, which provided the following findings:

Management capability, technical leadership, and support personnel. PRISMA has a large full-time staff. The Executive Director, Josephine Gilman, has had extensive project management experience in Peru and Bangladesh.

Financial structure and experience; adequacy of fiscal systems for financial management and reporting requirements. PRISMA has an A.I.D.-oriented financial infrastructure in place and works successfully with the Mission. Its accounting system is now being computerized. PRISMA has extensive experience managing complex financial tracking programs under the hyperinflationary conditions of Peru.

Experience in commodity management, inventory control and warehouse supervision. PRISMA's experience in this area derives from its oversight of the Food for Development Program. PRISMA has received high marks from USAID/Peru for its performance in overseeing distribution of 15,000 tons of commodities.

Physical infrastructure. PRISMA currently rents a three-story building. It has 25 microcomputers on-site and 12 located in off-site project offices, extensive software, and laser printers, and personnel trained in their use. It also has two vehicles, leases three, with a sixth awaiting release from customs.

Potential for overload. It appears that administration of the PVFP Project would be congruent with PRISMA's current growth plans. However, USAID is concerned that PRISMA could be overloaded, and is cognizant that careful on-going project monitoring is warranted.

3. Financial Review.

PRISMA's financial management systems and procedures were evaluated by a team of independent auditors during July, 1989. The auditors made the following observations and recommendations for improvement:

General Accounting System. A final accounting for 1988 has not yet been prepared, and monthly balance sheets are not available. PRISMA does not revalue its fixed assets to compensate for inflation. The auditors recommended that PRISMA expand and restructure its accounting department to reduce the work load of the chief accountant and to add sufficient auxiliary personnel.

Organizational Manuals and Procedures. The auditors recommended that PRISMA update its organizational chart. The organizational manual does not include the accounting and treasury unit and lacks uniformity across areas. Administrative personnel are unfamiliar with the organizational manual.

Independent Institutional Audit. PRISMA has not commissioned any independent institutional audit, although subproject audits have been performed. The auditors recommend annual institutional audits.

Budgets and Cash Flow. PRISMA currently prepares annual budgets and cash flow projections separately for each subproject. The auditors recommend the preparation of an institutional budget and cash flow projections. They also recommend that PRISMA establish a policy to require bids for purchases above a certain level.

Miscellaneous. PRISMA has no insurance policy on its assets. Vehicles have not been entered into the accounting books. Employee income tax deductions are made on an estimated basis, rather than on the basis of employee declarations, as is required by law.

4. Administrative and Management Review.

An administrative/management review was conducted by a two business consultants who visited PRISMA and interviewed administrative and program staff. Their assesment was highly positive. In the opinion of the consultants, PRISMA exhibits the positive attitude toward change, appropriate management capability, and congruency with the A.I.D. strategy needed to implement the PVFP Project.

PRISMA has developed strategic plans which have required minimal change and can be carried out with current staff. Its participatory system of work has resulted in a high degree of motivation. Flexibility in personnel practices is permitted by combining project administration with use of a technical coordinating committee. This results in high motivation and morale and encourages participation, creativity, and innovation among the group.

From a business perspective, the only structural weakness observed is PRISMA's financial self-sufficiency. Efforts are being made to generate income. The remaining deficiencies are procedural and mostly related to the accounting system, which is being replaced by a computerized system. PRISMA's evaluation system requires minor changes which can be achieved with staff training.

C. Technical Analysis.

The technical analysis for this project addresses the feasibility of the technologies to be used to improve the financial sustainability of the family planning VVOs and to increase their capacity to deliver long-lasting contraceptive methods and collaborate with the public sector in extending effective family planning coverage to rural areas. The approaches and techniques described in this project have all been tested in the family planning private voluntary sector, either in Peru or in other countries in the Latin American region.

1. Contraceptive Technology

All of the contraceptives to be included in this project are already being used in Peru at this time. This project will support the provision of the standard variety of scientific contraceptive methods: oral contraceptives (a low-dose estrogen pill), intra-uterine devices (IUDs - Copper T-380, a recently improved Copper-T model which provides protection from pregnancy for probably up to ten years as compared to the earlier Copper T-200 model which provided three years of protection), condoms, contraceptive foam and vaginal foaming tablets (VFTs), and male and female voluntary surgical contraception (VSC) using either laparoscopy or "mini lap" for women who are in a high risk reproductive category. These methods are all well beyond the experimental stage. Their efficacy and safety under a variety of conditions are known and are a function of such user characteristics as age, health, parity, education, personality, cultural background, and user application.

A more recently developed contraceptive technology which will also be included in this project is the subdermal hormonal implant, Norplant. Norplant has been undergoing extensive field trials in numerous countries for some time and has already been approved for public use in several of them, including Peru (as well as Finland, Dominican Republic, Indonesia, and Chile). A program is currently underway in Peru to train physicians in Norplant insertion and removal so that this new method can be offered in U.S. supported family planning programs as soon as it is registered in the United States and available for procurement by A.I.D. This is expected early in 1990.

2. Management Technologies

In order to achieve the improved sustainability of the PVOs as called for by the end of the project, a series of management systems must be developed and incorporated in PVO operations. Systems for audit, accounting, logistics, service statistics and other management information such as personnel, payroll, etc. will be designed and implemented according to well tested and proven techniques and methodologies. The technologies on which these systems will be based are basically well established and successful.

While management systems are needed to ensure the success of any plan for strengthening the PVOs and expanding their capacity to deliver high-quality family planning services, they are not in themselves sufficient to produce sustainability. The PVOs lack an entrepreneurial orientation and instinct which must be instilled in them before real sustainability for their operations can be achieved. Therefore, while the first year of the project will concentrate on developing and establishing the needed management systems, years 2 - 4 will focus on the provision of technical assistance to inculcate the requisite outlook and animus among the PVOs that will lead to substantial sustainability by the project's end. The T.A. provided for this purpose will employ the latest standard business techniques and utilize the services of Peruvian business consultants who are experienced in dealing with the unique challenges posed by Peru's current hyperinflationary context.

D. Social Soundness Analysis.

This project will assist the private voluntary sector to become more economically sustainable and to strengthen its capability to deliver all methods of family planning with an emphasis on increasing the availability of long-lasting contraceptive methods and achieving greater rural coverage through collaboration with the public sector. This section examines the socio-cultural context in which the project will operate and the socio-cultural feasibility of the proposed family planning interventions, project beneficiaries, and the anticipated impact of the project.

1. Socio-Cultural Context.

Peru, the fourth largest and fifth most populous country in Latin America, is characterized by extreme geographic and cultural variations. Its land area is approximately 1.28 million square kilometers, with only a small percentage of it arable; its population in 1989 was estimated to be nearly 22 million. It is divided into three clearly defined regions:

- the coast, which includes approximately 50 percent of the population and 11 percent of the land;
- the sierra, with about 40 percent of the population and 26 percent of the land; and

- 1 -

- the jungle, with only 10 percent of the population, but with 63 percent of the land.

Each region has its own ethnic groups and culture; a recent World Bank report indicated that, of the total population, almost half is classified as indigenous, the majority of whom are not fully integrated into the economic, social, and political life of the country. Another 10 percent is of European (primarily Spanish) origin, with a small number of Asians. The remaining one-third is of European/Indian mixture. Peruvians of European and Asian origin live primarily in the coastal cities (mostly in Lima), where they dominate much of the political and commercial activities of the country.

According to the latest data available from the National Statistics Institute, the Peruvian population is relatively young, with 40 percent less than 15 years old, and predominantly urban, with 68 percent located in urban centers. Over the years, there has been and continues to be an outward migration from the rural areas to the cities. As a result, nearly one third of the total population now lives in the Lima-Callao metropolitan area, and by the year 2000, three out of four Peruvians will live in large cities.

Despite the wide range of cultural and ethnic diversity, it is safe to say that all regions in Peru have begun the demographic transition from higher to lower fertility rates, with the coastal and urban areas being farther along in the process. Driving this demographic transition has been a steady increase in the prevalence of contraceptive practice to postpone or limit future births. Over the last 10 years, contraceptive prevalence has increased from 31 percent of women in union of reproductive age in 1977-78 to 46 percent in 1986. Prevalence rates vary substantially with geographic region, from a high of 63 percent of women in union in the Lima metropolitan area to a low of 31 percent in the sierra. However, the absolute gain in prevalence in the sierra over the last 10 years (13 percent) equalled the increase in metropolitan Lima, and in terms of relative increases, the sierra led the country with a 74 percent gain over 1977 levels.

By 1986, knowledge of contraception was nearly universal: 87 percent of all women in union of reproductive age (and 86 percent of all women of reproductive age) could name at least one modern contraceptive method, principally pills (77 percent), female sterilization (75 percent), and IUD (72 percent). Nevertheless, half of all women using contraception were practicing a traditional method, principally rhythm (39 percent of all contraceptive use). This phenomenon, coupled with the finding that large proportions of women who were familiar with modern methods reported having heard of problems associated with their use, has led many investigators to conclude that serious cultural and knowledge barriers still exist to

more widespread use of modern contraceptive methods.

Other interpretations of these findings are also plausible. Reporting having heard of a problem associated with the use of a specific contraceptive method is not necessarily the same as not using the method for fear of contracting the problem. Since it appears that both users and non-users of modern contraceptives report having heard of the same problems, it cannot be concluded that these "fears" or "rumors" are significantly associated with non-use. Another interpretation of the high use of rhythm and other traditional methods is that many women who are motivated to adopt fertility limitation have no access to modern methods. Thus, the high prevalence of traditional methods, rather than being an obstacle to adoption of modern contraception, would operate as a facilitating factor.

2. Socio-Cultural Feasibility.

Available information suggests that the demand for family planning services and supplies is higher than the use rate due to the inability of the public and private health systems to meet that demand. Health care providers are, in general, supportive of most modern family planning methods, although individual preferences may lead them to promote certain methods more strongly than others. Family planning is widely accepted and practiced, despite some anti-family planning influences in the country, chiefly among the far right and the far left of the political spectrum.

Political support for family planning has grown significantly under the APRA government. In late 1986, the President of Peru, for the first time in history, made several strong public statements in favor of family planning and established a Presidential Commission on Population to set demographic and contraceptive prevalence goals for the country. A public opinion survey held in metropolitan Lima in January, 1989, found that

- 81 percent of the respondents were in favor of the policy to reduce the population growth rate,
- 95 percent supported "responsible parenthood",
- 87 percent supported the use of mass media to promote family planning, and
- 77 percent supported the distribution of contraceptives.

Several family planning IEC campaigns have been conducted using mass media, such as television, radio, and billboards, as well as printed matter such as pamphlets and posters. Messages have been targeted primarily towards younger married couples and adult women, principally emphasizing the concept of responsible parenthood and the right of families to decide on the number and timing of their children. Religious groups have criticized, on occasion, the

overall economic and social development and on the environment are well known and established.

4. The Role of Women.

The involvement of women will be critical to achieving the objectives of this project. This includes not only their roles as the principal consumers of family planning services and supplies but also as managers, decision makers, and service providers in the private voluntary sector. Women have traditionally served as outreach workers, service providers, and supervisors in PVO programs. This project will promote their participation in higher management levels as well.

5. Summary.

The socio-cultural context of Peru is multi-faceted, with enormous regional, ethnic, and urban-rural variations that affect and complicate the delivery of family planning services and supplies. The GOP population policy emphasizes the need for effective family planning service delivery throughout both the public and private sectors.

The family planning services and methods supported under this project are socio-culturally acceptable and recognized under the Population Law and MOH norms. With the exception of two methods (vasectomy and contraceptive implants, still in the phase of clinical trials in Peru), all are well-known and widely practiced. Family size preferences have declined dramatically in recent years, and Peruvian women and men are increasingly motivated to adopt family planning practices appropriate to their fertility preferences.

E. Economic Analyses.

The goal of the project is to enhance the ability of Peruvian families to achieve the desired number and spacing of children. This would be achieved by increasing the capacity of the six target agencies to deliver long-lasting contraceptive methods while maintaining support for the delivery of temporary and natural methods. This in turn will support GOP efforts to relieve pressure on the country's health, education, and nutrition infrastructures by slowing population growth. The project has three specific objectives: institutional development, increased availability of long lasting methods, and improved access in rural areas.

1. Institutional Development

This component of the project aims at increasing the operating efficiency of the target agencies, at expanding their service delivery, and at increasing their financial self-reliance. Prior Mission experience with technical assistance provided to planning agencies under the previous SPF project shows that improved operating efficiency is an achievable objective.

A recent study of service delivery costs over a one year period showed an increase in couple years of protection (CYP) accompanied by a reduction in the average delivery costs per CYP. If this project is able to achieve a further 15% average reduction in unit costs for all six participating PVOs, it would be possible to increase output by more than 10% without increasing donor subsidies.

The economic viability of increasing service delivery was analyzed using the economic cost benefit methodology, where the potential productive value of individuals not born as a result of the project is compared against society's potential costs of providing for them. The principal limitations of this analysis are: a) society does not include the unborn and their "utility" function; and, b) the lost "psychological" utility associated with having children is not included in the cost side because it is impossible to measure.

Bearing in mind these limitations, the analysis, described in Annex III, led to the conclusion that the net present value to society of each birth is -\$411. Stated differently, for every birth averted, society will save \$411 stated in net present value terms.

The next question is whether the money invested in averting a birth is lower than the savings that would accrue to society. Using a simple arithmetic calculation that divides savings to society (\$411) per birth averted by the average number of couple years of protection (8.85) that need to be delivered in order to avert one birth, one obtains the maximum that can be spent on delivering one couple year of protection, which in this case is \$46 per CYP.

The same study that analyzed service delivery and associated costs shows that CYP delivery costs are already below the maximum figure. In fact, at current rates of output and costs, the benefits to cost ratio of investment in family planning is approximately \$3.70 saved for every dollar invested. The potential savings that could be achieved by the project in terms of increasing cost effectiveness of PVO service delivery would increase the benefits to cost ratio to \$4.40 to \$1, or an improvement of almost 20 percent.

The feasibility of the PVOs reaching financial self-sufficiency is analyzed in the following section of the project paper.

2. Increased Availability of Long Lasting Methods

The justification for an increased focus on long lasting methods is not primarily economic, but rather responds to the expressed reproductive preferences of project beneficiaries. While VSC and IUDs are 100 and 95 percent effective, temporary supply methods and NFP show lower effectiveness rates. An increment in the use of long-lasting methods would increase the overall effectiveness of contraception in Peru from its current weighed average of 85 percent. While VSC and IUDs show higher delivery costs than temporary supply methods (NFP is the most expensive method of all to deliver), evidence from Ecuador and Colombia suggest that economies of scale can be achieved as their prevalence increases.

3. Improved access in rural areas

It is often the case that family planning service delivery is more expensive in rural areas, as demonstrated by studies of community-based distribution in Ecuador and Colombia. However, the service delivery model proposed for this project differs from either case. This project proposes to use existing MOH and IPSS health facilities. A pilot program conducted by the Population Council to test the feasibility and cost-effectiveness of this approach found the costs per CYP below the \$46 cut-off point estimated above.

Furthermore, in analyzing the cost-effectiveness of rural family planning service delivery, it is necessary to take into account the fact that both contraceptive prevalence and the quality of life are lower in rural areas. This means that the economic impact of the project will be greater than the national average estimated in the economic cost benefit analysis.

F. Financial Analysis

This project will not generate revenue for its Implementing Agency, PRISMA. PRISMA's role is to channel funding and commodities to the six participating PVOs and to provide and coordinate technical assistance that will, among other objectives, enhance the PVOs' economic sustainability. Therefore, the Financial Analysis will examine the feasibility of the sustainability goal for the six participating PVOs.

The degree to which economic self-sufficiency can be attained depends in part on the characteristics of the clients served by the PVOs, the services that are offered, and the prices that could be charged. At the present time, the most important potential source of revenue for the PVOs is donated contraceptive commodities.

Client Characteristics and Current Fee Structure. Currently, none of the participating PVOs recover even 10% of their operating costs from client fees. The extent to which they might become more self-sufficient depends in large part on the ability of their clients to pay for services and supplies. This is a great unknown, due to the lack of information about client income and the uncertainties posed by the current hyperinflationary environment.

In the absence of more precise data on client income, analysis of clients' ability to pay must be based on proxy variables, such as education and place of residence. For example, data from INPPARES indicate that 79 percent of their clinic clients have at least a secondary education and do not live in a pueblo joven, as do 19 percent of rotating post clients. Clearly, many of these clients do not require the near 100 percent subsidy they receive.

The income levels of APROSAMI and PROFAMILIA clinic clients are probably below those of INPPARES clients, nevertheless, many are capable of paying a larger share of their service costs. This is demonstrated by the results of a survey of APROSAMI, Instituto Marcelino, and INPPARES clinic clients. APROSAMI clients come from a lower socioeconomic class and those of INPPARES from a higher one than the clients of Marcelino. Instituto Marcelino is almost completely self-supporting from user fees, while the other two PVOs are almost completely donor subsidized.

Potential Income Generation Through Sales of Contraceptive Commodities. Contraceptive commodities are a substantial part of the project budget, exceeding the subsidies for other PVO institutional operating costs by some 44 percent. While the project will continue to provide donated commodities for the PVOs' own activities, it is clear that in the not-too-distant future, the PVOs will have to assume this responsibility on their own.

Over the period 1987-1988, the five PVOs (less ATLF) which distribute modern contraceptives put into circulation an annual average of \$674,000 worth of donated commodities. The average prices charged for these commodities were considerably lower than the A.I.D. cost. PVO prices are usually considerably lower than the retail price of locally-distributed products, and in the case of spermicides (vaginal foaming tablets), the cost to A.I.D. of the imported product is four times higher than the retail price of the locally-manufactured product.

The prices currently charged by the PVOs do not cover the value of the donated commodities, and much of the income generated stays with the distributor and never reverts to the institution. Furthermore, a considerable proportion of the commodities distributed are sent to other, often commercial, outlets for final distribution to users. Not only do these commercial users pay much higher prices for their

methods, but the PVOs do not realize the income from those sales.

It should be possible for the PVOs to charge between a 25 to 50 percent mark-up (over procurement costs) for the IUDs, pills, and condoms they distribute through their own outlets, and between a 150 to 500 percent mark-up on those commodities distributed to commercial outlets. After allowing the CBD distributor to keep half of his/her pill and condom sales, this would gross \$720,000 annually at total 1987-1988 distribution levels.

If the PVOs continued to receive donated commodities for their own services and purchased, at A.I.D. prices the commodities distributed to commercial outlets, they could net \$587,000 annually. This represents more than the total institutional operational subsidy for clinical as well as CBD programs.

Implementation of appropriate pricing strategies could allow the PVOs to generate, through sales of contraceptives alone, enough revenue to purchase commodities at A.I.D. prices and offset a small portion of their operating costs as well. Revenues would be available to capitalize operations (purchasing instead of renting office space, purchasing equipment, etc.), further improving economic sustainability.

G. Cost Estimate and Financial Plan.

1. Financial Plan

The total cost of the AID Financed Inputs for this four-year project is estimated to be U.S.\$7,755,000. It is anticipated that neither the Implementing Agency, PRISMA, the GOP nor the six participating (program implementation) PVOs will provide a measurable financial contribution. Therefore all project budgets reflect AID Financed Inputs only, and a waiver of the 25 percent contribution requirement will be approved by the Mission Director. USAID-financed inputs have been described in detail in earlier sections.

TABLE 4
SUMMARY OF TOTAL PROJECT COSTS BY FUNDING SOURCE AND
FOREIGN EXCHANGE (FX) AND LOCAL CURRENCY COSTS (L.C.)
(in U.S. \$ 000)

<u>Funding Source</u>	<u>FX</u>	<u>LC</u>	<u>TOTAL</u>	<u>%</u>
USAID	4,097	3,658	7,755	100

These projections will be amended for later years as soon as the contributions from the participating PVOs can be quantified.

2. Methods of Implementation

Table 5 outlines the planned methods of implementation and financing for the Operating Program Cooperative Agreement as conceived by A.I.D. While this type of Agreement is not normally treated as a "bi-lateral type" project in implementation terms, we believe that the preferred methods established by A.I.D. policy are appropriate under the circumstances to ensure adequate monitoring and control of A.I.D. funds and to provide methods for implementing A.I.D.'s substantive involvement. To ensure and clarify various implementing procedures and clearances that will be necessary during the LOP, the Mission will issue various PIL type documents, included will be a "PIL No.1" type document that will set the stage, so to speak, for implementation of the project.

The reason for this treatment is to provide PRISMA with substantial implementation assistance during the life of the project to assure that PRISMA and the cooperating PVOs achieve the highest level of institutional development possible. Accordingly, A.I.D. will directly administer a large percentage of Agreement funds. With respect to the A.I.D. funds that will be directly administered by PRISMA and the PVOs, disbursement and reporting procedures have been developed to assure their planned use. Mission Staff has reviewed the procedures and find them adequate. A description of these procedures appears in the Implementation Plan.

TABLE 5
METHOD OF IMPLEMENTATION BY
TYPE OF ASSISTANCE AND FINANCING METHOD

<u>INPUTS</u>	<u>Method of Implementation</u>	<u>Method of Financing</u>	<u>Estimated Amount</u>
A. <u>Program Costs</u>			
1. PVO Institutional Support	PIL-type documents under Operating Program Cooperative Agreement (OPCA) with PRISMA	Direct Reimbursement/ Periodic Advances	2301
2. Technical Assistance/ Technical Studies	Contracts executed by PRISMA under PIL/OPCA Contract (PIO/T)	Direct Reimbursement/ Periodic Advances Direct Payment	515
3. Commodities and Freight	PIO/Cs thru A.I.D./W Purchasing Agreement	Direct Payment/ Advice of Charge	3517
B. <u>Administrative Costs</u>			
1. Project Management (PRISMA)	PIL-type documents	Direct Reimbursement/ Periodic Advances	580
2. USAID Coordination	PSC Contract (PIO/T)	Direct Payment	220
3. Evaluation	Contract (PIO/T)	Direct Payment	70
4. Audits/Financial Reviews:			
a) PRISMA, PVO Annual Audits	PIL-type documents	Direct Reimbursement/ Periodic Advances	160
b) Project Audits	Contract (PIO/T)	Direct Payment	50
c) Financial Management Reviews (NFA)	Contract (PIO/T)	Direct Payment	40
C. Overhead	PIL-type documents	Direct Payment	117
D. Contingencies/ Inflation			185
TOTAL PROJECT			7755

G. Environmental Analysis.

An Initial Environmental Examination (IEE) was carried out during the preparation of the PID and a Negative Determination was recommended by the Mission Director. The Environmental Threshold Decision was reviewed and the Negative Determination approved by the LAC Environmental Coordinator on September 15, 1989. A copy of the Environmental Threshold Decision is attached as Annex VII.

VI. CONDITIONS, COVENANTS, AND NEGOTIATING STATUS.

The Cooperative Agreement will be subject to the following essential terms, covenants, and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

A. Source and Origin of Commodities and Nationality of Services.

Commodities financed by A.I.D. under the Cooperative Agreement shall have their source and origin in Peru or in the United States, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services financed under the Cooperative Agreement shall have Peru or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Cooperative Agreement shall be financed only on flag vessels of the United States, except as A.I.D. may otherwise agree in writing.

B. Condition.

Prior to the hiring of key personnel under the Project, A.I.D. shall approve, in writing, such personnel, including the Administrative/Management Specialist, Accountant/Analyst, and Logistics/Statistics Coordinator.

C. Covenant.

The Implementing Agency agrees that none of the funds made available under the Cooperative Agreement for family planning activities will be used to finance any costs relating to:

1. the performance of abortion or involuntary sterilization as a method of family planning;
2. the motivation or coercion of any person to undergo abortion or involuntary sterilization;

3. biomedical research which relates, in whole or in part, to methods of, or the performance of, abortion or involuntary sterilization as a method of family planning;
4. the active promotion of abortion or involuntary sterilization as a method of family planning; or
5. the procurement of any equipment or materials for the purpose of abortion or involuntary sterilization.

D. Contributions from Non-A.I.D. Sources.

The A.I.D. requirement for Operational Program Cooperative Agreements ("OPCAs"), that a minimum of at least twenty-five percent of total project costs be contributed from non-U.S. government sources, is hereby waived, the justification for which is included as an Annex to the Project Paper.

E. Standard Mandatory and Required as Needed Conditions.

The Cooperative Agreement that will be negotiated with the Implementing Agency for PY 1 will include the standard conditions required of non-U.S. nongovernmental organizations and required as needed conditions for non-U.S. NGOs.

F. Substantive Involvement of USAID/Peru.

Participation of and/or prior approval from USAID/Peru will be required in the design and/or execution of the following Project activities:

- (1) Project Monitoring Arrangements. The Implementing Agency will request USAID to issue PIO/Ts to locally compete and contract the Project Monitor and secretary positions. Selection of these individuals will be made by USAID.
- (2) Contraceptive Commodities. The Implementing Agency will request USAID to issue a funded PIO/C to purchase contraceptives to be distributed under the Project. USAID will review commodity requests and issue the necessary cables to A.I.D./W. The Implementing Agency will be responsible for receiving, storing, and distributing contraceptives to the PVOs once the commodities are in-country. USAID approval of local handling arrangements (i.e., direct arrangements by the Implementing Agency or subcontract to another local organization) will be required prior to issuing the first request for shipment.
- (3) Buy-ins to AID/W centrally-funded projects. USAID may recommend and will review and approve all requests for buy-ins to A.I.D./W centrally-funded projects under the Cooperative Agreement.

After such approval, the Implementing Agency will request USAID to issue the necessary PIO/Ts.

- (4) Project personnel. USAID approval will be required prior to selection and contracting of Project key personnel by the Implementing Agency. These include the Administrative/Management Specialist, Accounting Analyst, and Logistics/Statistics Coordinator (PY 1) and Program/Evaluation Specialist (PY 2). Any deviation from the number of support personnel as specified in the Project Paper will require the prior approval of USAID, as will any changes in level of effort of PRISMA's director during PY 1.
- (5) Local contracts for technical services and consultants. USAID will participate in the preparation of scopes of work for all subcontracts issued by the Implementing Agency under the Cooperative Agreement for local technical services and consultants. This will include, but not be limited to, institutional financial audits of the Implementing Agency and the participating PVOs, and the two technical studies (cost study and market study). Prior approval from USAID will be required for all Requests for Proposal (RFPs), and selection of subcontractors and consultants.
- (6) PVO subgrants. USAID will participate in the preparation of PVO subgrant budgets for institutional support and, where appropriate, technical assistance. Prior approval from USAID will be required for all PVO subgrants made under the Cooperative Agreement.
- (7) Technical Advisory Group. The Project Manager and/or Project Monitor will participate in all meetings of the Technical Advisory Group, as described in the Implementation Plan.
- (8) Threshold Evaluation of PRISMA. Using funds under this Cooperative Agreement, USAID will conduct a threshold evaluation of PRISMA during month 8 of PY 1, as described in the Implementation Plan. USAID will use the results of this evaluation to determine the funding mechanism for PY 2-4 (i.e., a new Cooperative Agreement with PRISMA or another vehicle). PRISMA will authorize USAID to issue the necessary PIO/Ts and other documentation to carry out this evaluation.
- (9) Evaluation of participating PVOs. USAID will participate with the Implementing Agency in end-of-year evaluations of progress made by the participating PVOs in achieving their institutional and service delivery goals. All decisions regarding continuation or discontinuation of PVOs in the Project will require the prior approval of USAID.

PERU

PVO FAMILY PLANNING SERVICE EXPANSION PROJECT

527-0335

VII. ANNEXES

ANNEX I

- Exhibit A: PROJECT STATUTORY CHECKLIST
- Exhibit B: CABLES RELATING TO AID/W PID REVIEW
- Exhibit C: GOVERNMENT OF PERU CONCURRENCE
- Exhibit D: ENVIRONMENTAL THRESHOLD DECISION
- Exhibit E: JUSTIFICATION FOR WAIVER OF 25 PERCENT CONTRIBUTION REQUIREMENT
- Exhibit F: JUSTIFICATION OF NONCOMPETITIVE AWARD

ANNEX II

- Exhibit A: LOGICAL FRAMEWORK
- Exhibit B: ILLUSTRATIVE LIST OF COMMODITIES
- Exhibit C: CONSOLIDATED PROJECT BUDGET BY INPUTS, PROJECT YEARS, AND PROJECT COMPONENTS
- Exhibit D: CONTRIBUTORS TO THE PROJECT PAPER

ANNEX III

- Exhibit A: REVIEW OF PRIVATE SECTOR FAMILY PLANNING PROJECT (527-0269)
- Exhibit B: INSTITUTIONAL ANALYSES OF SIX PARTICIPATING FAMILY PLANNING FVOS
- Exhibit C: INSTITUTIONAL ANALYSIS OF PRISMA
- Exhibit D: ECONOMIC ANALYSIS
- Exhibit E: FINANCIAL ANALYSIS

PROJECT STATUTORY CHECKLIST

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded with Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 1989 Appropriations Act Sec. 523; FAA Sec. 634A. If money is sought to obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified?
2. FAA Sec. 611(a)(1). Prior to an obligation in excess of \$500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?
3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

Congressional Notification for the project was sent on July 24, 1989, and expired on August 7, 1989. Technical Notification was sent on September 7, 1989, and expired on September 21, 1989.

- (a) YES
(b) YES

No legislative action by Peru is required.

4. FAA Sec. 611(b); FY 1989 Appropriations Act Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) N/A
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? N/A
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. No
7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to:
(a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.
(a) Yes - may increase demand of Peruvians for US made contraceptives
(b) Yes - will increase ability of local PVOs to engage in marketing
(c) No
(d) Yes - will increase market competition
(e) Yes - will improve PVO efficiency
(f) N/A
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).
The project will use US-made contraceptives and, by helping develop the market for such supplies, encourage manufacturers to trade and invest abroad in contraceptives.

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9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars. Government of Peru is not a direct participant in the project. Local PVOs will contribute their own resources to extent possible.
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No
11. FY 1989 Appropriations Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A
12. FY 1989 Appropriations Act Sec. 549. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel? No
13. FAA Sec. 119(q)(4)-(6) & (10). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other (a) No
(b) No

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- wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?
- (c) No
(d) No
14. FAA Sec. 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)?
- N/A
15. FY 1989 Appropriations Act. If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?
- N/A
16. FY 1989 Appropriations Act Sec. 538. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?
- Yes
Yes
17. FY 1989 Appropriations Act Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has prior approval of the Appropriations Committees of Congress been obtained?
- N/A
18. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).
- These actions will be taken after the Cooperative Agreement has been signed.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FY 1989 Appropriations Act Sec. 548
(as interpreted by conference report
for original enactment). If
assistance is for agricultural
development activities (specifically,
any testing or breeding feasibility
study, variety improvement or
introduction, consultancy,
publication, conference, or
training), are such activities (a)
specifically and principally designed
to increase agricultural exports by
the host country to a country other
than the United States, where the
export would lead to direct
competition in that third country
with exports of a similar commodity
grown or produced in the United
States, and can the activities
reasonably be expected to cause
substantial injury to U.S. exporters
of a similar agricultural commodity;
or (b) in support of research that is
intended primarily to benefit U.S.
producers?

N/A

b. FAA Secs. 102(b), 111, 113, 281(a).
Describe extent to which activity
will (a) effectively involve the poor
in development by extending access to
economy at local level, increasing
labor-intensive production and the
use of appropriate technology,
dispersing investment from cities to
small towns and rural areas, and
insuring wide participation of the
poor in the benefits of development
on a sustained basis, using
appropriate U.S. institutions;
(b) help develop cooperatives,
especially by technical assistance,
to assist rural and urban poor to
help themselves toward a better life,
and otherwise encourage democratic
private and local governmental

(a) Project will assist
6 family planning PVOs
to offer subsidized
services and goods to
people who cannot afford
to pay commercial prices.
Through collaboration
with MOH, the project
will increase the
availability of services
in rural areas.

(b) N/A

- institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.
- c. FAA Secs. 103, 103A, 104, 105, 106, 120-21; FY 1989 Appropriations Act (Development Fund for Africa). Does the project fit the criteria for the source of funds (functional account) being used?
- d. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?
- e. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?
- f. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?
- (c) Project will assist local non-profit organizations to improve their capacity to deliver family planning
- (d) Gender-disaggregated targets will be developed for project participants and beneficiaries.
- (e) N/A
- Yes
- Yes
- Cost-sharing requirement will be waived by Mission Director for first year of project.
- Yes - the beneficiaries of increased institutional capabilities of the PVOs are those people who cannot afford to pay commercial prices for contraception. Marketing studies will monitor project progress.

g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.

The majority of Peruvian women do not want more children, and one third of all births are unmarked. The project will assist Peruvians to have the children they want by improving the capability of PVOs and their staff to deliver high quality, low-cost family planning services. In some degree the same skills are needed to participate in processes essential to self-Government.

h. FY 1989 Appropriations Act Sec. 536. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?

Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?

No

No

Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

No

i. FY 1989 Appropriations Act. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization?

No

If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services?

No

j. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes

k. FY 1989 Appropriations Act. What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

N/A. The only non-Peruvian firms to be used will be procured through buy-in procedures to AID/W projects, some of which may be administered by 8-A firms.

l. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been degraded by helping to increase

An IEE was carried out during the preparation of the PID and a negative determination made by the Mission Director. The Environmental Threshold Decision was reviewed and the Negative Determination approved by the LA Bureau Environmental Officer.

- (a) N/A
- (b) N/A
- (c) N/A
- (d) N/A
- (e) N/A

production on lands already cleared or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) utilize the resources and abilities of all relevant U.S. government agencies?

(f) N/A
(g) N/A
(h) N/A
(i) N/A
(j) N/A
(k) N/A

m. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity?

N/A

- n. FAA Sec. 118(c)(14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas?
- (a) N/A
- (b) N/A
- o. FAA Sec. 118(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; or (d) the construction of dams or other water control structures which flood relatively undegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?
- (a) N/A
- (b) N/A
- (c) N/A
- (d) N/A
- p. FY 1989 Appropriations Act. If assistance will come from the Sub-Saharan Africa DA account, is it (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) being provided in accordance with the policies contained in section 102 of the FAA;
- N/A

(c) being provided, when consistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (d) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups; (e) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

- q. FY 1989 Appropriations Act Sec. 515. If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same general region as originally obligated, and have the Appropriations Committees of both Houses of Congress been properly notified?

N/A

2. Development Assistance Project Criteria
(Loans Only)

- a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

N/A

- b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

N/A

- c. FAA Sec. 122(b). Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

N/A

3. Economic Support Fund Project Criteria

- a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA? N/A
- b. FAA Sec. 531(e). Will this assistance be used for military or paramilitary purposes? No
- c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? N/A

ANNEX I Exhibit B

CABLES RELATING TO AID/W PID REVIEW

The following cables relating to AID/W review and approval of the PID and instructions to go on to PP preparation and project authorization/obligation are provided in this Annex.

<u>Cable Number</u>	<u>Date</u>	<u>Subject</u>
STATE 133475	April 28, 1989	Peru Private Voluntary Family Planning Service Expansion Project (527-0335), PID
LIMA 10729	July 21, 1989	Peru, Private Voluntary Family Planning Service Expansion Project (527-0335), PID
STATE 265276	August 18, 1989	Semi-Annual Portfolio Review for Peru
LIMA 12914	September 1, 1989	Peru Private Voluntary Family Planning Service Expansion Project (No. 527-0335) - Request for PID Approval
STATE 290998	September 12, 1989	Peru Private Voluntary Family Planning Service Expansion Project (No. 527-0335) - PID Approval
STATE 293926	September 14, 1989	Peru Private Voluntary Family Planning Service Expansion Project (No. 527-0335) - Congressional Notification.

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STATE 133475/01

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ACTION: AID-2 INFO: AMB DCM ECON

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 I MUIHPE
 DE RUEHC #3475/01 1180604
 ZNR UUUUU ZZH
 R 280003Z APR 89
 FM SECSTATE WASHDC
 TO AMEMBASSY LIMA 5704
 BT
 UNCLAS SECTION 01 OF 02 STATE 133475

RECEIVED
 MAIL ROOM
 APR 28 1989
 USAID/LIMA

28-APR-89

TOR: 06:13
 CN: 23281
 CYRG: AID
 DIST: AID
 ADD:

ACTION: POP (FILES)
 INFO: HR
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AIDAC

E.C. 12356: N/A

TAGS:

SUBJECT: PERU PRIVATE VOLUNTARY FAMILY PLANNING SERVICE EXPANSION PROJECT (527-0335), PID

1. THE REVIEW OF SUBJECT PID WAS CHAIRED BY T. BROWN, DIRECTOR LAC/DR, ON APRIL 13, 1989. THE MISSION WAS REPRESENTED BY J. PURDICK. PID APPROVAL WAS DEFERRED PENDING LAC RECEIPT AND REVIEW OF THE INFORMATION NOTED IN PARAGRAPHS THREE BELOW. FOLLOWING ARE THE RESULTS OF THE PID REVIEW MEETING WITH BUREAU GUIDANCE.

2. ISSUE: IS IT NECESSARY OR APPROPRIATE TO HAVE THIS OTHER COMPLEX IMPLEMENTATION ARRANGEMENT?

DISCUSSION: THE MANAGEMENT AND MONITORING OF THIS PROJECT INVOLVES A USDH PROJECT SUPERVISOR, A ONE-HALF TIME PROJECT-FUNDED PSC PROJECT MANAGER, A CORE MANAGEMENT ENTITY (AND THE TWO-PERSON TECHNICAL TEAM) AND APPROXIMATELY FIVE PVOS WHO WILL PROVIDE FAMILY PLANNING SERVICES. THE POSSIBLE COORDINATION DIFFICULTIES BETWEEN AND AMONG THE VARIOUS PVOS AND MISSION STAFF UNDER THIS ARRANGEMENT APPEAR TO BE GREATER THAN THEY WOULD BE UNDER OTHER IMPLEMENTATION

ALTERNATIVES. THE COMPLICATED IMPLEMENTATION ARRANGEMENTS PROVIDE NUMEROUS OPPORTUNITIES FOR DELAYED START UP AND SLOW IMPLEMENTATION. THE MISSION REPRESENTATIVE STATED THAT MISCELLANEOUS CONSTRAINTS (E.G., STAFFING LEVEL, OE FUNDING, BROOKS SANCTIONS) HAVE ALL LIMITED THE IMPLEMENTATION OPTIONS SO THAT THE PROPOSED ALTERNATIVE IS THE MOST VIABLE METHOD.

DECISION: DURING THE REVIEW MEETING THE BUREAU STATED ITS POSITION THAT A.I.D. DIRECT GRANTS TO PVO'S WERE THE PREFERRED METHOD OF IMPLEMENTATION. A SECOND BEST OPTION WAS A BUY-IN TO A CENTRALLY FUNDED ORGANIZATION SUCH AS THE POPULATION COUNCIL WHICH WOULD HAVE PRIMARY IMPLEMENTATION RESPONSIBILITY VIS-A-VIS LOCAL PERUVIAN PVO'S. REGARDLESS OF THE MISSIONS FINAL DECISION AS TO METHOD OF IMPLEMENTATION, THE PROJECT PAPER SHOULD INCLUDE IN THE ANALYSIS 1) A THOROUGH REVIEW OF ALL IMPLEMENTATION OPTIONS; 2) A REVIEW OF THE IMPACT OF

PERU CONTINUING UNDER SANCTIONS AND WHETHER THE PROPOSED IMPLEMENTATION ARRANGEMENTS CAN ACCOMMODATE THIS SITUATION, ESPECIALLY WITH REGARD TO THE ELIGIBILITY OF THE IMPLEMENTING ORGANIZATIONS UNDER FAA 123(E) (MISSION SHOULD CONSULT WITH RLA AND GC/LAC ON THIS POINT); 3) A FULL DESCRIPTION OF THE ROLES AND RESPONSIBILITIES OF EACH IMPLEMENTING ORGANIZATION AS WELL AS AN INSTITUTIONAL ANALYSIS OF THEIR TECHNICAL AND ADMINISTRATIVE CAPABILITY AND EXPERIENCE IN FILLING THESE ROLES AND RESPONSIBILITIES; AND 4) A THOROUGH DISCUSSION OF TYPES, AMOUNTS AND METHODS OF IMPLEMENTATION OF ALL BUY-INS TO CENTRALLY-FUNDED PROJECTS.

THE LAC BUREAU STRONGLY URGES THE MISSION TO RECONSIDER THE OPTION OF A.I.D. DIRECT GRANTS TO FAMILY PLANNING SERVICES PVOS WITH PROJECT MANAGEMENT BEING DONE IN THE MISSION. MISSION SHOULD ALSO CAREFULLY REVIEW AGENCY POLICY ON FUNDING PSCS FROM PROJECT ACCOUNTS, ESPECIALLY SINCE PROPOSED PSC WAS DESCRIBED BY THE MISSION REPRESENTATIVE AS THE PROJECT MANAGER FOR THIS NEW PROJECT.

2. ISSUE: ARE THERE ADEQUATE POP FUNDS WITHIN THE OYE TO FUND THIS PROJECT AT THIS HIGHER LOP FUNDING LEVEL?

DISCUSSION: THE MISSION ARGUED DURING THE FY 90/91 ACTION PLAN REVIEW THAT DUE TO LIMITED POP FUNDS BEING AVAILABLE FOR FAMILY PLANNING ACTIVITIES, CS FUNDS SHOULD BE USED TO FUND FAMILY PLANNING ACTIVITIES IN THE

CHILD SURVIVAL ACTION (CSA) PROJECT. GUIDANCE (STATE 123124) RESULTING FROM THE AP REVIEW DIRECTED THE MISSION TO EXAMINE THE POPULATION ACCOUNT TO DETERMINE THE FEASIBILITY OF IMPLEMENTING TWO NEW FAMILY PLANNING PROJECTS IN FY 89, IN THE ABSENCE OF FUNDING BEYOND THE \$2.3 MILLION IN POP FUNDS AVAILABLE FOR PROGRAMMING DURING THE FY 88-91 PERIOD. AID/W IS NOT AWARE OF THE OUTCOME OF SAID, EXAMINATION, YET THE MISSION HAS PROPOSED A \$6.3 MILLION PROJECT WHILE ONLY A \$5.0 MPD WAS APPROVED. A RELATED ISSUE CONCERNS THE TYPES OF FAMILY PLANNING ACTIVITIES FUNDED UNDER CSA (STERILIZATION, IUD-INSERTIONS) AND WHETHER THEY SHOULD, IN FACT, BE FUNDED USING CHILD SURVIVAL FUNDS.

DECISION: LAC BUREAU WILL NOT APPROVE SUBJECT PID UNTIL IT HAS RECEIVED THE REQUESTED FUNDING ANALYSIS AND CONCURRED IN SAME. THE FUNDING ANALYSIS SHOULD SHOW 1) THE PROPOSED LIFE OF PROJECT AND LOP FUNDING FOR ALL ACTIVITIES IN THE HEALTH, CHILD SURVIVAL, AND POPULATION ACCOUNTS, 2) A CONSOLIDATED BUDGET FOR FISCAL YEARS 89, 90, AND 91, AND 3) THE RATIONALE FOR USING THE PARTICULAR

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FUNDING SOURCE(S) FOR EACH PROJECT.

IT WOULD BE VERY HELPFUL IF LOCAL CURRENCY CONTRIBUTIONS, EITHER BY GOP OR OTHER DONORS, FOR EACH PROJECT BY YEAR AND SOURCES WERE INCLUDED.

4. THE ISSUES MEETING HELD ON APRIL 7, 1989 REACHED CLOSURE ON THE FOLLOWING TWO ISSUES.

A. ISSUE: IS THERE A BALANCED APPROACH TO FAMILY PLANNING ACTIVITIES THROUGH THE THREE PLANNED ACTIVITIES (PVO, COMMERCIAL, AND PUBLIC SECTOR) BEING IMPLEMENTED BY THE MISSION?

DECISION: ALTHOUGH THE PVO FAMILY PLANNING ACTIVITIES ARE NOT PLANNED TO ACHIEVE THE CONTRACEPTIVE PREVALENCE OF THE OTHER TWO APPROACHES, AND WILL BE MORE COSTLY THAN THOSE ACTIVITIES, THE UNIQUENESS OF THE PROJECT HAS SEVERAL ADVANTAGES. THE PVO PROJECT WILL PROVIDE LONGER TERM METHODS AND WORK IN RURAL AREAS (MOST FAMILY PLANNING ACTIVITIES ARE NOW FOCUSED IN URBAN AREAS). DURING DESIGN OF THE PP, SPECIAL ATTENTION SHOULD BE TAKEN IN THE ANALYSIS OF HOW PVO ENHANCEMENT THROUGH MANAGEMENT IMPROVEMENT, ETC. WILL ALLOW A GREATER RETURN PER DOLLAR SPENT (COST EFFECTIVENESS) AND EMPHASIZE THE ECONOMIC BENEFITS DERIVED FROM USE OF LONGER TERM

METHODS. THE ECONOMIC ANALYSIS SHOULD ALSO COMPARE COST PER COUPLE YEARS OF PROTECTION ACHIEVED BY PVO ACTIVITIES AND THE CSM PROGRAM. THE PP SHOULD ALSO INCLUDE INFORMATION ON OTHER DONOR EFFORTS IN FAMILY PLANNING, INCLUDING A DISCUSSION OF RESOURCE LEVELS AND THE TYPES OF ACTIVITIES UNDERTAKEN.

B. ISSUE: CAN THE RELATIVELY WEAK FAMILY PLANNING SERVICES PVOS ACHIEVE SUSTAINABILITY DURING THE PROJECT?

DECISION: THE PVOS MAY NOT ATTAIN FULL SELF-SUFFICIENCY DURING THE PROJECT, BUT BY THE END OF THE PROJECT IT IS EXPECTED THAT VIRTUALLY ALL OF THE NON-COMMODITY COSTS WILL BE COVERED BY THE PVOS. THE ASSISTED PVOS DEMONSTRATE VARYING DEGREES OF INEFFICIENCY IN THEIR USE OF RESOURCES (IN A LARGE PART DUE TO EXCESS UNUSED CAPACITY). THE INTENT OF THE PROJECT IS TO BOLSTER THESE PVOS BY PROVIDING TA TO IMPROVE MANAGEMENT CAPABILITY THUS IMPROVING THEIR CASH FLOW AND OTHER INDICATORS OF IMPROVED FINANCIAL MANAGEMENT. AS A PART OF PP DESIGN THE MISSION WILL DO ANNUAL PROJECTIONS/TARGETS FOR EACH PVO'S IMPROVEMENT IN FINANCIAL STATUS. ANNUAL FINANCIAL TARGETS AND COVERAGE TARGETS FOR EACH FAMILY PLANNING SERVICE PVO WILL BE DEVELOPED AND AGREED TO BY THEM. IN ADDITION, A MID-PROJECT EVALUATION WILL COMPARE THE PVO'S SITUATION TO PROJECTIONS.

UNCLASSIFIED STATE 133475/02

5. ADDITIONAL GUIDANCE - TO ENSURE COMPLIANCE OF STERILIZATION ACTIVITIES WITH PERUVIAN LAW, FURTHER DESCRIPTION OF THE LEGAL CRITERIA FOR STERILIZATION IN LRU SHOULD BE INCLUDED IN THE PP AS WELL AS HOW THE PROJECT WILL BE MONITORED TO ENSURE OBSERVANCE OF THESE CRITERIA. ADDITIONALLY, THE PROJECT SHOULD INCLUDE FUNDS FOR CLIENT SATISFACTION SURVEYS (SUCH AS THOSE CARRIED OUT IN LAC BY AVSC) BY A REPUTABLE, PREFERABLY U.S., ORGANIZATION TO ENSURE STERILIZATION IS VOLUNTARY AND MEETS PERUVIAN LEGAL REQUIREMENTS. BAKER

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LIMA 01029/01

ORIGIN: AID-2 INFO: AMB DGM EC0N

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FP RUEHC
DE RUEHPI #0729/01 202 **
ZNR UUUUU ZZH
P 212015Z JUL 89
FM AMEMBASSY LIMA
TO SECSTATE WASHDC PRIORITY 0371
BT
UNCLAS SECTION 01 OF 06 LIMA 10729

CLASS: UNCLASSIFIED
CHRG: AID 07/17/89
APPRV: AD:ASILVA
DRFTD: POP:JBURDICK
CLEAR: 1.POP:CN 2.AI
3.CONT:PK 4.F
DISTR: AID

AIDAC

FOR LAC/DR AND LAC/SAM

F.O. 12356: N/A

SUBJECT: PERU, PRIVATE VOLUNTARY FAMILY PLANNING SERVICE
- EXPANSION PROJECT (527-0335), PID

RFF: A) STATE 133475
- B) LIMA 07667
- C) STATE 202412
- D) LIMA 8652
- E) STATE 200349
- F) STATE 245761 (1987)

1. REF A INDICATED THAT OVERALL DESIGN, CONCEPTUAL FRAMEWORK, AND PHILOSOPHY OF SUBJECT PROJECT HAD BEEN APPROVED AND THAT OFFICIAL PID APPROVAL HAD BEEN DEFERRED PENDING MISSION COMMENTS ON TWO SALIENT ISSUES: POPULATION PORTFOLIO FUNDING AND IMPLEMENTING ARRANGEMENTS. WE ARE APPRECIATIVE OF LAC'S SUPPORT AND HAVE SPENT THE LAST TEN WEEKS ATTEMPTING TO EXPLORE FUNDING AND IMPLEMENTATION ALTERNATIVES, WHILE ADVANCING TO THE PP DESIGN STAGE (SO AS NOT TO DELAY UNDULY PROJECT AUTHORIZATION/OBLIGATION). FUNDING CONSIDERATIONS BECAME COMPLICATED IN APRIL WHEN WE RECEIVED WORD (AS INDICATED R/F B) THAT WE WOULD NOW HAVE TO FUND WHAT WERE PREVIOUSLY CENTRALLY-FUNDED CONTRACEPTIVES FROM WITHIN OUR OYB. WITH NO DEFINITIVE WORD FROM AID/W ON WHETHER SST OR LAC FUNDS COULD ASSIST IN COVERING CONTRACEPTIVE PROCUREMENT, WE HAVE HAD TO INCLUDE SUCH PROCUREMENT WITHIN AN ADMITTELY ALREADY TIGHT POPULATION OYB ACCOUNT.

2. IN OUR DESIGN, WE HAVE UNDERTAKEN A TRUE COLLABORATIVE EFFORT WITH LOCAL PVO'S, SOLICITING THEIR IDEAS/INPUT IN WORKSHOPS AND ACTIVELY INVOLVING THEM IN DESIGN WORK FOR SUBJECT PROJECT. AS A RESULT OF THESE MEETINGS, WE HAVE DEVELOPED AN ALMOST FINAL DRAFT OF A PP WHICH CALLS FOR PRISMA (A LOCAL PVO, WITH EXCELLENT MANAGEMENT AND FINANCIAL CAPACITIES PROVEN UNDER THREE ON-GOING OPG'S) AS THE LEAD ORGANIZATION THROUGH WHICH WE SHALL ASSIST OTHERS. WE HAVE ALSO INCORPORATED THOSE DESIGN RECOMMENDATIONS MADE IN REF A, PARA 4.

3. THE FOLLOWING INFORMATION IS PROVIDED IN RESPONSE TO

THE TWO ISSUES WHICH SURFACED IN REF A DURING REVIEW OF SUBJECT PID.

4. ISSUE: IS IT NECESSARY OR APPROPRIATE TO HAVE THIS RATHER COMPLEX IMPLEMENTATION ARRANGEMENT?

A. IMPLEMENTATION MODALITY.

(1) THE MISSION HAS DETERMINED THAT BECAUSE OF THE MANY MISCELLANEOUS CONSTRAINTS WHICH BURDEN PROJECT DESIGN AND IMPLEMENTATION IN PERU (E.G., STAFFING LEVELS, OF FUNDING AND OYB LEVELS, S200 AND BROOKE SANCTIONS, ETC.)

THE IMPLEMENTATION METHOD PROPOSED IN THE PID IS NOT ONLY THE MOST VIABLE ALTERNATIVE; BUT INDEED IS THE ONLY OPTION CURRENTLY AVAILABLE. WE INTEND TO HAVE A US PSC AS PROJECT MONITOR/COORDINATOR/FACILITATOR IN THE USAID POPULATION DIVISION WHO WILL WORK EXCLUSIVELY ON THIS AND THE COMMERCIAL SECTOR PROJECT -- AND THUS BE FUNDED (50/50) BY THOSE PROJECTS.

(2) SECONDLY, PRISMA --- A LOCAL PVO WHICH HAS EXCELLENT MANAGEMENT/ADMINISTRATIVE CAPABILITY AND EXPERIENCE IN WORKING WITH USAID --- WILL IMPLEMENT SUBJECT PROJECT THROUGH A TWO-PERSON TECHNICAL UNIT (AN ADMINISTRATION/MANAGEMENT SPECIALIST AND A TRAINING/PROGRAM/EVALUATION SPECIALIST). PRISMA WILL BE RESPONSIBLE FOR PROVIDING FUNDS AND CONTRACEPTIVE COMMODITIES TO PVO'S IN THE PROJECT, WILL PROCURE (THROUGH CENTRAL BUY-IN'S) CONTRACEPTIVES FOR PUBLIC AND PRIVATE ENTITIES, TRACKING AND ACCOUNTING FOR SAME.

(3) THIS IMPLEMENTATION MODE AND THE INCLUSION OF PVO'S IN (AND THEIR COMMITMENT TO) PROJECT DESIGN AND MANAGEMENT MODALITIES AUGURS WELL FOR EXPEDITIOUS START UP AND SMOOTH IMPLEMENTATION. (FYI. THE CURRENT PROJECT ENDS SEPTEMBER 30, 1989, WITH THE PATHFINDER PROJECT OFFICE IN LIMA ALREADY IN THE LAST STAGES OF PHASING-OUT.)

B. OTHER OPTIONS.

(1) AS REQUESTED BY LAC/DR IN REF A, THE PROJECT PAPER INCLUDES A THOROUGH REVIEW OF IMPLEMENTATION OPTIONS. THIS REVIEW CONCLUDES THAT DIRECT OPG'S HAVE BEEN PRECLUDED BY THE FINANCIAL AND MANAGEMENT BURDEN IMPLIED

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IN CREATING SIX NEW MANAGEMENT UNITS EACH WITH MONI- ADVANCES AND LIQUIDATIONS, AS WELL AS STAFFING CONSEQUENCES, COORDINATION OF SECTOR FP EFFORTS, AND CONSOLIDATED ACCOUNTING FOR CONTRACEPTIVE COMMODITIES. OVERALL PROJECT MANAGEMENT WILL BE CARRIED OUT IN THE MISSION AS IT ALWAYS IS, BUT THE DOCUMENTATION AND MANAGEMENT RESPONSIBILITIES REQUIRED FOR A.I.D. DIRECT GRANTS TO SIX DIFFERENT FAMILY PLANNING PVOs ARE SIMPLY TOO LABOR-INTENSIVE TO BE ACCOMMODATED BY AVAILABLE USAID STAFF.

(2) THE REVIEW ALSO REFERS TO OUR EXPERIENCE THUS FAR WITH BUYING IN TO A CENTRALLY FUNDED ORGANIZATION. THIS WOULD MEAN LESS FINANCIAL ACCOUNTABILITY BY THE INTERMEDIARY THEN WE DEEM ADEQUATE, A LOSS OF LOCAL CONTROL AND IMMEDIATE RESPONSIVENESS TO UNIQUELY PERUVIAN SENSITIVITIES, AND TRYING TO FIT OUR PROJECT INTO A CENTRAL BUY-IN, RATHER THAN SELECTIVELY USING SUCH BUY-INS TO SUPPLY CERTAIN COMPONENTS OF A PROJECT TAILORED TO THE PERUVIAN REALITY.

C. SANCTIONS AND IMPLEMENTATION MODE.

THE PP REVIEWS THE IMPACT OF PERU CONTINUING UNDER SANCTIONS AND HOW THE PROPOSED IMPLEMENTATION ARRANGEMENT CAN ACCOMMODATE THIS SITUATION. WE HAVE SUBMITTED A SECTION 123(E) CERTIFICATION REQUEST TO CONTINUE ASSISTANCE WITH PRISMA, A LOCAL REGISTERED PVO, WHICH CURRENTLY MAINTAINS THREE OPG'S WITH USAID IN THE MATERNAL CHILD/HEALTH, NUTRITION, AND FOOD FOR DEVELOPMENT FIELDS. PRISMA HAS BEEN INTEGRATING FAMILY PLANNING INTO ITS USAID MCH AND SUPPLEMENTAL FEEDING PROGRAM WITH THE MINISTRY OF HEALTH. IT WILL SERVE AS "PASS THROUGH" AND TECHNICAL/MANAGERIAL UNIT FOR SOME PVOs ALREADY RECEIVING ASSISTANCE UNDER THE FAMILY PLANNING PROJECT. ITS EXPANSION INTO THE FAMILY PLANNING REALM IS A LOGICAL EXPANSION OF ITS MCH AND CHILD SURVIVAL ACTIVITIES. THE CRITICAL NEXUS TEST OF 123 (E) IS THUS FULFILLED.

D. IMPLEMENTATING AGENCY INTERACTION.

A FULL DESCRIPTION OF IMPLEMENTING ROLES AND RESPONSIBILITIES OF PRISMA VIS-A-VIS OTHER PVO BENEFICIARIES/IMPLEMENTING IS INCLUDED IN THE PP. THE PP WILL ALSO ANALYZE EACH INSTITUTION'S TECHNICAL AND ADMINISTRATIVE CAPABILITY, AS WELL AS PREVIOUS EXPERIENCES WITH SUCCESSFULLY ACCOUNTING FOR AND MANAGING AID-PROVIDED FUNDS.

E. CENTRAL BUY-IN'S.

AS NO BUY-INS TO CENTRALLY-FUNDED PROJECTS ARE ANTICIPATED, REF (A) REQUEST FOR A THOROUGH DISCUSSION DOES NOT APPLY. IN LIGHT OF NEED TO INCLUDE PREVIOUSLY CENTRALLY-FUNDED CONTRACEPTIVE PROCUREMENT WITHIN OUR OYB (NOT ORIGINALLY FORESEEN WHEN THE PID WAS PREPARED), WE DO, NOW, PROJECT THE NEED FOR CENTRALLY-PROCURED

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CONTRACEPTIVE BUY-INS; SUCH WILL BE EXECUTED BY PROJECT-FUNDED PIO/C'S AUTHORIZED BY PRISMA, WHICH WILL CALL FORWARD, RECEIVE, ARRANGE FOR STORAGE, INVENTORY, AND TRACK SUCH COMMODITIES. IN KEEPING WITH OUR SUSTAINABILITY OBJECTIVE, PRISMA WILL ALSO ENSURE THAT PVOS RECEIVING SUCH CONTRACEPTIVES PROVIDE THEM TO CLIENTS AT LEAST AT COST. (FYI. FREE OR HIGHLY SUBSIDIZED DISTRIBUTION CURRENTLY SUPPORTED BY IPPT AND INPPARES WILL BE ELIMINATED).

F. FUNDING PSCS FROM PROJECT ACCOUNTS.

IN ITS DECEMBER 1987 STAFFING REDUCTION PLAN, AT THE REQUEST OF LAC, USAID REVIEWED EACH OF FUNDED POSITION AND AS APPROPRIATE, TRANSFERRED PERSONNEL TO PROJECT FUNDING. WE ARE UTILIZING THE SAME CRITERIA --- REVIEWED AND FOUND ACCEPTABLE TO LAC IN DECEMBER 1987 --- FOR THE TWO NEW POSITIONS ESTABLISHED IN THE POPULATION DIVISION TO PROVIDE MONITORING, COORDINATION, AND SUPPORT SERVICES TO THE PVO AND COMMERCIAL SECTOR FAMILY PLANNING PROJECTS. MISSION'S COMMITMENT TO REDUCED CE-FUNDED POSITION LEVELS MITIGATES AGAINST OE-FUNDED POSITION(S).

5. ISSUE: ARE THERE ADEQUATE POP FUNDS WITHIN THE OYB TO FUND THIS PROJECT AT THIS HIGHER LEVEL LOP FUNDING LEVEL?

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A. PVO PROJECT LOP EXTENDED WITH NO ADDITIONAL MORTGAGE.

ANY ANALYSIS OF POP ACCOUNT FUNDING SHOULD RECOGNIZE USAID'S EFFORTS TO TERMINATE ITS CURRENT EXPENSIVE PVO PROJECT (HIGH OVERHEAD AND ADMINISTRATIVE COSTS) AND REPLACE IT WITH A MORE COST EFFICIENT AND FOCUSED PROJECT WHICH WILL OPERATE WITH NO ADDITIONAL MORTGAGE OVER A TWO YEAR LONGER PERIOD THAN THE ORIGINAL PROJECT NOW BEING PHASED OUT (8.322 MILLION LOP). THE NEW PROJECT WAS PROPOSED IN THE PID FOR A USDOL 6.3 MILLION LOP; HOWEVER, THE NEED TO ACCOUNT FOR PREVIOUSLY CENTRALLY-FUNDED CONTRACEPTIVES WITHIN OUR OYB REQUIRED ADDING USDOL 2 MILLION TO THE PROJECT FOR FIVE YEARS WORTH OF CONTRACEPTIVES FOR INPPARES. PLEASE NOTE THAT WERE IT NOT NECESSARY TO FUND ADDITIONAL CONTRACEPTIVES, THE OVERALL LOP COSTS WOULD HAVE BEEN REDUCED BY USDOL 2 MILLION.

B. EFFORTS ALREADY TAKEN TO SUPPLEMENT POP ACCOUNT OYB.

SINCE APRIL WE HAVE UNDERTAKEN A VARIETY OF EFFORTS TO INCREASE OUR USDOL 2.06 MILLION OYB IN POPULATION. BY REF (C), WE SWAPPED DOLS 177,018 CS FOR POP FUNDS WITH S&T. BY REF (D), WE SOUGHT TO DEOB DOLS 337,000 IN POPULATION LOAN FUNDS; HOWEVER, REF (E) INDICATED THAT SUCH FUNDS COULD ONLY BE USED FOR HEALTH LOAN REOBLIGATION, EFFECTIVELY PRECLUDING ITS USE. WE HAVE ALSO IDENTIFIED USDOL 103,000 IN DEOB/REOB FROM PD&S AND INTEGRATED HEALTH AND FAMILY PLANNING PROJECTS WHICH AID/W HAS CONFIRMED FOR REOB TO THE PVO FAMILY PLANNING PROJECT. WE HAVE TRIED OUR BEST TO SCRAPE UP ALL AVAILABLE DOLLARS FOR OUR POPULATION ACTIVITIES.

C. PROPOSED LIFE OF PROJECT AND LOP FUNDING.

- (1) OPCA APROPO: PRIVATE COMMERCIAL SECTOR FAMILY PLANNING (527-0326)
LIFE OF PROJECT: FOUR YEARS
LOP FUNDING: USDOLS 1,900,000
- (2) OPCA PRISMA: PRIVATE VOLUNTARY SECTOR FAMILY PLANNING SERVICE EXPANSION (527-0335)
LIFE OF PROJECT: FOUR YEARS
LOP FUNDING: USDOLS 8,322,000 (INCLUDES USDOLS 2,200,000 CONTRACEPTIVE FOR INPPARES)
- (3) CHILD SURVIVAL ACTION (527-0285)
LIFE OF PROJECT: FIVE YEARS
LOP AMOUNT: USDOLS 19,000,000
- (4) STRENGTHENING PRIVATE SECTOR HEALTH INSTITUTIONS (527-0319)
LIFE OF PROJECT: FOUR YEARS
LOP AMOUNT: USDOLS 7,000,000
- (5) OPG PRISMA: SUPPLEMENTARY FEEDING WITH THE MINISTRY OF HEALTH (527-0323)

(A) USES.

PROJECT NO.
PROJECT TITLE
(LIFE-OF-PROJECT AMT.) FY1989 FY1990 FY1991 FY1992

527-0000
PROGRAM DEVELOPMENT
AND SUPPORT 111 100 100 208

527-0326
PRIVATE COMMERCIAL
SECTOR FAMILY PLANNING
(DOLS 1,900) 500 500 500 400

527-0335
PRIVATE VOLUNTARY
SECTOR FAMILY PLANNING
SERVICE EXPANSION
(DOLS 8,322) 2,230 2,200 2,200 1,692

- DISAGGREGATED, AS FOLLOWS:
- (A) AS PRESENTED IN PID (1,705) (1,650) (1,650) (1,317)
- (B) CONTRACEPTIVES
- PREVIOUSLY
- CENTRALLY FUNDED (525) (550) (550) (375)

TOTAL, POPULATION ACCOUNT 2,841 2,800 2,800 2,300

(B) SOURCES OF FUNDING:

OYB (FY1989: BUDGET
ALLOWANCES RECEIVED /
OTHER FYs: PLANNING LEVELS) 2,238 2,300 2,300 2,300

DEOB/REOB (FROM PD&S AND
INTEGRATED HEALTH/FP) 103 - - -

WITH NO FUNCTIONAL ACCOUNTS,
TRANSFER FROM STRAIGHT-LINED
FY1990 ARW LEVELS (MADE
POSSIBLE BY DEOB REOB TO ATT
IN FY1989) - - 500 -

ADDITIONAL OYB REQUESTED
(FALL-OUT FUNDS) 500 500 - -

(2) HEALTH (H), CHILD SURVIVAL (C), AND AIDS (A)
- ACCOUNTS:

(A) USES

PROJECT NO.
PROJECT TITLE
(LIFE-OF-PROJ. AMT.) FY1989 FY1990 FY1991 FY1992

527-0000
PROJECT DEVELOPMENT
AND SUPPORT - HEALTH 50(H) 50(H) 61.6(H) 400(H)

130

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527-0285

CHILD SURVIVAL
ACTION PROJECT
(DOLS 19,000)

495.6(H) 200(H) 97.4(H) -
2,773(C) 4,000(C) 3,720(C)

527-0319

STRENGTHENING PRIVATE
SECTOR HEALTH INST.
(DOLS 7,000)

- - - 1,000(C)

527-0323

OPG PRISMA
(DOLS 785.521)

150(C) 150(C) 135(C) -

527-0328

OPG ADRA/OFASA
(DOLS 618)

140(C) 140(C) 168.4(C) -

527-0329

OPG-CRS
(DOLS 190)

190(C) - - -

527-0330

OPG-CARE
(DOLS 360)

60(C) 60(C) 61.6(C) -

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527-0336				
OPG CARITAS	-	150(C)	250(C)	250(C)
(DOLS 750)				
527-0333				
HIV-AIDS EDUCATION				
AND PREVENTION	50(H)	50(H)	-	-
(DOLS 500)	100(A)	100(A)	200(A)	-

TOTAL, HEALTH,				
- CHILD SURVIVAL,				
- AND AIDS ACCTS.	4,008.6	4,900	4,694	1,650

(B) SOURCES OF FUNDING:

OIB (FY1989: BUDGET				
ALLOWANCES RECEIVED /				
OTHER FYS:				
PLANNING LEVELS)	3,920	4,900	4,694	1,650
- DISAGGREG.: H	(507)	(300)	(159)	(400)
- C	(3,313)	(4,500)	(4,335)	(1,250)
- A	(100)	(100)	(200)	(-)

DEOB/REOB (FROM PD&S) 88.6(H)

F. RATIONALE FOR USING PARTICULAR FUNDING SOURCE(S) FOR EACH PROJECT:

(1) USAID BELIEVES THIS TO BE SELF EVIDENT WITH THE POSSIBLE EXCEPTION OF THE USE OF CHILD SURVIVAL (CS) FUNDS FOR FAMILY PLANNING ACTIVITIES IN THE CHILD SURVIVAL ACTION PROJECT (CSAP). THE CSAP WAS AUTHORIZED ORIGINALLY TO BE FUNDED EXCLUSIVELY FROM CS AND HEALTH ACCOUNTS; IN CONSONANCE WITH PROGRAMMING GUIDELINES NO FURTHER ACCOUNT (EXCEPT ESF) MAY BE ADDED.

(2) THE FAMILY PLANNING ACTIVITIES COVERED BY CS FUNDS (TOTALING APPROXIMATELY USDOLS 4.3 MILLION) ARE PLANNED FOR TRAINING, PROVISION OF CONTRACEPTIVES, AND RELATED EQUIPMENT. THE MISSION VIEWS FAMILY PLANNING AS A CRITICAL, INTEGRAL ASPECT OF ALL CHILD SURVIVAL PROGRAMS; THE PERU CSAP WAS SPECIFICALLY DESIGNED TO INCLUDE FAMILY PLANNING AS A MAJOR COMPONENT. FUNDING PUBLIC SECTOR FAMILY PLANNING ACTIVITIES UNDER THE CSAP IS JUSTIFIED ON GROUNDS THAT IMPROVING BIRTH SPACING AND REDUCING THE NUMBER OF HIGH-RISK PREGNANCIES CAN SIGNIFICANTLY IMPACT ON CHILD SURVIVAL. USAID BELIEVES IT TO BE BOI FOR FAMILY PLANNING IN CSAPS IN ORDER TO ACCENTUATE THE IMPORTANCE OF FAMILY PLANNING AS A CHILD SURVIVAL MEASURE AND TO DEMONSTRATE AID'S COMMITMENT TO ENSURING THAT FAMILY PLANNING BECOMES AN INTEGRAL PART OF CHILD SURVIVAL ACTION PLANS WORLDWIDE.

(3) NOTE THAT THE PUBLIC SECTOR PROGRAM WILL BE SUPPLEMENTED BY POPULATION FUNDS AUTHORIZED UNDER THIS NEW PRIVATE SECTOR PROJECT. THESE POP FUNDS WILL SUPPORT PVO PARTICIPATION IN AN INNOVATIVE PVO/PUBLIC

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SECTOR PARTNERSHIP IN THE FORM OF AFTER-HOURS PVO FAMILY PLANNING CLINICS IN MOH AND IPSS FACILITIES.)

G. THE BOTTOM LINE.

(1) THE HEALTH, CHILD SURVIVAL, AND AIDS ACCOUNTS ARE WITHIN FY1989 OYB AND PLANNED FUTURE YEAR LEVELS.

(2) USAID FULLY RECOGNIZES PROBLEMS CONNECTED WITH THE POPULATION FUNDING REVIEW OUTLINED ABOVE. THE AMOUNT WE NEED TO DO THE POP/FP JOB IN PERU IS, IN FACT, BAREBONES: THE ABSOLUTE MINIMUM NECESSARY TO CARRY OUT OUR TASK OF HELPING PERU ACHIEVE ITS DEMOGRAPHIC TARGETS IN A REASONABLE TIME FRAME. USAID HAS BEEN ROCKED BY THE RECENT REVELATION THAT APPROXIMATELY 70 PERCENT OF THE CONTRACEPTIVES FOR FAMILY PLANNING IN THE PRIVATE SECTOR --- WHICH WE HAVE ALL ALONG THOUGHT WERE FUNDED UNDER THE IPPE CENTRALLY-FUNDED MATCHING GRANT FROM AID --- SHOULD HAVE BEEN MISSION FUNDED AND MUST BE INCLUDED WITHIN OUR OYB FROM FY 1989 ONWARD. THIS ITEM ALONE HAS INCREASED THE COST OF OUR NEW PRIVATE VOLUNTARY FAMILY PLANNING SERVICE EXPANSION PROJECT BY MORE THAN USDOLS 2 MILLION OVER THE 4-YEAR FUNDING PERIOD.

(3) IN SHORT, TO FINANCE OUR TWO NEW STARTS IN POPULATION, WE NEED AN ADDITIONAL USDOLS 500,000 IN EACH OF FY1989 AND FY1990 IN FALL-OUT POP FUNDS. WERE NO

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FALL-OUT FUNDS TO BE AVAILABLE, WE WOULD REDUCE EACH PROJECT BY USDOLS 500,000 WITH PRIVATE COMMERCIAL FP HAVING AN FY1989 OBLIGATION OF DOLS 100,000 AND PVO FAMILY PLANNING DOLS 2,130,000. WE WOULD ATTEMPT TO MAKE UP THE DOLS 1,000,000 IN PP AMENDMENTS IN FY1990 OR 1991, WHEN DEBT-FOR-DEVELOPMENT CONVERSION RESOURCES AND/OR SINGLE DEVELOPMENT ASSISTANCE ACCOUNT WOULD BECOME AVAILABLE.

7. PER PARA 5, REF (A), THE PP WILL SET OUT PERMISSIBLE STERILIZATION ACTIVITIES WITHIN THE CONFINES OF PERUVIAN LAW AND WILL DESCRIBE HOW THE PROJECT MONITORING WILL ENSURE THAT STERILIZATION IS VOLUNTARY AND MEETS PERUVIAN LEGAL REQUIREMENTS.

8. AS INDICATED IN PARA 2, ABOVE, WE HAVE ALREADY PROCEEDED TO PP PREPARATION, GIVEN THE POSITIVE RESPONSE TO THE PROJECT CONCEPT CONTAINED IN REF A. A FEW ACTIONS REMAIN TO BE FINALIZED. (IMPLEMENTATION AND FUNDING SECTIONS HAVE BEEN PREPARED IN CONSONANCE WITH THIS CABLE.) SECTIONS YET TO BE FULLY COMPLETED INCLUDE FINANCIAL PLAN; DESCRIPTION OF AID/W-CENTRALLY FUNDED PROJECTS; LESSONS LEARNED FROM ON-GOING AND RECENT AID-FINANCED PROJECTS; PROCUREMENT AND DISBURSEMENT PLANS; SUPERVISION, MONITORING, EVALUATION AND FINANCIAL REVIEW/AUDIT PLANS; INSTITUTIONAL AND ECONOMIC ANALYSES AND CONDITIONS PRECEDENT, COVENANTS AND NEGOTIATION STATUS. WE HAVE A U.S. PSC (KAREN FOREIT) WHO WILL BE HELPING US FINALIZE THE PP; IF NECESSARY, WE ARE PREPARED TO USE PD&S FUNDS TO HIRE LOCALLY ANOTHER U.S. PSC TO ASSIST IN COMPLETING THE PP. WE ANTICIPATE AUTHORIZATION BY AUGUST 30. GIVEN PRISMA'S STATUS AS A REGISTERED PVO, WITH THE USE OF SECTION 123(E) AUTHCRITIES, USAID COULD PROCEED IMMEDIATELY TO OBLIGATION AUGUST 30. AT PRISMA'S REQUEST, ON AUGUST 30, USAID WILL ALSO ISSUE A PROJECT-FUNDED PIO/C FOR CONTRACEPTIVE COMMODITIES FOR INPARRES.

9. ACTION REQUESTED.

(A) BASED ON OUR FOREGOING CLARIFICATIONS OF THE TWO ISSUES SURFACED IN THE PID REVIEW, USAID/PERU REQUESTS DAFC APPROVAL OF SUBJECT PID AT A USDOLS 8.372 MILLION LEVEL. SUCH LEVEL WILL INCLUDE CONTRACEPTIVE PROCUREMENT FOR INPARRES (A LOCAL FP PVO) --- PREVIOUSLY CENTRALLY PROVIDED --- THAT NOW MUST BE AUTHORIZED WITHIN THE OYB. WE REQUEST APPROVAL TO PROCEED TO FINALIZE THE PP AND AUTHORIZE THE PROJECT IN THE FIELD.

(B) ADDITIONALLY, PARA 5, REF (F) STATES QUOTE AS A MATTER OF BUREAU POLICY, THE AA/LAC REQUESTS TO BE CONSULTED PRIOR TO SOLICITING PROPOSALS FROM A SINGLE PVO OR RESPONDING TO AN UNSOLICITED PVO PROPOSAL INVOLVING A.I.D. RESOURCES IN EXCESS OF TWO MILLION DOLLARS UNQUOTE. THE CABLE GOES ON TO SAY QUOTE CABLED REQUESTS FOR CONCURRENCE MAY BE TRANSMITTED OUTSIDE OF ACTION PLAN WHEN NECESSARY UNQUOTE. MISSION HEREWITHE REQUESTS AA/LAC CONCURRENCE TO MOVE FORWARD WITH THIS PP

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AND OPERATING PROGRAM COOPERATIVE AGREEMENT WITH PRISMA,
A DULY REGISTERED PERUVIAN PVO, INVOLVING A.I.D.
RESOURCES OF 8.322 MILLION DOLLARS. WATSON

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VZCZCFEI *
 PP RUEHSD
 DE RUEHFF #0729/05 2022020
 ZNR UUUUU ZZH
 P 2120187 JUL 89 ZFL CITE RUEHSD 0615W 2051450
 FM AMEMBASSY LIMA
 TC SECSTATE WASHDC PRIORITY 0375
 BT
 UNCLAS SECTION 05 OF 06 LIMA 10729

CLASS: UNCLASSIFIED
 CHRGF: AID 07/17/89
 APPRV: AD:ASILVA
 DFPTD: POP:JEURODICK:MP:L
 CLEAR: 1.PDF:GN 2.ADD:WR
 3.CONT:PK 4.PROG:
 DISTR: AID

C O R R E C T E D C O P Y (PAPA F. SUBPARA (2) LINE 12)

ATDAC

FDR LAC/DR AND LAC/SAM

E.O. 12356: N/A

SUBJECT: PEFU, PRIVATE VOLUNTARY FAMILY PLANNING SERVICE
 - EXPANSION PROJECT (527-0335), PID

527-0336 DFC CARITAS (DCLS 750)	-	150(C)	250(C)	250(C)
527-0333 HIV-AIDS EDUCATION AND PREVENTION (DCLS 500)	50(H) 100(A)	50(H) 100(A)	- 200(A)	- -

 TOTAL, HEALTH,
 - CHILD SURVIVAL,
 - AND AIDS ACCTS. 4,008.6 4,900 4,694 1,650

(B) SOURCES OF FUNDING:

DYB (FY1989: BUDGET ALLOWANCES RECEIVED / OTHER FYS: PLANNING LEVELS)	3,920	4,900	4,694	1,650
- DISAGGREG.: H	(507)	(300)	(159)	(400)
- C	(3,313)	(4,500)	(4,335)	(1,250)
- A	(100)	(100)	(200)	(-)

DECB/REQB (FROM PDES) 88.6(H)

F. RATIONALE FOR USING PARTICULAR FUNDING SOURCE(S) FOR
 - EACH PROJECT:

(1) USAID BELIEVES THIS TO BE SELF EVIDENT WITH THE POSSIBLE EXCEPTION OF THE USE OF CHILD SURVIVAL (CS) FUNDS FOR FAMILY PLANNING ACTIVITIES IN THE CHILD SURVIVAL ACTION PROJECT (CSAP). THE CSAP WAS AUTHORIZED ORIGINALLY TO BE FUNDED EXCLUSIVELY FROM CS AND HEALTH ACCOUNTS; IN CONSONANCE WITH PROGRAMMING GUIDELINES NO FURTHER ACCOUNT (EXCEPT ESF) MAY BE ADDED.

(2) THE FAMILY PLANNING ACTIVITIES COVERED BY CS FUNDS

Pat. [Signature]

Pat

(TOTALING APPROXIMATELY USDCLS 4.3 MILLION) ARE PLANNED FOR TRAINING, PROVISION OF CONTRACEPTIVES, AND RELATED EQUIPMENT. THE MISSION VIEWS FAMILY PLANNING AS A CRITICAL, INTEGRAL ASPECT OF ALL CHILD SURVIVAL PROGRAMS; THE PERU CSAP WAS SPECIFICALLY DESIGNED TO INCLUDE FAMILY PLANNING AS A MAJOR COMPONENT. FUNDING PUBLIC SECTOR FAMILY PLANNING ACTIVITIES UNDER THE CSAP IS JUSTIFIED ON GROUNDS THAT IMPROVING BIRTH SPACING AND REDUCING THE NUMBER OF HIGH-RISK PREGNANCIES CAN SIGNIFICANTLY IMPACT ON CHILD SURVIVAL. USAID BELIEVES IT TO BE BOTH REASONABLE AND ESSENTIAL TO USE CS FUNDS FOR FAMILY PLANNING IN CSAPS IN ORDER TO ACCENTUATE THE IMPORTANCE OF FAMILY PLANNING AS A CHILD SURVIVAL MEASURE AND TO DEMONSTRATE AID'S COMMITMENT TO ENSURING THAT FAMILY PLANNING BECOMES AN INTEGRAL PART OF CHILD SURVIVAL ACTION PLANS WORLDWIDE.

(3) NOTE THAT THE PUBLIC SECTOR PROGRAM WILL BE SUPPLEMENTED BY POPULATION FUNDS AUTHORIZED UNDER THIS NEW PRIVATE SECTOR PROJECT. THESE POP FUNDS WILL SUPPORT PVO PARTICIPATION IN AN INNOVATIVE PVO/PUBLIC SECTOR PARTNERSHIP IN THE FORM OF AFTER-HOURS PVO FAMILY PLANNING CLINICS IN MDH AND IPSS FACILITIES.)

G. THE BOTTOM LINE.

(1) THE HEALTH, CHILD SURVIVAL, AND AIDS ACCOUNTS ARE WITHIN FY1989 OYB AND PLANNED FUTURE YEAR LEVELS.

(2) USAID FULLY RECOGNIZES PROBLEMS CONNECTED WITH THE POPULATION FUNDING REVIEW OUTLINED ABOVE. THE AMOUNT WE NEED TO DO THE POP/FP JOB IN PERU IS, IN FACT, BAREBONES: THE ABSOLUTE MINIMUM NECESSARY TO CARRY OUT OUR TASK OF HELPING PERU ACHIEVE ITS DEMOGRAPHIC TARGETS IN A REASONABLE TIME FRAME. USAID HAS BEEN SHOCKED BY THE RECENT REVELATION THAT APPROXIMATELY 70 PERCENT OF THE CONTRACEPTIVES FOR FAMILY PLANNING IN THE PRIVATE SECTOR --- WHICH WE HAVE ALL ALONG THOUGHT WERE FUNDED UNDER THE IPPF CENTRALLY-FUNDED MATCHING GRANT FROM AID --- SHOULD HAVE BEEN MISSION FUNDED AND MUST BE INCLUDED WITHIN OUR OYB FROM FY 1989 ONWARD. THIS ITEM ALONE HAS INCREASED THE COST OF OUR NEW PRIVATE VOLUNTARY FAMILY PLANNING SERVICE EXPANSION PROJECT BY MORE THAN USDCLS 2 MILLION OVER THE 4-YEAR FUNDING PERIOD.

(3) IN SHORT, TO FINANCE OUR TWO NEW STARTS IN POPULATION, WE NEED AN ADDITIONAL USDCLS 500,000 IN EACH OF FY1989 AND FY1990 IN FALL-OUT POP FUNDS. WERE NO

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ACTION: AID-2 INFO: CHARGE AQCM/BGEN

NVZCZCPED295
PP RUEHPE
DE RUEHC #5276 2301907
ZNR UUUUU ZZH
P 181904Z AUG 89
FM SECSTATE WASHDC
TO AMEMBASSY LIMA PRIORITY 7401
BT
UNCLAS STATE 265276

USAID
MAIL ROOM
21 AUG 1989
RECEIVED

18-AUG-89 TOR: 21:57
CN: 45801
CHRG: AID
DIST: AID
ADD:

ACTION: PROG (FILES)
INFO: DR-
D
DD

AIDAC

E.O. 12356: N/A

TAGS:

SUBJECT: SEMI-ANNUAL PORTFOLIO REVIEW FOR PERU.

1. (SUMMARY) A SOUTH AMERICA REGIONAL SEMI-ANNUAL REVIEW WAS HELD ON AUGUST 9, 1989. USAID DIRECTOR CRAIG BUCK PARTICIPATED IN THE PERU REVIEW ON BEHALF OF THE MISSION. THANK YOU FOR REDUCING THE LENGTH OF THE SAR DOCUMENT AND SUBMITTING IT IN A TIMELY FASHION. (END SUMMARY)

2. THE FOLLOWING PROJECTS WERE DISCUSSED IN SOME DETAIL:

--A. UPPER HUALLAGA AREA DEVELOPMENT - AID/W NOTES THE EXTREME DIFFICULTY IN CARRYING OUT THIS SENSITIVE PROJECT UNDER CURRENT SECURITY CONDITIONS. NEVERTHELESS, OUR ROLE IN THE USG'S ANTI-NARCOTICS PROGRAM IN PERU IS IMPORTANT IF WE ARE TO MAKE ANY HEADWAY WITH COCA FARMERS ON THE GROUND. AS DISCUSSED IN THE PREVIOUS SAR GUIDANCE CABLE, WITH THE POLITICAL SENSITIVITY OF THIS PROJECT AND CONGRESSIONAL INTEREST IN IT, THE MISSION IS REQUESTED TO CABLE BRIEF QUARTERLY STATUS REPORTS OUTSIDE THE NORMAL SAR CYCLE. DIRECTOR BUCK AGREED THAT THE MISSION WOULD PROVIDE QUARTERLY

CABLE REPORTS ON THE PROJECT STARTING IN JANUARY 1990. LAC/SAM WILL BE RESPONSIBLE FOR DISTRIBUTING THESE REPORTS TO OTHER CONCERNED OFFICES SUCH AS INM, APA AND LEG. THE CABLES SHOULD ADDRESS KEY CHANGES IN PROJECT CONDITIONS, WHAT THE PROJECT IS DOING FOR FARMERS ON ERADICATED LANDS, AND WHAT MAJOR ISSUES SHOULD CONCERN AID/W. DIRECTOR BUCK ALSO INDICATED HIS INTEREST IN REVIEWING AID'S STRATEGY IN THE UPPER HUALLAGA TO SEE IF THERE ARE ANY ALTERNATIVE WAYS TO ADDRESS THE PROBLEMS ON THE GROUND. LAC IS PREPARED TO SUPPORT THE MISSION WITH ASSISTANCE WHEN IT IS READY TO REVIEW AID'S APPROACH TO THE COCA PRODUCTION PROBLEM IN PERU.

-B. PVD FAMILY PLANNING SERVICE EXPANSION- AID/W HAS BEEN CONCERNED WITH THE SIZE OF THE PROJECT AND THE MISSION'S ABILITY TO FINANCE THE PROJECT AT THE OLS 8.322 MILLION LEVEL AS WELL AS THE ROLE OF PRISHA IN ITS IMPLEMENTATION. HOWEVER BASED ON A REVIEW WITH DIRECTOR BUCK AND INVOLVED LAC STAFF, WE UNDERSTAND THE MISSION

See date 8/25
ACTION COPY
ACTION TAKEN: _____
DATE: _____
INITIALS: _____

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MOST LIKELY WILL DO AN OPG WITH PRISMA FOR A RELATIVELY
SHORT TIME FRAME. THE GRANT WILL ENSURE THAT RESOURCES
CONTINUE TO FLOW TO THE LOCAL PVDS THIS YEAR AND NEXT
AND PROVIDE FUNDING FOR A CONTRACEPTIVE PURCHASE BY
AID/W WHILE THE MISSION REVIEWS OPTIONS ASSOCIATED WITH
A LONGER TERM PROJECT. AID/W CONCURS WITH THIS
APPROACH. PLEASE CABLE US NOT LATER THAN AUGUST 31 WITH
YOUR PLANS TO UTILIZE YOUR POPULATION FUNDS THIS FISCAL
YEAR AND ADVISE WHETHER ANY FUNDS WILL BECOME AVAILAELE
FOR BUREAU REPROGRAMMING IN SEPTEMBER. EAGLEBURGER

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UNCLAS SECTION 01 OF 03 LIMA 12914

CLASS: UNCLASSIFIED
CHRG: AID 08/25/89
APPRV: D:CBUCK
DRFTU: HR:DKENNEDY
CLEAR: 1.AHF:JSURDICK
2.CONT:PKRAMER
3.APROG:CV
4.DD:ASILVA

AIDAC

FUR LAC/DP/SA (MARK SILVERMAN) AND LAC/SAM (D. MUNCIE)
QUITO FOR RLA AND RCD

E.O. 12356: N/A
SUBJECT: PERU PRIVATE VOLUNTARY FAMILY PLANNING SERVICE
- EXPANSION PROJECT (NO. 527-0335) - REQUEST FOR
- PID APPROVAL

REF: (A) STATE 265276 (B) LIMA 10729 (C) STATE 133475

1. SUMMARY.

A. AS OUTLINED IN RECENT MISSION AND AID/W DISCUSSIONS, MISSION HAS CONTINUED TO WORK ON DOCUMENTATION FOR A FOUR-YEAR PROJECT WITH THE PERUVIAN PVO PRISMA. THE ACTIVITY WOULD PROVIDE NEEDED BRIDGE FUNDING FOR FAMILY PLANNING PVOS, THEREBY ALLOWING UNINTERRUPTED PROVISION OF SERVICES AND COMMODITIES FOR FAMILY PLANNING. PRISMA WILL PLAY A KEY ROLE IN PROVIDING ASSISTANCE TO SIX PVOS, EACH OF WHICH WILL REQUIRE SUBSTANTIAL SUPPORT TO DEVELOP INSTITUTIONAL STRENGTH IN SUCH AREAS AS MANAGEMENT, LOGISTICAL CONTROLS, FINANCIAL REPORTING, AND COST CONTROL.

B. WHILE PRISMA HAS A GOOD RECORD IN MANAGING AND ACCOUNTING FOR RESOURCES UNDER OTHER USAID PROGRAMS, WE ARE CONCERNED ABOUT ITS CAPACITY TO FUNCTION EFFECTIVELY WITH A SERIES OF WEAK INSTITUTIONS, PARTICULARLY WHEN WE HAVE QUESTIONS ABOUT ITS ROLE AS THE COOPERATING ENTITY. A RECENTLY COMPLETED INSTITUTIONAL ANALYSIS OF PRISMA ADDS CONFIDENCE TO THE MISSION'S DECISION TO USE IT AS THE VEHICLE FOR COORDINATING RESOURCES TO THE SIX SERVICE DELIVERY PVOS.

C. NEVERTHELESS, WE ARE RELUCTANT TO AUTHORIZE FULL PROPOSED FOUR YEAR PROJECT UNTIL MISSION HAS HAD THE OPPORTUNITY TO EVALUATE PRISMA'S PERFORMANCE UNDER CURRENT CONDITIONS. HOWEVER, IT IS IMPERATIVE THAT WE ENSURE THE UNIMPEDED SUPPORT FOR THE SIX PVOS, WHICH CURRENTLY PROVIDE SERVICES TO SOME 260,000 PERUVIANS. THEREFORE, SUBJECT TO AID/W APPROVAL OF THE PID, WE PLAN TO AUTHORIZE ONLY THE FIRST YEAR OF THIS PROJECT, ALTHOUGH THE FP WILL CONTAIN ALL INFORMATION NEEDED FOR A FULL LIFE OF PROJECT AUTHORIZATION, FOR WHICH WE

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ESTIMATE LOP COST TO BE USD 7.755 MILLION.

D. UNDER THIS APPROACH, USAID PLANS TO NEGOTIATE A 12-MONTH COOPERATIVE AGREEMENT WITH PRISMA, FOR USD 2,217,302 IN FY 1989 FUNDS. PRISMA WOULD CARRY OUT MOST ACTIVITIES PLANNED IN PROJECT YEAR ONE OF THE ORIGINAL PID BUT WOULD HANDLE A LARGER VOLUME OF CONTRACEPTIVES THAN WAS ORIGINALLY ANTICIPATED IN THE ORIGINAL PID. PENDING AID/W APPROVAL AND AA/LAC CONCURRENCE, MISSION PLANS TO FINALIZE PROJECT PAPER AND 12-MONTH AGREEMENT WITH PRISMA. PRISMA PROJECT ACTIVITIES INCLUDE PASS THRU FUNDING TO EXISTING PVOS, ORDERING AND DISTRIBUTING CONTRACEPTIVES, AND CONDUCTING THREE TECHNICAL STUDIES.

E. PRISMA'S PERFORMANCE WILL BE EVALUATED IN MONTH EIGHT OF THE AGREEMENT IN ORDER TO DETERMINE IF THIS ARRANGEMENT IS THE MOST EFFECTIVE MANNER OF COORDINATING SUPPORT FOR THE SERVICE DELIVERY PVOS FOR YEARS 2, 3, AND 4. AUTHORIZATION OF REMAINING PROJECT LIFE, AND ANY MODIFICATIONS TO THE PP, ARE CONTINGENT UPON THIS EVALUATION.

F. IF AID/W CONCURS, PLEASE PROVIDE:

- (1) PID APPROVAL,
- (2) AA/LAC CONCURRENCE IN COOPERATIVE AGREEMENT WITH PRISMA,
- (3) TN FOR FY 89 OBLIGATIONS OF USD 2,217,302 (INFORMATION PROVIDED IN SEPTEL), AND
- (4) INCLUSION OF THIS SAME AMOUNT IN SECTION 123 (E) CERTIFICATION.

END SUMMARY.

2. PID APPROVAL.

A. PER REF A, USAID SUBMITTED AND AID/W REVIEWED PRIVATE VOLUNTARY FAMILY PLANNING SERVICE EXPANSION PROJECT (PVFP) PID FOR TOTAL PROPOSED FUNDING OF USD 6.3 MILLION. PID APPROVAL WAS DEFERRED PENDING LAC RECEIPT OF ADDITIONAL INFORMATION REQUESTED DURING PID REVIEW.

B. IN REF B, USAID ADDRESSED ISSUES RAISED BY AID/W DURING REVIEW (REF A) AND INCORPORATED BUREAU GUIDANCE IN THE DRAFT PROJECT PAPER. HOWEVER, IN THE INTERIM, USAID LEARNED THAT SET/POP WOULD NOT BE ABLE TO PROVIDE THE BULK OF CONTRACEPTIVES REQUIRED FOR THE PROJECT FROM CENTRAL AID/W FUNDING, AS HAD BEEN PREVIOUSLY

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ANTICIPATED. THEREFORE, CONTRACEPTIVE COSTS WERE FACTORED INTO THE PID AND DRAFT PP DESIGN, BRINGING TOTAL PROJECT COSTS TO USD 8.322 MILLION.

C. GIVEN CONCERNS ABOUT THE LEVEL OF POPULATION ACCOUNT FUNDING THAT IS LIKELY TO BE AVAILABLE FOR USAID/PERU, WE HAVE SCALED BACK OVERALL LOP COSTS FOR THE PRIVATE VOLUNTARY FAMILY PLANNING SERVICES EXPANSION PROJECT TO USD 7.755 MILLION. WE HAVE ALSO DEFERRED THE PRIVATE COMMERCIAL SECTOR FAMILY PLANNING PROJECT UNTIL FY 1990. THUS, WE NOW BELIEVE THAT WE CAN ACCOMMODATE FUNDING FOR POPULATION ACCOUNT ACTIVITIES AS OUTLINED BELOW.

PROJECT NO. PROJECT TITLE (LIFE-OF-PROJECT AMT.)	FY1989	FY1990	FY1991	FY1992
527-0000 PROGRAM DEVELOPMENT AND SUPPORT	98	100	100	108
527-0230 CONTRACEPTIVE SOCIAL MARKETING (DOLS 4,100)	25	-	-	-
527-0326 PRIVATE COMMERCIAL SECTOR FAMILY PLANNING (DOLS 1,900)	-	300	500	600
527-0335 PRIVATE VOLUNTARY SECTOR FAMILY PLANNING SERVICE EXPANSION (DOLS 7,755)	2,218	1,900	2,000	1,637
TOTAL, POPULATION ACCOUNT	2,341	2,300	2,600	2,345
SOURCES OF FUNDING	FY1989	FY1990	FY1991	FY1992
DYB (FY1989: BUDGET) ALLOWANCES; OTHER FYS: PLANNING LEVELS)	2,238	2,300	2,300	2,300
DEOB/REOB (FROM PDS AND INTEGRATED HEALTH/FP)	103	-	-	-
WITH NO FUNCTIONAL ACCOUNTS, TRANSFER FROM STRAIGHT-LINED FY 1990 ARDN LEVELS (MADE POSSIBLE BY				

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DEOB/REOB TO ATT IN FY 1989)

300

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Q. THE PROJECT COST COMPONENTS OF THE ORIGINAL PID REQUEST AND THE CURRENT AMENDED PID FOR TOTAL LOP AND YEAR ONE FUNDING ARE PRESENTED BELOW. IN SUMMARY, WHILE TOTAL PROJECT COSTS HAVE INCREASED BY USD 1.433 MILLION, CORE COSTS HAVE BEEN CUT BY USD 906,000, AND CONTRACEPTIVES HAVE BEEN CUT TO "BARE BONES" AS TOTAL PROJECTED REQUIREMENTS ARE, IN FACT, 4 MILLION DOLLARS, AND THE PROJECT WILL BE ABLE TO FUND ONLY USD 3.339 MILLION. (FYI. WE WOULD HOPE THAT INCREASED COST RECOVERY AND LOCAL PROCUREMENT WOULD ENABLE PVOS TO SECURE CONTRACEPTIVES WITH THEIR OWN RESOURCES, THEREBY REDUCING THIS PROJECT FINANCING REQUIREMENT. END FYI.)

TABLE IS IN USD MILLIONS.

	ORIGINAL 4/89 PID REQUEST	AMENDED PID REQUEST	DIFFERENCE
TOTAL FUNDING	6.322	7.755	(+ 1.433)
PROJECT COSTS	(5.322)	(4.416)	(- 906)
CONTRACEPTIVES	(1.000)	(3.339)	(+ 2.339)
YEAR 1 TOTAL FUNDING	1.370	2.218	(+ 848)
YEAR 1 PROJECT COSTS	(1.120)	(1.215)	(+ 95)

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YEAR 1 CONTRACEPTIVES (0.250) (1.003) (+ 753)

3. PRISMA COOPERATIVE AGREEMENT.

A. MISSION COMPLETED AN INSTITUTIONAL ASSESSMENT OF PRISMA CAPABILITIES THIS PAST WEEK, WHICH INCLUDED A CONSULTANT EVALUATING ITS OPERATIONS AND REVIEWS OF EXISTING ASSESSMENTS OF OTHER A.I.D. ACTIVITIES CARRIED OUT BY PRISMA. WHILE MISSION HAS BEEN IMPRESSED WITH PRISMA TRACK RECORD TO DATE, DUE TO COMPLEXITY AND VOLUME OF OVERALL PROJECT, WE PREFER TO MOVE FORWARD IN STAGES, TO TEST THIS IMPLEMENTATION MODALITY. AS PART OF STAGE ONE, USAID PLANS TO ENTER INTO A 12-MONTH AGREEMENT WITH PRISMA TO PROVIDE FUNDING AND CONTRACEPTIVE COMMODITIES TO PVDS AND TO CARRY OUT CERTAIN DISCREET ACTIVITIES AS DESCRIBED FOR PROJECT YEAR 1 IN SUBJECT PID.

B. DURING MONTH 8 OF THIS AGREEMENT AN IN-DEPTH EVALUATION WILL BE UNDERTAKEN TO ASSESS PRISMA'S PERFORMANCE TO DATE AND ITS CAPACITY TO IMPLEMENT REMAINING PROJECT ACTIVITIES. ASSUMING THAT THE EVALUATION FINDINGS ARE POSITIVE, STAGE TWO WILL FOLLOW, PROBABLY WITH A THREE-YEAR USD 5,537,698 COOPERATIVE AGREEMENT WITH PRISMA. SHOULD THE EVALUATION FINDINGS SUGGEST THE NEED TO IDENTIFY OTHER IMPLEMENTATION ARRANGEMENTS OR MAKE CERTAIN PROJECT REVISIONS, THE MISSION WILL BE ABLE TO MAKE CHANGES WITHIN AN ORDERLY TIME FRAME FOR FOLLOW ON FUNDING FOR YEARS 2, 3 AND 4.

4. ACTION REQUESTED:

A. REQUEST PRIORITY AID/W APPROVAL OF: PID FOR PERU PRIVATE VOLUNTARY FAMILY PLANNING SERVICES EXPANSION PROJECT (NO. 527-0335) FOR 4-YEAR LOP FUNDING OF USD 7.755 MILLION; AND PLAN TO EXECUTE A 12-MONTH COOPERATIVE AGREEMENT WITH PRISMA FOR USD 2.218 MILLION.

B. PER REF B, PARA 9 (B), REQUEST AA/LAC CONCURRENCE TO MOVE FORWARD WITH THIS PP AND COOPERATIVE AGREEMENT WITH PRISMA FOR USD 2.218 MILLION, WHICH INVOLVES A.I.D. RESOURCES IN EXCESS OF TWO MILLION DOLLARS. PURSUANT TO HANDBOOK 13, CHAPTER 2, SELECTION OF RECIPIENTS, JUSTIFICATION FOR AN EXCEPTION TO THE COMPETITION REQUIREMENT IN THIS INSTANCE IS BASED ON SECTIONS 3.B AND 3.D OF CHAPTER 2 -- COMPETITION NOT REQUIRED FOR: QUOTE ASSISTANCE AWARDS FOR WHICH ONE RECIPIENT IS CONSIDERED TO HAVE EXCLUSIVE OR PREDOMINANT CAPABILITY, BASED ON EXPERIENCE, SPECIALIZED FACILITIES OR TECHNICAL COMPETENCE, OR BASED ON AN EXISTING RELATIONSHIP WITH THE COOPERATING COUNTRY OR BENEFICIARIES UNQUOTE: AND QUOTE FOLLOW ON ASSISTANCE AWARDS INTENDED TO FURTHER DEVELOP AN EXISTING ASSISTANCE RELATIONSHIP UNQUOTE.

C. AS TOTAL BUDGET FOR FY-89

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TO CONGRESS TO REFLECT AMENDED FIGURES. ALSO INCLUDE THIS NEW FIGURE IN SECTION 123 (E) CERTIFICATION TO CONGRESS.

5. APPRECIATE AID/W ASSISTANCE AND ADVICE ON FINALIZING PLANS FOR 12-MONTH PRISMA AGREEMENT AND IN SECURING NEEDED CLEARANCES AND REQUESTS SO MISSION CAN MOVE FORWARD TO COMPLETE THIS AUTHORIZATION AND ISSUE PID/T FOR COOPERATIVE AGREEMENT BEFORE SEPTEMBER 15, 1989. OBLIGATION (SIGNATURE OF COOPERATIVE AGREEMENT BY RCD AND PRISMA) SCHEDULED ON OR BEFORE SEPTEMBER 22, 1989.
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AIDAC FOR ROCAP

E.O. 12356: N/A

TAGS:

SUBJECT: CONGRESSIONAL NOTIFICATION ALERT

1. THE FOLLOWING NOTIFICATIONS WERE SENT TO THE HILL ON
SLPT. 7, 1989:

A. PERU

-- DPG CN NO. 529 FOR PROJECT 527-0330 DPG CARE-FOOD
 ASSISTED INTEGRATED DEVELOPMLNT ORGANIZATION, FOR DOLS
 80,000 OF ARDN FUNDS AND DOLS 63,000 OF CHILD SURVIVAL
 FUNDS;

-- DPG CN NO. 529 FOR PROJECT 527-0320 REFORESTATION
 FOOD-FOR-WORK, FOR DOLS 130,000 OF ARDN FUNDS.

-- TN NO. 532 FOR PROJECT 527-0335 PRIVATE VOLUNTARY
 SECTOR FAMILY PLANNING SERVICES EXPANSION, FOR 2,218,000
 OF POPULATION FUNDS.

B. HAITI

-- NO. 531 FOR PROJECT 521-0640 PRESIDENTIAL TRAINING
 INITIATIVE FOR THE ISLAND CARIBBEAN (PTIIC), FOR DOLS

500,000 OF ARDN FUNDS, DOLS 920,000 OF HE FUNDS, AND
 DOLS 500,000 OF PN FUNDS.

C. ROCAP

- TN NO. 532 FOR PROJECT 596-0150 REGIONAL ENVIRONMENTAL
 AND NATURAL RESOURCES MANAGEMLNT, FOR DOLS 6,000,000 OF
 ARDN FUNDS AND DOLS 3,000,000 PSEE FUNDS, OF WHICH DOLS
 2,877,000 PSEE FUNDS WILL BE DEOB/REDB FUNDS.

2. SEPTEL WILL ADVISE WHEN NOTIFICATIONS EXPIRE WITHOUT
 OBJECTION. COPY OF NOTIFICATIONS BLING FAXED AND
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MINISTERIO DE SALUD

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Lima, agosto 31 ,1989

SA-DM-626-89

Señor
Alan Silva
Director a.i. de la Misión en el Perú de la
Agencia para el Desarrollo Internacional
PRESENTE.-

don este 9/8

ACTION
ACTION TAKEN:
DATE:
INITIALS:

Estimado señor Silva :

Me es grato dirigirme a usted para expresarle, en nombre del Gobierno y en el mío propio, nuestra complacencia por el espíritu que anima al Gobierno de los E.E.U.U., a través de la Agencia - de Desarrollo Internacional, para colaborar en la ejecución de las actividades de planificación familiar que dentro del Proyecto 527 - 0285 Sobrevivencia Infantil, se llevan a cabo en el país.

He revisado las actividades consignadas en dicho Proyecto y estoy seguro que satisfacen las prioridades que, de acuerdo con la Política Nacional de Población, se consideran prioridades a juicio del Consejo Nacional de Población y de este Despacho. Es muy seguro que dicho Proyecto permitirá una más estrecha asociación entre los organismos oficiales y las instituciones privadas que hacen planificación familiar, para completar la acción gubernamental en este sentido.

Asimismo, deseo expresarle mi convencimiento que esta participación de las Instituciones del Sector Privado servirá de acicate para fortalecer las funciones de coordinación, promoción y mejoramiento de la situación actual de los Programas de Protección a la Salud de la Madre y el Niño, en especial los destinados a proteger la salud de la mujer durante su ciclo reproductivo. Especial consideración merece dentro del Proyecto la acción rectora que el Ministerio a mi cargo tiene sobre las organizaciones privadas, de conformidad con los lineamientos de la actual Política Nacional de Salud.

Hago propicia la oportunidad para renovarle los sentimientos de mi consideración más distinguida.

Atentamente,

David A. Tejada de Rivero

DR. DAVID A. TEJADA DE RIVERO
Ministro de Salud

ACTION:	<i>HR</i>
Info:	<i>HR</i>
<i>FED 415</i>	

17

ENVIRONMENTAL THRESHOLD DECISION

148

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

LAC-IEE-89-68

ENVIRONMENTAL THRESHOLD DECISION

Project Location : Peru
Project Title : PVO Family Planning Services
Expansion
Project Number : 527-0335
Funding : 6,322,000 (G)
Life of Project : 5 years
IEE Prepared by :

Recommended Threshold Decision : Categorical Exclusion
Bureau Threshold Decision : Concur with Recommendation
Comments : None
Copy to : Donor M. Lion, Director
USAID/Peru
Copy to : Claudio Saito, USAID/Peru
Copy to : Howard Clark, USAID/Quito
Copy to : Mark Silverman, LAC/DR/SA
Copy to : IEE File

James S. Hester Date SEP 15 1989

James S. Hester
Chief Environmental Officer
Bureau for Latin America
and the Caribbean

ENVIRONMENTAL DETERMINATION

Project Location: Peru

Project Title and Number: Private Sector Family Planning Services Expansion Project, 527-0335

Funding: FY 1989 - FY 1992

Project Purpose and Activities: To maximize the availability of all family planning methods to women and men who wish to use them by increasing the capacity of the private voluntary sector to deliver long-lasting contraceptive methods while maintaining support for temporary supply methods and natural family planning.

Statement for Categorical Exclusion: It is the opinion of USAID/Peru that the Project does not require an Initial Environmental Examination because its activities are within the classes of actions described in Section 216.2, Paragraphs c(1) and c(viii) "Categorical Exclusions of 22CFR Part 216".

"Section 216.2 c(1)": "The action does not have an effect on the natural or physical environment."

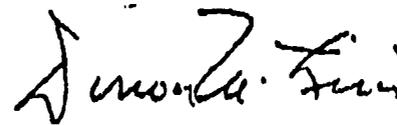
"Section 216.2 c(2) (viii)": "Programs involving nutrition, health care or population and family planning services except to the extent designed to include activities directly affecting the environment (such as construction of facilities, water supply system, waste water treatment)".

Concurrence of the Mission Director

I have reviewed the above statement and concur in the determination that the "Private Sector Family Planning Services Expansion Project" does not require an Initial Environmental Examination.

23 March 89

Date



Donor M. Lion
Director
USAID/Peru

JUSTIFICATION FOR WAIVER
OF 25 PERCENT CONTRIBUTION REQUIREMENT

It is the policy of A.I.D. that a 25 percent contribution to total life-of-project costs from non-A.I.D. sources is required for operational program grants (OPG's) and operational program cooperative agreements (OPCA's) to PVOs. Although it is not mandated by legislation, A.I.D. has administratively determined to establish this requirement. This non-A.I.D. contribution may include cash and in-kind contributions from PVOs, local collaborators and other non-governmental donors as well as from host governments, other governments and international organizations.

This is not the typical PVO project in which A.I.D. receives a proposal from the PVO requesting A.I.D.'s assistance in carrying out one of their programs. Rather, in this case A.I.D. has approached PRISMA and requested it to be the coordinating organization for funding assistance to six local PVOs which at this time lack the administration and financial maturity required to control and monitor A.I.D. project funds. In addition, a major purpose of this four-year effort is to assist these six participating PVOs in acquiring the skills required to undertake income-generating activities, specifically, to increase local in-kind and cash donations and to undertake profit-making activities. These efforts will not begin to bear fruit for at least a year or more; hence, neither they nor PRISMA can reasonably be expected to make any significant contributions to the project during the first year.

For these reasons it is inappropriate, at least during the first year of the project, which is basically a test year, to require PRISMA not only to act as the coordinating organization for this A.I.D. project but, in addition, to match A.I.D.'s contribution on a 1 to 3 basis, in order to comply with A.I.D.'s 25 percent contribution requirement. The same is true for the six local PVOs which are totally dependent on donor support and, which we want to make more efficient and cost conscious during this project in order for them to move toward self-sufficiency. Once cost and marketing studies have been conducted and income-generating activities identified and tested, A.I.D. will have be in a much better position to determine the real contribution potential of these PVOs and to fix an appropriate contribution requirement which, hopefully, will equal at least 25 percent of total project costs.

JUSTIFICATION OF NONCOMPETITIVE AWARD

According to Handbook 13, Chapter 2, para 2B3, Competition is not required for:

Assistance awards for which one recipient is considered to have exclusive or predominant capability, based on experience, specialized facilities or technical competence, or based on an existing relationship with the cooperating country or beneficiaries.

A noncompetitive award of a Cooperative Agreement to PRISMA for the first year of project activities is justified on the grounds of predominant capability, based on special circumstances surrounding Peru and the private voluntary family planning sector in Peru.

1. Need for a 123 (e)

Due to debt arrearages, Peru determination most likely will continue under Section 620(q) and Brooke-Alexander Amendment sanctions for the remainder of Fiscal Year (FY) 1989. Therefore, the Mission has requested and received the A.I.D. Administrator's determination, under Section 123(e) of the FAA, that obligations to PRISMA for this project are in the national interest. As a PVO registered with A.I.D. since 1986 and as an organization that has received A.I.D. funding for population related activities (Milpo Mining Project, the Risk Project, and Ninos Journal), PRISMA is eligible to receive A.I.D. funding under a Section 123(e) determination.

2. Project success will be enhanced if implemented by a non-family planning PVO.

The Mission determined that it would be in the best interest of the project that it be implemented by a Peruvian PVO that was not a family planning service delivery organization, so as not to be seen as a competitor by the family planning PVOs that would be the direct beneficiaries of the project.

3. Technical competence of PRISMA.

The project design team made a careful search of potential candidates, which needed to satisfy the following criteria:

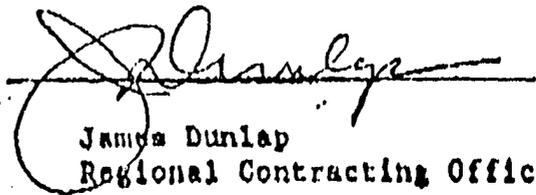
- previous experience with USAID/Peru Mission disbursement and reporting requirements;
- strong background and experience in a related development field; and
- previous collaborative relationship with the public sector.

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JUSTIFICATION OF NONCOMPETITIVE AWARD

Page 2 of 2

Three potential candidates were identified: Vecinos Peru, APROPO, and PRISMA. PRISMA was chosen as the strongest of the three, for its administrative/managerial capabilities, its linkages with the Ministry of Health both centrally and at the departmental level throughout the country, its experience in working with Mission reporting requirements, and its experience in primary health care and P.L. 480 food distribution.


James Dunlap
Regional Contracting Officer

9/21/89
Date

Clearances:

- J. Burdick, HR
- C. Kassebaum, PO
- P. Kramer, CONT
- A. Silva, DD



17

LOGICAL FRAMEWORK

754

PROJECT LOGICAL FRAMEWORK (PRELIMINARY): PRIVATE VOLUNTARY FAMILY PLANNING SERVICES EXPANSION

<u>Narrative Summary</u>	<u>Objectively Verifiable Indicators</u>	<u>Important Assumptions</u>	<u>Means of Verification</u>
<p><u>Program or Sector Goal:</u> Improved quality of life for Peruvian families through increased access to the means to achieve the desired number and spacing of their children</p>	<p><u>Measures of Goal Achievement:</u> GOP program target to reduce the total fertility rate from 4.3 in 1986 to 2.5 in 2,000 and to raise contraceptive prevalence from 28 percent in 1986 to 42 in 2,000. Targets for 1993 are 3.4 TFR and 35 percent prevalence.</p>	<ul style="list-style-type: none"> - Continued GOP commitment to family planning. - Increased contraceptive prevalence will reduce fertility. - Continued economic viability of commercial sector. 	<ul style="list-style-type: none"> - 1991 National Census - 1992 Demographic and Health Survey (DHS) - Economic indicators - Wholesale pharmaceutical company sales figures - Service statistics.
<p><u>Project Purpose:</u> Maximize the availability of all family planning methods to women and men who wish to use them by increasing the capacity of the private voluntary sector to deliver long-lasting contraceptive methods while maintaining support for temporary supply methods and natural family planning.</p>	<p><u>Conditions Expected at End of Project:</u></p> <ul style="list-style-type: none"> - Improved contraceptive method mix showing higher proportion of long-lasting methods and lower proportion of traditional methods - Higher prevalence of male family planning methods - Increased contraceptive prevalence in rural areas - Improved sustainability of PVOs 	<ul style="list-style-type: none"> - Existing unmet need for contraception. - Ideal family size will continue downward trend - Women and men reaching ideal family size will increasingly elect long-lasting contraceptive methods. - Users will be willing to pay more for PVO supplies and services than is currently charged. 	<ul style="list-style-type: none"> - 1992 DHS results, including findings on source, methods expenditures, and users' income. - Service statistics.

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Outputs:

- Increased clinical capacity and improved operational efficiency among FVOs.
- Increased number of rotating medical posts, especially outside Lima.
- Increased numbers of acceptors of long-lasting methods.
- Maintenance of numbers of acceptors of temporary supply methods and NFP.
- Improved financial sustainability of FVO sector.
- Increased rural contraceptive coverage.

Magnitude of Outputs:

- Fixed full-service clinics will achieve 85% use of installed capacity.
- Urban community distribution programs will generate enough revenue to cover operating costs (except for donated commodities).
- 10% annual increase in acceptors of long-lasting methods.
- FVO-public sector collaboration institutionalized in up to 50 hospitals and/or health centers.

- Economic conditions will permit FVO clients to pay for supplies and services.
- Public and commercial sectors will continue to serve family planning users.
- Restrictions on availability of long-lasting methods will not increase.
- Willingness of public and private sectors to cooperate will continue.

- Service statistics.
- Market evaluation research
- Annual and long-term strategies and workplans.
- Management and financial reviews.
- User surveys.

Inputs (Operational budget):

Project Management	580,000
FVO Institutional Support	2,301,000
Technical Assistance/studies	515,000
Evaluation/Audit/Fin. Review	320,000
Contraceptive Commodities	3,517,000
USAID Condition	220,000
Overhead	117,000
Contingencies and Inflation	185,000
Total	7,755,000

Implementation Schedule (Target Dates)

Grant or buy-in 4th. Qtr. FY 89

- USAID obligations can be made.
- Availability of local qualified TA.
- Availability of contraceptive commodities.

Project Documentation.

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ILLUSTRATIVE LIST OF COMMODITIES

Upon authorization from the Implementing Agency, USAID will issue a funded PIO/C for purchase and shipment of contraceptive commodities. Funds from this PIO/C may only be used by ST/POP/CPSD to procure and ship oral contraceptives, condoms, copper T IUDs, and vaginal foaming tablets. Specific orders against this PIO/C will be cabled to ST/POP/CPSD in accord with Attachment 6 of ST/POP/CPSD's guidance to USAID missions dated 10/01/88.

Project Commodities: Contraceptives
Basis of Delivery: CIF Callao, Lima, Peru
Shipping Instructions: By ocean in accordance with Form AID-II-94. Goods must be insured.

Delivery dates as follows:

- Item 1 - Oral contraceptives, low dose
549,600 cycles - November 1989
549,600 cycles - April 1990
550,800 cycles - July 1990
- Item 2 - Condoms
3,300,000 units - November 1989
3,300,000 units - April 1990
3,300,000 units - July 1990
- Item 3 - Vaginal Foaming Tablets
480,000 units - November 1989
484,800 units - April 1990
484,800 units - July 1990
- Item 4 - Copper T 380 IUDs
30,000 units - November 1989
30,000 units - April 1990
30,000 units - July 1990

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CONSOLIDATED PROJECT BUDGET
BY INPUTS, PROJECT YEARS, AND PROJECT COMPONENTS



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CONTRIBUTORS TO THE PROJECT PAPER

The following individuals served on the Project Design Team:

USAID/Peru

John Burdick, Acting Chief, Office of Human Resources,
Gloria Nichtawitz, Project Coordinator, Population Division,
Barbara Kennedy, TDY, AID/W,
Cary Kassebaum, Program Officer,
Leroy Jackson, Project Development Officer,
Gerald Martin, Financial Analyst Advisor,
Karen Foreit, Consultant, Population Division, and
Alan Silva, Deputy Director.

The following individuals also contributed to the Project design:

USAID/Peru

Craig Buck	Director
Paul Kramer	Controller
Rita Fairbanks	Health and Population Advisor

AID/Washington (AID/W) and AID/Regional

Earle Lawrence	AID/W/S&T/POP
John Paul James	AID/W/S&T/POP
Alex Newton	RLA

The following individuals participated in the technical analyses:

James Laity	Summer Intern, USAID/Peru
Larry Day	Consultant
Enrique Suarez	FEMAP
Denis Falvey	Consultant
Roberto Tirado	Consultant
Alberto Ramirez	Ramirez y Asociados
Hilario Hurtado Koo	Instituto Marcelino
Patricia Mostajo	Consultant
Rosa Monge	Consultant

The following individuals reviewed the PID and/or sections of the Project Paper:

Donor Lion	Former Mission Director, USAID/Peru
Linda Lion	Former Chief, Office of Human Resources, USAID/Peru
Catherine Crone Coburn	Management Sciences for Health

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AID
SUMMARY OF TOTAL PROJECT COSTS
by Foreign Exchange (FX) and Local Currency (LC)

Project Components	PY1		PY2		PY3		PY4		LOP	
	FX	LC	FX	LC	FX	LC	FX	LC	FX	LC
A. Program Costs										
1. PVO Institutional Support		694,302		600,698		550,000		456,000		2,301,000
2. Technical Assistance/ Technical Studies		75,000		125,000	40,000	150,000		125,000	40,000	475,000
3. Commodities	1,003,000	67,000	942,000	—	792,000	—	713,000	—	3,517,000	—
TOTAL PROGRAM COSTS	<u>1,003,000</u>	<u>836,302</u>	<u>942,000</u>	<u>725,698</u>	<u>832,000</u>	<u>700,000</u>	<u>713,000</u>	<u>581,000</u>	<u>3,557,000</u>	<u>2,776,000</u>
B. Administrative Costs										
1. Project Management		151,000		143,000		143,000		143,000		580,000
2. USAID Coordination	110,000		55,000		55,000		—		220,000	
3. Evaluation	20,000		—		—		50,000		70,000	
PRISMA Project	20,000		—		—		—		20,000	
4. Audit/Financial Reviews	70,000		60,000		60,000		50,000		50,000	
PRISMA Audit	20,000		10,000		10,000		60,000		250,000	
PVO Audits	30,000		30,000		30,000		10,000		50,000	
Project Audit	20,000		—		—		20,000		110,000	
Financial Management Reviews	10,000		10,000		10,000		30,000		50,000	
TOTAL ADMINISTRATIVE COSTS	<u>200,000</u>	<u>151,000</u>	<u>115,000</u>	<u>143,000</u>	<u>115,000</u>	<u>143,000</u>	<u>110,000</u>	<u>143,000</u>	<u>540,000</u>	<u>580,000</u>
C. Overhead	—	27,000	—	30,000	—	30,000	—	30,000	—	117,000
D. Contingencies	—	—	—	70,000	—	70,000	—	45,000	—	185,000
TOTAL PROJECT	<u>1,203,000</u>	<u>1,014,302</u>	<u>1,057,000</u>	<u>968,698</u>	<u>947,000</u>	<u>943,000</u>	<u>823,000</u>	<u>799,000</u>	<u>4,097,000</u>	<u>3,658,000</u>

EXPENDITURES

PROJECT COMPONENTS	1990 PY 1	1991 PY 2	1992 PY 3	1993 PY 4	Life of Project
A. PROGRAM COSTS	<u>1,839,302</u>	<u>1,667,000</u>	<u>1,532,000</u>	<u>1,294,000</u>	<u>6,333,000</u>
1. PVO Institutional Support	694,302	600,698	550,000	456,000	2,301,000
2. Technical Assistance/ Technical Studies	75,000	125,000	190,000	125,000	515,000
4. Commodities	1,070,000	942,000	792,000	713,000	3,517,000
B. ADMINISTRATIVE COSTS	<u>351,000</u>	<u>258,000</u>	<u>258,000</u>	<u>253,000</u>	<u>1,120,000</u>
1. Wages & Benefits	88,000	87,100	87,100	87,100	349,300
2. USAID Coordination Staff	110,000	55,000	55,000	0	220,000
3. Local Travel	27,000	26,900	26,900	26,900	107,700
4. Vehicle costs	13,000	6,000	6,000	6,000	31,000
5. Office expenses	23,000	23,000	23,000	23,000	92,000
6. Evaluation	20,000	0	0	50,000	70,000
7. Audit	70,000	60,000	60,000	60,000	250,000
C. OVERHEAD	<u>27,000</u>	<u>30,000</u>	<u>30,000</u>	<u>30,000</u>	<u>117,000</u>
D. CONTINGENCIES/INFLATION	<u>0</u>	<u>70,000</u>	<u>70,000</u>	<u>45,000</u>	<u>185,000</u>
TOTAL PROJECT	<u><u>2,217,302</u></u>	<u><u>2,025,698</u></u>	<u><u>1,890,000</u></u>	<u><u>1,622,000</u></u>	<u><u>7,755,000</u></u>

PRIVATE SECTOR FAMILY PLANNING PROJECT
(527-0269)

A. Project History.

The Private Sector Family Planning Project was designed as the third part of a three-pronged approach followed by USAID to support family planning services in Peru. The other two initiatives, already in place, included a public sector project (the then ongoing Integrated Health and Family Planning (527-0230) and its planned follow-on project for the MOH) and a commercial sector project (Contraceptive Social Marketing, launched in 1984).

This initiative in the private (PVO) sector was also intended to respond to the slow and poor results experienced in the public sector. The rationale was to capitalize on the purported greater effectiveness, flexibility, innovation, and agility of the private sector agencies to meet the demand for family planning services. At the same time, it was recognized that the numerous and diverse family planning PVOs existing in Peru were not altogether prepared to meet the challenge, and that to attain the goals of the private sector initiative, these groups would need to be coordinated and strengthened.

A conscious decision was made to include all of those PVOs which had received or were then currently receiving A.I.D. funding, either directly from the Integrated Health and Family Planning Project or through A.I.D.-financed Cooperating Agencies (CAs). These groups knew how to account for funds received and had at least rudimentary systems, staff, and infrastructure in place to begin the task. With the exception of the IPPF affiliate, INPPARES, none had had access to a steady flow of technical assistance (TA) and funding which would have given them the stability to develop comprehensive management systems and service provider capabilities.

Thus, the Mission concluded that many of their performance problems could be attributed to the start/stop nature of multiple CA funding, sporadic TA, administrative delays, etc. The new project was therefore designed to offer all of the PVOs the opportunity to receive ongoing TA and funding to develop their institutional capabilities. Those that proved to be unable or unwilling to develop efficient management systems would cease to receive AID financial support.

The project was intended to proceed in stages. An institutional analysis of all of the PVOs was included in the PP and provided some baseline measures of institutional characteristics and family planning users. Funding and TA were to be provided to all interested PVOs during Project Year (PY) 1. The first assessment of

each institution's progress as measured against its own baseline was scheduled to be conducted after PY 1, and those groups which had not responded adequately were to be dropped from the project.

The intended scope of the new project and the sheer number of PVOs to be assisted and monitored created an enormous management burden for the Population Division, recognized at the time, but, in retrospect, probably under-estimated. Provision was made within the PP for what was considered adequate staff to carry out the activities required.

The conditions that existed at the time the PP was finalized (offers for bids could be extended only to the three CAs already registered in Peru, and only one submitted a proposal), plus the time constraints vis-a-vis the 620Q and Brooke-Alexander sanctions imposed a difficult burden on the Mission and Prime Recipient to execute the project agreement. Once the project was initiated and began its activities, it soon became evident that the hurriedly-tooled agreement was not sufficiently detailed to avoid differences of opinion regarding some aspects of project implementation and reporting between the Mission and the implementing agency.

As future experience would show, the decision to leave some of the design details "open", to be resolved by the awardee, led to the inclusion of ambiguous or internally inconsistent goals within the PP. This lack of detail was compounded by differing interpretations of the Mission's role in the project, as the Mission requested more in-depth financial reporting than that required by central contracts with AID/W. These difficulties were exacerbated by what was observed as the high administrative cost of the project in times of declining overall population funds. An evaluation of the project was commissioned by the Mission, which produced the recommendation for a more in-depth look at the project once the Mission had defined its overall population strategy.

B. Project Rationale and Strategy.

The PP for the previous PVO project contains the following rationale:

This project focuses on the private sector to enhance and expand family planning activities... This project will also help develop the private sector's ability to determine and promote population policy as it relates to the private sector. Because the public sector is currently operating inefficiently and has limited ability to utilize its resources, and because the private sector offers a greater capacity to utilize funds more efficiently to expand services, it is logical to focus funding efforts on the

private sector at this time. The need for increased intrasectoral coordination is well recognized by the individual private sector agencies, and this project provides the means and opportunity to improve cooperation via the formation of a Peruvian Coordinating Agency (PCA).

Based on this rationale, the project strategy is comprised of the following:

1. Increase institutional development through TA and training to promote program and service expansion to reach more acceptors.
2. Develop the ability of the private sector to determine its policy needs and effectively research and articulate them to the GOP.
3. Foster cooperation and coordination between the private sector agencies to learn to best utilize existing resources and foster increased financial independence for the sector through income generation training.

C. Project Purpose, Inputs, and Outputs.

The SPF project had the following purposes:

- (1) to expand and improve the capability of the Peruvian private family planning agencies to increase cost-effective contraceptive coverage;
- (2) to strengthen the capacity of these same agencies and the CNP to influence, improve, and strengthen population policy in Peru particularly as it relates to the private sector; and
- (3) to strengthen coordination among the private sector agencies, at least partly via the creation of a Peruvian Coordinating Agency (PCA) for private sector family planning agencies."

1. Purpose 1: Institution Building.

The management components to be addressed included the following:

- developing agency objectives and work plans,
- improving accounting systems,
- developing and implementing evaluation plans,
- utilizing a comprehensive logistical support system, and
- developing and implementing a standardized statistical data collection and reporting system.

An illustrative list of sixteen technical assistance and training topics to be conducted in Peru was provided, of which eleven refer to management systems.

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The quantitative output measures specified in the PP related to services expansion include:

- 400,000 additional contraceptive users over the life of the project,
- 650 additional trained medical personnel,
- 1,000 non-medical service delivery personnel,
- 65 additional clinical sites, and
- 40 new CBD sites throughout the country.

As explicit measures/outputs of institution building were not specified in the PP, service delivery expansion and IEC activities received the most attention, both in terms of in-country expenditures and in terms of project staff and consultant time.

2. Purpose 2: Population Policy Component.

The formulation of the population policy component in the PP included both institutional development of private research agencies and the CNP, as well as research studies on policy topics. Outputs included strengthened institutional and enhanced research capabilities in two private agencies (AMIDEP, INANDEP) and the CNP.

As a measure of the private sector's "increased ability ... to influence population policy", the project would underwrite:

- 10 seminars/conferences for leaders and parliamentarians,
- publish and distribute 25 books, monographs, and studies, and
- publish and distribute a regular policy bulletin for policy-makers and legislators.

The PP also called for "actual changes in the GOP population laws [sic] as it affects the private sector family planning agencies".

3. Purpose 3: Inter-Agency Coordination.

The PP conceptualized the inter-agency coordination component to promote intercommunication and cooperation on issues of common interest to the PVOs and to reduce duplication of services. Outputs were to include the establishment of the Peruvian Coordinating Agency and "the increased ability of the private sector to become more financially independent through the PCA...".

In summary, while the original PP contained all of the essential components for a successful private sector family planning initiative and the grantee addressed these components, during an in-house mid-term evaluation, the Mission came to the conclusion that some of the components and subcomponents were defined with inappropriate output measures and were inappropriately prioritized

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in the PP and in the operational plan. Furthermore, events in Peru subsequent to the design of the Project and the preparation of the PP contributed to the Mission's decision to terminate the Project two years earlier than planned and design and implement a new PVO project.

D. Project Accomplishments.

The Project formally began operations on October 1, 1986, as "Apoyo al Sector Privado en Planificacion Familiar" (SPF) and inaugurated its Lima headquarters later that month. The four-person core team was fully contracted by January 1, 1987, and eventually expanded to include ten full-time and one part-time technical staff and seven support staff: Executive Director, Administration and Program Director, Program Officer (2), Program Assistant, Finance Director, Financial Supervisor, Accountant, IEC Director, IEC Assistant, and Logistics Coordinator.

1. Resource Allocation.

Table 1 summarizes relative resource allocation by project component during the first 20 months of the project. While it was not possible to assign dollar values to staff days, consultant days, and workshops, the table clearly shows that the greatest share of project resources were directed at services delivery: 45 percent of the SPF professional staff time allocated to PVOs, 58 percent of the consultant days allocated to PVOs, 82 percent of the subgrants, and 13 percent of the workshops. Inter-agency coordination received the smallest allocation of project resources, followed by Population Policy. This closely follows the resource allocation stipulated in the PP.

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TABLE 1.
PRIVATE SECTOR FAMILY PLANNING PROJECT (527-0269):
RESOURCE ALLOCATION, BY PROJECT COMPONENT

Project Component	SPF Staff Days		Consult Days		Subgrants		Workshops	
	No.	%	No.	%	Amount	%	No.	%
A. Institution-								
Building	9097	91	232.5	96	749440	86	14	93
- Management	2868	29	44.0	18	11850	1	8	53
- Services	4450	45	139.0	58	716450	82	2	13
- IEC	1780	18	49.5	21	21140	2	4	27
B. Population Policy	494	5	8.0	3	73950	8	0	0
C. Inter-Agency								
Coordination	373	4	0.5	0	47625	5	1	7
TOTALS	9964	100	241.0	100	871015	100	15	100

a/ Not all columns total 100 percent due to rounding.

b/ Does not include \$21,125 in miscellaneous subgrants.

2. Achieved Project Outputs.

With the exception of SMISSA and Marcelino-Lima, all of the PVOs identified in the PP received subgrant support. A total of 63,800 new contraceptive users were attributed to these service delivery projects. All of the PVOs identified in the PP participated in at least one workshop, and the three major service providers (APROSAMI, PROFAMILIA, INPPARES) have participated in all of the workshops. A total of 164 individuals representing 33 institutions in Lima and throughout Peru were trained in one or more workshops.

A study of current population policy and law was commissioned. At the request of, and on behalf of the PVOs, the project undertook advocacy efforts to support liberalization of the voluntary sterilization laws. Finally, the Executive Directors of the PVOs met at SPF on a monthly basis. A major project accomplishment was achieved through the zonification sub-project, in which the three largest service providers in Lima coordinated their programs to reduce duplication of services.

Project outputs are basically congruent with the quantitative measures specified in the PP. However, these measures are insufficient to assess progress in all components, especially that of institutional strengthening, and they bias project activities away from that central feature and towards services expansion.

Table 2, below, summarizes the achievement of output targets against PP-identified benchmarks. It also shows those areas in which targets were not specified.

TABLE 2.
PRIVATE SECTOR FAMILY PLANNING PROJECT (527-0269):
OUTPUT EVALUATION MEASURES SPECIFIED IN THE PP

<u>Component</u>	<u>Target</u>	<u>Achieved</u>
A. Institutional Strengthening:		
Contraceptive Users	400,000	156,400
Medical Personnel	650	61
Non-medical Service Personnel Managers, Administrators, etc.	1,000 200	1,515 169
New Clinical Sites	65	9
New CBD Sites (Posts)	40	161
Institutional Work Plans	Unspecified	4
Improved Accounting Systems	Unspecified	3 Workshops
Evaluation Plans	Unspecified	1 Workshop
Logistical Support System	Unspecified	2 Workshops
Development of IEC Materials	Unspecified	8 Workshops, TA
Trained IEC Personnel	Unspecified	25
Sex Education for Young People	4	1 Subgrant
Public Seminars	10	0
B. Population Policy:		
Policy Research Studies	4	2 Subgrants
Operations Research Studies	10	2 Subgrants collaboration w/ INOPAL
Seminars for Leaders	10	2
Publications	25	15
Policy Bulletin	1	2
Changes in GOP Population Laws	Unspecified	Advocacy for Sterilization
C. Inter-agency Coordination:		
Establishment of PCA	Operations	Draft Bylaws
Income Generation Training	Unspecified	1 Workshop

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INSTITUTIONAL ANALYSIS
OF SIX PARTICIPATING FAMILY PLANNING PVOS

In-depth analyses of the six family planning PVOs, which are the central participants in this project, were conducted by a team of external consultants coordinated by the Population Division of the Office of Human Resources, USAID/Peru. As described earlier, the six PVOs included four organizations in Lima (APROSAMI, ATLF, INPPARES, and PROFAMILIA) and two organizations outside of Lima (CENPROF, in Trujillo, and PLANIFAM, in Cusco). The analyses were based on review of relevant organizational documents, reports and other materials prepared under the SPF project, structured interviews with managers and staff, and observations of family planning service delivery operations. In addition, the six organizations participated in a strategic planning workshop held by consultants from the AID/W centrally-funded Family Planning Management Training Project, and materials prepared as part of the workshop were made available for the institutional analyses.

The institutional analyses focused on three main components of organizational strengths and weaknesses: administration and management, financial operations, and programmatic functioning (family planning service delivery). A family planning market segmentation study was conducted at the same time, collecting commodities distribution information from the public, private commercial, and private voluntary sectors. It also analyzed the logistics and inventory control systems of the PVOs. Each of the four analyses summarized below was conducted by a separate team of local consultants.

A. Administrative and Management Analysis.

The administrative and management analysis focused on two broad issues:

- (a) the organizational capacity of the institution, and
- (b) the "fit" between the institution and the programmatic objectives of USAID/Peru's population sector strategy.

It was conducted by a team of two management consultants who visited each of the six PVOs and conducted a standardized interview with the executive director and his/her administrative staff. They also visited the warehouses, clinics, and some rotating posts.

1. Organizational Capacity.

The consultants adopted a business approach to this analysis. They rated each PVO on 12 scales measuring different aspects of organizational structure and functioning. These scales were weighted according to their importance in developing and implementing marketing strategies.

The rankings showed wide variations among the scales and among the PVOs; however, the relative rankings of the PVOs were fairly consistent across the scales. In general, the PVOs tended to be strongest in the areas of supplies and procurement (mean score = 60%) and financial management (mean score = 61%). Most of the PVOs had logistics and financial management systems in place, but they require significant improvements. Weakest areas were cost analysis (mean score = 0) and revenue generation (mean score = 27%). Not one PVO had implemented any cost analysis system, and their revenue generation schemes were rudimentary at best and require extensive development. Table 1, below, presents the mean scores obtained for each scale.

TABLE 1.
MEAN SCORES BY SCALE

<u>Scale</u>	<u>Weight</u>	<u>Mean Score</u>
<u>High priority (50 percent):</u>		
1. Planning Systems and Capabilities	15	51%
2. Cost Analysis	15	0
3. Financing; Revenue Generation	10	27%
4. IEC/Marketing	10	45%
<u>Medium priority (30 percent):</u>		
5. Supplies/procurement	15	60%
6. Management information systems	10	52%
7. Evaluation	5	45%
<u>Low priority (20 percent):</u>		
8. Financial management	10	61%
9. Quality assurance	5	39%
10. Relations with outside groups	2.5	55%
11. Personnel practices	2.5	50%

Table 2 presents the ranking of the six family planning PVOs based on their overall scores.

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TABLE 2.
RANKING OF PVOS BY MANAGEMENT CAPABILITIES

<u>Agency</u>	<u>Total Score</u>
INPPARES	55.1
PROFAMILIA	53.1
ATLF	*
PLANIFAM	41.2
APROSAMI	37.3
CENPROF	26.0

* A total score could not be derived for ATLF, because several scales were not applicable. Its relative ranking on those scales that did apply was third.

The consistent weakness across all of the agencies evaluated --- in cost analysis and income generation --- poses a considerable challenge to improving their financial sustainability. The extent to which an agency carries out cost analyses determines its ability to identify and control costs in an effective manner. Income generation determines the institution's capacity to identify users' ability to pay, to modify operations and prices, and ultimately to move in the direction of better sustainability.

As demonstrated above, none of the PVOs studied has even the most rudimentary system for cost analysis in place. This area is vital. The lack of internal self-awareness of costs coupled with a general institutional inertia means that any attempt at income generation will suffer from a lack of information on which to base determination of prices.

In general, the lack of awareness and institutional development in these areas speaks to widespread financial inertia and is a constraint to achieving any strategy. In the opinion of the consultants, the high level of dependency on outside donors observed among all of the PVOs presents a significant obstacle to achieving the goals of the project. In order to underline the seriousness with which AID views sustainability, concrete standards of performance need to be established for each PVO and continued AID funding needs to be integrally related to those standards. To be successful, the project needs to establish this linkage --- and separate those PVO that are unable or unwilling to undertake what is needed.

As a consequence of this dependency on donors, all of the PVOs share to a greater or lesser degree the following management problems:

- self-centered instead of market-centered values,
- dependency for leadership on donor agencies and, most recently, on SPF,
- lack of a market strategy, and
- to increase production, they tend to disperse already scarce resources in trying to cover new zones, instead of consolidating and strengthening their existing geographic coverage.

To succeed financially, a business must position itself well with respect to its market and to its competition. There are basically only three marketing strategies available, and the company must adopt one or the other of them:

1. cost leader - because of technological advances, cheap labor, efficiency of scale, etc., the company is able to offer its product at a lower price than the competition;
2. market segmentation - the company finds a niche not being served by its competition; this niche may be defined geographically, by income, or by other consumer characteristics; or
3. differentiation - consumers are willing to pay a higher price for a higher quality product or for a well-known label.

In a competitive market situation, the PVOs would not be able to adopt the first strategy, that of cost leader, because they do not know what their costs are. Given their social orientation of serving lower income groups, the third strategy, differentiation, is also not viable, with the possible exception of the APROSAMI and INPPARES central clinics, which are relatively well furnished and located in higher income areas. It is not reasonable to attempt to mount a differentiation strategy around only two service outlets.

In the opinion of the consultants, the only viable market strategy open to the PVOs is that of market segmentation, targeting their efforts at specific income groups in specific geographic areas. Donor subsidies and commodities permit the PVOs to offer family planning services at lower than market prices affordable by these groups, and the areas themselves are relatively unserved by private physicians and clinics. Zonification is the key to successful implementation of a market segmentation strategy. It is critical that each PVO concentrate its efforts in well-defined zones; left to their own devices, the agencies would probably revert to their old practice of dispersion. Trying to cover larger geographic areas only increases the agency's complexity without achieving economies of scale.

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Organizational capacities and market strategies interact in a synergistic way such that strengths in one area can compensate for weaknesses in another, and the whole is different than the sum of its parts. The consultants ranked each PVO into four qualitative categories as follows:

- Group A: good strategy and a strong organization; characteristics of an excellent organization;
- Group B: poor strategy and a strong organization; characterized by resistance to change and lack of strategic planning;
- Group C: good strategy and a weak organization; characterized by over dependence on a central executive, obsessed with growth, and overly opportunistic to short-lived environmental changes; and
- Group D: poor strategy and a weak organization; characterized by a lack of problem-oriented thinking, defensive posture, and lack of consistency.

Figure 1, below, presents the current qualitative ranking of each of the six PVOs. The arrow indicates the most likely direction of future change.

FIGURE 1.
SUMMARY ORGANIZATIONAL RANKINGS OF THE PVOs

<u>GROUP A</u>	
<u>GROUP B</u>	<u>GROUP C</u>
INPPARES*	*PROFAMILIA
PLANIFAM*	
	*APROSAMI
	*ATLF
	* CENPROF
<u>GROUP D</u>	

- 13' =

2. Individual Assessments.

APROSAMI. APROSAMI can be classified as a type D organization. It suffers both from a limited market strategy and an underdeveloped organizational capacity. Problems of personnel motivation and development negatively impact on its progress. Another important consideration is APROSAMI's primary focus on maternal/child health (MCH), with family planning seen as a part of that activity rather than the institution's principle purpose. The executive director is required to spend time and energy on promoting MCH activities, and as a result has less time available for family planning. With a better marketing strategy, APROSAMI could improve to level C; with a better organizational structure and capacity, it could evolve into level B. Over the medium term, it is not realistic to expect the institution to improve both its strategy and its organizational capacity.

ATLF. ATLF is a level D organization. Its exclusive emphasis on NFP constitutes a severe strategic marketing barrier. The most logical path for ATLF would be to consolidate its organizational capabilities, evolving into a level B organization.

CENPROF. CENPROF is classified as a type D organization due to its lack of internal consistency in its institutional goals. It has evolved as far as it has, more as a function of donor requirements on its subprojects than because of any institutional strategy or decisions. The direction of CENPROF appears defensive and unmotivated.

INPPARES. INPPARES is a typical level B organization. Its classification is due not so much to a lack of internal organization as to an insufficient marketing strategy. INPPARES' direction confuses bureaucracy with production; its institutional development focuses on internal form rather than orienting itself to the external market. In order to develop into a level A organization, INPPARES must overcome its weak marketing strategy, which up to now has not permitted it to improve its income generation.

PLANIFAM. PLANIFAM's classification as a type B organization is largely circumstantial. The charisma and values of its executive director have created a common work ethic among its staff. However, given its inherent institutional fragility, PLANIFAM runs the risk of regressing to level D.

PROFAMILIA. PROFAMILIA is a typical level C organization. It owes its classification to its indefatigable executive director, whose personality is one and the same as the institution's. Its marketing strategy has succeeded in diversifying its donor base. However, as

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an institution, PROFAMILIA lacks organizational cohesion. If it could improve its organizational capacities, it could advance to level B or even level A.

3. Consistency with USAID Strategy.

The aspects of USAID/Peru's population sector strategy that have the most important immediate programmatic impacts on the PVOs include the following:

- (1) increased availability of long-lasting contraceptive methods through expansion of clinical capacity;
- (2) maintained availability of temporary supply methods and NFP; and
- (3) improved economic self-sufficiency.

The consultants evaluated each PVO in terms of its commitment to family planning as its sole institutional objective and in terms of its commitment to long-lasting methods and self-sufficiency. The leadership was also evaluated in terms of their reaction to USAID's change in priority emphasis.

Identification with USAID Priorities. The consistency between organizational objectives and USAID long-term population strategy was rated as high, utilitarian, or low. "High consistency" PVOs showed the following characteristics:

- family planning as the principle institutional objective,
- positive attitude or commitment to long-lasting contraceptive methods,
- orientation to clinical services, and
- diversification of donors.

The consultants rated three PVOs as showing a high consistency with USAID strategy objectives: INPPARES, PLANIFAM, and PROFAMILIA. In the opinion of the consultants, all three agencies have family planning as their central institutional objective, maintain a stated and positive attitude towards long-lasting methods, and show a clear clinical orientation. With the exception of PLANIFAM, they have a broad donor base.

PVOs rated as having a utilitarian identification with USAID strategy maintained family planning as complementary to their institutional objectives. Only one PVO was rated as showing a utilitarian identification with USAID strategy: APROSAMI. This rating was based on the fact that APROSAMI regards family planning as complementary to its principle objective of maternal/child health. As a consequence, its institutional commitment to family planning appears more passive than the three top-rated PVOs.

In illustration of this point, the consultants compared the PVOs in terms of percentage of all consultations devoted to family planning. In 1988, only 18 percent of all consultations provided by APROSAMI were for family planning, compared with approximately 50 percent for INPPARES, PLANIFAM, and PROFAMILIA. Second, in comparison with the other three PVOs, APROSAMI charged the lowest prices for family planning services and commodities. Finally, APROSAMI appeared to have a greater dependence on its principal donor, SPF, for programmatic direction. Its three-year plan was developed by SPF and shows continuing need for technical assistance.

PVOs rated as having low consistency with USAID strategy showed the following characteristics:

- rejection of all but "natural" family planning (NFP) methods, especially long-lasting methods, and
- uncertain or confused institutional commitment to family planning.

Two PVOs were rated in the lowest category: ATLF and CENPROF. ATLF, as an agency dedicated exclusively to NFP, shows an obvious divergence from USAID's goal of improving availability of long-lasting methods; but is consistent with the A.I.D. commitment to the cafeteria approach and maintaining access to temporary supply methods and NFP.

The case of CENPROF is particularly interesting. It reveals an uncertain or confused institutional commitment to family planning. On the one hand, the agency responds to the demands of its donors and runs the gamut from clinical services to sex education, but on the other hand, seemingly without an integrated and coherent institutional service strategy. CENPROF has rented an excellent facility, which is vastly underutilized from the standpoint of clinical services. Its long-term strategy calls for institutional strengthening in administrative systems without clear reference to family planning services goals. Finally, the executive director appeared confused as to his priorities. The administrative staff lacked motivation and appear to be looking to leave the agency.

B. Financial and Accounting Analysis.

This analysis was conducted by a local accounting firm. The team included a senior partner of the firm, certified accountants, and assistants. The study evaluated all subprojects financed by SPF during the period May 31, 1988 - June 30, 1989 and included the following:

- examination and review of the operations and transactions effected during the study period to determine the reasonableness of the expenses charged to the subproject budgets;

- evaluation of the agency's accounting and administrative systems;
- verification of the fixed assets acquired with subproject funds to determine their current status and inventory registration;
- evaluation of the activities carried out by agency administrative personnel to identify incompatible functions which could adversely affect the operation of the agency's internal control system;
- evaluation of each institution's accounting of funds donated by SPF, including the procedures utilized in the preparation of subproject reports; and
- review of external audits and other reports to verify compliance with the recommendations that had been made.

The conclusions and recommendations focused on three broad areas: (a) organizational structure and management; (b) purchasing and inventory; and (c) personnel policies and procedures.

1. Organizational Structure and Management.

General Principles. Given the size and complexity of the institutional budgets, each PVO should have a separate accounting department with an explicitly defined organizational chart, job descriptions, and up-to-date procedures manuals. These systems should make provision for short- and medium-term institutional growth and ensure adequate internal supervision of all steps of the accounting process.

Annual budgets with short-, medium-, and long-term goals should be prepared for the institution as a whole. These institutional budgets should integrate subproject budgets, other sources of income, and other fixed and recurrent expenses. Budgets prepared for individual subprojects cannot substitute for institutional budgets. Monthly institutional cash flow projections should also be made and updated, which permit adequate administration of financial resources and control of the institutional budget.

The accounting system should be computerized and provide for periodic reports. Accounts should be liquidated at least on a monthly basis, and at no time should the balance statements be more than one month out of date. Statements should cover both funds and donated commodities. All monthly and annual reports should be reviewed personally by the executive director.

Peruvian law requires that all institutions, including non-profit organizations, file annual income tax declarations with the Direccion General de Contribuciones. Although they are not required by law to do so, it is advisable that the agencies' annual reports

include revaluations of their fixed assets. Although A.I.D. regulations do not require it, all PVOs should commission annual independent, external institutional audits in addition to the subproject audits stipulated by contract. Subproject financial reviews should not be considered a substitute for global institutional audits.

Finally, each agency should be appropriately equipped with office furniture and equipment, a photocopying machine, and a computer. Insurance policies should be purchased for fixed assets and supplies, tailored to the characteristics of the activities and situation of each institution.

Findings.

Organizational and Procedural Manuals. All of the PVOs lack updated organizational manuals, and their organizational charts do not reflect their real structures. Procedural manuals are not specified in sufficient detail. In many cases, the problem stems from the lack of specialized personnel and/or funds to contract external services. In some cases, the study identified incompatible personnel functions originating from the lack of procedural manuals. For example, at APROSAMI the Administrator is responsible for processing checks and making purchases. At PROFAMILIA, a single person prepares and processes the payroll without any separate review.

Annual Budgets and Cash Flow. Only INPPARES and PROFAMILIA have prepared institutional budgets; the others (ATLF, APROSAMI, CENPROF, and PLANIFAM) have never prepared global budgets. With the exception of INPPARES, none of the PVOs appear to have prepared either monthly or quarterly cash flow projections.

Financial Statements. Three of the PVOs (APROSAMI, INPPARES, and PROFAMILIA) prepare annual institutional balance sheets. The other three PVOs (ATLF, CENPROF, PLANIFAM) do not prepare annual institutional reports and, as a consequence, have not prepared legally certified income tax declarations. None of the PVOs prepares carefully analyzed monthly financial statements. Generally speaking, their accounting activities are focused on preparing subproject financial reports required by their donors.

There appears to be a number of deviations from accepted accounting procedures on the part of the PVOs. For example, APROSAMI debits depreciation from its institutional assets account, and PLANIFAM does not calculate depreciation at all. Only APROSAMI and PLANIFAM revalue their fixed assets; the other PVOs do not. Only INPPARES and PROFAMILIA keep their accounting registers up to date; the other PVOs do not.

In general, the PVOs' accounting systems are not computerized. ATLF and PLANIFAM do not have computers, and not all of the PVOs have adequate accounting software.

Institutional Audits. Only INPPARES conducts independent institutional audits, although individual subprojects have been partially examined by their respective donors.

Liquidation of Expenses. None of the PVOs liquidates expenses on time, in keeping with the time tables stipulated in their subcontracts. A selective review of the PVOs turned up isolated cases at APROSAMI, INPPARES, and PROFAMILIA, in which payments could not be adequately substantiated by the files.

2. Purchasing and Inventory.

General Principles. All the PVOs make substantial purchases of consumable office and medical supplies, as well as infrequent purchases of non-expendable equipment. Sound procurement practices should include bulk purchases whenever possible and obtaining at least three competing bids for all purchases above a certain amount. Bids should be dated and submitted in writing and filed for future reference.

A maximum amount for purchases from petty cash should be established and reviewed periodically. Vouchers for payments made from petty cash should be signed by the cashier and the staff member receiving payment; whenever possible, vendors' receipts should also be collected. Purchase orders for all purchases above the petty cash ceiling should be prepared and submitted to the vendor, with copies filed in the accounting department. Filled orders should be validated against their original purchase orders; delivery invoices should be obtained, and vendor receipts should be stamped "paid" when payment is made. All documents associated with each transaction should be coded with a common identification number and filed for future reference.

Agencies should maintain adequate inventory control of supplies and fixed assets. This includes logging each receipt in at the warehouse or central receiving point before making distributions. Similarly, all distributions should be logged out as they are made and the inventory of consumable supplies updated on a regular basis. Fixed assets (furniture, equipment, etc.) should be tagged with an identification number, and the inventory updated at least on an annual basis.

Findings.

Procurement. None of the PVOs follows a routine practice of soliciting bids from different vendors prior to purchasing supplies or equipment. In some cases, verbal bids are requested, but never as part of an adequately organized system. Four of the PVOs (APROSAMI, ATLF, INPPARES, and PROFAMILIA) prepare purchase orders; CENPROF and PLANIFAM do not prepare purchase orders. In the case of INPPARES, the purchase orders prepared by the agency are not forwarded to the supplier. Three of the PVOs (APROSAMI, ATLF, and PLANIFAM) do not properly document receipt of purchased supplies and equipment.

The value of the inventory of consumable supplies, i.e., stock on hand, should be included in the financial balance sheets. Two PVOs (ATLF, CENPROF) do not include the value of any of their inventory --- neither purchased nor donated supplies --- on their balance sheets. Three PVOs (APROSAMI, INPPARES, and PROFAMILIA) include purchased supplies but do not assign monetary values to donated contraceptives.

Fixed Assets. Two PVOs (ATLF, PLANIFAM) do not tag the non-consumable equipment purchased with donated funds and, consequently, do not have a system of inventory control. The remaining PVOs have appropriate systems of internal control, but they are limited in scope and could be improved.

Only two PVOs (APROSAMI, INPPARES) carry insurance policies against theft, loss, and other risks. The other PVOs (ATLF, CENPROF, PLANIFAM, and PROFAMILIA) do not carry any kind of property insurance.

3. Personnel Policies and Procedures.

General Principles. Under Peruvian labor law, employees acquire "stable" employment status after three months on the job, as a result of which they are entitled to social benefits, additional compensation, and termination benefits. The only exceptions to this rule are workers hired under emergency contracts ("PROEM") and workers given one-time fixed-term contracts. However, should a fixed-term contract be renewed, under current legislation, the worker immediately acquires stable status.

For adequate personnel and payroll management, the employer should maintain a personal record for each worker on the payroll, including a certified statement from the worker listing his/her dependents and all sources of income. The law requires that the employer deduct

income taxes from each worker, based on his/her total remuneration (including overtime and salary supplements) and family size. The employer is also required to pay into social security and other social benefits.

Good payroll management dictates that each employee should fill out and sign a daily time sheet, which in turn is reviewed and approved by his/her immediate supervisor. If the agency's personnel policy includes deductions for tardiness or absence, these deductions should be made by the payroll office before payment is made to the worker.

Findings.

Contracts. Two PVOs (CENPROF and PLANIFAM) maintain personnel on fixed-term contracts to keep them from acquiring "stable" employment status. These contracts are constantly renewed. Under current legislation, these employees have acquired employment stability despite their contractual status.

Employee Time sheets. None of the six PVOs follows the contractual stipulations to maintain signed time sheets for employees paid with subproject funds.

Payroll Deductions. Three PVOs (ATLF, CENPROF, and PROFAMILIA) maintain full-time personnel whom they pay as though they were independent professionals. The agencies deduct only 5 percent income tax for these employees. Instead, these employees should be included on the agency's staff roster and are subject to all of the withholdings and benefits assigned by law.

TABLE 3.
SUMMARY OF FINANCIAL REVIEW: INTERNAL CONTROL SYSTEMS

<u>Criteria</u>	<u>Points</u>	<u>APRO SAMI</u>	<u>ATLF</u>	<u>GEN- PROF</u>	<u>INHP ARES</u>	<u>PLAN IFAM</u>	<u>PRO- FAMILIA</u>	<u>Mean</u>
Accounting	20	12.0	3.5	5.5	19.0	3.5	16.0	50%
Structure	10	3.0	4.5	3.0	3.5	4.5	2.0	34%
Planning	10	-	-	-	8.5	-	3.0	19%
Procurement	15	10.0	6.0	6.0	10.3	6.0	11.5	55%
Personnel	18	14.5	12.0	12.5	16.5	13.5	14.0	77%
Treasury	10	8.5	8.0	9.5	8.0	9.5	8.0	86%
Agreement Compl.	12	8.4	8.4	8.4	8.4	8.4	8.4	70%
Other	5	4.0	0.5	1.5	4.5	1.5	4.0	53%
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Agency Total	100	60.4	42.9	46.4	78.7	46.9	66.9	

C. Programmatic Analysis.

The programmatic analysis was conducted by a two-person team consisting of a family planning physician from a Lima-based PVO not scheduled to participate in the PVFP project and an evaluation specialist. They visited each of the six PVOs during the month of July, 1989. The analysis focused on five programmatic aspects of service delivery: (a) physical facilities; (b) medical equipment and furnishings; (c) service delivery personnel; (d) productivity and cost recovery; and (e) patient flow. The first three relate to quality of care and the last two to sustainability.

1. Physical Facilities.

In general, the PVO clinics presented at least the minimum physical requisites for IUD insertion in terms of space, illumination, utilities, and cleanliness. Some problems were noted in the surgical facilities being readied to offer voluntary surgical contraception. For example, the APROSAMI site is a bit cramped and suffers from frequent power outages due to rationing in the zone. The INPPARES facility has a wood parquet floor that should be taken up or covered with tile to allow easier cleaning.

The conditions of the rotating posts reflect the communities in which they are located. Those located in community facilities tend to be of better construction and sometimes have electricity, water, and bathrooms. Those located in promoters' homes, especially in the pueblos jovenes, are poorly constructed and lack electricity, water, and bathrooms. Minimal but adequate privacy is ensured by placing screens or curtains around the patient examination area.

To compensate for the lack of running water, service delivery personnel have to bring their own water, as they do already with their medical equipment. The lack of bathrooms is harder to remedy; international consultants have suggested that as a minimum, IUD insertion sites should have bathrooms available for patient use; and some patients complained about the lack of this facility. One solution might be to construct or remodel a latrine in the promoter's yard and pay her a small fee for keeping it clean and making it available to clients. Alternatively, given the low rates of complications observed so far, it may be necessary to accept the fact that posts located in pueblos jovenes will not have bathrooms and take special precautions that the equipment and linens brought from the clinic be thoroughly sterilized.

TABLE 4.
SUMMARY OF REVIEW OF PHYSICAL FACILITIES

<u>Agency</u>	<u>No.</u>	<u>Owner.</u>	<u>Space</u>	<u>Electricity</u>	<u>Water</u>
A. <u>Central Facilities:</u>					
APROSAMI	2	rent	insufficient	insufficient	adequate
ATLF	1	rent	adequate	adequate	adequate
CENPROF	2	rent	adequate	adequate	adequate
INPPARES	6	own	adequate	adequate	adequate
PLANIFAM/CUSCO	1	rent	insufficient	insufficient	adequate
PLANIFAM/PUNO	1	rent	adequate	adequate	insufficient
PROFAMILIA/CLINIC	1	rent	adequate	adequate	adequate
PROFAMILIA/MODULE	4	own	adequate	adequate	insufficient
B. <u>Rotating Posts:</u>					
APROSAMI	30	loan	insufficient	none	none
ATLF	11	loan	adequate	adequate	adequate
CENPROF	6	loan	adequate	adequate	insufficient
INPPARES	60	loan	insufficient	none	insufficient
PLANIFAM/CUSCO	5	rent	insufficient	insufficient	none
PLANIFAM/PUNO	8	loan	adequate	none	none
PROFAMILIA	30	loan	insufficient	insufficient	insufficient

2. Medical Equipment and Furnishings.

In general, the clinical facilities of all the PVOs --- both clinics and rotating posts --- were equipped with at least the minimum necessary for carrying out gynecological examinations and inserting IUDs. PLANIFAM/Cusco needs a few basic equipment items to bring its clinic up to the norm. The consultants also recommended that the ATLF field installations be equipped with electrocautery equipment so that they can provide that service locally instead of referring patients to their central facility, and thus provide another potential source of income for the institution.

Four PVOs either are planning to open facilities for voluntary surgical contraception (VSC) or could open a surgical facility with minimal modifications of their current physical plant. They include APROSAMI, CENPROF, INPPARES, and PROFAMILIA. At the moment, none of them possesses the necessary equipment to deal with emergency complications such as cardiac or respiratory arrest. These deficiencies will be brought to the attention of the appropriate GAS (AVSC and JHPIEGO) before the facilities are opened.

3. Service Delivery Personnel.

To evaluate the level of knowledge regarding the institution's philosophy and goals, as well as specific contraceptive methods among the service delivery personnel, the consultants applied a written test that had been developed previously by the Population Council's INOPAL project for use with CBD distributors and validated in Lima at INPPARES. In general, service delivery personnel showed reasonable familiarity with institutional philosophy, but almost total unawareness of service delivery targets or goals. With the exception of ATLF (which offers exclusively NFP), service delivery staff were knowledgeable about modern contraceptive methods.

TABLE 5.
SUMMARY OF EVALUATION OF SERVICE DELIVERY PERSONNEL

Agency	No.	Knowledge Concerning:			Training Needs
		Agency	Targets	Methods	
APROSAMI	15	adequate	none	adequate	Supervisors
ATLF	7	complete	insufficient	insufficient	Instructors
GENPROF	6	adequate	insufficient	complete	Physicians
INPPARES	23	adequate	insufficient	complete	Reception.
PLANIFAM/CUSCO	10	adequate	insufficient	complete	Nurses, Midwife
PLANIFAM/PUNO	4	insufficient	insufficient	adequate	All
PROFAMILIA	20	insufficient	none	adequate	All

4. Productivity and Cost Recovery.

In this analysis, the consultants attempted to quantify the service capacity, production, costs, and cost recovery associated with each PVO's clinic and rotating medical posts. Given the deficiencies in all of the PVOs' information systems (including both accounting and service statistics), as discussed earlier, the following analyses should be considered as preliminary and subject to modification as better data become available. As a follow-up to the present analysis, a detailed cost study of all of the PVOs will be a priority activity during Project Year (PY) 1.

Utilization of Installed Capacity. The installed capacity of a clinical service delivery outlet is a function of the number of consulting areas available, the number and configuration of service delivery staff, the hours the facility is open and staff available, and the clinical services provided. Different clinical procedures (IUD insertion, check-up, Pap smear, etc.) require different

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amounts of time to complete, and different staffing configurations (physician alone, physician plus auxiliary) are capable of producing different levels of output. The consultants devised a standard consultation "unit"; they rated each procedure in terms of units required, and each staffing configuration in terms of maximum unit output. Table 6, below, presents the unit values of each clinical procedure and the production capacity of each staff configuration.

TABLE 6.
DETERMINATION OF CLINICAL FIXED CAPACITY

<u>Clinical Procedure</u>	<u>Unit Value</u>	<u>Staff Configuration</u>	<u>Units/ Hour</u>
Check-up	1.0	Physician alone	4
IUD insertion	2.0	Physician + auxiliary	5
Pap smear	0.5	Midwife	4
Electrocauterization	2.0		
Other procedures	0.5		

Thus, a team of a physician and an auxiliary in two hours could perform 10 check-ups, or 5 IUD insertions, or 4 check-ups and 3 IUD insertions, etc.

In all of the facilities surveyed, the limiting factors were numbers of staff and hours worked (in other words, none of the programs made the mistake of employing more staff than available consulting areas). As can be seen in Table 7, clinic capacity ranged from more than 4,000 consultation units per month (INPPARES clinic and the four PROFAMILIA modules) to 400 units per month (PROFAMILIA clinic). The capacity of the rotating post programs ranged from 1600 units per month (PLANIFAM) to 400 units per month (CENPROF).

Client utilization was calculated from program service statistics. Optimal utilization of a full-time, full-service clinic would be 85 percent (allowing a margin to prevent overcrowding during peak hours) and 85-90 percent for a rotating post. Utilization rates above optimal levels suggest that the installed capacity should be expanded. Utilization rates below 50 percent suggest that installed capacity could be reduced (by reducing staff or hours) to save costs.

Clinic utilization rates ranged from 76 percent (INPPARES) to 16 percent (PROFAMILIA clinic). Two of the clinics (PROFAMILIA and PLANIFAM) should definitely consider cost saving measures. In the case of PROFAMILIA, the consultants recommended moving the clinic to a location closer to the clients served by its outreach program.

Post utilization rates ranged from 99 percent (INPPARES) to 35 percent (PLANIFAM). INPPARES should consider expansion of post capacity, preferably by increasing frequency from the present two sessions a month to weekly sessions. PLANIFAM should consider reducing post capacity, perhaps by reducing the number of biweekly posts or by relocating them. APROSAMI, ATLF, and GENPROF should improve their promotion efforts. (Since ATLF field posts offer only NFP and reproductive health services, they might consider reducing installed capacity.)

TABLE 7.
PRODUCTIVITY AND COST RECOVERY

<u>Category</u>	<u>APRO SAMI</u>	<u>CEN- PROF</u>	<u>INPP ARES</u>	<u>PLAN IFAM</u>	<u>PROFAM. CONSULT</u>	<u>PROFAM. MODULES</u>	<u>ATLF (1)</u>
A. Central Clinics:							
Installed Capacity	1520	800	4400	720	400	4960	-
% Utilization	0.63	0.66	0.76	0.32	0.16	0.54	-
Fixed Cost/Consult.	5143	2488	2668	2972	3180	1292	-
% Cost Recovery (2)	0.09	0.84	0.42	0.06	0.11	0.48	-
B. Rotating Posts:							
Fixed Capacity	900	400	1440	1600	1200	-	600
% Utilization	0.57	0.52	0.99	0.35	0.78	-	0.42
Fixed Cost/Consult.	4906	5203	5854	2394	4757	-	4657
% Cost Recovery (2)	0.03	0.04	0.03	0.06	0.07	-	0.03

Notes: (1) Offers only NFP and reproductive health services.

(2) Expected income if all clients paid posted fees.

Cost Recovery. Cost recovery is a central feature of sustainability. Program managers need to know how much it costs to run their facility and how much income they can expect to generate. Cost recovery is simply the ratio of income to operating expenses. The ratio can be improved by reducing costs and/or increasing income --- the latter by raising prices and/or increasing productivity (leading to economies of scale).

As was revealed in the financial analysis, none of the PVOs have accurate cost information available. Therefore, the results of the following cost recovery analysis are preliminary at best and must be validated by further study. One important source of information that will soon be available is the evaluation of the Lima zonation project, being performed by the Population Council

INOPAL Project. That study will include detailed cost data and cost effectiveness measures for clinics and rotating posts operated by APROSAMI, INPPARES, and PROFAMILIA. Some of the early findings are discussed in the economic analysis. (See Annex VI.)

A full cost recovery analysis must consider both fixed and variable program costs, and actual and potential productivity. Fixed costs include those expenditures incurred as part of the maintenance of a facility and its staff, regardless of productivity. For example, the rent paid on a clinic is the same, regardless of whether one or 100 patients are served. Variable costs are incurred as a result of services delivered and vary directly with productivity; they include consumable medical supplies (gloves, alcohol, etc.) and promotion.

The consultants estimated costs and income as best they could from existing program data. Fixed costs included the facility, equipment and furnishings, health personnel, administration, and transportation. Facility costs were estimated from the monthly rent or as 4 percent of the value of the facility. The rent was prorated, if the facility was shared with other service centers. Program directors were asked to estimate the replacement value in dollars of medical equipment and furnishings; these were depreciated at a constant 10 percent annual rate converted to intis on a monthly basis. Health personnel included those directly involved in patient contact --- physicians, nursing staff, midwives, social workers, and receptionists. Administrative costs were based on administrative staff payroll, prorated by the program director among the clinic, rotating posts, and other service cost centers. Transportation costs included fuel and maintenance, drivers' salaries, and vehicle depreciation (10 percent per year for the first five years, 20 percent thereafter), prorated among the various programs.

Variable costs included consumable supplies and the cost of promotion. Arbitrary costs of \$1.00, \$0.10 and \$0.20 were assigned to IUD insertions, check-ups, and electrocauterization, respectively. Promotion costs were derived from sales of the CBD distributors, who are the major source of reference for the rotating posts. Clinic promotion costs were calculated at 5 percent of CBD proceeds and rotating posts at 20 percent.

Income was derived from patient fees. With the exception of one PVO (PLANIFAM), none of the agencies could furnish these data. Therefore, the consultants asked each facility for its fee structure and estimated the income that would have been generated if all the patients registered in the service statistics had paid the full fee. This estimate may overestimate actual income by several orders of magnitude. On many occasions, observers have reported that many patients either are never asked to pay or pay only a portion of the posted fee. Furthermore, in some of the PVOs, the prices quoted

represent recent increases that went into effect after the study period.

TABLE 8.
PVO FEE SCHEDULES

<u>Service</u>	<u>APRO SAMI</u>	<u>CEN- PROF</u>	<u>INPP ARES</u>	<u>PLAN IFAM</u>	<u>PROFAM CLINIC</u>	<u>PROFAM MODULES</u>	<u>ATLF</u>
A. Clinics:							
Consultation	700	4500	2000	300	2500	1500	
IUD Insertion	2300	8000	2000	3000	3000	1500	
Cauterization	3000	9500	4000	5000	5000		
Pap Smear	3000	8000	2000	3000	3000	2000	
Other		6500	1875				
B. Rotating Posts:							
Consultation	300	500	200-300	200	500		300
IUD Insertion	300	1000	800	3000	1000		
Cauterization				5000			5000
Pap Smear	3000	4000	1000-1800	3000	1000		400

Most PVOs charge more for a service delivered in their clinic than for the same service delivered at a rotating post, on the premise that the posts serve a lower-income clientele. However, there is little consistency from one agency to another: the price of a simple consultation ranges from 700 to 2500 intis in Lima, and the highest price of all is charged in Trujillo. Furthermore, it could not be determined how much clients were actually paying.

Assuming that all clients pay the posted fees (which is almost certainly not the case), cost recovery varies widely by PVO, with clinics recovering more of their costs than rotating posts. Clinic rates range from a theoretical high of 84 percent (CENPROF) to a low of 6 percent (PLANIFAM), and most of the posts average below 5 percent (PROFAMILIA shows a high of 7 percent).

Potential for Self-Sufficiency. It is obvious from the preceding analysis that at the present time, none of the PVOs is anywhere near self-sufficiency. However, given as productivity is also low, it is not clear how much better the situation would be if utilization rates were higher. For this analysis, we calculated the minimum fixed cost of delivering one consultation unit at each facility, assuming that the facility operated at 100 percent of its current installed capacity. That is, we divided the total fixed costs of the facility by its total installed capacity.

The results of this analysis are presented in Table 9. We find that there is great variation among the PVOs; indeed, for three of the five PVOs that operate both clinics and rotating posts, the minimum fixed unit costs are higher in posts than in clinics.

TABLE 9.
MINIMUM FIXED UNIT COSTS
(in July 1989 Intis)

<u>Service</u>	<u>APRO SAMI</u>	<u>CEN- PROF</u>	<u>INPP ARES</u>	<u>PLAN IFAM</u>	<u>PROFAM CLINIC</u>	<u>PROFAM MODULES</u>	<u>ATLF</u>
A. Central Clinics:							
Facility	230	475	11	139	1000	7	
Equipment & Furniture	73	68	30	77	187	47	
Health Personnel	1421	749	1415	756	1141	781	
Administration	3360	1007	1212	1681	931	204	
Transportation	<u>59</u>	<u>189</u>	<u>0</u>	<u>320</u>	<u>0</u>	<u>252</u>	
T o t a l	5143	2488	2668	2972	3180	1292	
B. Rotating Posts:							
Facility	36	18	62	48	25	-	53
Equipment & Furniture	214	18	220	37	154	-	73
Health Personnel	1490	864	1844	976	1372	-	1740
Administration	2270	2685	1852	757	776	-	1825
Transportation	<u>896</u>	<u>1515</u>	<u>1876</u>	<u>576</u>	<u>2431</u>	-	<u>957</u>
T o t a l	4906	5203	5854	2394	4757	-	4647

These results raise a number of important questions. First, are the data correct. This can be answered only by further study. Assuming that the data, if not completely correct, are representative, we must then ask why there is so much variation from one PVO to another, why post costs are higher than clinic costs, and what the implications are for sustainability.

Examination of the cost structure of the different facilities leads to several important, if tentative, conclusions. First, some administrative costs are too high: 65 percent of APROSAMI's clinic unit cost goes to overhead, as does 52 percent of CENPROF's post cost. Second, it appears cheaper to own than to rent: less than 1 percent of INPPARES' clinic cost goes to facility (owned), compared to 31 percent of PROFAMILIA's clinic cost (rent). Third, post unit costs are higher than clinic unit costs because of higher relative equipment costs (less possibility of economies of scale) and because of higher transportation costs. PROFAMILIA's office is located at a considerable distance from its community program, and as a result,

51 percent of its post cost goes to transportation, compared to 18 percent of APROSAMI's post cost (PROFAMILIA's cars are also very old and need frequent repair).

TABLE 10.
COST DISTRIBUTION AS PERCENTAGE OF FIXED OPERATING COSTS

<u>Service</u>	<u>APRO SAMI</u>	<u>CEN- PROF</u>	<u>INPP ARES</u>	<u>PLAN IFAM</u>	<u>PROFAM CLINIC</u>	<u>PROFAM MODULES</u>	<u>ATLF</u>
A. Central Clinics:							
Facility	0.04	0.19	0.00	0.05	0.31	0.01	
Equipment & Furniture	0.01	0.03	0.01	0.03	0.03	0.04	
Health Personnel	0.28	0.30	0.53	0.25	0.36	0.60	
Administration	0.65	0.40	0.45	0.57	0.29	0.16	
Transportation	<u>0.01</u>	<u>0.08</u>	<u>0.00</u>	<u>0.11</u>	<u>0.00</u>	<u>0.20</u>	
T o t a l	1.00	1.00	1.00	1.00	1.00	1.00	
B. Rotating Posts:							
Facility	0.01	0.00	0.01	0.02	0.01	-	0.01
Equipment & Furniture	0.04	0.02	0.04	0.02	0.03	-	0.02
Health Personnel	0.30	0.17	0.32	0.41	0.29	-	0.37
Administration	0.46	0.52	0.32	0.32	0.16	-	0.39
Transportation	<u>0.18</u>	<u>0.29</u>	<u>0.32</u>	<u>0.24</u>	<u>0.51</u>	-	<u>0.21</u>
T o t a l	1.00	1.00	1.00	1.00	1.00	-	1.00

In terms of sustainability, it appears that with appropriate cost containment and high productivity, clinic facilities can approach self-sufficiency through patient fees. Four clinics (CENPROF, INPPARES, PLANIFAM, and PROFAMILIA modules) already show minimum unit fees of less than \$1.00 (with the exception of PLANIFAM, less than \$2.00 at current productivity levels). Market studies are needed to determine how high the fees can be set, and a sliding scale may prove effective.

Second, it is clear that posts are inherently more expensive to operate than clinics, and given lower client income, they can never reasonably expect to become self-sufficient through patient fees. Post programs must strive to achieve higher productivity and greater installed capacity (perhaps through longer and/or more frequent sessions at popular post sites) to attain better economies of scale. Increased use of nurse auxiliaries and midwives at post locations should also be studied as a way of containing costs. Even in the best programs, rotating posts will require external operating subsidies, either from donors or from PVO income-generating activities.

5. Patient Flow.

Given the suboptimal utilization rates in clinic facilities, observed patient waiting time was generally within reasonable limits. In some of the facilities, patients began to arrive before the physicians, producing an initial backlog at the beginning of the session. Similarly, the post sessions that were observed did not present major problems in patient flow. Given these observations, and the urgency of other problems, formal evaluations of patient flow do not appear warranted at this time in any of the PVOs.

D. Commodities and Logistics Analysis.

Information for this analysis was collected by a local consultant with previous experience in PVO family planning programs, who visited each of the five PVOs which distribute modern contraceptive methods: APROSAMI, CENPROF, INPPARES, PLANIFAM, and PROFAMILIA. These visits were conducted during the months of May-June, 1989.

The study was originally designed to collect monthly movement of contraceptives out of and into the agencies' warehouses and to compare these totals with the amounts actually delivered to family planning users by CBD distributors and supervisors and clinical staff. However, not all of the agencies had previously summarized their warehouse movement, and the service statistics formats varied from agency to agency.

Therefore, it was decided to confine the study to movement of commodities out of central agency warehouses. For each institution, monthly commodity shipments from the agency's central warehouse to distribution outlets were recorded for the calendar years 1988 and 1989; in the case of INPPARES, only annual totals were available. Commodities delivered to users were not recorded. Therefore, it is possible that the warehouse shipments either overestimate distribution to users (if stock on hand increased during the period) or underestimate distribution to users (if stock on hand decreased during the period). However, this is the only standard measure that could be applied to all PVOs.

1. General Conclusions.

Annual commodity movements out of central agency warehouses are presented in Tables 11 (for 1987) and 12 (for 1988), listed by contraceptive method and PVO.

TABLE 11.
DISTRIBUTION OF COMMODITIES
BY FAMILY PLANNING PVOS, 1987

<u>Destination</u>	<u>APRO SAMI</u>	<u>CEN- PROF</u>	<u>INPP ARES</u>	<u>PLAN IFAM</u>	<u>PRO- FAMILIA</u>	<u>Total</u>
Method: IUD						
Own Services	893	240	27971	363	2577	32044
Other Institutions	0	0	25200	0	1300	26500
Commercial	112	76	33332	0	0	33520
Miscellaneous	<u>1</u>	<u>0</u>	<u>435</u>	<u>0</u>	<u>13</u>	<u>449</u>
T o t a l	1006	316	86938	363	3890	92513
Method: Pills						
Own Services	87709	9932	438893	10200	65300	612034
Other Institutions	0	0	69420	0	200	69620
Commercial	554	0	51142	0	0	51696
Miscellaneous	<u>0</u>	<u>0</u>	<u>1670</u>	<u>0</u>	<u>200</u>	<u>1870</u>
T o t a l	88263	9932	561125	10200	65700	735220
Method: Condoms						
Own Services	1818360	59011	3241644	173000	47700	5339715
Other Institutions	0	0	724991	0	67000	791991
Commercial	61325	133430	1174202	0	36000	1404957
Miscellaneous	<u>298</u>	<u>0</u>	<u>2762</u>	<u>0</u>	<u>8</u>	<u>3068</u>
T o t a l	1879983	192441	5143599	173000	150708	7539731
Method: Foam/Jelly						
Own Services	22716	6003	3708	3474	1858	37759
Other Institutions	0	0	2402	0	1412	3814
Commercial	2404	1179	1471	0	0	5054
Miscellaneous	<u>7</u>	<u>0</u>	<u>146</u>	<u>0</u>	<u>2</u>	<u>155</u>
T o t a l	25127	7182	7727	3474	3272	46782
Method: Vaginal Tablets						
Own Services	0	0	23040	0	15460	38500
Other Institutions	0	0	0	0	0	0
Commercial	0	0	0	0	0	0
Miscellaneous	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>2</u>	<u>2</u>
T o t a l	0	0	23040	0	15462	38502

TABLE 12.
DISTRIBUTION OF COMMODITIES
BY FAMILY PLANNING PVOS, 1988

<u>Destination</u>	<u>APRO SAMI</u>	<u>GEN- PROF</u>	<u>INPP ARES</u>	<u>PLAN IFAM</u>	<u>PRO- FAMILIA</u>	<u>Total</u>
Method: IUD						
Own Services	1610	405	36693	146	4512	43366
Other Institutions	30	0	15214	0	7	15251
Commercial	394	1990	9573	0	81	12038
Miscellaneous	<u>189</u>	<u>0</u>	<u>793</u>	<u>0</u>	<u>0</u>	<u>982</u>
T o t a l	2223	2395	62273	146	4600	71637
Method: Pills						
Own Services	79200	11207	439020	15744	63400	608571
Other Institutions	5000	0	52144	0	15000	72144
Commercial	3367	2104	26292	0	200	31963
Miscellaneous	<u>426</u>	<u>0</u>	<u>6359</u>	<u>35</u>	<u>0</u>	<u>6820</u>
T o t a l	87993	13311	523815	15779	78600	719498
Method: Condoms						
Own Services	856173	369695	3725867	25700	131100	5108535
Other Institutions	129	0	514924	0	11300	526353
Commercial	670254	70972	54763	0	16200	812189
Miscellaneous	<u>3136</u>	<u>0</u>	<u>3213</u>	<u>280</u>	<u>0</u>	<u>6629</u>
T o t a l	1529692	440667	4298767	25980	158600	6453706
Method: Foam/Jelly						
Own Services	10355	2386	5090	2774	2637	23242
Other Institutions	0	0	0	0	6	6
Commercial	11122	132	0	0	202	11456
Miscellaneous	<u>118</u>	<u>0</u>	<u>0</u>	<u>201</u>	<u>0</u>	<u>319</u>
T o t a l	21595	2518	5090	2975	2845	35023
Method: Vaginal Tablets						
Own Services	130600	64365	423854	23518	54920	697257
Other Institutions	336	0	50509	0	2200	53045
Commercial	56175	28800	22032	0	9400	116407
Miscellaneous	<u>327</u>	<u>0</u>	<u>8480</u>	<u>280</u>	<u>0</u>	<u>9087</u>
T o t a l	187438	93165	504875	23798	66520	875796

It can be seen that agencies differ widely in quantities moved. As expected, INPPARES showed the greatest movement, accounting for 87 percent of the IUDs, 73 percent of the pills, and 67 percent of the condoms moved in 1988. With the exception of vaginal foaming tablets, total movement of all contraceptive methods decreased from 1987 to 1988, although the agencies reported serving more family planning users. In most cases, only the two largest agencies (INPPARES and APROSAMI) reported decreases in stock moved, while the smaller agencies (CENPROF, PLANIFAM, and PROFAMILIA) reported increases. This net decline may reflect overstocking in 1987 and a subsequent decrease in inventories in 1988.

Table 13 summarizes annual movement of commodities by method and destination for all five PVOs.

TABLE 13.
DISTRIBUTION OF COMMODITIES BY FAMILY PLANNING PVOS

<u>Destination</u>	<u>1987</u>		<u>1988</u>	
	<u>Total</u>	<u>% Total</u>	<u>Total</u>	<u>% Total</u>
Method: IUD				
Own Services	32044	0.35	43366	0.61
Other Institutions	26500	0.29	15251	0.21
Commercial	33520	0.36	12038	0.17
Miscellaneous	<u>449</u>	<u>0.00</u>	<u>982</u>	<u>0.01</u>
T o t a l	92513	1.00	71637	1.00
Method: Pills				
Own Services	612034	0.83	608571	0.85
Other Institutions	69620	0.09	72144	0.10
Commercial	51696	0.07	31963	0.04
Miscellaneous	<u>1870</u>	<u>0.00</u>	<u>6820</u>	<u>0.01</u>
T o t a l	735220	1.00	719498	1.00
Method: Condoms				
Own Services	5339715	0.71	5108535	0.79
Other Institutions	791991	0.11	526353	0.08
Commercial	1404957	0.19	812189	0.13
Miscellaneous	<u>3068</u>	<u>0.00</u>	<u>6629</u>	<u>0.00</u>
T o t a l	7539731	1.00	6453706	1.00
Method: Foam/Jelly				
Own Services	37759	0.81	23242	0.66
Other Institutions	3814	0.08	6	0.00
Commercial	5054	0.11	11456	0.33
Miscellaneous	<u>155</u>	<u>0.00</u>	<u>319</u>	<u>0.01</u>
T o t a l	46782	1.00	35023	1.00
Method: Vaginal Tablets				
Own Services	38500	1.00	697257	0.80
Other Institutions	0	0.00	53045	0.06
Commercial	0	0.00	116407	0.13
Miscellaneous	<u>2</u>	<u>0.00</u>	<u>9087</u>	<u>0.01</u>
T o t a l	38502	1.00	875796	1.00

Significant quantities of contraceptives were delivered to non-PVO service outlets, including other institutions (often municipalities and other public sector outlets) and the commercial sector (including private physicians, factories, and "marketing" activities carried out by PVO personnel). Totals range from 65 percent of all IUDs moved in 1988 to 15 percent of all pills moved in 1988. These do not include commodities originally delivered to PVO clinical and CBD outlets which may have been subsequently marketed.

The study also revealed a number of deficiencies in management of commodities and logistics that were common to all PVOs. They included the following:

- at the level of the central warehouse, none of the PVOs maintain systematic reports of the movement of contraceptives, although all keep records in one form or another;
- none of the PVOs validate their service statistics (users served, commodities distributed to users) against the warehouse shipments;
- the official reports published by the PVOs do not coincide with the information obtained from the warehouses; and
- all PVOs need technical assistance to develop, install, and maintain adequate logistics control norms and procedures.

2. Individual Findings.

APROSAMI maintains a card file in its warehouse which records movement into and out of the warehouse. Due to overstocking, in some months, the quantity of outdated commodities returned to the warehouse exceeds the amount distributed out of the warehouse. In addition to its Lima operations, during the period 1987-1988, APROSAMI sent commodities to Arequipa, Cajatambo, Huacho, and Piura.

CENPROF registers warehouse shipments separately for supervisors, posts, and physician offices. Balance sheets for supervisors and physician offices are prepared separately by a controller. CENPROF's IUD "marketing" and CBD activities extend as far as the city of Tumbes.

INPPARES maintains a computerized logistics system, but the data are not cleaned and are therefore unusable. The warehouse also maintains manually derived annual totals of commodities moved, which formed the basis of the present study. In addition to its central warehouse, INPPARES stocks 14 regional warehouses: Arequipa, Ayacucho, Cajamarca, Callao, Chiclayo, Chimbote, Ica, Ilo, Iquitos, Juliaca, Moquegua, Piura, Tacna, and Tumbes.

PLANIFAM's central warehouse is too small to store its inventory, commodities received are transferred immediately to storerooms located in each of its five service outlets. The two largest storerooms supply the other three. Each storeroom keeps its own records, and there is no feedback or consolidation at the central level. Shipments to Puno are recorded in Cusco.

PROFAMILIA. Due to the recent move of PROFAMILIA's administrative offices, it appears that some of the warehouse records have been lost or misplaced. The warehouse figures often differ substantially from the official reports; sales and shipments to provincial programs are entered under the Lima CBD program. During the period 1987-1988, PROFAMILIA shipped commodities to Canete, Huancayo, Mala, and Tingo Maria.

INSTITUTIONAL ASSESSMENT OF PRISMA

A. Background.

Proyectos en Informatica, Salud, Medicina y Agricultura (PRISMA) was legally constituted in Peru as a charitable association in April 1986. It was registered in the Lima Public Registry for Registered Associations in Peru on June 5, 1986. It is also registered with the Ministry of Health, the National Planning Institute (Registry of Private Non-profit Institutions Receiving International Technical Cooperation in Welfare and Culture), and the Ministry of Economy and Finance as a tax-exempt organization and as an institution to which donations are tax deductible. PRISMA was granted a certificate of eligibility as a registered foreign PVO by USAID/Peru on November 3, 1986.

PRISMA's raison d'etre is to work with urban and rural poor populations fostering their participation in, and benefit from, modern technology in the areas of medicine, public health, agriculture, and information systems. PRISMA's medium term (1989-1994) objectives include:

1. Development of services and operation research projects that will improve the quality of life and reduce and/or prevent maternal and child mortality and malnutrition in the peri-urban and rural poor.
2. Work in coordination with the MOH and international agencies to insure that the results of PRISMA operational research would be appropriately used by the MOH in making decisions effecting policy.
3. Develop research projects addressing current scientific problems of infections diseases, which directly or indirectly effect the maternal and child population of the urban and rural poor.
4. Develop research and/or service projects on animal diseases which create a public health risk to target population.
5. Continue to develop institutional capacity to publish educational material directed to all levels and offer publishing services which will contribute to self sufficiency.
6. Continue to apply computer technology to all above mentioned programs and offer computer services as an income generating activity.

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7. Maintain an institutional base, which will continue to support the work of the members of the technical committee, in the above mentioned areas; the institutional development of funds generated for self-sufficiency and other services will be placed at the disposal of pilot and preliminary programs if necessary.

PRISMA's offices are located in a rented house of 350 square meters, containing 16 separate rooms, in San Borja, a residential area of Lima. The house is fully furnished as offices and includes equipment such as 25 computers (an additional 12 computers are located at various project locations), 2 laser printers, a scanner, and an assortment of typewriters, calculators, etc. PRISMA owns two vehicles (one purchased with private funds and the other provided by a USAID food project) and leases an additional 3 vehicles. The estimated value of the items owned is \$230,000.

B. Organization.

PRISMA is administered by an Executive Director, Josephine B. Gilman, MPH, and an Administrative Director, Dr. Jose Flores Priale. It has an eight-person Board of Directors, of whom six are Peruvians. At the present time, PRISMA employs 23 full- and part-time professional staff, principally physicians, four technical personnel, and almost 50 full and part-time auxiliary personnel. Its administrative department employs two professional and four auxiliary staff members.

During 1988, PRISMA executed a total budget of \$756,400 among its A.I.D.-related projects. At the present time, its A.I.D.-related budget to be administered during 1989 is \$533,800, plus \$5,977,025 worth of food commodities under Project 527-0323 - Integrated Food, Nutrition and Child Survival: A Joint Effort Between a PVO and the MOH.

C. Experience with A.I.D.-Funded Projects.

1. **Integrated Food, Nutrition, and Child Survival: A Joint Effort Between a PVO and the MOH - Project No. 527-0323.**

PRISMA manages a four-year operational program grant (OPG) for \$750,000 which began in FY 1989 with a Project Year (PY) 1 budget of \$322,980 for the Ministry of Health Supplementary Feeding Program (from ARDN, HE, CS accounts). Subsequent PY budgets are \$181,125; \$177,905; and \$68,000 for Years 2, 3, and 4, respectively. The overall budgets, however, increase significantly beginning in PY 2 as a result of food monetization.

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Under this project, PRISMA is responsible for supervising, facilitating, and tracking the distribution of food, donated under the P.L. 480, Title II Program, to 25 Ministry of Health Departmental Health Units (UDES), which then distribute to hospitals, clinics, and posts for a total of approximately 2,000 distribution points nationwide. During 1989, PRISMA plans:

- to identify approximately 75,000 families at risk of maternal and child malnutrition and mortality;
- to train 1250 Ministry of Health personnel in all aspects of Child Survival Actions such growth and development, nutritional surveillance immunizations, breast-feeding, health and sanitation, and family planning; and
- to distribute donated foods to high risk families and school age children (166,000, during PY 1, and 216,000, during PY 2).

PRISMA also plans to conduct a national level nutritional surveillance base line and develop a model for nutritional surveillance to be used by the UDES.

2. Ninos Magazine - Project No. 527-0316.

PRISMA received a two-year OPG for a total of \$214,260 to prepare, print, and distribute 10 issues of a magazine, Ninos, dedicated to various child survival topics. To date, six issues have been prepared and distributed on subjects including, immunizations, acute respiratory infections, breast-feeding, growth and development, family planning and prenatal care. The remaining four issues to be published during 1989 will include: birth and puerperium, peri-natal mortality, nutrition, and community participation.

3. High Risk Child Mortality - Project No. 527-0311.

PRISMA manages a three-year grant for \$980,000. This project entails developing and applying a screening tool to identify families at high risk of childhood malnutrition and mortality. The screening tool has been developed and field tested, and a health promoters' training manual has been developed. Three hundred and forty community health promoters have been trained. A baseline census has been taken in Cajamarca Department, and field trials of a training module for community health workers are being carried out.

4. TIPPS Project.

PRISMA received a \$5,000 work order from the TIPPS Project, an AID/W centrally funded population activity, to prepare training and supervision materials to be used in the implementation of integrated

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family planning/maternal/child health services in mining companies in Peru. These materials have been prepared and pretested and are awaiting final testing (which has had to be postponed due to security problems at the mine) and revision.

5. Involving Family Planning Workers in AIDS Prevention Campaign - INOPAL and Population Communication Services.

PRISMA serves as the pass-through agency for a Ministry of Health project in AIDS prevention jointly funded by two AID/W centrally funded projects: INOPAL (Latin American family planning operations research, undertaken by The Population Council) and Population Communications Services (Johns Hopkins University). PRISMA provides full program administration and accounting for these two subgrants, which employ two permanent professionals and supporting staff to carry out a series of activities including special IEC campaigns and surveys.

6. Development of Promotional Services for the Private Sector Distribution of Oral Rehydration Salts - Project No. 87-AID-343 (PATH).

During the first phase (October 1987 to January 1988), PRISMA worked with a local pharmaceutical company, Laboratorios Unidos S.A. (LUSA), on the design and testing of new packets of oral rehydration salts (ORS). Activities included the selection of a product name, field testing of the name and packet design. A second phase initiated in May 1989 is for the development of promotional materials. This work should be completed by September 30, 1989. Total project costs: \$51,081.

7. Health Systems Analysis - PRICOR Project.

PRISMA was the local subcontractor to a U.S.-based entity (PRISM) operating under the AID/W centrally funded PRICOR Project (operations research in primary health, undertaken by the Center for Human Services). The purpose of this 18-month, \$79,963 project (which terminated in June 1989) was to conduct a systems analysis of primary health care services delivery in Ministry of Health installations in the Southern Cone of Lima. Other activities connected with this project have included a household census in three districts of the Southern Cone and an evaluation of the 1988 Ministry of Health Vaccination Campaign.

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D. Experience with Non-A.I.D. Funding Sources.

In addition to A.I.D. project experience, PRISMA has also received funds from various foundations, other donors and Peruvian based organizations. Some of these and activities carried out include:

1. Milpo Mining Company.

Along with Instituto Marcelino, PRISMA has a contract with the Milpo Mining Company to provide training and supervision for the mine's integrated family planning/maternal/child health service delivery project. Now in its second year, PRISMA has received \$3,122 for training and supervision services.

2. University of Arizona Veterinary Department, Thrasher Foundation.

In conjunction with the Universidad Peruano Cayetano Heredia, PRISMA is participating in a study of transmission of Cryptosporidium, which causes diarrhea in young children. PRISMA is responsible for the management of the grant and for the collection of field data and specimens. This one-year, \$30,000 study is the second time PRISMA has participated in similar work with the Thrasher Foundation.

3. World Health Organization (WHO).

PRISMA received a \$60,000 grant from the Safe Motherhood Program to conduct a "multidisciplinary approach for the prevention of abortion", for two years beginning in 1989. The purpose of this grant is to identify women who have experienced illegal abortions, establish a profile of those at risk of future abortions, and design clinic-based interventions and materials responding to the needs of this risk group.

4. International Foundation for Science.

In 1989 PRISMA received a \$12,000 grant to conduct a study on the use of vaccination to prevent porcine Cysticercosis. This 6-month project which began in June 1989, was carried out in coordination with the San Marcos School of Veterinary Medicine.

E. USAID In-House Management Review.

Using the findings from a financial review recently conducted and an administrative capability assessment done in May, 1989, a financial analysis team from the USAID/Controller's Office made a summarizing determination of financial and administrative capability which was accepted by the RCO as the base for his award. However, in anticipation of its possible role in the Private Voluntary Family

Planning Services Expansion Project, a preliminary capability assessment of PRISMA for administration of that project was conducted by the USAID Population Division during April 1989. That assessment provided the following findings:

- a. Management capability, technical leadership, and support personnel currently on board to oversee grants to PVOs and to provide technical assistance:

PRISMA has a large full-time staff in Lima. The technical committee, senior staff members who oversee projects, is made up of a dozen public health professionals, nine of whom are physicians. The Executive Director, Josephine Gilman, has had extensive project management experience in Peru and Bangladesh.

- b. Financial structure and experience commensurate with handling a project involving over \$2,000,000 a year; adequacy of fiscal systems to handle financial management and reporting requirements:

PRISMA has an A.I.D.-oriented financial infrastructure in place and works successfully with the Mission on projects totaling approximately \$500,000 annually. The PRISMA accounting system is in the process of being computerized and is supervised by a well-qualified lawyer/accountant and financial expert. PRISMA has extensive experience managing complex financial tracking programs under the hyperinflationary conditions of Peru.

- c. In-depth experience in commodity management, including inventory control and warehouse supervision:

PRISMA's experience in this area derives from its oversight of the Food for Development Program. Food commodities are one of the most difficult to manage, and PRISMA has received high marks from USAID/Peru for its performance in overseeing distribution of 15,000 tons of commodities.

- d. Physical infrastructure (computers, office space, vehicles, etc.):

PRISMA currently rents a three-story building and plans to seek a new locale enabling it to expand. The organization has 25 microcomputers on-site and 12 located in off-site project offices, extensive

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software, including desktop publishing and laser printers, and personnel trained in their use. It also has two vehicles, leases three, with a sixth awaiting release from customs.

- e. Potential for overload, jeopardizing not only management of the PVFP Project but also other, current A.I.D. and other projects:

It appears that, given PRISMA's base in project implementation, changes to accommodate the PVFP Project would be additive and would fit within the agency's current growth plans. However, one of USAID's concerns is that PRISMA could be overloaded, and is cognizant that careful on-going project monitoring is warranted. One Cooperating Agency did report that PRISMA may be showing signs of overload (simple and repeated mistakes on vouchers, for example). Therefore, the Mission should be prepared to offer management guidance to PRISMA and will assist in staffing for implementing the PVFP Project.

F. Financial Review and Management Assessment.

Additionally, USAID/Peru included PRISMA in a financial review and management assessment that was being conducted for the PVO institutional analysis. The results were provided immediately below.

1. Financial Review.

PRISMA's financial management systems and procedures were evaluated by a team of local auditors during July, 1989. As is often the case with financial audits and reviews, the report focused exclusively on agency weaknesses and did not detail agency strengths. These auditors made the following observations and recommendations for improvement:

General Accounting System. The following problem areas were noted, and PRISMA has begun to take steps to correct them:

- At the time of the review, a final accounting for 1988 (December 31) had not yet been prepared, and monthly balance sheets were not available. According to the Executive Director, this delay was caused by the on-going conversion from the current manual accounting system to a computerized system. For the same reason, the agency's 1988 income tax statement had not yet been presented to the Direccion General de Contribuciones.

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- The organization does not revalue its fixed assets to compensate for inflation. Although as a non-profit institution, PRISMA is not required by law to do so, the auditors felt that it was a good accounting practice to follow.
- The auditors recommended that PRISMA expand and restructure its accounting department. The chief accountant appeared to be overloaded, mainly because he spends a large part of his time preparing subproject reports and accounts. In addition, in the opinion of the auditors, the accounting department lacks sufficient auxiliary personnel.

Organizational Manuals and Procedures.

- The auditors recommended that PRISMA update its organizational chart, which had been prepared in 1987 and which did not reflect recent expansion to include the offices of project coordination and planning and budgets, and the food logistics unit.
- The organizational manual does not include the accounting and treasury unit in particular, and in general lacks uniformity across areas. As a result, the manual is practically unused.
- Administrative personnel are unfamiliar with the organizational manual.

Independent Institutional Audit.

- It appears that PRISMA has not commissioned any independent institutional audit, although subproject audits have been performed. The auditors recommend annual institutional audits as a sound accounting practice.

Budgets and Cash Flow.

- At the present time, PRISMA prepares annual budgets and cash flow projections separately for each project it administers. The auditors recommend the preparation of an institutional budget and cash flow projections which incorporate all sources of income and expenses, and which is related to the organization's short-, medium-, and long-term objectives.
- The auditors recommend that PRISMA establish a policy to require bids whenever purchases above a certain level are made.

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Miscellaneous.

- PRISMA has not taken out an insurance policy on its assets.
- Donated and other vehicles have not been entered into the accounting books.
- Employee income tax deductions are made on an estimated basis, rather than on the basis of employee declarations, as is required by law.

2. Administrative and Management Review.

An administrative/management review was conducted by a two-person team of business consultants who visited PRISMA and interviewed administrative and program staff. They applied the same instrument used in the administrative/management review of the family planning service delivery PVOs. The highly positive results of this study were provided below:

- a. PRISMA has developed mid-term strategic plans which have required minimal change and can be carried out with current staff.
- b. PRISMA has developed a participatory system of work which has resulted in a high degree of motivation.
- c. The most notable element of staff coordination is found in the food program, for which a computerized tracking system has been developed to monitor from its arrival in country to points of distribution.
- d. Effort is being made to generate income, i.e. desk top published and computer services.
- e. A computerized system of accounting is being implemented.
- f. An organization chart, personnel manuals and salary policies are in place. The most important aspect of PRISMA's personnel practices is the flexibility permitted by combining project administration with use of a technical coordinating committee. This results in highly motivated personnel, encourages participation, creativity, and innovation among the group and results in a high morale level.
- g. Its evaluation system requires minor changes which can be achieved with staff training.

- h. Because PRISMA is to lead the change required of the PVO's by the A.I.D. strategy, a special effort was made to verify PRISMA's attitude toward change. The findings were positive: PRISMA ranked highest among those studied.

The salient conclusions of the management assessment are the following:

- The institutional weaknesses observed are procedural and mostly related to the accounting system which is being corrected by implementing a computerized system.
- PRISMA possesses management capabilities sufficient to carry out the logistical functions of the project.
- PRISMA exhibits the strong positive attitude toward change, the appropriate management capability, and the total congruency with the A.I.D. strategy, needed to lead the change proposed and replace SPF; it will have the added advantage of uprooting SPF's dominating management style with a participatory one, as is evidenced by PRISMA's organizational culture.
- The evaluation of PRISMA as a catalytic agent for change was oriented toward defining the degree of institutional maturity and its ability to carry out the role assigned to it by AID. The institution presents an organization, which provides the degree of flexibility needed to execute an project assignment without organizational disruption.
- Its planning system is simple but participatory, to obtain the motivation of staff necessary to achieve goals.
- The organization carries out the logistic tasks of the current large and complex project with the MOH.
- In a ranking to assess reactions to change, PRISMA surpassed all other groups, perceiving change as a clear opportunity for institutional development.

ECONOMIC ANALYSIS

The goal of the project is to enhance the ability of Peruvian families to achieve the desired number and spacing of children by increasing the capacity of the six target agencies to deliver long-lasting methods while maintaining support for their delivery of temporary supply and natural methods. This in turn will support GOP efforts to relieve pressure on the country's health, education, and nutrition infrastructures by slowing population growth. The project has three specific objectives: institutional development, which includes enhanced efficiency, greater service delivery capacity, and increased self-sufficiency for the target agencies; increased availability of long lasting methods; and improved access in rural areas. This section will examine the economic justification and feasibility of each of these objectives.

A. Institutional Development.

1. Efficiency.

As this project builds on the previous SPF project, it is therefore useful to start by examining the extent to which SPF-initiated policies were successful in producing measurable results. A recent study by the Population Council compared service delivery and cost effectiveness of the three Lima-based agencies (APROSAMI, INPPARES, PROFAMILIA) for the periods Oct 86-Sept 87 and Oct 87-Sept 88, before and after the city of Lima was divided into three zones. A significant expansion of services and reduction in average costs was found for each agency.

APROSAMI more than doubled its level of services in the second period, from 12,215 couple years of protection (CYPs) to 28,044, while the average cost per CYP dropped from \$7.44 to \$6.98 (including the cost of donated contraceptives), despite the fact that a new program of rotating posts was instituted. INPPARES increased the level of CBD output by a factor of 2.5, from 14,265 to 36,325 CYPs, and in its rotating health posts by a factor of 1.5, from 2,687 to 4,395 CYPs. (The INPPARES clinic was not included in the study.) PROFAMILIA showed a modest increase in service delivery, from 8,463 CYPs to 9,836 CYPs, including a seven-fold increase in IUD insertions at mobile health posts and a drop in average cost per CYP for these insertions of 75%, from \$81.90 to \$20.80. Clearly, all three agencies show dramatic evidence of both growth and increased efficiency after zonification.

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The drop in average cost per CYP at APROSAMI (the only agency for which complete information is available) was 15% (not counting the new health post program), which represents a savings of about \$30,000 on the 40,000 CYPs delivered in the second year of the study. The 75% drop in cost at the PROFAMILIA rotating posts represents a total savings of \$70,000 on the 1,173 CYPs delivered. Incomplete data from INPPARES and the clinic/CBD operations of PROFAMILIA suggests that modest cost savings were realized in these programs as well. If the project were able to achieve a further 15% average reduction in unit costs by the EOP for all 6 of the agencies included, it would be possible to increase output by more than 10 percent per year without increasing donor subsidies.

TABLE 1.
POTENTIAL SAVINGS THROUGH INCREASED COST EFFECTIVENESS

<u>Agency</u>	<u>For 1988</u>		<u>EOP Status</u>	
	<u>CYPs</u>	<u>Average Cost</u>	<u>Average Cost</u>	<u>Annual Savings</u>
APROSAMI	22,000	\$14.00	\$12.00	\$ 44,000
ATLF	850	\$83.50	\$70.00	\$ 11,500
CENPROF	6,700	\$19.00	\$16.00	\$ 20,000
INPPARES	168,000	\$ 9.50	\$ 8.00	\$250,000
PLANIFAM	2,600	\$37.00	\$31.50	\$ 14,000
PROFAMILIA	18,500	\$27.75	\$23.50	\$ 78,000
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TOTAL	218,650			\$417,500

Source: 1988 CYPs calculated from contraceptives shipped (VSC not included). Average cost = total agency budget (including cost of contraceptives) divided by CYPs. Note that these figures are higher than those cited in the Population Council cost effectiveness study, because they include the cost of reproductive health services not directly related to family planning.

2. Service Delivery Expansion.

Calculating the social benefit of CYPs requires that measure their impact on fertility. It is clear that offering couples the means to plan effectively the number and spacing of their children will enhance their quality of life, particularly through improvements in maternal and child health. It also has been demonstrated that in a country which is currently unable to provide adequate nutrition, health care, education, and employment to a significant portion of its citizenry, rapid population expansion hinders development.

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To quantify the economic benefit of family planning we may compare the potential productive value of individuals not born because of family planning with the lifetime cost to society of providing for them. This approach implicitly defines "society" as those who are actually born, without accounting for the lost utility of those whose births are averted.

With this limitation in mind, the quantitative analysis is performed as follows. First, CYPs are translated into births averted (BAs), using the formula:

$$BAs = CYPs \times Eff \times GFR$$

where Eff equals the likelihood that the woman will not get pregnant during a year of contraceptive use (i.e., effective protection per CYP) and GFR is the general fertility rate, defined as the number of births in a year per thousand women of fertile age (WFA).

According to the 1986 DHS², the general fertility rate in Peru is .130. An overall estimate of effectiveness can be obtained by combining international estimates of contraceptive effectiveness³ with the contraceptive method mix, as reported in the DHS. This calculation is summarized in Table 2.

TABLE 2.
EFFECTIVENESS OF MODERN METHOD FAMILY PLANNING IN PERU

Method	Relative Prevalence	Effectiveness	Contribution To Overall Effectiveness <u>(2 x 3)</u>
NFP	39%	75%	29.3%
IUD	19%	95%	18.0%
Pill	17%	92%	15.7%
VSC	16%	100%	16.0%
Injectibles	4%	94%	3.8%
Vaginal Barrier	3%	75%	2.3%
<u>Condom</u>	<u>2%</u>	85%	<u>1.7%</u>
TOTAL	100%		86.8%

The weighted-average overall effectiveness for modern method contraceptive use in Peru is therefore about 87%. Using the above formula, this gives a total of 113 BAs per 1,000 CYPs.

To estimate the economic value of one averted birth, it is necessary to compare the present discounted value (PDV) of consumption over an average life span with the PDV of production over the same period. If the PDV of consumption exceeds that of production (due to the fact that consumption begins immediately while production does not start until later in the life cycle and is thus heavily discounted), the analysis will show a net economic benefit to society of preventing births.

One limitation of this approach can be seen by carrying it to its logical extreme: if each BA results in a net economic benefit to society, then the maximum benefit should be obtainable by reducing the birth rate to 0. The flaw lies in the concept of present discounted value, which is closely linked to the interest rate, and depends on there being enough workers in the future to make efficient use of available resources. In a developing country, however, with abundant underemployed labor, it is valid to assume that a reduction in population growth at the margin will not adversely affect the productivity of land and capital. The other major limitation of this type of analysis is that any intangible benefits or costs of having children are not considered.

To calculate net cost and benefit streams, a similar AID project in El Salvador⁴ used the following assumptions, which seem reasonable in the Peruvian context as well:

- consumption per capita (CPC) = total consumption/population
 - CPC for ages 0 - 4 is 12% of adult CPC
 - CPC for ages 5 - 9 is 40% of adult CPC
 - CPC for ages 10 - 15 is 70% of adult CPC
- production per capita (PPC) = GDP/population
 - PPC for ages 0 - 4 is 0% of adult PPC
 - PPC for ages 5 - 9 is 20% of adult PPC
 - PPC for ages 10 - 15 is 70% of adult PPC.

Total consumption for 1987 was \$18.7 billion (I/586.2 billion converted at average 1987 financial market exchange rate of \$1 = I/31.35)⁵. Assuming that this level were recovered by 1990 (there was a 5.7% drop in 1988),⁶ consumption per capita in PY 1 would be \$839 (projected population = 22.332 million)⁷. Because most of the averted births will be among the poorer sectors of the population, with lower than average consumption, the analysis will use a reduced CPC of 75% of the national average, or \$629.

GDP for 1987 was \$24.25 billion (I/760.2 billion)⁸. Again assuming that this level were recovered by 1990 (there was an 8.9% drop in 1988),⁹ production per capita in PY 1 would be \$1086. Since un/underemployment has stood at over 50% for most of the decade,¹⁰ however, it seems reasonable to assume that the marginal productivity of unborn children would be less than the national average. The analysis will thus use a reduced figure for the PPC as well, of 60% of the average, or \$652.

Productivity and consumption growth have been erratic over the last two decades, with figures for 1987 (a good year) below those for 1974¹¹. Growth prospects for the near future are not promising. As the effects of modest growth in the medium to long term on the present analysis would be negligible, they will be omitted for simplicity.

Table 3 shows the structure of population¹², and the estimated value per year of production and consumption per capita for each age group, based on the above figures.

TABLE 3.
PRODUCTION AND CONSUMPTION ESTIMATES, BY AGE COHORT

Age Cohort	Percent of Pop.	Production per capita (PPC)	Consumption per capita (CPC)
0 - 4	15	\$ 0 (\$ 0)	\$ 88 (\$ 81)
5 - 9	13	\$162 (\$143)	\$295 (\$262)
10 - 15	12	\$565 (\$502)	\$516 (\$458)
16 - 99	70	\$807 (\$717)	\$737 (\$654)

The figures in parentheses represent expected values adjusted for mortality rates. Currently, 7.6% of children die in the first year of life, an additional 2% die in the second year, and .5% die in each of the next three years, for a total mortality rate of 11.2% in the first five years.¹³ Incorporating these figures into the CPC for the 0-4 cohort gives an expected CPC at birth of 91% of the unadjusted figure, or \$81. Individual mortality rates are not

available for the other cohorts, but life expectancy at birth is 65¹⁴, which means that life expectancy for the 88.8% of the population that is still alive at age 5 must be 73. A fairly accurate approximation of the effects of mortality can thus be obtained by reducing the figures for the upper 3 cohorts by 11.2% and using a life expectancy of 73.

Using this methodology and a discount rate of 10%, the net cost to society of a child born, discounted to its present value at year of birth, is about \$400 (see Table 4).

TABLE 4.
CALCULATION OF BENEFIT STREAM FROM ONE BIRTH, BY AGE COHORT

<u>Age Range</u>	<u>PDV At Birth Of Exp. Prod. During Range</u>	<u>PDV At Birth of Exp. Cons. During Range</u>	<u>Net Economic Gain/Loss to Society</u>
0 - 4	\$ 0	\$ 338	- \$338
5 - 9	\$ 371	\$ 679	- \$308
10 - 14	\$ 806	\$ 736	\$ 70
15 - 73	<u>\$1,881</u>	<u>\$1,716</u>	<u>\$165</u>
	\$3,058	\$3,469	- \$411

At the current contraceptive method mix, every 1,000 CYP delivered by family planning PVOs can be expected avert approximately 113 births. (Actually, the births averted should be somewhat higher, as the efficiency of the contraceptive method mix delivered by the PVOs is higher than the national norm). Thus, to avert one birth requires delivering 8.85 CYP. Since the PDV of one birth averted is \$411, for family planning service delivery to be cost-beneficial, the cost of delivering one CYP must be less than \$46 ($\$411/8.85$).

As was shown in Table 1, the average cost per CYP is already lower than this amount in all of the PVOs except for ATLF. At current rates of output and costs, the benefits to cost ratio of investment in family planning is approximately \$3.70 saved for every dollar invested. The potential savings that could be achieved by the project in terms of increasing cost effectiveness of PVO service delivery would increase the benefits to cost ratio to \$4.40 to \$1.00, or an improvement of almost 20 percent.

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3. Self-Sufficiency.

Self-sufficiency for the participating family planning PVOs is a principal Project objective. Although it is unrealistic to expect that the PVOs will be able to completely attain this goal within the four-year LOP, especially given the current economic context, it is reasonable to expect that significant progress toward this end can be achieved. A complete discussion of this issue is contained in the Financial Analysis (Annex III, Exhibit E).

B. Long-Lasting Methods.

The justification for an increased focus on long-lasting methods is not primarily economic. 64% of married women of fertile age (MWFA) do not desire any more children, but only 46% are currently using any form of family planning and only 14% use effective long-lasting methods (VSC and IUDs)¹⁵. Thus, increasing the availability of these methods is primarily a way of improving the quality of life by giving limiters a way of actualizing their desire not to have any more children.

In the Peruvian context, long-lasting methods, which must be delivered at clinics and health posts, are currently more expensive than temporary methods delivered through CBD. For example, a 1988 cost effectiveness study of 3 CBD programs, 2 clinics, and 1 health post found that the average cost per CYP in the clinic and post settings was \$17.22, two and a half times greater than the average \$6.64 per CYP of the CBD programs.¹⁶ This is attributable largely to the low level of service delivery in clinics. In the study just cited, the number of APPS delivered by the three CBD programs was over 33,000 while the number delivered in clinics and posts was less than 3,500.

Since the costs of long-lasting methods are primarily fixed (facilities and personnel) --- while those of temporary supply methods are mostly variable (contraceptives), one would expect that as service levels for the long-lasting methods increased, costs would decline significantly. This conclusion is supported by a 1988 study from Ecuador which showed a 38% drop in average cost (from \$14.71 to \$9.07 per CYP) in three clinics over the same time period that service delivery increased by 62%.¹⁷

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A study from Colombia showed an average cost in 1980 of \$15.27 per CYP for all clinic and over-the-counter methods, but a cost of only \$2.18 for CYPs provided through voluntary surgical contraception, with over 35,000 operations performed (446,000 CYPs delivered). The same study showed costs of \$3.42 for urban-based and \$18.70 for rural-based CBD programs.¹⁸ Thus, the most expensive method was clinic-based IUD insertion (due to the relatively high level of pre/post counseling/care required and relatively low number of CYPs per insertion) and the least expensive was VSC.

In summary, while the primary reason for focusing on long-lasting methods is not economic, the evidence suggests that at least in the case of VSC, low costs per CYP are possible if service levels can be increased to a level where clinics can take advantage of the economies of scale implicit in their mostly fixed cost structure.

C. Increased Rural Access.

It is generally accepted that delivery of family planning services is more expensive in rural than in urban areas, for both logistical and cultural reasons. For example, a 1987 study of CBD programs in Ecuador¹⁹ estimated that rural services were about twice as expensive per CYP (\$14 vs. \$7), while a study of CBD programs in Colombia (cited above) found an average cost of \$18.70 per rural CYP compared to only \$3.42 for CYPs delivered in urban areas.

Both of the above studies are based on community-based distribution, however. This is not the model proposed for rural service expansion in the current project. Rather, existing health posts under the jurisdiction of the Ministry of Health (MOH) and Social Service Institute (IPSS) will be staffed after-hours with personnel provided by the PVOs. The costs of facilities and contraceptives will be born by MOH/IPSS.

A pilot program conducted by the Population Council to test the feasibility and cost-effectiveness of this approach found an average cost of \$17.42 per CYP (of which \$15.06 represented costs that would be born by the project) for services delivered in the after-hour clinics and of \$6.82 (\$4.91 of which would be born by the project) for services delivered in an "integrated clinic," that is, one providing both family planning and other health services.²⁰

The large cost disparity between the two models is explained by the different clientele served (and methods demanded) in the two settings. In the after-hours clinics, many of the clients were men requesting condoms, while in the integrated clinic, most of the clients were women, many of whom were there with sick children, who

received either pills, IUDs, or VSC. Condoms are one of the most expensive methods to deliver because of the very low number of CYPs associated with their use.

One important factor that is often overlooked in considering the cost effectiveness of rural programs is the much lower level of contraceptive prevalence in rural areas. According to ENDES, total prevalence among MWFA in rural areas is less than one half that of MWFA in urban areas (24% vs. 59%). This is important because it is much more likely in areas where contraceptive prevalence is high that CYPs provided by PVOs are simply replacing those which might be obtained elsewhere, and thus not impacting on either births averted or family health.

By contrast, services delivered by PVOs in rural areas are much more likely to increment total prevalence. Although this effect is difficult to measure, a rough estimate can be based on existing prevalence levels. Thus, if prevalence in urban areas is 2.5 that of rural areas, then a random client entering an urban clinic is 2.5 times more likely to already be a contraceptive user or to have some other potential source of family planning services. Add to this the fact that average incomes are much lower in rural areas and that the main alternative to PVO services is those provided commercially, and it may well be that the average urban PVO user is more than 2.5 times as likely to have a workable alternative source of family planning services.

If we take the pilot study cost-effectiveness figures for after-hours clinics of the type proposed in the project and adjust them for the greater impact of rural CYPs, we find a cost of only \$7 per urban equivalent CYP (\$6 of which are costs to be born by the project). These figures are in the same range as the CYPs currently delivered by the Lima-based agencies.

Thus, the more qualitative project objective of improving life in depressed rural areas by delivering services that are currently not available at all to many potential users can also be justified in cost effectiveness terms, if the more sophisticated measure of effectiveness proposed here is used.

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NOTES

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2. Instituto Nacional de Estadística, Encuesta Demografica y de Salud Familiar, April, 1988, p. 28.
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13. Instituto Nacional de Estadística, Encuesta Demografica y de Salud Familiar, April, 1988, p. 96.
14. World Bank, Peru: Policies to Stop Hyperinflation and Initiate Economic Recovery, Vol. II, December, 1988, pp. 96.
15. Instituto Nacional de Estadística, Encuesta Demografica y de Salud Familiar, April, 1988, pp. 62, 79.

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16. James Rosen, Cost Effectiveness in Four Family Planning Programs in Lima, Peru, Paper presented at Annual Meeting of American Public Health Association, November 17, 1988.
17. CEMOPLAF, Estudio Sobre Costo Efectividad, October, 1988.
18. Data provided by the Association for Voluntary Surgical Contraception from a cost-effectiveness study done for PROFAMILIA, Colombia.
19. James Rosen, Analysis of Ecuador's Community Based Distribution of Contraceptives Programs and Projection of Demographic Impact and Cost of Expansion, Population Council for USAID/Ecuador, April, 1987, p. 32.
20. Population Council, Final Report: Operations Research to Improve Family Planning Services in the Departments of Ayacucho and Huancavelica, July, 1989.

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FINANCIAL ANALYSIS

This project is not expected to generate revenue for its Implementing Agency, PRISMA. PRISMA's role is to channel pass-through institutional funding and commodities to the six participating PVOs and to provide and coordinate technical assistance that will, among other objectives, enhance their economic sustainability. Therefore, the Financial Analysis will examine the feasibility of the sustainability goal for the participating PVOs.

The degree to which economic self-sufficiency can be attained depends in part on the characteristics of the clients served by the PVOs, the services that are offered, and the prices that could be charged. At the present time, the most important potential source of revenue for the PVOs is donated contraceptive commodities.

Client Characteristics and Current Fee Structure. Currently, none of the participating PVOs recover more than 10% of even their administrative costs (excluding donated contraceptives) from client fees. Table 1 shows fee structures of two of the target PVOs and of Instituto Marcelino, an agency that receives no USAID subsidies and recovers almost all of its operating expenses from client fees.

TABLE 1.
FEES CHARGED FOR FAMILY PLANNING SERVICES
(In US\$)

Method	Cost to A.I.D.	APROSAMI	PROFAMILIA	Marcelino
IUD	1.09	0.67	0.50 - 3.50	0.67 - 1.00
VSC	NA	12.07		
Pills	0.15	0.08	0.05	free with consultation
Condoms	0.05	0.03	0.03 - 0.05	
Tablets	0.11	0.03	0.03	
Foam	1.58	0.27	0.17	
Jelly	NA	0.17	0.07	
Consultation	NA	0.40	0.50 - 0.83	1.00

Clearly, neither APROSAMI nor PROFAMILIA currently charges more than token fees. Fees at the other PVOs are comparable.

The extent to which the PVOs might become economically more self-sufficient depends in large part on the ability of their clients to pay for the services and supplies they receive. This is a great unknown, due to the lack of information about client income

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and the uncertainties posed by the current hyperinflationary environment. At the present, none of the PVOs collect information on client income. Analysis of clients' ability to pay must be based on proxy variables. Two such variables are currently available for clinic patients: education and place of residence. CBD distributors do not maintain client records.

Data on characteristics of INPPARES, APROSAMI, and PROFAMILIA clinic acceptors were provided by the Population Council/INOPAL project. Review of INPPARES client records showed that 87% of the clinic clients and 59% of the post clients have a secondary education or higher, which would suggest that they could afford at least part of the cost of family planning services. In terms of residence, 85% of the clinic clients and 27% of the post clients do not live in pueblos juvenes ("young towns", the city's poorest areas). In total, 79% of the clinic clients have at least a secondary education and do not live in a pueblo joven, as do 19% of the post clients. Clearly, a sizeable proportion of INPPARES clients do not require the near 100% subsidy they receive.

Client information was less complete for APROSAMI and PROFAMILIA. 80% of APROSAMI clients have at least some secondary education, and 53% have completed high school. 29% of APROSAMI's clinic clients and 11% of PROFAMILIA's clients do not live in a pueblo joven. While the income levels of APROSAMI and PROFAMILIA clinic clients are probably below those of INPPARES clients, nevertheless, many are capable of paying a larger share of their service costs.

Supportive findings were reported in a survey of APROSAMI, Marcelino, and INPPARES clinic clients, conducted by the SPF project. In an individually administered questionnaire, clients were asked where they sent their children to school. Of the school age children represented, 15% of the APROSAMI clients, 25% of the Marcelino clients, and 40% of the INPPARES clients attended private schools. Private school education is more common among lower income families in Peru than in the United States and tuitions are relatively low (\$5 to \$100 per month), but a family that can afford private tuition should still be able to pay for a larger portion of family planning services than is currently charged by the participating agencies.

The same survey, comparing the three clinics on a number of other variables, including job status, medical attendance at birth of last child, and infant formula used to supplement breast feeding (with formulas ranked by cost), found a consistent pattern in which clients of APROSAMI come from a lower socioeconomic class and those of INPPARES from a higher one than the clients of Marcelino, even though Marcelino is almost completely self-supporting and the other

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two almost completely subsidized.

Potential Income Generation Through Sales of Contraceptive Commodities. Procurement of contraceptive commodities forms a substantial part of the project budget, exceeding the subsidies for other PVO institutional operating costs by some 44 percent. While the project intends to continue to provide donated commodities for the PVOs' own activities, it is clear that in the not-too-distant future, the PVOs will have to assume this responsibility on their own. The implementation plan calls for phasing out operational subsidies to urban CBD programs by the end of PY 2; as demonstrated below, these costs can easily be covered by imposing reasonable, below-market charges for donated commodities.

Over the period 1987-1988, the five PVOs (less ATLF) which distribute modern contraceptives put into circulation an annual average of \$674,000 worth of donated commodities, to outlets including their own programs (CBD, clinical, and provincial), other institutions, and commercial distributors (private physicians, employers, and "marketing" activities). The following tables summarize the movement of stocks from central warehouses to outlets for each PVO; Table 2 refers to 1987 distribution, while Table 3 provides the distribution for 1988.

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TABLE 2.
DISTRIBUTION OF COMMODITIES
BY FAMILY PLANNING PVOS, 1987

<u>Destination</u>	<u>APRO SAMI</u>	<u>GEN- PROF</u>	<u>INPP ARES</u>	<u>PLAN IFAM</u>	<u>PRO- FAMILIA</u>	<u>Total</u>
Method: IUD						
Own Services	893	240	27971	363	2577	32044
Other Institutions	0	0	25200	0	1300	26500
Commercial	112	76	33332	0	0	33520
Miscellaneous	<u>1</u>	<u>0</u>	<u>435</u>	<u>0</u>	<u>13</u>	<u>449</u>
T o t a l	1006	316	86938	363	3690	92513
Method: Pills						
Own Services	87709	9932	438893	10200	65300	612034
Other Institutions	0	0	69420	0	200	69620
Commercial	554	0	51142	0	0	51696
Miscellaneous	<u>0</u>	<u>0</u>	<u>1670</u>	<u>0</u>	<u>200</u>	<u>1870</u>
T o t a l	88263	9932	561125	10200	65700	735220
Method: Condoms						
Own Services	1818360	59011	3241644	173000	47700	5339715
Other Institutions	0	0	724991	0	67000	791991
Commercial	61325	133430	1174202	0	36000	1404957
Miscellaneous	<u>298</u>	<u>0</u>	<u>2762</u>	<u>0</u>	<u>8</u>	<u>3068</u>
T o t a l	1879983	192441	5143599	173000	150708	7539731
Method: Foam/Jelly						
Own Services	22716	6003	3708	3474	1858	37759
Other Institutions	0	0	2402	0	1412	3814
Commercial	2404	1179	1471	0	0	5054
Miscellaneous	<u>7</u>	<u>0</u>	<u>146</u>	<u>0</u>	<u>2</u>	<u>155</u>
T o t a l	25127	7182	7727	3474	3272	46782
Method: Vaginal Tablets						
Own Services	0	0	23040	0	15460	38500
Other Institutions	0	0	0	0	0	0
Commercial	0	0	0	0	0	0
Miscellaneous	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>2</u>	<u>2</u>
T o t a l	0	0	23040	0	15462	38502

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TABLE 3.
DISTRIBUTION OF COMMODITIES
BY FAMILY PLANNING PVOS, 1988

<u>Destination</u>	<u>APRO SAMI</u>	<u>CEN- PROF</u>	<u>INPP ARES</u>	<u>PLAN IFAM</u>	<u>PRO- FAMILIA</u>	<u>Total</u>
Method: IUD						
Own Services	1610	405	36693	146	4512	43366
Other Institutions	30	0	15214	0	7	15251
Commercial	394	1990	9573	0	81	12038
Miscellaneous	<u>189</u>	<u>0</u>	<u>793</u>	<u>0</u>	<u>0</u>	<u>982</u>
T o t a l	2223	2395	62273	146	4600	71637
Method: Pills						
Own Services	79200	11207	439020	15744	63400	608571
Other Institutions	5000	0	52144	0	15000	72144
Commercial	3367	2104	26292	0	200	31963
Miscellaneous	<u>426</u>	<u>0</u>	<u>6359</u>	<u>35</u>	<u>0</u>	<u>6820</u>
T o t a l	87993	13311	523815	15779	78600	719498
Method: Condoms						
Own Services	856173	369695	3725867	25700	131100	5108535
Other Institutions	129	0	514924	0	11300	526353
Commercial	670254	70972	54763	0	16200	812189
Miscellaneous	<u>3136</u>	<u>0</u>	<u>3213</u>	<u>280</u>	<u>0</u>	<u>6629</u>
T o t a l	1529692	440667	4298767	25980	158600	6453706
Method: Foam/Jelly						
Own Services	10355	2386	5090	2774	2637	23242
Other Institutions	0	0	0	0	6	6
Commercial	11122	132	0	0	202	11456
Miscellaneous	<u>118</u>	<u>0</u>	<u>0</u>	<u>201</u>	<u>0</u>	<u>319</u>
T o t a l	21595	2518	5090	2975	2845	35023
Method: Vaginal Tablets						
Own Services	130600	64365	423854	23518	54920	697257
Other Institutions	336	0	50509	0	2200	53045
Commercial	56175	28800	22032	0	9400	116407
Miscellaneous	<u>327</u>	<u>0</u>	<u>8480</u>	<u>280</u>	<u>0</u>	<u>9087</u>
T o t a l	187438	93165	504875	23798	66520	875796

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As was shown in Table 1, the average prices charged for these commodities were considerably lower than the A.I.D cost. PVO prices are usually considerably lower than the retail price of locally-distributed products, and in the case of spermicides (vaginal foaming tablets), the cost to A.I.D. of the imported product is four times higher than the retail price of the locally-manufactured product.

The prices currently charged by the PVOs do not cover the value of the donated commodities, and much of the income generated never reverts to the institution (e.g., INPPARES CBD distributors keep all of the money from their sales). Furthermore, a considerable proportion of the commodities distributed are sent to other, often commercial, outlets for final distribution to users. Not only do these commercial users pay much higher prices for their methods, but the PVOs do not realize significant income from those sales. The most striking disparity is found in the case of IUDs: while the retail price of an IUD in August, 1989, was approximately I/. 50,000 (if purchased from a pharmaceutical outlet), INPPARES sold IUDs to private physicians for I/. 1,000 --- who in turn charged between I/. 150,000 and 300,000 for the insertion.

It should be possible for the PVOs to charge between a 25 to 50 percent mark-up (over procurement costs) for the IUDs, pills, and condoms they distribute through their own outlets, and between a 150 to 500 percent mark-up on those commodities distributed to commercial outlets. After allowing the CBD distributor to keep half of his/her pill and condom sales, this would gross \$720,000 annually at total 1987-1988 distribution levels, or \$625,000, if distribution to other institutions were eliminated.

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If the PVOs continued to receive donated commodities for their own services and purchased, at A.I.D. prices the commodities distributed to commercial outlets, they could net \$587,000 annually (not including distribution to other institutions). This represents more than the total institutional operational subsidy for clinical as well as CBD programs.

Table 4 demonstrates the value of the commodities received and the revenues that could be generated under the above pricing scheme.

TABLE 4.
POTENTIAL INCOME GENERATED
BY SALE OF CONTRACEPTIVE COMMODITIES
(MEAN 1987-1988)

<u>Destination</u>	<u>AID Cost</u>	<u>Total Revenue</u>	<u>Agency Gross</u>	<u>Agency Net (1)</u>	<u>Agency Net (2)</u>	<u>Assumptions</u>
Method: IUD						
Own Services	41023	51279	51279	51279	10256	Markup
Other Institutions	22713	28391	28391	0	5678	25% own services
Commercial	24784	148701	148701	123918	123918	500% commercial
Miscellaneous	778	0	0	-778	-778	
S u b - T o t a l	89298	228371	228371	174418	139073	
Method: Pills						
Own Services	89104	133656	66828	66828	-22276	Markup
Other Institutions	10349	15523	7762	0	-2587	50% own services
Commercial	6107	15268	15268	9161	9161	150% commercial
Miscellaneous	634	0	0	-634	-634	Distrib. keeps 50% sales
S u b - T o t a l	106194	164447	89857	75354	-16337	
Method: Condoms						
Own Services	271655	407482	203741	203741	-67914	Markup
Other Institutions	34277	51415	25708	0	-8569	50% own services
Commercial	57646	172937	172937	115292	115292	200% commercial
Miscellaneous	252	0	0	-252	-252	Distrib. keeps 50% sales
S u b - T o t a l	363829	631835	402386	318780	38557	50% sales

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TABLE 4 (continued).
POTENTIAL INCOME GENERATED
BY SALE OF CONTRACEPTIVE COMMODITIES
(MEAN 1987-1988)

<u>Destination</u>	<u>AID Cost</u>	<u>Total Revenue</u>	<u>Agency Gross</u>	<u>Agency Net (1)</u>	<u>Agency Net (2)</u>	<u>Assumptions</u>
Method: Foam/Jelly						
Own Services	28173	8452	5663	5663	-22510	Sale price
Other Institutions	0	0	0	0	0	30% own services
Commercial	17781	17781	17781	0	0	100% commercial
Miscellaneous	186	0	0	-186	-186	Distrib. keeps 50% sales
S u b - T o t a l	<u>46141</u>	<u>26233</u>	<u>23444</u>	<u>5476</u>	<u>-22697</u>	
Method: Vaginal Tablets						
Own Services	67451	16863	11298	11298	-56153	Sale price
Other Institutions	5542	1386	928	0	-4614	25% own services
Commercial	11664	11664	11664	0	0	100% commercial
Miscellaneous	960	0	0	-960	-960	Distrib. keeps 50% sales
S u b - T o t a l	<u>85617</u>	<u>29912</u>	<u>23890</u>	<u>10338</u>	<u>-61727</u>	
Total, Commodity Value	<u>691079</u>	<u>1080798</u>	<u>767948</u>	<u>584367</u>	<u>76869</u>	

Notes:

Agency Net (1): No sales to other institutions, purchase only commercial

Agency Net (2): Sales to other institutions, purchase all commodities

Net revenues are sufficient to pay the operating costs of urban CBD programs, as long as PVOs receive donated commodities for their own program operations. However, they cannot offset both the operational costs and total commodity costs (only \$77,000 would be generated annually net of total commodity costs).

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The economic picture improves considerably if donation of spermicides (foams and foaming tablets) were to be phased out. The current retail value of these products is only 25 to 30 percent of the cost to import them. Consequently, distribution of foams and foaming tablets represents a net economic loss (as well as relatively few CYP) to the PVOs, and eliminating their import would almost double annual net revenues, to \$138,000.

Imported pills also represent a net loss at a 50 percent mark-up for CBD (allowing the distributor to keep half of her proceeds). Increasing the mark-up to 100 percent would allow pill distribution to break even or make a small net profit (depending on the margin to the distributor), and would leave the final price 50 percent lower than the pharmacy retail price.

If the assumptions of these analyses are correct, implementation of appropriate pricing strategies would allow the PVOs to generate, through sales of contraceptive commodities alone, enough revenue to purchase contraceptives at A.I.D. prices and offset a small portion of their operating costs as well. This represents more than 50 percent of the direct program subsidy provided under the Project. Implementation of other income-generation activities has not been analyzed, but should further improve economic sustainability.