

FAMILY PLANNING MANAGEMENT TRAINING PROJECT

BRAZIL TRIP REPORT

MANAGEMENT NEEDS ASSESSMENT OF SELECTED  
PRIVATE SECTOR FAMILY PLANNING ORGANIZATIONS

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SUBMITTED BY LAUREL KNIGHT COBB  
FPMT LATIN AMERICAN DIRECTOR  
MANAGEMENT SCIENCES FOR HEALTH  
BOSTON, MASSACHUSETTS

TABLE OF CONTENTS

I	EXECUTIVE SUMMARY.....	1
II	BACKGROUND.....	4
III	OBJECTIVES OF THIS WORK.....	6
IV	SUMMARY OF THE FINDINGS OF THE MANAGEMENT NEEDS ASSESSMENTS.....	7
V	INSTITUTIONAL ASSESSMENTS	
	1. ABEPF.....	9
	2. CPARH.....	14
	3. SAMEAC.....	18
	4. PROPATER.....	23
	5. CPAIMC.....	28
	6. CLAM.....	33
	7. CMI.....	37
	8. CAEMI.....	41
	9. CEPECS.....	45
	10. HOSPITAL SÓFIA FELDMAN.....	50
	11. BERTHA LUZ.....	55
VI	SUMMARY: SMALL INSTITUTIONS IN THE PRIVATE SECTOR.....	59
VII	PROPOSED STRATEGY FOR THE PRIVATE SECTOR.....	63
	PERSONS CONTACTED.....	67

## I. EXECUTIVE SUMMARY

In March 1988 a FPMT team of financial management consultants, Rolf Stern and Tonia Papke, led by FPMT Director for Latin America, Laurel Cobb, conducted a management needs assessment of the largest ABEFF affiliates \* in order to understand that segment of the private sector service delivery system and to develop a workplan to assist the sustainability of private sector family planning services following the projected AID phase out of support for family planning in Brazil. In December 1987 FPMT completed a management evaluation of ABEFF itself and examined ABEFF's role in the private sector and in the family planning system as a whole. This report, dealing with the ten affiliates identified by the mission as the most significant among the 140 ABEFF affiliates, compliments that ABEFF evaluation. An upcoming management needs assessment of BEMFAM, the provider of the vast majority of private sector services, will complete the private sector assessment.

Approximately 140 institutions and medical offices are affiliated with ABEFF, the Association of Brazilian Family Planning Entities. Led by BEMFAM, the largest and oldest private sector institution (and not affiliated with ABEFF), institutions in the private sector have played a leading role in initiating access to and acceptance of family planning.

\* And an additional non-affiliated institution, Bertha Luz

It should be noted here, in addition to putting the various private sector institutions discussed in this report in perspective, relative to BEMFAM, the private sector itself is not the main family planning provider. Most of the persons who comprise the 65.8% contraceptive prevalence rate in Brazil obtain their supplies from the commercial sector. 92% all pill users obtain their pills from pharmacies.

The private sector has been important, however. The questions now loom "How will the multitude of private sector providers be able to sustain quality service delivery to low income as well as middle and upper income persons with the phase out of AID funding? "Which have the institutional potential and capacity for financial self sufficiency once international donor funding is gone? In light of the importance of these smaller institutions, relative to BEMFAM, and relative to the commercial sector, what management training and technical assistance should be provided to them, and how?"

In summary the team's answers to these questions are as follows:

1. Although there are significant institutional and managerial differences among the eleven institutions, in general there has been little or no formal institutional or strategic planning. While a few have considered sustainability issues prior to the current funding crisis, most have a short-term perspective, devoted to survival. Almost none of them have growth plans.

2. The institutions appear to concentrate on one or another segment of the socio-economic ladder, despite their statements otherwise. Maintaining services to low income persons while pursuing financial self sufficiency will be a major challenge if the institutions are not cross subsidizing between socio-economic groups.
3. Financial planning and monitoring have been performed principally in relation to donor projects; of secondary consideration has been the financial development of the institution as a whole.
4. Training in strategic planning and financial management is important for all but a few of these institutions.
5. We recommend a workshop for these institutions on strategic planning and we recommend the development of a workplan for future training activities in financial management and marketing which would be undertaken depending on the budget prospects and opportunities for impact and work with BEMFAM.

Note: The Cruzado was worth 120/1, on the informal market, at the time this work was undertaken.

## II. BACKGROUND:

At the request of AID/Brasilia, in 1986 FPMT undertook and completed a management needs assessment of the three most important private sector family planning institutions in Brazil, ABEFF, CPAIMC and BEMFAM. That assessment recommended a series of training interventions to increase institutional and managerial effectiveness and efficiency. Training in MIS was initiated the following year.

An AID/Washington evaluation of its Brazilian population program (Summer, 1987) intensified awareness of the need to increase institutional efficiency. The outcome of that evaluation, which addressed both AID's longtime support of Brazilian population activities and the high Brazilian prevalence rate (65.8%), is a phase-down of AID population funds in Brazil. Brazilian institutions were notified by AID/Washington and the Mission of the phase-down at an AID meeting with the FP providers and contracting agencies in December 1987. Brazilian institutions were notified that they must work immediately to develop and implement plans for financial self-sufficiency. The sustainability of their institutions was at stake. They were told that technical assistance and training would be provided by FPMT to assist them in their move towards self-sufficiency.

At that same time, at the request of AID/Brasilia, FPMT provided consultants to carry out a management evaluation of ABEPF which had been formed in 1981 with the assistance of AID and had been dependent on AID funding since its inception. With the phase-down of AID funding, AID wished to examine continued support to ABEPF in light of the AID/Washington evaluation, the efficiency and effectiveness of ABEPF, and its role in family planning in Brazil.

In January preliminary findings of that evaluation were presented to ABEPF; they recommended increased support to ABEPF to enable the long-term institutional development which had been lacking in the past. The final version of that evaluation recommended technical assistance to ABEPF which focused on developing financial self-sufficiency, including financial management, internal reorganization and cost curtailment.

Additionally at that time, fifteen ABEPF affiliated institutions attended a one-day FPMT seminar on planning for sustainability. It was a difficult session; Brazilian institutions were angry and anxious. Implicit in the discussions about reduced financing was the recognition that some institutions currently receiving AID funding may not be sustainable without those funds; others faced curtailing of services and staff.

It was obviously important to understand those institutions better, so as to appropriately design and implement management training interventions to promote the sustainability of the private sector in the most efficient and effective manner possible. Hence the management needs assessments which are presented in the following pages.

### III. The objectives of this work were to:

1. Perform succinct financial planning and management needs assessments of ABEFF and of the ten affiliates of ABEFF which had been identified by the mission as being priority for management training intentions. The assessments were to focus on institutional capacity for financial self sufficiency and continued services to low income persons after the projected phase out of AID population assistance in Brazil.
2. Development of a FPMT strategy which would assist the sustainable development of these institutions, within the constraints of FPMT budget cutbacks and the relative importance of these institutions in the total family planning system in Brazil.

#### IV. SUMMARY OF THE FINDINGS OF THE MANAGEMENT NEEDS ASSESSMENT

The following summarizes the findings of the needs assessment, and suggests a strategy for promoting the effectiveness, reach and efficiency of the sector.

1. The major external challenges to the FP organizations are:
  - a. The threat of the Church still exists and is felt by these institutions.
  - b. The government vacillates on its FP policy and the provision of services, and has issued standards without consulting the private sector.
  - c. The private FP organizations expect the government to start providing services, competing directly with the private FP institutions, and has influenced some organizations to be less aggressive on service expansion, even to consider some withdrawal when the government will enter the market.
  - d. The small FP institutions that do not have lobbying power and funds, may find it desirable to provide integrated health services to survive their "exposure".
  - e. There is very limited representational capability of the sector as a whole, with some individuals exercising some personal influence at the central government level.
  - f. There is little competition in provision of FP services:
    - The central government entities are not providing services to low and middle income individuals.
    - Pharmacies are the major competition for FP methods, counselling and provision of supplies.
    - Vasectomies are a small but growing activity.
  - g. The FP services sector seems to have a highly fragmented structure, with at least 150 known organizations (FVO's and for-profits as well as small private organizations) of varying size, and many thousands individual practitioners. There is one association, at a national, level that provides technical assistance, training, and limited funding to its affiliates.
2. There are very significant institutional and internal management challenges among the FP institutions:
  - a. There is practically no formal institutional planning.
  - b. The successful organizations look to the future, exploit their resources and develop their profitability to expand.
  - c. The "unsuccessful" organizations may have had successful entrepreneurship in their creation but currently lack management skills at the top management level.

- d. The organizations have been aware and some have confronted sustainability issues:
- some have had a short-term orientation, mostly towards survival.
  - a few have considered longer-term issues
  - almost none have developed growth plans
  - they do not have the capital required nor have they been creative in looking at alternative source of funding to expand services, even if those services would be profitable
- e. The institutions seem to concentrate on one or other segment of socio-economic clientele, despite their statements otherwise. Maintaining services to low-income clientele while pursuing financial sustainability is a major challenge.
- f. Marketing is done mostly intuitively, if at all. Market research, informed price setting, competitive strategy development and implementation are not developed as a matter of course in, for example, deciding where to locate a services clinic and what can be expected of its performance.

Development of new services, products, facilities and capabilities which would open new horizons for an organization's sustainability have not been experienced by most FP PVO's in way that could be characterized as formal and analytical.

- g. Financial planning and monitoring is performed mainly in relation to donor-funded projects, leaving for very secondary consideration the financial development of the institution as a whole. Audits are contracted, mostly by donor agencies, to review only project funding. As donor funding decreases and self-generated funding increase, the institutional view should become pre-eminent.

Most of the financial planning is cash and operations oriented, with little attention given to capital budgeting required for investment into projects that will generate fund-generation activities.

- h. Getting the best use of institutional resources has not been a management consideration to date, especially among those organizations that are a distance away from financial sustainability.
- i. Accounting systems are not utilized for management decision-making: they are often late in providing information, and usually report on projects individually not on the institution on the whole.

Accounting systems do not provide usually cost accounting per service, product, clinic, department and so forth, severely handicapping management capability on decision making towards sustainability.

Massive cuts of USAID Central Office funds, combined with the lack of available funds at the country level, requires a very focused and multiplied applicability of work by Cooperating Agencies.

## Associação Brasileira de Entidades de Planejamento Familiar - ABEFF

### I. Introduction

Founded in 1981, the Associação Brasileira de Entidades de Planejamento Familiar - ABEFF is a private, non-profit organization with offices in Rio de Janeiro. Its principal purpose, as per its statutes, is to represent the family planning sector in Brazil and to contribute to the strengthening of its members. Both are classical private sector association expectations. ABEFF initiated its membership with 34 organizations and now has about 140. These members range widely from a small individual clinic that provides some family planning services to clinics networks that have multiple locations, provide training and technical assistance, and provide special services.

#### Clients

Since its inception, ABEFF has concentrated its attention on, and received most of its income from, international donor agencies for executing family planning projects for these donor agencies, including Johns Hopkins University, Development Associates, the Pathfinder Fund and others. ABEFF executes some of these projects through its members, by passing to them funding for the realization of specific activities. As such, the association has been carrying out the role of distributor of international agency funds for its members.

In turn, ABEFF does not see "its clientele" to be members of the association and the rest of professional individuals and organizations that are somehow involved with family planning in Brazil. As such, it is more used to producing a few pieces of work related to projects rather than continuous services and products for its current and future membership.

At the same time, the larger organizations are highly critical of the association and have indicated that they consider their own work, such as the production of materials, to be better than ABEFF's.

#### Service Delivery

ABEFF maintains an ongoing relationship with the agencies for which it executes projects, by means of progress and budget reports, attendance at meetings and receiving visitors from these agencies. This relationship seems to be good with the possible exception of FPIA.

Its relations with its membership are more distant. The General Coordinator has visited not more than five members this year, but usually sees the membership at the annual general assembly. Some of the line managers deal more often with the members, such as inviting them for courses, providing them with technical assistance. The members periodically receive a publication that brings together news clippings concerning Family Planning in Brazil, from international and Brazilian sources.

ABEPP's power relations with the policy formulators and the policy enforcers is scant, if existent. The 1987 law modifying the sector outlook for family planning received no input from ABEPP.

#### Competition

The larger members of ABEPP are also its competitors, since they produce and sell instructional and IEC materials, they compete to capture students for their courses, and some larger associations compete in the training and technical assistance market. There is also competition from these members for agency funding of projects.

A major competitor in the representational function is BEMFAM, Sociedade Civil de Bem-Estar Familiar no Brasil, that has more than 60 owned clinics and several hundred associated clinics and posts around the country. BEMFAM has an active political role in the Brazilian FP sector.

## II. Financial Analysis

The revenues and expenditures of the association for 1986 and 1987 reveal its role as a funneler of international agency's funds to members for participation in the work of particular projects, and the role of ABEPP itself as an executor of agency projects.

Less than 10% of its income is completely independent from the agencies, and self-generated from Brazilian oriented activities. This substantial challenge to the organization's survival was addressed in 1985 and 1986 but not much appears to have happened to date in terms of specific results for generation of income to cover overhead and to direct the organization's attention and efforts to Brazilian sources of revenues.

## III. Quality and Description of Management

#### Budgeting

One year cash forecasts are prepared and utilized to manage project by project cash, and to attempt to manage covering the cash needs of the rest of the organization. Budgets that mesh with accounting data do not exist and an Assistant Accountant furnishes the project managers with some information on the balances left in their budgets. Budgets that develop an overall institutional patrimony are not foreseeable in the near future.

#### Budget Analysis

The managers spend the project monies according to the limits indicated in the project budgets approved by each agency. When there are cash balances in some accounts and insufficient funds in others, where expenditures are needed to be made still, the project managers agree with agency representatives in Brazil or abroad on the re-structuring and use of these funds.

The accounting of ABEFF is done externally and monthly, only on a project by project basis, without consolidation into an overall institutional view. This information is processed by a service and ABEFF project managers do not see it nor use it. The lack of consolidated information can cause difficulties in the overall management of the organization's financial position as agency funds decrease and as locally-generated funds must pick up more and more of the overhead burden and later carry the operational areas of the association.

Variance analysis and cause-effect relationship on the project budgets' results are sometimes done at the end of projects by some managers. Unfortunately, ABEFF does not have a financial manager that could assist in these matters and this is a critical need.

#### Financial Management and Control

Considering the amount of funds that ABEFF manages and the challenges that face it before it becomes self-financing, the association has a serious weakness in the financial management and control area, due to the lack of adequately qualified people, and due to the lack of adequate information systems that would allow project and institutional management. The strategic plan developed during 1987 is so far missing an institutional budget. Such a budget is necessary for planning and managing agency funding decreases and self-financing increases: an essential component at this stage of projected donor phase-down. The lack of institutional financial controls and a audit points to gaps to be filled quickly.

#### Pricing

The competition with other potential service providers and the agencies' own rules and regulations establish competitive pricing for agency projects. How membership dues and prices for ABEFF's services and products are established was not possible to clarify.

#### Marketing

As an association interested in its membership, ABEFF would need to know their needs, not only in training and technical assistance where information is exchanged, but also in the other areas of service to the members. By knowing their needs, ABEFF could design specific packages of services and products for each member category and have highly satisfied members. This could then lead to an increase in membership numbers and dues, a source of income for overhead costs and other uses.

#### Organizational Chart and Personnel

The Board of Directors has not had an active role in the direction of ABEFF; it has been a weak link between the management group and its membership constituency. The Board meets periodically and participates in the decision-making as to which member is to get "passed-through" funds for projects. It needs to become involved and approve a sustainability plan.

The General Coordinator reports to the President to the Board. In turn, to the General Coordinator report project and area managers in:

- \* Training
- \* Technical Information Center
- \* Technical Assistance
- \* Consolidation of Entities in Stage of Excellence
- \* Preparation of Entities for Stage of Excellence
- \* Preparation of Internal Programs on Health
- \* Specialized Information for Mass Communications

There are also external consultants in strategic planning, the financial area and marketing who report to the General Coordinator.

Total personnel is about 30.

#### Willingness to Make Changes

Given the annual expenditures of about 1 million dollars and the scant self-financing state of ABEFF, it is somewhat puzzling to understand the little progress that has been made to date. Attention needs to be paid to develop as quickly as possible a budget that covers the points indicated beforehand, a budget that will help the organization focus on the critical financial issues it needs to resolve in order to become sustainable.

#### IV. External Threats and Opportunities

##### Threats

The reduction of agency funding, upon which ABEFF is so dependent, is the major threat. Minor threats include the competition from other networks of service providers.

##### Opportunities

The critical opportunity the association needs to take is to define its future, including financially, and reorganize as quickly as possible in what may be needed to be successful.

#### V. Planning for Self-Sufficiency

##### A. Available Internal Resources

The organization has competent programmatic personnel who can work out an appropriate strategic plan and budget, with the hiring of a qualified financial manager and the support of the Board of Directors.

## V. Training and Technical Assistance

ABEPP indicated interest in a mix of training and technical assistance to prepare a strategic plan and budget, and to develop proposals for agencies to fund for achieving ABEPP sustainability.

## VII. Conclusions and recommendations

This organization was recently created for the development of the Family Planning sector in Brazil and the strengthening of its membership. It is suddenly facing a situation that will require it to change course dramatically towards servicing the Brazilians. To achieve this it will need training and technical assistance to provide it with an entirely new institutional capability. It also requires institutional investments, which will lay the bases from which sustainable generating activities will occur. It is recommended to continue support of ABEPP, counting upon ABEPP's enthusiastic interest in their own survival.

## Centro de Pesquisas e Assistencia em Reprodução Humana - CPARH

### I. Introduction

Founded in 1981 and operational as of 1983 as a sociedade civil sem fins lucrativos for social assistance, CPARH was established in Salvador do Bahia by Dr. Elsimar Metzker Coutinho, to develop research in the area of human reproduction. CPARH's specific objectives include:

- \* educational campaigns with the purpose of transmitting consciousness for the need of family planning,
- \* contraception through oral contraceptives, injectables, intra-uterine devices, condoms, diaphragms, spermicidal jelly,
- \* training in the use of natural methods,
- \* surgical contraception,
- \* treatment for infertility, and
- \* training for medical and paramedical teams to act in family planning.

Dr. Coutinho is an expert in the area of family planning and is the Chief Executive Officer for CPARH. His reputation has contributed to the acceptance of the clinic from all levels, and the consultant observed that the clinic served a mixture of middle and lower class clients.

### Clients

The population of Salvador that receives services from the clinic is a mix of lower and middle class origins. Occasionally, clients come to Dr. Coutinho for treatment of infertility. Approximately 100 patients per day attend the clinic, between the hours of 8AM to 6PM.

### Services

CPARH offers a variety of services with an emphasis on quality: infertility, sterilizations (male and female), family planning including training in natural methods, consultations, vaginal pills, counselling on methods, and information on research and family planning issues. The family planning services most sought are sterilizations, although the selection criteria excludes women under the age of 35 and with three children or less, as well as medical constraints. Other services provided include PAP smears, blood counts and diagnostic laparotomies.

### Pricing

A minimum service charge of Cz \$100 is paid by all patients. The concept behind this payment is that no doctor can force a patient to receive the service. A sliding-scale for fees is used, with about 10% of the clients paying Cz \$300 per consultation. All clients pay one-half the regular fee for new consultations.

### Service Delivery

CPARH considers the clinic's prime catchment area to be the city of Salvador and the state of Bahia. CPARH's market segment is a population of about 208,000 women, of which CPARH has a small market share. There are no CBD programs and it is considered that expansion into a network of levels I, II and III will require a community-based approach.

### Competition

CPARH considers it does not have significant competition in the State of Bahia nor the city of Salvador. Several private clinics have opened and closed in the last ten years in Salvador, while the public clinics are often closed for strikes at unpredictable times.

## II. Financial Analysis

The donation of land, buildings, equipment and full remodelling costs for CPARH's clinic has provided CPARH with a significant advantage in reaching financial self-sufficiency. In 1987, income totalled about Cz \$6.9 million with expenditures equalling approximately Cz \$5.8 million. CPARH obtains its income from charges to walk-in patients and by subscribing to convenios with companies, whereby CPARH receives a fixed monthly fee to provide services to the company's work force. A brief calculation showed that the income derived from these convenios with companies can significantly increase the revenues of the clinic.

Several strategies are being considered to increase income to fund expansion. One of them is the use of IESC retired-executives to establish a fund-raising program of US \$1 million to organize an Infertility Institute. Another is to significantly increase the number of convenios with companies in Salvador, a task for which a public relations / marketing / sales person was hired. A third strategy being considered by CPARH is to offer an employee candidate referral service, referring and certifying to employers the sterilized status of a women, whose employment is more attractive due to new labor laws giving extended maternity leave.

Although CPARH seems to be financially sound, it is also true that increasing the network of clinics will require investments and expenditures.

### III. Quality and Description of Management

#### Budgeting

Annual budgets are not prepared for the institution. There are no written plans.

#### Budget Analysis

There is no analysis of general accounting results. Costs accounting is non-existent.

#### Financial Management and Controls

CPARH has only a bank book to roughly manage their cash flow.

#### Pricing

This is done on a combination of a customer-related comparison basis.

#### Marketing

This is a subject given considerable thought and effort, particularly with the orientation of increased revenues. Sales are emphasized with a rough approach to market segmentation.

#### Organizational Chart and Personnel

The Board of Directors consists of four members, including the President, Vicepresident, Treasurer and First Secretary of CPARH. To the President reports a Superintendent (currently the President's wife) and she supervises a medical Supervisor and an Executive Manager. The Medical Supervisor supervises medical services delivery, the clinic and surgery areas, nursing, sterilization, training, medics and paramedics. The Executive Manager (a vacant position) supervises accounting, maintenance, warehouse and housekeeping services.

There are three part-time doctors, five doctors that work one day a week, three nurses, five auxiliary nurses, and three social services personnel.

#### Willing to Make Changes

CPARH seems interested and willing to make some changes, particularly in the areas of financial and administrative matters, fund-raising and marketing for sustainability and growth.

#### IV. External Threats and Opportunities

##### Threats

A minor threat is the entry of government into the provision of family planning services.

##### Opportunities

Several opportunities for CPARH lie in the geographic expansion of their services in the state of Salvador and other urban areas. Also, the expertise of Doctor Coutinho should continue to bring a good mix of clientele into the clinic.

#### V. Planning for Self-Sufficiency

##### A. Available Internal Resources

The organization has an established leader that could be the core of leading the organization building process towards a geographically-expanded entity. However, this may not be compatible with research interests.

##### B. Other Options

The CPARH services could be put at the disposition of the government to diversify its family planning strategy.

#### V. Training and Technical Assistance

The organization manifested interest in a practical implementation oriented technical assistance.

##### Technical Assistance

Fund raising

Policies and Politics strengthening

Marketing (pricing, research, promotion and publicity)

#### VII. Conclusions and Recommendations

This organization is providing a unique service and is moving well into the road of sustainability. It appears needing training and technical assistance to allow it to expand the reach of services and ensure long-term survival. Before that could be provided, an appropriate manager in charge of finance and administration should be hired.

Sociedade de Assistencia a Maternidade  
Escola Assis Chateaubriand - SAMEAC

## I. Introduction

Founded in 1965 as a entidade civil sem fins lucrativos, SAMEAC is financially dependent on the Centro de Ciencias de Saude of the Universidade Federal de Ceara, a public university. The original purpose for the founding of SAMEAC was to provide some independence of action from the university bureaucracy in order to be able to establish a wide range of health services, including family planning.

Today the university is again becoming interested in its health programs, including SAMEAC, and slowly the bureaucracy is becoming involved in the policy-making and supervision of the health program. With the advent of democracy in Brazil and the heightened political interest in the universities, the local General Accounting Office (Tribunal de Contas) is being used as a bridge to increase control of the funds and personnel at the University and SAMEAC. Although to date it still has some operational freedom, if the trend continues it is expected that SAMEAC will be university controlled within the next few years.

Throughout its network of urban and rural clinics, SAMEAC has grown successfully to about 8,000 consultations in family planning per year. In 1975 the family planning services became part of an extended maternal health care program, and in 1986, it became part of integrated health services. Funds received from the Kellogg Foundation, Project Hope, and INAMPS served to establish and operate the Programa de Ações Integradas de Saude (PROAIS), a primary health care organization which includes family planning.

Today PROAIS has an extended network of 32 first level units ("postos"), three level two units (clinics) and one level one hospital. PROAIS's policy is that no client is to be charged for services. SAMEAC is dependent on university funding for the personnel at its clinics, but is less dependent regarding the funds necessary for its rural posts network.

### Clients

Since its inception, the majority of clients have been from the poor population from in and around the city of Fortaleza, in Northern Brazil, where the central offices of SAMEAC are located. Of the 8,000 consultations per year, about 2,500 are made in the urban clinics with the remainder being made to the rural postos. However, SAMEAC has only approximately 5,000 users of FP methods. The reason for the small number is considered to stem from the level of education of the population and the slow rate of resupplying the rural postos.

### Services

SAMEAC's key activity areas are as a provider of primary health care and as contributing to the teaching at the University. It provides training for doctors at all levels, consultancy on health techniques and evaluation, provides personnel, and the services of two cars for supervision. Primary health care services are provided through field station ("postos"), whereas secondary and tertiary attendance is provided at clinics and support facilities. By means of convenios with INAMPS, it has been able to provide a wide gamut of services that are reimbursed by the state.

However, family planning services are difficult to maintain due to the scarcity of supplies. These scarcities are partially compensated with working agreements with other FP organizations. Consultations last year resulted in the following distribution per method:

- \* 60% pills
- \* 30% IUD
- \* 5% sterilization
- \* 2.5% condom
- \* 2.5% foam

Another major difficulty is the population's low income that limits money that may be used to buy supplies.

Considering SAMEAC's catchment area of the 150 kilometers radius surrounding Fortaleza, with 5,000 users the PROAIS has a 9% market share. The Director of SAMEAC believes that this could be increased to a 60% share, equivalent to approximately 37,000 users.

### Pricing

All levels of services are free of charge to all patients. However, in order to start funding the program, and induce self-maintenance of operations of the network, there are 2,000 members that contributed a total of nearly Cz \$30,000 per month, from 16 health units.

### Service Delivery

The 32 rural postos are located in the central and northern region of the state of Ceara, one of the poorest of Brazil. Of those, 26 have convenios with INAMPS that reimburses them for ambulatory and rural consultations, 27 are primary health centers and five are mid-wife offices, next door to the mid-wife's house.

Facilities at the mid-wife's office includes one or two beds and is tended by the mid-wife. The primary health centers are classified into three groups: A, B and C. Primary health center type C has one birth unit, two beds, pre and post-natal maternal care, including family planning and child assistance. It usually is staffed with two mid-wives, a domestic, one traveling doctor that stops by once a week, and a nurse that comes one day a week. There are 10 type C health centers. Health center type B has the same equipment as type C plus: 4-8 beds, 1 maternal-infant system, one steady doctor or nurse, and curative assistance to adults. There are 15 type B centers. A primary health center type A has what a type B has, plus a dentist, a small laboratory, several doctors and nurses, and adult health assistance.

The program has dedicated great amounts of training to mid-wives in family planning, as a bridge to service provision for the rural poor in the hard-to-reach areas.

Community-based distribution has not included in SAMEAC's programs, as it is poorly accepted. Another term has been coined for it: follow-up at the client's house.

#### Competition

SAMEAC has little competition in its activities to provide services to the poor by their peers. But it has formidable handicaps in the low level of education of the population and their very low levels of income available to buy supplies.

## II. Financial Analysis

PROAIS is currently funded by the Kellogg foundation with US\$410,000 for three years ending 1988. These funds pay for personnel, training of doctors, consultancy to health technicians and evaluation, training of mid-wives and health agents, program administration, two cars and operations of the program. There are some private sector funds and Project Hope contributes with personnel.

To increase self-financing, a number of strategies are being tried. One of these is to increase the number of members that provide dues to support the operations of the postos network. The second is to have Project Hope contribute funds and to extend the funding from the Kellogg Foundation funding. Another strategy is to establish fund-raising and contributions in the private sector. And finally, another possibility is to try to obtain agreements with the municipal government to provide health services.

### III. Quality and Description of Management

#### Budgeting

Annual budgets are prepared for the institution, but they lack programmatic content, activities and unit prices and costs. For the time being, the SAMEAC staff only has control on the Kellogg Foundation funds. They have almost no influence as to how university funds are to be allocated, these are the funds which pays for many of the personnel at the Centro de Saude.

#### Budget Analysis

There is no monthly or regular frequent analysis.

#### Financial Management and Controls

SAMEAC has Kellogg Project evaluation and reporting. They receive no information from the university that identifies the FP activities specifically.

#### Pricing

None is done since the services are supposed to be free. But, in fact, they are doing some comparisons and trying to develop a logic that may self-finance the postos.

#### Marketing

No marketing is done.

#### Organizational Chart and Personnel

The supervisory organization of SAMEAC has 27 people, which includes ten doctors, one agronomist, two dentists, 12 nurses, one anthropologist and one statistician.

#### Willing to Make Changes

It appears that there is a willingness to consider innovations in marketing, finance and fund-raising, as well as spinning off the network of postos.

### IV. External Threats and Opportunities

#### Threats

A major threat is the entry of more university control and politics into the organization of SAMEAC. Another is that the teaching and training function of the university may at some point come in conflict with SAMEAC's traditional emphasis on the provision of health care services.

### Opportunities

One is to develop models of urban and rural health services to the poor, with support of research grants. Another is to innovate marketing, finance, fund-raising and organizational development so as to spin-off the whole network, under such conditions that it will become self-sustaining.

## V. Planning for Self-Sufficiency

### A. Available Internal Resources

The organization has an established group of professionals that could be the core of an expanded training function for the personnel of the spun-off network.

On the other hand, SAMEAC's accumulated information and experience, combined with its clinics could well serve to research and establish new service approaches that could design models for alternative self-sufficiency strategies, including reducing costs, increasing revenues, changing the delivery mix and so forth.

### B. Other Options

The SAMEAC network could be put at the disposition of the government, either as a network consultant service providers, or in increasing the level of convenios with INAMPS to a point where the clinics become profitable. The same is applicable to the business community that employs people in the Fortaleza area.

## V. Training and Technical Assistance

The organization manifested interest in a practical mix of training and implementation oriented technical assistance in:

- \* Funds-generation in the rural areas
- \* Marketing strategy for increased service delivery.
- \* Development of alternative rural models

## VII. Conclusions and Recommendations

For 23 years, this organization has been able to build a small rural network. If experimentation and development of rural models in very-low income areas is of interest, then some of this assistance may be worthwhile.

## Promoção da Paternidade Responsável - PRO-PATER

### I. Introduction

Founded in 1980 as a sociedade civil sem fins lucrativos and operational as of 1981, PRO-PATER was established in São Paulo by Dr. Marcos Paulo Pelliciani de Castro, founder and Executive Director. As Chief of the Family Planning Division of the Hospital at the Universidade de São Paulo, Dr. Marcos had noticed there were no services available for male sterilization, and he decided to fill that void.

Since then, PRO-PATER has successfully progressed through several stages of development, having started out slowly and grown rapidly in the provision of vasectomy services, later successfully diversifying into infertility, and other high level services related to men and family planning.

PRO-PATER has a strong reputation for a successful program in vasectomies and has been a trainer for other Brazilian clinics interested in entering into the provision of this service.

In the last few years, the organization has been working on establishing a geographical diversification of its own and to date, the challenge of succeeding in that area is still there. Although the patterns for increasing financial self-sufficiency are there, that stage has not been reached. The organization has had support from AVSC since inception, and also from FHI.

PRO-PATER has one major well-established clinic in downtown São Paulo. A new clinic, further east and more convenient to the current pattern of clients travelling long distances to the city, is being established, after careful study of its prospects.

### Clients

In its inception, Pro-Pater assumed that clients to be attracted would be the poor, but this did not happen. The strategy was changed to attract more lower middle class clients, and then word spread and the clientele increased. Later on, with the use of publicity, volume increased significantly and has continued to do so. Number of consultations resulting in vasectomies in early 1981 were in the tens per month, increased to about 250 per month by 1984, and have settled to about 350 monthly in 1987 with a slowly decreasing pattern.

### Services

PRO-PATER's key activity area is providing services of permanent male contraception, and secondarily, in the areas of male infertility and sexual disturbances. All these services are provided at its one clinic in São Paulo.

### Pricing

Fees are generally charged for all patients, but there are exceptions granted by the clinic doctors. Prices initially charged were 10-15% of the monthly salary of a patient. Experience showed this to be too little for poor patients and too much for well-to-do ones. Today fees for vasectomies are charged on a sliding scale, with minimum being about Cz \$2500 and maximum about Cz \$8000, with the average about Cz \$4300. A consultation costs about Cz \$400. Patients are classified into categories, by means of an initial interview done by a trained social worker who considers certain indicators, classifies patients and advises them accordingly. Prices change about every 5 months. The price includes: first consultation, surgery, laboratory exams and 1-2 follow-up visits. Much is done to insure the male patient understands the nature, and the consequences, of the procedure; and very good documentation exists to reduce potential liability risks.

### Service Delivery

PRO-PATER considers the clinic's prime catchment area to be the factories of São Paulo and their surrounding neighborhoods. To deliver educational material and information, as well as promote the service, talks are delivered to the social assistance organizations in those factories. In the three and a half years between April 1983 and November 1986, 578 social assistants were trained by PRO-PATER lectures. Social workers do not get paid for referring patients, but they are responsible for a significant number of referrals. In addition, in the six years ending December 1987, 3,487 participants from companies, schools, public entities and others attended courses provided by the organization.

A few years ago PRO-PATER tried to establish a branch clinic in Rio de Janeiro, but was not successful. A reason attributed to the failure was the lack of a top-notch Rio de Janeiro doctor being present to manage and promote the clinic. The clinic that is soon to be opened in eastern São Paulo will be run by Dr. Marcos himself, initially, and one of the principal doctors at the downtown clinic will be responsible for that one.

PRO-PATER for several years established 2-year cooperative agreements with clinics in the cities of Fortaleza (PROVAS), Belo Horizonte (PROCREAR), Londrina (CEIRHO), Riberão Preto (FAMPATER), and Santos (CLINI-URO). These clinics decided to go on their own at the end of the 2-year period and today operate independently, providing vasectomy services. Reasons given for the separation included: an insufficient capacity to supervise the clinics medically; some clinics had bad-quality services, and others did not pay enough attention to the control of the incoming documentation.

### Competition

PRO-PATER believes it does not have significant competition in its principal service: vasectomies and less in the more specialized ones. Rather, they think that the difficulty is the lack of interest in vasectomies by men. PRO-PATER believes they have performed 18% of the vasectomies performed in the São Paulo Area in the last 5 years. Currently their market share is 5%; they would like to double that to 10%.

## II. Financial Analysis

Their significant efforts to be successful in all aspects have produced relatively good results in progressing towards sustainability and financial self-sufficiency. In 1987, income totalled about US\$380,000, of which about 64% came from patient income and about 36% came from international organizations. In 1987, general expenditures for patient services were about US\$263,600, so in fact, PRO-PATER was 92% self-sufficient on these expenditures, almost equal to related revenues. For 1988, PRO-PATER expects to receive about an equal amount of money from international donors, as that received last year. They expect to increase their locally-generated funds by means of a number of strategies, which includes; charging professional fees for training, establishing courses for continuing education, and obtaining overhead contributions. Another major strategy to increase volume is by establishing a clinic in the eastern part of São Paulo and spreading the large laboratory costs over a greater number of patients and tests. Thirdly, they are considering providing specialized services such as fertilization in-vitro, fertility clinics, prosthesis and research. They consider they are ready and equipped to provide most of these now.

Although PRO-PATER seems to be financially sound, it is also true that increasing patient flow will require investments and expenditures to increase the level of vasectomies considerably, as was needed at each previous stage. It is clear that since the margins in their basic business are reducing, the organization cannot just do more of the same.

## III. Quality and Description of Management

### Budgeting

Annual budgets are prepared for the institution, but they lack programmatic content, activities and unit prices and costs.

### Budget Analysis

There is monthly analysis of general accounting results. Costs accounting is sporadic.

### Financial Management and Controls

PRO-PATER has computerized general accounting reports that provide information on revenues by activity and categories, in general and detailed terms. Its reporting of expenses allows them to develop costs information per service but not as often as they would like. Their in-house accounting also serves to prepare the annual fiscal report.

However, they would like to be able to get more frequent costs comparison and calculation of break-evens.

### Pricing

Pricing is done on a combination of a market-related comparison basis and the results of their cost accounting.

### Marketing

Marketing is taken very seriously at PRO-PATER, particularly since it has proven to be the formula for initial success. Whereas no formal form occurs, marketing strategy is defined each year, and publicity is carefully considered. In 1982, publicity at a vacation colony brought the overall level of vasectomies up from the fifties per month to over hundred per month. Publicity at a TV show interview, in 1984, provided a push to increase a plateau of services to the three hundred per month level. A mass media campaign did the same for the 350 per month level in 1986.

Their strategic planning is not formal but exists in a rough form.

### Organizational Chart and Personnel

There are 16 partners at PRO-PATER, who elect an outside Board of Directors of three members, who in turn nominate the Executive Director. The organization is run by the Executive Director and his wife, who is in charge of Administration. The total organization now has about 27 persons, distributed in four divisions: Administration, Medical Division, Laboratory and Projects. Administration has about six people in charge of finances, accounting, and services. The Medical Division employs about 15 persons, who provide the medical services, and includes: five part-time doctors, three full-time nurses, and two social assistants. At the laboratory, there are two technicians and in the Projects Division there are four people, dedicated mostly to research projects funded by Pathfinder and FHI.

### Willingness to Make Changes

PRO-PATER has been quite willing to face challenges and overcome them, many relating their activities more closely and more responsively to the market. Interestingly, they are again attempting a geographic expansion even though the first one was not successful.

## IV. External Threats and Opportunities

### Threats

A minor threat is the entry of the Government into the provision of vasectomy services; rather more likely is the possibility that the Government's provision of services to the female population may serve to drive competitors into the male services market.

### Opportunities

Several opportunities for PRO-PATER exist in the geographic expansion of their services and the increased specialization of more sophisticated services, not supplied by other organizations.

## V. Planning for Self-Sufficiency

### A. Available Internal Resources

The organization has an established group of entrepreneurs and professionals that could be the core of a geographically-expanded entity. On the other hand, PRO-PATER's accumulated information and experience, combined with its clinics, could well serve to research and establish new service approaches, that could design models for alternative self-sufficiency strategies, including reducing costs, increasing revenues, changing the delivery mix and so forth.

### B. Other Options

The PRO-PATER services could be put at the disposition of the government to diversify its family planning strategy. Also, PRO-PATER could seek to establish a network of service providers under a brand identification and quality supervision. It also could consider INAMPS convenios to increase the clinics volumes and to establish new ones.

## V. Training and Technical Assistance

The organization manifested interest in a practical implementation oriented technical assistance.

### Technical Assistance

Marketing (pricing, research, promotion and publicity)

Management Information Systems

Cost accounting

Clinic simulation and modelling

## VII. Conclusions and Recommendations

This organization has provided a unique service and is moving on the road to sustainability. It has been a unique, and so far successful, example of how to provide vasectomy services; it now appears to stand at a critical institutional stage and could benefit from technical assistance to ensure long-term survival.

It would be commendable to provide this organization with the technical assistance it needs and could use to develop alternative service models useful for other countries that wish to diversify their family planning target markets.

Centro de Pesquisas da Assistencia Integrada  
A Mulher e a Crianca - CPAIMC

## I. Introduction

Founded in 1975 as a sociedade civil sem fins lucrativos, and operational as of 1978, CPAIMC was established in Rio de Janeiro by Dr. Helio Aguinaga and a group of doctors and nurses who were interested in serving the urban poor with maternal and child health services. Since that time, CPAIMC has undergone several stages of development, growing rapidly as a provider of family planning services, and functioning as a quality training program.

CPAIMC has, in the municipality of Rio de Janeiro, twelve clinics which are used for training sites, and a smaller number of clinics outside the state. These clinics have had a short period of FPIA support.

### CLIENTS

Since its inception, CPAIMC has continued to serve a poor population, with over 150,000 clients annually.

### SERVICES

CPAIMC's key activity is the provision of primary health care and the training of personnel. In primary health, it provides family planning services, obstetrics, gynecology, sex education and infertility treatment. Child health services are also provided including; immunization, growth monitoring, and pediatric services. The emphasis has mixed community health services with clinic services; the primary health care services are provided through a series of health field stations (postos), and secondary and tertiary care are provided at clinics and support facilities.

Other services offered by CPAIMC to its network, are technical assistance and evaluation. In addition, CPAIMC is the major distributor of family planning supplies, provided by international donors, in Brazil.

### PRICING

Patients are charged a modest fee for all services. At the time of this assessment, CPAIMC was charging twice as much.

### SERVICES DELIVERY

Due to retrenching of the organization, in its efforts to become more self-financing, a greater emphasis has been placed on training, the provision of technical assistance, and other activities, resulting in a de-emphasis of service delivery, and an accompanying drop in the number of clients served. This retrenchment has been accompanied by the relocation of the central offices to a neighborhood in the northeast section of Rio de Janeiro. And, in a further effort to reduce costs, primary and secondary health activities are in the process of being combined.

## COMPETITION

CPAIME has competition in all of its activities, with the exception of providing health care services to the poor. The organization has a well-established reputation in training and is a major training organization, with a strong potential for growth.

## II. Financial Analysis

Despite significant efforts by CPAIME to develop and implement a new strategic plan, total revenues for CPAIME have been decreasing in the last few years. It was planned that locally generated funds would come from INAMPS convenios, with smaller portions from government reimbursement, and a smaller percentage from client payment for services. These budget expectations did not occur, due to problems with the INAMPS convenios. Funding has been received from a variety of international donor agencies, including JHPIEGO, Development Associates, the Pathfinder Fund, and FPIA; CPAIME expects to continue to receive funds from these organizations during 1988. The current budget calls for 30% of the 1988 funds to come from locally generated sources; however this consultant doubts it is feasible.

To increase self-sufficiency, a number of strategies are being tried. Between September 1987 and February 1988, personnel at the central clinic were reduced from 200 to 100 persons, largely due to the relocation of the central office. CPAIME intends to maintain this number, or slightly higher, but with better paid personnel.

Another area where CPAIME expects to increase revenues comes from their role as sole distributors, to approximately 350 organizations, of commodities provided by FPIA and Pathfinder. CPAIME expects to start charging for the distribution service, but is not sure of the percentage to be charged. In order to fund the personnel and organization needed for this undertaking, a possible USD 300,000 loan from USAID is being discussed.

### III. Quality and Description of Management

#### BUDGETING

Annual budgets are prepared for the institution, but they lack programmatic content, activities, as well as unit prices and costs.

#### BUDGET ANALYSIS

There is no monthly or regular analysis. They hope to start this practice in 1988.

#### FINANCIAL MANAGEMENT AND CONTROLS

CPAIMC's general accounting reports list revenues by activity categories and projects, in both general and detailed items. However, CPAIMC's reporting of expenses is reported in general terms, not by project, making the reporting process difficult.

#### PRICING

Pricing is upon a market comparison.

#### MARKETING

There have been some efforts to relate their planning to strategic planning and marketing, but the leadership appears to be lacking to make major advances in this area.

#### ORGANIZATIONAL CHART AND PERSONNEL

Decision making is clearly concentrated upon the President and the top management. The president, who acts in a very hands-on capacity, runs the Board of Directors, with an Executive Committee reporting to him as well. The General Coordinator, at the present time the President's daughter, reports to the President, and as a result of the personnel reductions oversees three staff functions (legal advice, information center, and the planning unit) and two major units, the Department of Services and Department of Administration.

The Department of Services employs about 70 people, and has sections dedicated to training, with seven people teaching medical and nursing courses, another division of nearly 60 responsible for the now fused primary and secondary health services.

The Administrative Department is overseen by a Manager, and divided into three sections, personnel, supplies, and general services.

#### WILLINGNESS TO MAKE CHANGES

Although CPAIMC has been through many changes in the past and faces as many challenges in the future, there appears to be a lack of leadership for bringing about the major changes needed to reorient the organization into a more sustainable direction.

#### IV. External Threats and Opportunities

##### THREATS

A major threat is the entry of the Government into the provisions of family planning services. It is a major reason for the organization placing an emphasis on training and teaching.

##### OPPORTUNITIES

Some of the opportunities for CPAIMC lie in the area of converting their contraceptive distribution program into a commercial operation, and establishing fast-growing, venture capital funded services, such as ultrasound services. A focused effort to evaluate the alternatives and move on to decision making is necessary.

#### V. Planning for Self-Sufficiency

##### AVAILABLE INTERNAL RESOURCES

The organization has an established group of professionals that could be the core of an expanded training center. Likewise, CPAIMC's accumulated information and experience, combined with its clinics could be used for research to establish new service approaches and models for alternative self-sufficiency.

##### OTHER OPTIONS

The CPAIMC network could be put at the disposal of the Government, either as a network of contracted service providers, or as a means of increasing INAMPS levels of convenios to where the clinics become profitable.

#### VI. Training and Technical Assistance

The organization manifested interest in a practical mix of training and technical assistance, including: cost accounting, marketing and pricing, clinic modelling for self-sufficiency, planning, control and evaluation, as well as Management Information Systems.

## VII. Conclusions and Recommendations

During the last few years, CPAIMC has participated in several technical assistance efforts, with little to show for the investment. Training could be provided selectively to members of the management level, but technical assistance should be conditional on specific investment and managerial changes. Any technical assistance provided should concentrate on investing in, and the organization of, new ventures that have a high income generating potential.

## Conselho Londrinense de Assistencia a Muhler-CLAM

### I. Introduction

CLAM was formed in 1969 as an privada filantropica de utilidade publica. Considered one of the most successful of the private family planning organizations in the country, CLAM has developed into a mature organization that provide a wide range of services to its clients. Two clinics, a hospital and a well-equipped modern laboratory provides modern high quality health care in a cheerful, pleasant atmosphere.

### Services

The two clinics provide a wide variety of Ob-Gyn services:

- \* prenatal care
- \* family planning services
- \* prevention of cancer
- \* treatment of varicose veins
- \* urology

Clinic hours are,

Monday through Friday:                    8-12 and 2-6

In 1986, the clinics reported 4,018 medical visits in family planning and 16,119 gynecological examinations.

The CLAM hospital offers surgery in the areas of gynecology, obstetrics, urology, treatment of varicose veins, and plastic surgery in general.

In 1986, 1,928 surgical procedures were performed and 1,693 in-patients.

The laboratory is well-equipped to provide general clinical analyses, pathological samples, pap smears, ultra-sound, mimeograph, and electrocardiograms. In 1986, a total of 91,371 exams were completed, as follows:

* patologia clinica	48,242
* anatomia-patologica	1,219
* citopatologia	29,813
* ultra-sonografia	10,288
* mamografia	1,465
* eletrocardiografia	344

In addition, CLAM provides training to nursing professors, community leaders, educators, atendentes, and doctors. In 1986, 255 individuals were trained in 24 courses.

### Clients

CLAM clients are lower and middle class individuals from the city of Londrina.

### Pricing

Prices are set monthly according to tabelas established by the appropriate medical associations. For example, prices charged for services provided in the hospital are taken from the tabela prepared by the Asociação de Hospitales de Norte de Parana. Prices for the clinics are calculated by the Associação de Médicos Brasileiros. Prices for laboratory services are similarly set. There are two tabelas developed to cover patients. Patients that are covered by one of the 50 convenios fall under the official tabela. Private patients with the ability to pay are charged up to 50% more. Individuals who do not have the ability to pay and who are not covered by a convenio may receive up to a 30% discount.

### Service Delivery

Middle class and lower class patients are covered by two different clinics. The middle-class patients receive an appointment for a particular time. Lower-class individuals receive an appointment for a particular period of time.

## II. Financial Analysis

Financial information was not available to the consultant. However, CLAM staff indicated that the clinics, laboratory, and hospital are self-sufficient, with net income which is used to invest in additional infrastructure. The Department of Community Extension, which runs the FPIA-funded CBD project as well as carries out other community, information, and education projects, is heavily dependent on external resources.

## III. Description and Quality of Management Structure

### Budgeting

CLAM prepares an annual budget for projects as well as for the organization which is adjusted quarterly for inflation.

### Budget Monitoring

That budget is monitored on a monthly basis.

### Pricing

Prices are set by the tabelas which govern the various convenios. According to CLAM, 59% of the patients receive a discount of up to 30% of the price indicated on the tabela, 20% fall under convenios, 10% receive services for free, and 20% are private patients.

#### Organizational Chart and Personnel

CLAM has 117 employees divided into six departments: Administration, Medical Assistance, Community Extension, Clinics, Laboratory, and Hospital. The organizational structure appears appropriate for present operations.

#### Willing to Make Changes

CLAM has demonstrated its ability to look at their institution and operations from an analytical and financial point of view. They can make decisions based on relative profitability, priorities, and are able to make the necessary decisions.

### IV. External Threats and Opportunities

#### Threats

- \* The macro-economic environment of the country has a negative impact.
- \* Certain institutions, such as the church, maintain pressure against family planning services, which requires that family planning services be provided within the context of general health care.
- \* Family planning is a dirty word that at times is equated with prostitution.
- \* CLAM competes with doctors for the same patients—a doctor would rather see a patient in his/her private office rather than in the CLAM clinic.

### V. Planning for Self-Sufficiency

#### A. Available Resources

By their estimate, the organization is running at slightly below capacity. The laboratory is running at 80% of installed capacity. At 75%, the hospital is running at slightly below the ideal capacity of 80%. One clinic is running at 75%. The other is running at 40% at present but with a new convenio that will be signed shortly, the percentage should rise to 80-90%.

#### B. Options

1. Expand services to include human reproduction areas such as infertility, sexuality, and pre-natal care.
2. Expand the number of doctors in order to increase services.
3. Expand existing services, without increasing fixed costs.

## VI. Training and Technical Assistance

### Training

Strategic Planning

Cost Analysis

### Technical Assistance

None

## VII. Conclusions and Recommendations

CLAM is not recommended as a priority organization for provision of technical assistance and training for the following reasons:

1. It is doing well financially and strategically.
2. The level of expertise within the organization is high at the present time.
3. The area served by the organization does not fit into the priority geographic locations.

## Centro Materno Infantil—CMI

### I. Introduction

Based on research on the MCH situation in Sao Paulo which indicated a need for family planning services for low income individuals, the Centro Materno Infantil (CMI) was founded to provide training, services, and research in family planning. Created in April of 1979 as a not-for-profit institution, it was declared an entidad de utilidad publica in 1983.

The President of the Board, Dr. Milton Yakamura, appears to be the prime mover on the board and donated the building in which the organization is located and provides logistical support to the clinic as required.

### Clients

Throughout the decade, clients have remained poor although the number of truly indigent individuals decreased when they began to charge a fee for services. With the institution of a fee, clientele has changed from gente cariente to lower middle and upper lower class. Clients tend to have little education—69.6% have 0-4 years of school. They tend to be poor—43.2% have 0-2 times the minimum wage with 41.2% having an income equal to 2.1-4 times the minimum wage. 70.6% of the women are housewives. Clients are from Sao Paulo, although staff indicated family members of Sao Paulo residents came from as far as Bahia to have their sterilization at the clinic.

### Services

CMI started providing family planning services in August 1979. In 1983, they began to work, with the assistance of a donation from Organizacao Japonesa para Cooperacao de Parasitoses (JOICFP), with postos comunitarios in the control of intestinal parasites. In addition to working in parasites, these eleven postos also provide information, motivation, and referrals for family planning services. The clinic provides both surgical and non-surgical contraceptive methods, lab exams, and pap smears. Female sterilizations were the most common method chosen. Clients could also have IUD's inserted, diaphragms fitted, and purchase pills and condoms.

Non-surgical family planning services are offered five afternoons a week. Sterilizations are performed three days a week.

Service delivery has been decreasing during the last couple years from a high of 2661 new users in 1982 down to 1334 in 1986. Continuing users have also dropped from a high of 5959 in 1982 to 3380 in 1986.

### Pricing

Prices for services are set quarterly, with sliding fees, depending on the patients' income. Prices for contraceptives were lower than market prices, but the clinic found it difficult to sell them to patients. At Cz \$4-5,000 for females and Cz \$3,500-4,500 for males, sterilizations are priced well below market.

### Marketing

Marketing of services occurs by word of mouth.

### Competition

There are few other services available for low and middle income women in Sao Paulo.

## II. Financial Situation

Financial information for 1986 indicated that 83.0% of total operating income was from the JOIFP grant, 1.4% was from fees charged to patients and 10.6% was from local donations. The remaining 5% was from various sources.

By the end of 1987, this situation had improved to some degree as the clinic began to charge user fees. In December 1987, income from sale of contraceptives, lab exams, and medical visits was 65% of total expenses. Of that income, 74.6% was from sterilizations.

## III. Quality and Description of Management Structure

### Budgeting

The organization prepares an annual budget for the Japanese project which is more a connotation of last year's program rather than a result of program planning and budgeting.

### Budget Monitoring

A monthly analysis of expenses and income is prepared for the Japanese project and compared against the budget in a complete series of books. Those funds are well controlled. Monthly financial reports prepared by the bookkeeper do not control actual against budget. No analysis is made of the non-grant funds.

### Pricing

Quarterly, the costs of surgical procedures are calculated and a price is set that is as much market as cost oriented. There appears to be little knowledge of the unit cost of providing non-surgical services.

### Monthly Service Statistics

CMI has excellent monthly data on services provided and clients attended. It is unclear, however, what analysis is made of that information.

### Organization Chart and Personnel

The clinic has 19 employees organized into four departments: Administration, Nursing, Psychology, and Medical and Surgical Services. The organizational structure appears appropriate for present operations.

### Storage of Commodities

The organization keeps its' contraceptives in a locked secure area.

### Willingness to Make Changes

As the consultant spoke only with staff and did not talk to either the Director of the organization nor to any board members, it is difficult to assess top management's attitude toward and willingness to make change. Staff were committed and motivated and had thought about possible alternatives.

## IV. External Threats and Possibilities

### Threats

- \* There are no public funds available.
- \* There is no clear idea of where the government is going and what their attitude and policy is towards family planning.
- \* There appears to be a lack of demand for their services.

### Opportunities

- \* The clinic is on a good transportation route, one block from the metro.
- \* There is little competition for provision of family planning services.

## V. Planning for Self-Sufficiency

### A. Available Resources

CMI is in a large building which is terribly underutilized. There is space for training, additional offices, and for a general, and not insignificant, expansion of services and activities. There are 11 recovery beds upstairs in the surgical unit.

At their estimate, the clinic is operating at 50% capacity of installed physical and human resource capacity. Sterilizations are performed only three days a week, operating at 50% of physical capacity.

## B. Options

1. Expand non-surgical medical family planning services without increasing fixed costs.
2. Diversity market to include middle income individuals or adolescents.
3. Expand surgical services without increasing fixed costs by increasing the number of days that sterilizations are performed.
4. Improve the quality of the surgical unit and rent the space out to doctors for their private use.
5. Sell training in family planning.
6. Obtain convenios with private businesses for provision of services to their employees.

## VI. Training and Technical Assistance

### Training

- \* Strategic Planning
- \* Planning and Budgeting
- \* Budget Monitoring
- \* Financial Analysis
- \* Cost Analysis and Pricing
- \* Marketing
- \* Cash Flow Analysis

### Technical Assistance

None

## VII. Conclusions and Recommendations

This organization should receive priority for training and technical assistance for the following reasons:

1. They are serving the urban poor.
2. They face serious problems with regard to strategic planning and utilization of agency resources but the absorptive capacity of technical assistance and training appears to be high.

## Centro de Asistencia Especial Materno Infantil—CAEMI

### I. Introduction

CAEMI was founded in 1978 by its present Administrative Director, Conceicao Resende, to rent out hospital equipment. In 1980, after Development Associates approached her with the possibility of providing training in family planning to nurses and other medical personnel, she brought in two additional partners, one of whom still works as a doctor within the clinic. DA has provided financial support to provide training to medical personnel, nurses and nursing staff in family planning. According to organization staff, almost all nurses in Brazil have been trained by CAEMI in family planning.

The organization is a sociedad limitada, consisting of Ms. Resende with 84% ownership, and two other individuals, with 8% each. The building is owned by Ms. Resende while the equipment is owned by CAEMI.

### Clients

According to CAEMI, clients are low and middle class, although the consultant was not able to confirm this through observation or statistics.

### Services

CAEMI provides the following services:

1. Trains nurses and teachers in nursing schools of universities in family planning;
2. Rents medical equipment to individuals, such as wheel chairs, crutches, hospital beds, oxygen tanks;
3. Hires part time nurses to home-bound individuals;
4. Provides surgical and non-surgical family planning services;
5. Rents clinic space and surgical facilities to doctors for 30% of gross fees and;
6. Provides nursing services to postos comunitarios

No service statistics were available.

### Pricing

In March, medical visits paid for by convenio were charged at Cz \$500 each, while private patients may be charged less, depending on their income.

### Service Delivery

While the clinic provides services in a wide variety of areas and the office hours for these services vary by the doctor, family planning services are offered both in the morning and afternoon by two gynecologists. The clinic is cheerful and clean.

Monday, Thursday, Friday	9-12:30
Tuesday, Wednesday	11-12:30
Monday-Friday	2-7:00
Saturday	9-12

### Competition

According to CAEMI, there are few alternative services available. There are no affordable services for low and middle income individuals. While the Universidad de Campinas provides free family planning services, it is relatively inaccessible to people without private cars. Only ten kilometers, away individuals must take three buses to get there. Ms. Resende also identified pharmacies as her competition; individuals can receive contraceptives without spending time or money for a doctor's visit.

## II. Financial Analysis

No financial information was made available to the consultant for 1986 or 1987. In January 1988, 25.1% of income was from medical services and space rental; 73.0% from rental of equipment, and 1.9% from sales of contraceptives. There was no income from DA as there was no course planned during that period. Ms. Resende estimated that 20% of the organization's income in 1987 came from DA.

## III. Quality and Description of Management

### Budgeting

There is no annual budgeting except for donor funds.

### Budget Monitoring

No budget monitoring nor analysis occurs except for donor funds.

### Pricing Information

Pricing for services is done monthly, based on costs. For surgical procedures, the average cost is calculated, based on actual expenses.

### Marketing

CAEMI markets services for the organization a whole, with family planning included as part of the entire package. Advertisements are placed in local newspapers and leaflets are passed out in streets, schools, associations, etc.

#### Organizational Chart and Personnel

The organization is tightly run, with clear lines of authority which is appropriate for present operations. CAEMI has nine employees and nine other doctors that rent office space. The organization has four departments, Medical, Nursing, Education and Training, and Auxiliaries Services.

#### Willing to Make Required Changes

The clinic is owned by Ms. Resende as a profit-making organization and as such she has the motivation to implement changes as required to ensure its economic survival. She indicated a number of thoughtful income-generation ideas and has demonstrated her ability in the past to successfully implement those plans.

### IV. External Threats and Opportunities

#### Threats

- \* The church maintains pressure on CAEMI, claiming that they accept American money for population control, to the point, as Ms. Resende indicated of putting announcements in the newspapers.

#### Opportunities

- \* There is no competition for family planning services in the area.

### V. Planning for Self-Sufficiency

#### A. Available Internal Resources

The organization has a physical installation that will allow for an increase in output, even without an increase in personnel. By their calculation, they are using 50% of their physical capacity. They have a surgical room, four recovery beds, four examining rooms, and one room for psychological counseling.

## B.Options

Ms. Resende has a number of ideas about decreasing her dependence on USAID funds and expanding her clinic.

1. Increase productivity of the clinic by increasing output, with no increase in fixed costs and little increase in variable costs.
2. Add a maternity facility with a blood bank, a strategy that she is pursuing at the present time.
3. Expand rentals of medical equipment.
4. Increase the number and breath of expertise of doctors renting space.

## **VI. Training and Technical Assistance**

### Training

Planning and Budgeting

Costing: Including cost accounting and accounting for depreciation Budget  
Monitoring.

### Technical Assistance

None

## **VII. Conclusions and Recommendations**

This organization is not a high priority for training and technical assistance for a number of reasons:

1. Ms. Resende is doing quite well—financially and strategically.
2. It is unclear the extent to which the clinic serves low income individuals.
3. The clinic is not located in a high priority geophysical area.

Conceicao Resende should be invited to attend the training courses but FRMT should not reimburse her travel or per diem costs.

## Centro de Estudios e Pesquisas Clovis Salgado - CEPECS

### I. Introduction

CEPECS was formed in 1980 by a group of professors from the Ob-Gyn Department of the Facultad de Universidad Federal as an entidad sem fines lucrativos to:

1. Conduct research on prevention of cancer;
2. Provide training in family planning;
3. Develop a center of applied research and;
4. Provide inoculative and integrated family planning services.

It was designated utilidad publica municipal in 1984 and utilidad publica estatal in 1986.

Since 1982, CEPECS has provided services in the prevention of cancer, prevention, diagnosis, and treatment of sexually transmitted diseases, and sexual education and family planning.

#### Clients

Patients of the organization are low income. The program serves men and women in both Belo Horizonte and rural areas of Minas Gerais.

#### Services

The central clinic offers a range of family planning services such as prevention of cancer, diagnosis and treatment of sexually transmitted diseases, sex education, and family planning services. Clinic hours are 8-11 and 1-4. Pap smears are taken in the postos and sent into the central office for analysis.

In 1987, they saw 57,798 patients of which 27,124 were new and 30,674 were continuing users.

#### Pricing

The postos of Belo Horizonte keep any funds generated through sale of contraceptives or user fees. The rural postos, however, do not charge anything. In the central office, specific user fees were instituted only in September of 1987. A tabela is prepared periodically. The latest tabela, of March 3, set the price of medical visits at Cz \$200 and sterilizations along a sliding scale from Cz \$3,500 to Cz \$9,000 depending on patients' monthly income.

### Service Delivery

Services are provided in both Belo Horizonte in 27 postos and in the interior of Minas Gerais in 60 postos. The relative level of activity differs significantly from location to location. Of the 27 urban postos listed in a December 1987 statistical report, only 14 indicated any medical visits during that month, including the two central clinics. Of the 62 rural postos listed in the December 1987 report, only 38 indicated any medical visits. It can be assumed that either December was slow because of the Christmas holidays or that the postos are not operating actively, perhaps due to the lack of systematic technical support and supervision. An FPIA grant picks up expenses of personnel in the central office as well as in the urban and two rural postos. All other personnel in the rural areas are provided under convenio with local governments and/or other organizations. In the postos, non-surgical methods are provided, with surgical patients referred to the central clinic.

CEPECS support to the postos includes provision of initial training of staff, educational materials, and contraceptives. In the past, with four supervisors, ongoing supervision and technical support was provided. At the present time, with only one supervisor, that support system to the rural postos has decreased significantly.

### Marketing

Marketing of services consists of talks in communities, visits to homes and businesses, and sporadic public relations coverage in radio, television, and journals.

## II. Financial Situation

Although this organization has been heavily dependent on outside financial assistance, recent financial information begins to present a more optimistic picture. The organization is heavily financed by FPIA, which pays for 87.2% of its staff. In 1986, the last year for which financial information is available, 80.5% of income was from international donors (ABEPP, FPIA, and JHPIEGO) of which FPIA accounted for 86.0%. During 1986, 8.7% of income was from user fees for clinic visits and sterilizations, and 10.8% was from other sources, including local donations. By February of this year, that situation had changed drastically. If FPIA expenses for February are considered as income, 53.9% of operating income is from FPIA, 29.9% is from income generated through the FPIA-funded project (of which 45.7% is from sales of contraceptives to private doctors and clinics), 3.6% comes from sterilizations, and the remaining 12.6% is from various sources including local donations and 10% of salaries of autonomous employees.

### III. Quality and Description of Management Structure

#### Budgeting

Budgeting occurs only for donor funds.

#### Budget Monitoring

Monthly budget monitoring occurs only for the FPIA grant. Monthly financial reports do not control expenses against the budget but do provide detailed financial information that can be analyzed.

#### Pricing

Pricing appears to be market rather than cost oriented. A sliding scale is provided for sterilizations.

#### Organization Chart and Personnel

The organizational structure is not clearly defined and had duplicative lines of authority. The FPIA organizational structure does not fit into the one for the institution as a whole but is superimposed with the result that an individual will have one supervisor when working on the FPIA project and another individual or individuals when working on other activities.

In addition, the President of the Board of Directors, a non-paid position, is also the "Executive Director" of the organization. As he does not receive a salary for that position, it appears that he is able to spend little time in CEPECS—according to staff, he is there in the mornings. Other members of the board are receiving salaries for technical positions. This lack of distinction between the elected and technical structures exacerbates the unclarity of the organizational structure.

There are 39 employees of whom 35 are paid by FPIA. The other five employees work in surgical sterilization and administration.

#### Willingness to Make Changes

It appears that not all members of the present Board of Directors may have the aggressiveness and vision required to make the changes required. However, several staff and board members with whom the consultant spoke indicated a general willingness and commitment to change on the part of both senior staff and most board members. They indicated that board members did not have a common vision of the future direction of the organization. However, this does not appear to preclude change. Staff interviewed indicated their active commitment to identification and analysis of problems, development of alternative solutions, and effective implementation of programs.

#### IV. External Threats and Opportunities

##### Threats

- \* The policies and future action of the government is hard to read which results in a certain level of uncertainty—both on state and federal levels.

##### Opportunities

- \* There is little competition for family planning services.
- \* The organization maintains solid relations with state and local governments throughout the state of Minas Gerais.
- \* They have built strong state-wide networks.

#### V. Planning for Self-Sufficiency

##### A. Available Resources

According to their estimates, they are operating at 75% of installed physical and human resource capacity, and 40% of physical capacity.

## B. Options

CEPECS has put considerable thought into self-sufficiency alternatives and prepared a report of alternatives as well as a financial analysis of one of those possibilities. Enterprise has spoken with them about the possibility of providing technical assistance and financing for an eventual project.

1. Increase productivity and lower costs by increasing production and demand.
2. Evaluate pricing policies of postos.
3. Look at related medical activities that can provide net income for family planning services
  - \* ultra-sound for breast cancer
  - \* convenios with private businesses
  - \* donations from local banks, businesses—in cash and in kind
  - \* training in family planning and MCH to health personnel
  - \* provide services to middle and upper class individuals

## VI. Training and Technical Assistance

### Training

Role of the Board  
Strategic Planning  
Planning and Budgeting  
Pricing  
Cost Analysis

### Technical Assistance

The organization requires assistance in the development of a more appropriate administrative structure with clear lines of authority and separation of technical and political parts of the organization. This ambiguous structure will prohibit the organization from growing and reacting efficiently and appropriately to the environment and its threats and opportunities.

## VII. Conclusions and Recommendations

This organization should be given priority for technical assistance and training for a number of reasons:

1. They are serving low income individuals.
2. They have a statewide network of health care centers, resulting in tremendous market reach.
3. They have demonstrated their commitment and ability to move quickly toward self-sufficiency.
4. Staff and board members have demonstrated their ability to think up ideas which will lead to self-sufficiency
5. Given the low income clientele of this organization, the fact that they have moved from self-sufficiency of 19.5% in 1986 to 46.1% in February 1988 is all the more admirable.

## Hospital Sofia Feldman

### I. Introduction

The Hospital Sofia Feldman was established in 1974 as a philanthropic institution, sociedad civil con fines benéficos. It received its utilidad pública municipal y estatal in 1975 and its utilidad pública federal in 1980. It has a relationship with the international organization Sociedad de Sao Vicente de Paulo, an organization loosely tied with the Catholic Church. While, they may have provided funding at the beginning of the institutions life, there does not appear to be a close relationship at this time. At the present the institution is analyzing the possibility of reorganizing into a fundación with statutes that would specifically mention family planning, allowing it "greater freedom" to address the family planning needs of community residents. The institution has a license to operate a hospital, a pharmacy, and a laboratory.

While there is a board of directors, the management and direction of the hospital appears to be centered with staff, specifically the Clinic Director, Dr. Ivo de Oliveira Lopez. The board is made up of community residents. Dr. Lopez appears committed to the provision of quality care services to the low income residents of the community.

### Clients

The hospital serves the poor in the neighborhood in which it is located. The income range of this poor neighborhood ranges from 1-5 SM (salario mínimo) a month. The population of the neighborhood is estimated at 250,000.

### Services

The hospital provides dental services, eye examinations, pediatric, pre-natal, and ob-gyn services. Five examination rooms, three hospital rooms with forty beds, the hospital has a surgical room, sterilization room, and delivery room as well as a pharmacy and simple laboratory.

The hospital is simple but clean and pleasant. Relations between medical personnel and patients appear to be characterized by respect and concern. Family planning services are provided within a context of overall health and MCH services.

### Pricing

With a government convenio with IMAMPS that reimburses the hospital for a maximum number of stipulated services each month, services are generally provided to community residents at no cost. According to the Clinic Director, 5% of patients are private and pay fees. The major exception is that of sterilizations. The government reimburses only 20 surgical sterilizations a month. As the hospital performs up to 150 a month, the remainder are paid for by clients. Monthly, the government publishes in the Diario Oficial the reimbursement prices that it will pay for those services.

### Service Delivery

Built in 1982 with the assistance and support of the community, the hospital has steadily increased its physical installations over the years; it has four postos comunitarios located in the neighborhood that provide non-surgical family planning methods and provide referrals for candidates for surgical contraception to the hospital.

### Competition

According to staff, the only other health resource to this community is a CEPECS clinic located at some distance from the hospital.

## II. Financial Analysis

The Clinic Director estimated that the hospital is 60% self-sufficient; this is confirmed by financial information for 1987. According to the financial statement, 6.3% of operating income was from user fees, 23.3% was from various local donations, and the remaining 70.4% was from convenios and from USAID funding. A rough estimate of 1987 income from the IMAMPS convenio indicates that most of that 70.4% is accounted for from government reimbursements—approximately 60% from the government and 10% from USAID sources. USAID funding has included Development Associates (US \$6,000/year) for training health agents for the Ministry of Health, FPIA (in the past), and AVSC (at present through ABEPF—approximately US \$10 per sterilization).

Funds for construction costs are raised each year through fund-raising campaigns. In 1987, the construction deficit was 43.3% of income. The operating results indicated a 2.2% deficit as a percentage of income.

## III. Quality and Description of Management

### Budgeting

No budget is prepared for the institution except for those required for donors.

### Budget Analysis

No analysis of actual expenses against the budget is performed.

### Financial Management and Controls

There is no accounting system that allows for monthly analysis and no monthly financial reports are prepared. At the end of the year, an annual financial report is prepared. They were never requested to maintain books and in the past there did not seem to be any reason to do so. The Clinic Director said since they never had enough money to do everything, they did what they could with the money they had and didn't see the need to control income and expenses.

### Pricing

No explicit pricing is done as reimbursement prices are set by the government. There is no cost accounting done that would indicate the margin of return.

### Marketing

No formal marketing occurs. The postos comunitarios operate as referral sources for clinic, lab, and hospital facilities. The community appears to be actively involved in and supportive of the hospital which in itself is a means of marketing of services. The Clinic Director indicated that the provision of family planning services within a broader health context makes it less threatening.

### Organizational Chart and Personnel

The organization appears to have clear lines of authority although it is unclear what kind of leadership the Administrator is able to provide to the organization. Leadership and motivation appears, rather, to be located in the Clinic Director, the second in command. The hospital has 57 employees and is divided into five departments: Laboratory Services, Administrative Services, Maintenance, Medical Services, and Nursing.

### Willingness to Make Changes

Despite the lack of elementary financial management systems, the organization appears strong and management appears committed to change and growth. The internal obstacles to that growth, the lack of appropriate financial control and management systems, have been identified by management.

### Control of Contraceptives

Supplies and contraceptives are kept in locked areas with adequate control of receipts and issues through Kardex.

## IV. External Threats and Opportunities

### Threats

- \* There is a need for growth, especially when it relates to family planning, to be slow so that it "won't call attention to the hospital."

### Opportunities

- \* The community has made a commitment to the hospital, including the provision of financial resources for its construction and maintenance.
- \* There is little competition for the services.
- \* They have good relations with the state and local governments.

## V. Planning for Self-Sufficiency

### A. Available Internal Resources

The hospital has slowly and steadily increased its physical installed capacity and at the present time, there are two major resources that it can take advantage of to move towards greater self-sufficiency:

1. Physical installation, including personnel
2. Convenio with IMAMPS which outlines maximum number of services that will be reimbursed monthly

Using either of these, the hospital is operating at below capacity. With regard to the convenio, the hospital is performing significantly more surgical sterilizations than their convenio reimburses and is operating at the limit for clinic visits; there is considerable room for expansion in the provision of hospital services and laboratory examinations. The clinic generally performs less than half (44.4%) of the monthly quota of lab exams and in February only 67% of the dental quota, 72.5% of deliveries, and 81.5% of hospital visits.

### B. Options

1. Increase the services covered under the existing convenio. The hospital has set as its first policy the increase of services that are presently covered by convenio. This would have resulted in an income raise of 37.5% in February, 84% of this increase possible through an increase in lab exams.
2. In conjunction with the Universidad Federal de Escola de Enfermeria, increase the number of postos. This will increase coverage as well as increase the source of referrals for hospital services.
3. Increase number of non-government convenios from the present three in order to diversify the market.
4. Decrease costs, by evaluating the means by which services are delivered. Costs can be lowered. For example, local anethesia is cheaper than general and mini-laps are cheaper than laps. As the reimbursements for these procedures is the same, the lower the costs, the higher the profit margin. An increase in output will also decrease unit costs. The Clinic Director indicated that if the clinic performs four mini-laps a day the cost is 0.75 SM each, while if only one mini-lap is done, the cost rises to 1 SM.

#### IV. Training and Technical Assistance

##### Training

- \* Cost Analysis
- \* Service Statistics
- \* Strategic Planning
- \* Planning and Budgeting
- \* Marketing
- \* Cost Controls and Cutting
- \* Financial Analysis: Break Even Points

Community Organizing and Relations (beyond the scope of this project)

##### Technical Assistance

The organization requires assistance in the development of appropriate financial control and management systems.

#### VII. Conclusions and Recommendations

This organization should be given priority in the provision of technical assistance and training for a number of reasons:

1. They are serving the urban poor.
2. They have identified and placed importance on the resolution of serious administrative and financial management problems facing their organization.
3. They have already gained a relatively high level of self-sufficiency, which in the light of the economic level of their patients, is laudatory.
4. The effectiveness of technical assistance appears to be high; i.e., the absorptive capacity is high.

**Centro Nacional Bertha Luz**  
**de Assistencia, Educacao e Promocao de Mulher e da Familia**

**I. Introduction**

Centro Bertha Luz was formed in 1983 as an instituicao filantropica with the following objectives:

1. Defend and promote basic human rights;
2. Provide medical assistance and education to women, adolescents, minors, and the elderly;
3. Carry out scientific research of medical, physiological, sociological, economic, and demographic topics;
4. Put on conferences, seminars, courses, and other activities geared to the education and orientation of women and their families;
5. Elaborate and publish educational and informative materials and;
6. Organize interchanges with other institutions and groups, domestically and internationally.

Clients

Women at the Tijuca clinic are middle class, while those individuals who go to the other project locations are low income women.

Services

Bertha Luz provides services in a number of areas:

1. Medical attention in ob-gyn:
  - \* pre-natal
  - \* gynecological examinations
  - \* prevention of cancer
  - \* sexual education
  - \* family planning
2. Pediatrics
3. Psychological counseling
4. Physical therapy
5. Legal services

In 1987, the center served 7,357 clients.

Pricing

Minimal prices are charged for medical visits and contraceptives. At present, the central office in Tijuca which served middle class individuals charged Cz \$400 for medical visits while the other locations charge Cz \$200. Prices charged for condoms and pills are set from one third to one half of the commercial price, respectively. Fees for IUD's, diaphragms, and sterilizations are set on sliding scales, depending on the income of the patient.

### Service Delivery

The Center operates in five locations

1. Center, Duque de Caxias. In conjunction with a university, they operate a clinic which provides ob-gyn, psychological, pediatrics, and prevention of cancer services, Monday through Friday in the mornings.
2. Xerem, Duque de Caxias. They operate a program in conjunction with a university and the evangelical church which provides a nurse five days a week and a doctor twice a week.
3. Ramos. Within the Fiat complex, they provide a nurse throughout the week and a doctor once a week.
4. Sao Joao de Meriti. With a university, they provide the services of a doctor.
5. Libertad. They are beginning a program in one of the favelas of Rio de Janeiro.
6. Tijuca. They provide ob-gyn services.

## II. Financial Situation

In 1986, according to financial information provided by the organization, 55% of Bertha Luz's income came from FPIA and the remaining 45% from user fees and contraceptive sales. The organization had a net margin of 21% over total income.

## III. Quality and Description of Management Structure

### Budgeting

The organization prepares an annual budget for its FPIA grant.

### Budget Monitoring

The organization does not prepare periodic financial analysis of actual versus budgeted expenses. No monthly financial reports had been prepared since 1987.

### Pricing

Pricing appears to be market rather than cost oriented. The organization did not have information on the costs of service provision except for sterilizations.

### Marketing

Recognizing that low-income individuals could not pay for family planning services, the center has attempted to obtain convenios which would pay for those services.

### Organizational Chart and Personnel

With thirteen employees, the center is divided into four departments: Medical, Finance and Administration, Training, and Education. The organizational structure is appropriate for present operations.

### Willing to make Required Changes

The organization appears to be willing and able to address self-sufficiency issues. They have thought about the possibilities open to them with regard to income generation projects.

## IV. External Threats and Opportunities

### Threats

- \* According to center personnel, the income of the population served by their programs is not able to pay the fees required in order to move towards self-sufficiency.

### Opportunities

- \* The organization had good relations with feminist groups.
- \* The group appears to have strong political ties at the local, state, and federal level.
- \* They have a strong outreach program with other women's and family planning organizations, both domestically and internationally.

## V. Planning for Self-Sufficiency

### A. Available Internal Resources

The organization has a well-rounded team of medical personnel, psychologist, a lawyer, and a sociologist. While no estimation was made of their availability, it is safe to assume that expansion into new projects and services is possible without increasing fixed costs. In addition, the organization has a well-organized mailing list of 15,000 names.

## B. Options

1. Increase services to new locations
2. Carry out fund-raising campaign to obtain cash and in-kind (rent, etc.) contributions.
3. Charge fees for training.
4. Sell contraceptives.
5. Develop a physical capacity for surgical sterilizations; this is being discussed at present with AVSC.

## VI. Training and Technical Assistance

### Training

Strategic Planning and Budgeting Cost Analysis

### Technical Assistance

None

## VII. Conclusions and Recommendations

This organization should be given priority for training for a number of reasons:

1. They are working with low income individuals in Rio de Janeiro and the surrounding areas.
2. They provide a service delivery model that differs from other family planning providers in that it is integrated with larger issues facing lower-class women.



At the same time, these organizations are highly skeptical that the government will be able to provide a sizable volume of services. They expect that there will be, in fact, opportunities for private/public sector agreements; the private sector would continue to offer these services and be reimbursed by government entities. Such agreements are already in place with INAMPS.

It can be expected that the restrictions on government budgets will place limitations on the reach of its services.

- d. The feminist movement appears to have influence at the federal level, including having a Comissao de Direitos de la Muhler who advises the Minister of Health. Their strong lobby has not necessarily favoured FP services in Brazil. It appears that this movement is concerned about quality of care issues in service delivery.

#### STATE GOVERNMENT

- e. Within the PVOs in a number of states there are important FP innovators and practitioners who have a strong state-level influence and public presence which provides a protective "umbrella" for continuing and increasing FP services provided as a specialty service. PVO's that have had a successful lobbying experience and expertise are in Sao Paulo, Bahia, Rio de Janeiro and Ceara.

The small FP institutions that do not have lobbying power and funds have found it desirable to provide integrated health services to survive their "exposure" and do not openly advertise provision of FP services.

- f. It appears that in the future the state governments will be more amenable to influence and provision of family planning funds.

#### SECTOR REPRESENTATION AND ORGANIZATION

- g. There is very limited representational capability of the sector as a whole, with some individuals exercising some personal influence at the central government level.
- h. Individual directors of private sector institutions have not marshalled common resources for lobbying. The larger PVO's have good potential, whereas the smaller ones feel they require a "umbrella of protection."

- i. There is little competition in provision of FP services:
  - The central government entities are not providing services to low and middle income individuals.
  - Pharmacies are the major competition on FP methods, counselling and provision of supplies.
  - Provision of vasectomies is a small but growing activity.
  - Brazil has the highest C section delivery rate in the world; 65% of all female sterilization (the most common FP method) are carried out in conjunction with a Caesarean delivery.
  - There appears to exist a major market that is inadequately service, or serviced not at all. The high prevalence reported is not necessarily supported by identified quality FP services.
  
- j. The FP services sector seems to have a highly fragmented structure, with at least 150 known organizations (PVO's and for-profits as well as small private organizations) of varying size, and many thousands of individual practitioners. There is one association, at a national level, that provides technical assistance, training, and limited funding to its affiliates. It has not concentrated its efforts, however, on a trade association or federation role.
  
- k. It is not clear that the Cooperating Agency (CA) programs have included institutional building components that place programs in an overall organizational context. To date, neither CA's or local FP PVO's have been aggressive in pursuing institutional development parameters, with only recent emphasis placed on development of income generating funds and resources. Related to this problem is the hesitance of CAS to provide an overhead rate to their subgrantees that would provide them with the funds required to develop an institutional, as compared to project, capability.
  
- l. Massive cuts of USAID Central Office funds, combined with the lack of funds available at the country level, requires very focused and leveraged work of Cooperating Agencies for FP future activities in Brazil, that emphasize fast institutional building and self-sufficiency.
  
2. THERE ARE VERY SIGNIFICANT INSTITUTIONAL AND MANAGEMENT INTERNAL CHALLENGES AND OPPORTUNITIES AT THE FP INSTITUTIONS:

## PLANNING

- a. There is little or no formal institutional planning.
- b. The successful organizations look to the future, exploit their resources and develop their profitability to expand.
- c. The weaker and smaller organizations have had successful entrepreneurship in their creation, but currently lack management skills at the top management level.
- d. The organizations have been aware of and some have confronted sustainability issues:
  - some have had a short-term orientation, mostly towards survival;
  - a few have considered longer-term issues;
  - almost none have developed growth plans; and
  - they do not have the capital required, nor have they been creative in looking, for alternative sources of funding to expand services, even if those services would be profitable

## MARKETING

- e. The FVO's seem to concentrate on one segment of socio-economic clientele, despite their statements otherwise. Maintaining services to low-income clientele while pursuing financial sustainability is a major challenge.
- f. Marketing is done mostly intuitively, if at all. Market research, informed price setting, competitive strategy development and implementation are not developed as a matter of course in, for example, deciding where to locate a clinic.

Development of new services, products, facilities and capabilities that open new horizons for an organization's sustainability have not been pursued by most FP FVO's in ways that could be characterized as formal and analytical.

- g. Due perhaps to lack of a distinct marketing strategy or to the environmental factors listed above, clinics generally run at below capacity. Staff of some family planning organizations stated that marketing of family planning services had to be done subtly in a way which will not call attention to the fact that those services are provided. Individuals interviewed stated that it is far better to market MCH services in general, without specifically mentioning the fact that family planning services are also provided.

## FINANCE

- h. Financial planning and monitoring is done mostly as it relates to donor-funded projects, leaving for very secondary consideration, the financial development of the institution as a whole. As donor funding decreases and self-generated funding increases, the institutional view should become pre-eminent.

Most of the financial planning is cash and operations oriented, with little attention given to the capital budgeting which is required for investment into projects that would generate fund-generating activities.

- i. Making the best use of institutional resources has not been a management consideration to date, especially for those organizations that are quite far away from financial sustainability.
- j. The accounting systems are not utilized for management decision-making. They are usually late in providing information, and usually report individually on projects whose budgets are controlled elsewhere with other systems. Usually, the systems do not cover the institution as a whole, and are generated to comply with donor or Brazilian statutory reporting requirements, rather than as an institutional planning tool.

Accounting systems usually do not provide cost accounting per service, product, clinic, department and so forth, severely handicapping management capability to decide how to mix these towards sustainability.

- k. The external audits contracted have concentrated on auditing programs of each donor-PVO relationship, with little emphasis on evaluating internal controls PVO-wide nor on providing a complete institutional view of its financial situation. Consequently, audits are not considered a management nor institutional development tool.

## VII. PROPOSED STRATEGY FOR THE PRIVATE SECTOR

### 1. SIGNIFICANTLY WIDEN FP SERVICES PROVIDED IN EACH STATE:

#### a. Interest existing FP-PVO's in massive increases of services:

- \* USAID/Brazilia to encourage CAs to discriminate in favor of projects which set goals for increased service coverage
- \* demonstrate leadership and innovation to reach many more users through existing health service nets that are open to FP services:
  - unions
  - employer-managed nets in industry (v.gr: SESI), commerce, banking and other
  - community-based organizations
- \* cut external support (supplies, funding, and other) to static PVO's and re-orient to growing and new ones.

#### b. Provide incentives to new-comers to provide FP services:

- \* show how inclusion of FP services can increase their overall practice
- \* support them with training and supplies
- \* show how to increase their net income over the short/long term

#### c. Develop and apply specialized FP service strategies for:

- \* urban, very low-income populations: community-based model
- \* rural Northeast: community-based model
- \* training of pharmacists

#### d. Develop appropriate marketing information and strategy

#### e. Do market research training on how to increase demand

### 2. DEVELOP A VERY STRONG FUND-RAISING CAPABILITY

#### a. Train selected FP institutions in state-level fund-raising

#### b. Encourage PVOs (including ABEFF) to incorporate and develop institutional capacity to generate significant charitable contributions to be used, particularly:

- \* to stimulate FP services expansion:
  - into urban low-income areas;
  - into rural poor areas;
- \* to maintain a steady supply of subsidized supplies for selected PVO's who may need this assistance as they work towards self-sufficiency; and
- \* to develop a much better statistical information system on services provided.

- c. Maintain a certain level/proportion of services to low income people by:
  - \* insisting that FVOs which receive AID/CA funds provide subsidized services and supplies to an agreed upon proportion of their client population; and
  - \* regular reporting and consolidation of socio-economic data on patients.
- d. Develop and apply lobbying capability at:
  - \* state level; and
  - \* federal level (after consolidating states).
- e. Provide support and information on obtaining "utilidad publica" federal-government approved status for receiving tax-deductible donations.

3. DEVELOP AN ACTIVE LEADERSHIP ON A MUCH WIDER FRONT:

- a. Start the program with new and politically-able participants:
  - \* unions
  - \* business community
  - \* rural communities
  - \* poor urban communities
  - \* other community-based organizations
- b. Build and strengthen lobbying capability and leadership at the state level in current institutions
- c. Develop services standards for FP services, promote and apply them (professional self-policing).
- d. Collect more accurate statistics and information on "lessons learned by FVOs" and share.
- e. At the state level, get FP clientele involved in lobbying and new services expansion, when the relationships are strong with the following:
  - \* rural communities
  - \* unions
  - \* urban communities
- f. Regionalize ABEPP

4. DEVELOP AND STRENGTHEN THE FINANCIAL SELF-SUFFICIENCY/ SURVIVAL OF FP INSTITUTIONS

- a. Train in strategic planning and develop individual strategic plans.
- b. Train in marketing-sales-pricing strategy and apply those strategies.

- c. Develop, make available, and assist in the installation of manual and micro computer based systems:
  - \* general ledger accounting
  - \* cost accounting
  - \* budgeting and control
  - \* management information
  - \* service statistics
  - \* logistics management
- d. Consider the role of nurses and obstetricians in providing FP services to increase productivity.
- e. Develop linkages of FVO's and private practitioners to take advantage of government funds that pay for services.
- f. Increase the use of convenios with built-in limits and stimulation of usage, by providing sales and marketing training to FP providers.
- g. Write institutional development clauses and plans in collaboration with the CA's and their beneficiaries, to provide the financial support for their implementation with the remaining program funding during the next two years.
- h. Develop capital investment projects that will provide for self-generating funds in the future.
- i. Encourage CA's to provide organizations with an audited and approved overhead rate that would cover all administrative, financial, and perhaps even project management functions.

APPENDIX A  
PERSONS CONTACTED

I. Rio de Janeiro

- A. Asociacao Brasileira de Entidades de Planejamento Familiar (ABEPP)  
Denise Das Chagas Leite,  
Executive Director  
Ilka Rordinelli,  
Chief of Training  
Rosele Bittencourt Collere Hanff,  
Project Manager  
Rue Visconde Silva, 25  
Botafogo  
22271 Rio de Janeiro - RJ  
286-9836
- B. Centro de Pesquisa e Assistencia Integrada a Mulher e a Crianca (CPAIMC)  
Lia Junqueira Kropsch, President  
Av. dos Italianos, 1280  
Coelho Neto  
21510 - Rio de Janeiro  
372-3831
- C. Centro Nacional Bertha Luz de Assistencia, Educacao e Promocao de Mulher e da Familia  
Florida Acioli Rodrigues, President  
Ana Lucia Ribeiro Pinto, Vice-President  
Rua Santo Alfonso 110  
Tijuca, Rio de Janeiro  
(021) 264-2888  
248-7352

II. Belo Horizonte

- A. Centro de Estudios e Pesquisas Clovis Salgado (CEPECS)  
Antonio Aleixo Neto, Clinic Director  
Anibal Lamego, Vice-President  
Tania Maria dos Santos, Social Worker  
Celma Lorenzatto, Accountant  
Roberto Marcio Lana Peixoto, FPIA Project Coordinator  
Alameda Ezequiel Dias 427  
Belo Horizonte, Minas Gerais  
226-0613

- B. Hospital Sofia Feldman  
Jose de Souza Sobrinho, Administrator  
Ivo de Oliveira Lopez, Clinic Director  
Rua Antonio Bandeira 1060  
Bairro Tupi CEP 31.840  
Belo Horizonte, Minas Gerais  
412-1589

### III. Sao Paulo

- A. Centro Materno-Infantil (CMI)  
Eudes Andrada Jardim, Administrator  
Cecilia Mayer, Psychologist  
Rua Prof. Souza Barros 140  
Mirandopolis CEP 04307  
Sao Paulo, Sao Paulo  
275-3246
- B. Centro de Assistencia Especial Materno Infantil (CAEMI)  
Conceicao Resende, Administrative Director  
Natalia Aid Lucila Zambrano Barnes, Clinic Director  
Maria de Moraes Pinto Teles Machado, Training Coordinator  
Rua Barbosa da Cunha 67  
Guanabara  
Central BIP 42-7333  
Campinas, Sao Paulo  
42-6357  
41-7910  
41-0157
- C. Promocao da Paternidade Responsavel (PRO-PATER)  
Dr. Marcos Paulo Pellicciari de Castro, Executive Director  
Sra. Silvia de Castro, Chief of Finance and Administration  
Silva Freitas, Chief of Projects  
Rua Marques de Paranagua, 359  
01303 - Sao Paulo  
258-7066

### IV. Parana

- A. Conselho Londrinense de Assistencia a Mulher (CIAM)  
Joao Fernando Caffaro Gois, Vice-President of Board of  
Directors  
Margarita Gois, Executive Coordinator  
Marli Elizz Tranin, Administrative Coordinator  
Rua Alagoas 1314  
CEPS 86100  
Londrina, Parana

V. Salvador

A. Centro Para Assistencia e Investigacao en Reproducao Humana (CPARH)

Dr. Elsimar Metzker Coutinho, President  
Tereza Cristina Duffda Motta Pereira, Superintendent  
Rua Caetano Moura, 35  
Bairro Federacao  
40210 - Salvador, Bahia  
245-4799

VI. Fortaleza

A. Sociedade de Assistencia a Maternidades Escola Assis Chateaubriand (SAMEAC)

Dra. Silvia Bonfim, Executive Director  
Universidade Federal de Ceara  
Rua Coronel Nunez de Medo s/n  
60440 Fortaleza, Ceara  
223-3632