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**EVALUATION OF MATCHING GRANT II
TO INTERNATIONAL PLANNED
PARENTHOOD FEDERATION/WESTERN
HEMISPHERE REGION
(IPPF/WHR) (1987-1992)**

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Fieldwork
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Glossary

A.I.D.	U.S. Agency for International Development
APROFA	Asociacion Chilena de Proteccion de la Familia (Chile)
APROFAM	Asociacion Pro-Bienestar de la Familia de Guatemala
BEMFAM	Sociedade Civil Bem-Estar Familiar No Brasil
CBD	community-based distribution
CP	Congressional presentation
CPR	contraceptive prevalence rate
CYP	couple year of protection
FPA	family planning association
FPATT	Family Planning Association of Trinidad and Tobago
FPSD	Family Planning Services Division (S&T/POP)
IEC	information, education, and communication
IMES	Mexican Institute of Social Studies
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
IUD	intrauterine device
MEXFAM	Fundacion Mexicana para Planificacion Familiar
MG	Matching Grant
MIS	management information system
MOH	Ministry of Health
MSH	Management Sciences for Health (Boston, U.S.A.)
OB/GYN	obstetrics/gynecology
OR	operations research
PROFAMILIA	Asociacion Pro-Bienestar de la Familia (Colombia)
PVO	private voluntary organization
RCC	real cost of contraception
VSC	voluntary surgical contraception
WHR	Western Hemisphere Region

Project Identification Data

SCOPE: Latin America and Caribbean

PROJECT TITLE: Expansion and Improvement of Family Planning Services
in Latin America and the Caribbean

PROJECT NUMBER: 936-3043

GRANT NUMBER: DPE-3043-G-SS-7062-00

CRITICAL PROJECT DATES: Project (MG I) authorized - 8/9/85
Project amendment (MG II) authorized - 7/10/87
Expiration date of grant - 8/30/92
Project assistance completion date - 12/31/93

PROJECT FUNDING: S&T/POP -- MG I: \$12 million (8/9/85)
MG II: \$27 million (7/10/87)

MODE OF IMPLEMENTATION: Grant to IPPF/WHO

GRANTEE: IPPF/WHO, 902 Broadway, New York, N.Y. 10010

MAJOR ACTIVITIES: sub-grants to FPAs
regional activities
project administration

Executive Summary

1. Overview

The International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) has achieved most of the objectives it set for itself in its 1987 unsolicited proposal to A.I.D.'s Office of Population for a Matching Grant. The grant funds have assisted a number of IPPF/WHR's affiliate family planning associations (FPA), many of which play an important role in the provision of family planning in the countries in which they are located. Assistance falls into three categories: it has enabled FPAs to reach new acceptors with quality services, to exert a leadership role vis-a-vis public sector providers, and to improve their own internal management. The five-year grant (MG II), approved in July 1987, was funded at \$27 million and represented a renewal of a \$12 million grant that had been in operation between 1985 and 1987 (MG I). Together, these grants total \$39 million.

2. Grant Design

The project design is essentially sound. A large proportion of the grant (in the range of 80 percent) goes as subgrants to the FPAs in Brazil, Colombia, and Mexico. The remainder of the funds has gone as smaller subgrants to support innovative projects in FPAs in nine other countries and to four regional activities — commodities, technical assistance among FPAs, management information systems (MIS), and evaluation support. The rationale emphasizing Brazil, Colombia, and Mexico is threefold: none of these demographically important countries receives bilateral population funds from A.I.D.; although all have high prevalence rates (CPR), they also all have pockets of need — geographic areas where prevalence is low, where services by other providers are inadequate, or where method mix needs to be improved; and the subgrants go to FPAs that are well established and which thus offer an effective conduit for A.I.D. funds. The regional component ensures that certain MG activities are potentially available to all members of the federation.

3. Programmatic Issues

3.1 Programmatic Accomplishments

The MG has succeeded in accomplishing many of the goals incorporated in the proposal:

In the area of service delivery, the FPAs are well on their way to attracting the 2.8 million new acceptors called for in the initial proposal. These acceptors, moreover, appear to be primarily the low-income populations in low-prevalence areas that the MG intended to target. Overall, FPA clinics offer high-quality services, albeit in sometimes crowded clinics where waits are long. It is recommended that FPAs offer more training to public sector providers and pay increased attention to method mix in their own programs as well as nationally.

With regard to providing leadership and helping accelerate the long-term spread of family planning services, FPAs have developed links with government and PVO programs that have stimulated more and better quality services by both types of organizations. These new relationships have enabled FPAs to diversify and strengthen their resource bases. Through the technical assistance component of the grant, FPAs have successfully disseminated these approaches. More, however, needs to be done in the area of formal documentation and dissemination.

In the area of management, the MG requires FPAs to make detailed plans and to comply with stringent financial reporting requirements. These stipulations are serving to help improve FPAs' ability to plan and monitor their activities. To assist the affiliates in drawing up these reports, a new MIS has been developed and is gradually being installed.

3.2 Areas Needing Improvement

The only serious omission in grant execution has been the very long delay in hiring an individual to carry out the regional evaluation component. This component was viewed as pivotal in the implementation of a number of the objectives in the MG. The evaluator was expected to analyze whether low-income/low-prevalence populations were being reached (rather than the *ad hoc* studies that were undertaken instead) and to develop a plan for dissemination of innovative service delivery models. Another role for the evaluator was to conceptualize the real cost of contraception (RCC), i.e., to identify the impediments to contraceptive use ranging from high cost of contraceptives to long waits in crowded clinics and to develop strategies to reduce or eliminate them. An evaluator was also expected to use the MIS to analyze the cost-effectiveness of various models of service delivery.

4. Management and Financial Issues

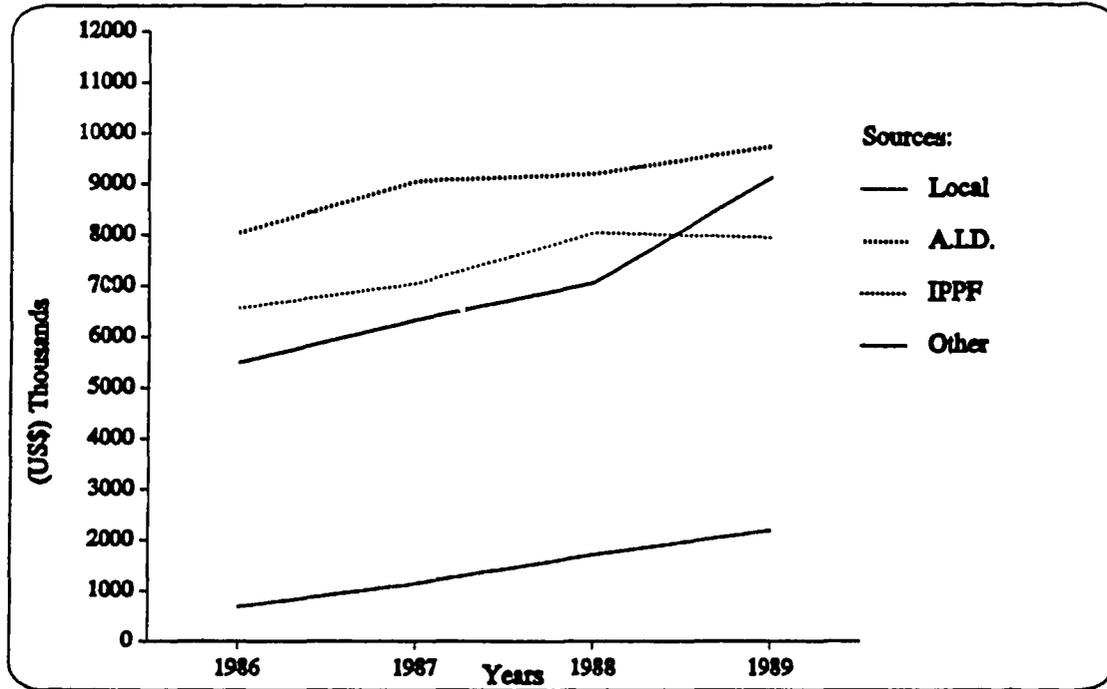
Since 1986, the FPAs have succeeded in increasing their income from other sources, thereby reducing their reliance on MG funding for their operations. At this point, MG support has dropped from nearly one-quarter of their aggregate budgets to only about one-sixth. This has been accomplished in good measure because of the FPAs' efforts to make their services more sustainable (through charging for services); the potential exists, however, for increased cost recovery (see figures, next page).

Recent funding uncertainties in the Office of Population have been of particular concern to IPPF/WHR because it feels considerable responsibility to its FPAs, which have payrolls to meet and programs that could founder if expected funds are not forthcoming on schedule. Particularly disruptive has been A.I.D.'s inability or unwillingness to forward fund (i.e., to provide funds prior to the start of IPPF's own program year) and to keep IPPF always fully informed on expected funding availability for the coming year. On the other side, IPPF/WHR has resisted suggestions that it be more flexible in its planning and more prudent in the rate at which it expends funds. In addition, in accordance with the grant agreement with A.I.D., IPPF/WHR's workplans are not presented to A.I.D. until two months before they are scheduled to be implemented, leaving far too little time for in-depth review. Better communication, resumption of forward funding (if possible), coupled with multi-tiered budgets and workplans, would contribute to a solution of these problems.

With regard to management, IPPF/WHR and the Office of Population have had some disagreement as to the roles and responsibilities of each party vis-a-vis the operation of the MG, which has led to miscommunication on a number of critical issues. IPPF/WHR has not always been forthcoming with detailed information on its operations and, perhaps in reaction, the Office has tended to take too active a role in management of the MG. Other areas of management, however, have been very satisfactory. Thanks to the modest MG staff size, together with use of WHR staff to assist the MG staff, management costs have been kept at reasonable levels. The quality of planning, budgeting, and financial management has been very good (although FPAs would benefit from more assistance in the area of strategic planning).

Figure 1

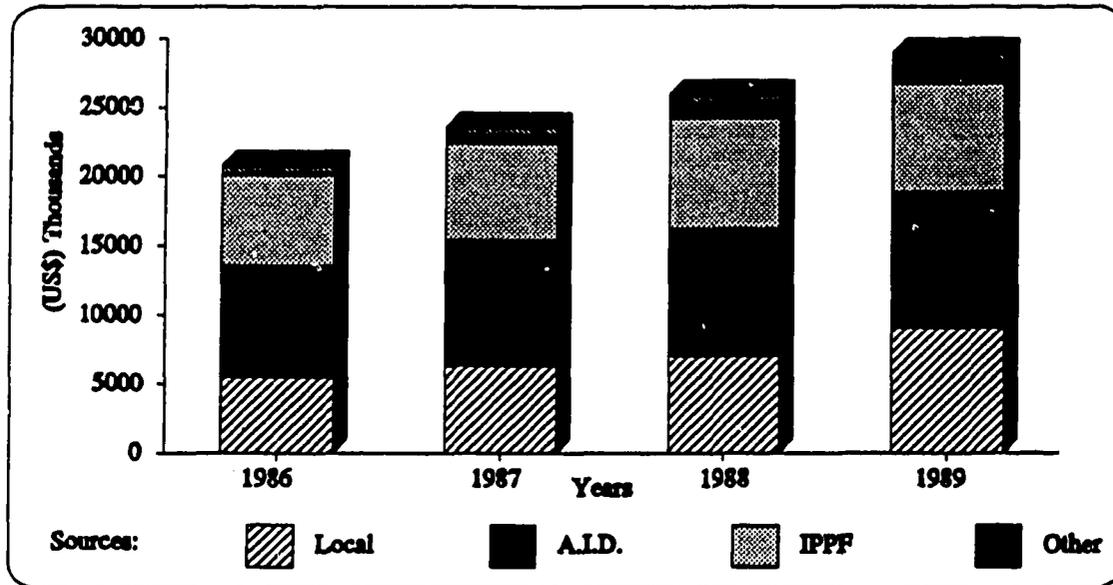
Increases in Subgrantee Income, by Source, 1986-1989



Source: Derived from Table 8

Figure 2

Sources of Subgrantee Income, 1986-1989



Source: Derived from Table 8

5. Conclusion

IPPF/WHR has proved to be excellently positioned to expand and improve family planning services throughout the large geographic area of Latin America. Furthermore, carrying out regional activities through a federation such as IPPF has offered economies of scale. In view of these considerations, coupled with IPPF/WHR's good performance to date, the recommendation is that the MG should be renewed in 1992, at the expiration of the present grant.

A complete list of recommendations for both MG II and a proposed MG III are provided in Chapter 7 of the full report.

1. Introduction

The International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) is a federation of 47 autonomous family planning associations (FPA) in the countries of Latin America, the Caribbean, and North America. IPPF/WHR is a non-profit organization incorporated in the United States. Throughout the western hemisphere, private FPAs affiliated with the WHR have been an important factor in provision of family planning, and in most cases have been the most cost-efficient providers of family planning services and information. Some FPAs are among the best-established family planning providers in the world. For example, PROFAMILIA in Colombia has been the major provider of contraceptives in that country for more than 25 years.

On August 9, 1985, the U.S. Agency for International Development (A.I.D.) authorized a two-year \$12 million project (No. 936-3043) for "expansion and improvement of family planning programs" in response to an unsolicited proposal from IPPF/WHR, referred to herein as Matching Grant I (MG I). A five-year \$27 million renewal was approved on July 10, 1987, for a total of \$39 million, referred to herein as Matching Grant II (MG II).

The grant documentation¹ specified that the "project will give special assistance to Brazil, Colombia, and Mexico." The document further specified that IPPF/WHR must match funds being provided under the project with an equal amount of "non-Federal funds" for expenditures for "each country program, regional activity, commodity cost" and must match at a two-to-one ratio with "non-Federal funds" grant funds expended for administrative costs of the New York office.

The grant has four components: subgrants to FPAs, regional activities, project management, and overhead. "Regional activities" include commodities, technical assistance among FPAs, management information systems, and evaluation support. Subgrants to FPAs are of two types: (1) large subgrants to the FPAs of Mexico, Colombia, and Brazil to expand and improve family planning services in these countries, with emphasis on the FPAs' seeking ways of collaborating with and mobilizing the resources of organizations in the public and private sectors; and (2) subgrants to selected FPAs in other countries to test and support innovative ways of expanding services.

This report is an evaluation of the performance of MG II during its first three years. Details regarding the scope of work, the team that conducted the study, and the aspects reviewed are found in Appendix A.

¹August 31, 1987 letter, with attachment from Grant Officer Joyce Frame to IPPF/WHR Director Dr. Hernan Sanhuesa.

**2. Performance in Meeting Programmatic Objectives
(As Set Forth in MG II Proposal)**

2. Performance in Meeting Programmatic Objectives (As Set Forth in MG II Proposal)

2.1 Objectives Relating to Service Delivery

2.1.1 Increase in Family Planning Services

One of the primary objectives of the Matching Grant was to increase family planning services as measured by two commonly used indicators of the quantity of service delivery: new acceptors and couple years of protection (CYP). Specifically, the unsolicited proposal anticipated a total of 2,799,000 new acceptors and 10 million CYP over the five-year MG II period in the seven countries in which the grant was operating in 1987. A.I.D. sees increasing services as one of the most important goals in the MG.

To measure progress made in relation to these two indicators, the FPAs established systems for tabulating both acceptors and CYPs and for reporting the results on a regular (quarterly) basis. In the case of new acceptors, FPAs also set annual targets. These, understandably, were not always in accord with the targets that had been set in the original unsolicited proposal (in 1988, the target was 30,000 above the proposal figure and for 1989, it was 11,000 below). For each year (1986 through 1989), the total number of new acceptors has exceeded the targets set by the FPAs for that year (see Table 1). This is an impressive record. If this trend continues, and if targets continue to be in the range set in the unsolicited proposal, it is certain that the overall 1988-92 target of nearly 2.8 million new acceptors will be achieved.

On the other hand, the goal of 10 million CYP will not be met, primarily because, as acknowledged by IPPF/WHR New York headquarters, the figure itself had little validity, not having been based on an analysis of anticipated numbers of acceptors, methods used, etc. In 1989, however, the FPAs began to set targets regarding CYP and, for that year, these were largely met (see Table 2). IPPF/WHR has not set a new overall CYP target for the remainder of the grant.

Although the FPAs in general seem to be doing a commendable job in increasing prevalence, several minor problems in reporting were identified.

For example, the FPAs visited defined a "new acceptor" as someone new to the FPA rather than someone new to family planning. In the main clinic of Guatemala, where new clients are routinely asked about their history with family planning, clients who have practiced family planning before and are switching to APROFAM for any number of reasons are still classified as new acceptors. In high-prevalence countries, where the IPPF affiliate strives to set quality standards as well as quantity standards, it can be assumed that many clients who are new to the FPA are not new to family planning. The result is that, in any given year, on a countrywide basis, there will be some double counting of acceptors, i.e., some new acceptors will be included in the reporting of both the FPA and the government family planning services program that they had used previously. Although how to count switchers represents an issue for all service delivery programs, the problem is more acute for programs in Latin America, where the high prevalence means that there are proportionately fewer genuinely new acceptors and correspondingly more switchers than in lower-prevalence countries.

Table 1
New Acceptors under MGs I and II
1986-1989

Country	1986		1987		1988		1989	
	Target ¹	Achieved	Target	Achieved	Target ²	Achieved	Target	Achieved
Brazil	147,000	151,086	221,400	250,081	239,260	230,061	181,400	218,466
Colombia	51,415	46,756	67,900	49,188	44,220	58,663	73,794	59,977
Mexico	76,000	111,035	112,400	151,439	158,000	216,803	164,900	258,653
Chile		2,406	4,200	17,485	17,085	17,464	30,000	18,941
Guatemala					0			
Jamaica					2,800	1,811		
Panama					1,144			
Paraguay					0		2,200	1,216
Peru		25,243	30,300	61,998	39,220	60,224	59,250	64,696
Trinidad		706	3,300	6,317	6,224	6,257	6,400	5,668
Uruguay		13,079	14,800	21,665	12,800	23,669	17,500	26,987
Other FPAs					0	63	1,440	995
Total	274,415	350,311	454,300	558,173	520,753³	615,015	536,884⁴	655,599

¹The 1986 target covers the period January through September.

²The 1988 targets were set for the 15-month period starting October 1987 and ending December 1988. The 15-month targets have been multiplied by 80 percent to bring the time period into conformance with the 12-month reporting period.

³In the unsolicited proposal, the 1988 target was set at 489,900 new acceptors.

⁴In the unsolicited proposal, the 1989 target was set at 525,400 new acceptors.

Table 2
Couple Years of Protection under MGs I and II
1986-1989

Country	1986		1987		1988		1989	
	Target	Achieved	Target	Achieved	Target	Achieved	Target	Achieved
Brazil		213,070		299,638		209,310	243,014	205,228
Colombia		556,978		571,051		713,011	718,415	732,568
Mexico		101,764		162,362		173,627	162,000	170,475
Chile		7,462		28,578		42,542	66,284	46,336
Guatemala								
Jamaica						431		
Panama								
Paraguay								1,629
Peru		28,049		55,903		49,808	47,400	55,738
Trinidad		6,411		28,353		87,432	101,621	78,751
Uruguay		17,162		30,989		38,485	31,000	41,700
Other FPAs						78		1,753
Total		930,896		1,176,874		1,314,724	1,369,734	1,334,178

Sources for Tables 1 and 2:

Matching Grant, Annual Report, January-December 1989.

Matching Grant, Annual Report, January-December 1989, Appendix A.

Matching Grant, Work Plan, October 1987 through December 1988.

Matching Grant, Quarterly Report, FY 1986: January 1-March 31, 1986.

Another issue, also generic to family planning programs but perhaps greater among IPPF/WHR affiliates that are attempting to increase collaborative efforts (see Section 2.2.2 below), is how to assign credit for an acceptor when two organizations are contributing to a service delivery effort. An example is the situation in Mexico in which MEXFAM, the IPPF affiliate, provides training and contraceptive supplies for health personnel in government facilities (e.g., the Health Secretariat and the Mexican Institute for Social Security), which in turn provide the family planning services. Typically, MEXFAM and the government agency will report the same acceptor, with the consequence that countrywide statistics for family planning acceptors will be inflated.

In this period of constrained resources, A.I.D. has become increasingly interested in developing comparability of indicators to allow for comparisons of programs within and across regions. Among the FPAs visited, it was clear that inconsistencies among FPAs existed with regard to the definition of new acceptors. Specifically, the IPPF/WHR guideline suggests three years should elapse between visits in order to classify a client as a new acceptor. In Mexico, however, one clinic was using five years while others used the standard definition. In some community-based distribution (CBD) programs in which staff are not in the employ of the FPA, the family planning history was not even taken. Regarding CYPs, the FPAs visited were using the standard IPPF/WHR guidelines to calculate the value. Because only three FPAs were visited, it was not possible to make a thorough assessment of consistency across FPAs for either new acceptors or CYPs.

Another issue relates to the method of calculating CYPs from a female sterilization. This calculation currently is independent of the age of the client, and therefore the same number of years of protection appears to be provided for a woman sterilized at the age of 27 as one sterilized at the age of 37, although most likely more births will have been averted in the former than in the latter case.

Despite the inconsistencies and instances of dual reporting noted above, the indicators used in MG reporting should be considered reasonably valid, particularly for demonstrating changes over time in numbers of new acceptors and CYPs in a given program.

Recommendations

- (1) To promote the comparability of the indicators over time and across projects, IPPF/WHR should continue to impress upon the FPAs the importance of defining both a new acceptor and a CYP according to IPPF/WHR guidelines.
- (2) IPPF/WHR should consider adopting a method of calculation of CYP from female sterilization that would take into account the age of the acceptor.

2.1.2 Shift toward Areas and Groups of Lower Income and Contraceptive Prevalence

The MG II unsolicited proposal called for a shift in emphasis from expansion of proven programs (the programming thrust during the two years of MG I) to efforts to reach lower-income and lower-prevalence groups. The proposal indicated that, over the next five years, IPPF/WHR would be pressing its FPAs to demonstrate that their services were reaching people who would otherwise not be practicing family planning.

Most of the program concentration is in countries with high contraceptive prevalence rates (CPR): Brazil — CPR 65 percent; Colombia — CPR 65 percent; and Mexico — CPR 53 percent². Within each of these high-prevalence countries, however, there are pockets of need — geographic areas where prevalence is low; where services by other providers are grossly inadequate; or where method mix needs to be improved. The issue is whether the program is successfully targeting and reaching these low-prevalence areas.

The MG II had included, as part of the evaluation activity, a provision for client surveys that would provide information (*inter alia*) on the socioeconomic status of clients and confirm whether the grant was supporting programs that were reaching the poor. As the position of staff evaluator has not yet been satisfactorily filled, these formal assessments were not carried out. In their place, in 1989, all FPAs receiving MG subgrants were asked by WHR to submit information on clients' socioeconomic status (except Guatemala, which receives funding only for regional VSC training and Paraguay where MG support was only just beginning). Some FPAs conducted special studies while others tabulated routine service statistics, analyzing data on client education — a proxy variable for socioeconomic status — and other variables.

In the countries in which comparable data existed for the country as a whole, these studies demonstrated that, with the possible exceptions of Venezuela and Trinidad and Tobago, the MG was serving the relatively poorer segments of the population. Because some of these studies were done rather quickly, they are subject to limitations insofar as their use for policy and planning is concerned.

Country visits confirmed that, primarily, low-income/prevalence populations were being served. In Chile, MG funds are channeled through APROFA to Chilean Red Cross clinics which provide family planning and selected health services to low-income people. For a substantial proportion of this population, access to the National Health Service is difficult. Likewise, in Mexico, MEXFAM's actions are oriented to provision of services in areas in which people are not served by regular government family planning programs: doctors participating in community doctors' and affiliate doctors' programs reach people who do not have easy access to other services, and MEXFAM specifically targets rural communities and factories not covered by existing government programs. In Colombia, MG II funding makes it possible to provide low-cost VSC to persons who might otherwise be unable to afford this method (see Section 4.1.3 for a full discussion).

Among the underserved populations, adolescents represent a critical target group which is growing in numbers and which generally is not being reached by existing family planning programs. The directors of the FPAs of Mexico, Guatemala, and Chile recognize the importance of reaching this group, but substantial work by the FPA is under way only in Mexico and, to some extent, in Guatemala. MEXFAM has developed an excellent strategy and pertinent informational materials with support from sources other than the MG.

Recommendations

- (3) FPAs should continue their efforts to target low-prevalence, low-income clientele.

²Population Reference Bureau, Inc., "1990 World Population Data Sheet."

- (4) MG staff should urge the FPAs to attempt to influence other providers to focus their efforts on underserved populations.
- (5) Consideration should be given to funding innovations in the area of adolescent fertility, under a future MG. To some degree, FPAs could learn from one another from such efforts, but program design and activities should respond primarily to country situations.

2.1.3 Improve Quality of Services

On the whole, the quality of service in most FPAs is believed to be quite good. Studies carried out with MG funds in countries such as Mexico and Colombia suggest, however, that crowded clinics, lack of privacy, and poor scheduling negatively affect the environment in which services are delivered.

The work of three FPAs was assessed in the course of field visits to Mexico, Guatemala, and Chile. Overall, the conclusion was positive: (1) the quality of services delivered by personnel directly linked to or trained by the FPAs was good; and (2) method mixes were generally satisfactory within the constraints set by government regulation and cultural practices.

In the assessment, the following factors were taken into account: existence of standards/procedures; technical performance of providers; interpersonal relations; information provided to current and potential users; equipment/supplies; drop-out rates; method mix; and accessibility and availability. These are discussed below.

Standards. In the unsolicited proposal, mention was made of a medical consultant to be funded through the MG who would advise IPPF and the FPAs on how best to reconcile issues of quality (i.e., safety, choice, and informed consent) with issues of cost reduction. This strategy was subsequently changed, and a plan undertaken that involved development of guidelines for quality. A meeting of FPAs was held in May 1990 in Miami to discuss these guidelines. The plan is to encourage FPAs to incorporate these guidelines into their own medical standards.

At the same time, at the local level, standards and procedures for quality of care had been developed in the three countries visited, all of them adequate. Particularly impressive was the attention to standards at the APROFA-Chilean Red Cross clinics, where manuals, written standards, and procedures were widely available to both providers and supervisors.

Technical Performance. The MG has placed considerable emphasis on the training and monitoring of providers and, with only a few exceptions, the doctors, nurses, midwives, supervisors, and community workers in both urban and rural settings were carrying out their work in accordance with internationally accepted standards. On the other hand, standards were less impressive among providers from other organizations receiving assistance through the MG (either receiving contraceptives [see Section 3.4.3] or collaborating with an FPA [see Section 2.2.2]). In two instances (BEMFAM and MEXFAM), FPAs have offered training directly to workers in government facilities in an effort to improve performance of these non-FPA providers.

Interpersonal Relations. In most cases, staff-client relations were deemed appropriate and the FPAs were found to have an adequate understanding of the need for good communication

as a component of quality of care. The quality standards should help FPAs take additional strides in this area.

Information Education, and Communication (IEC). The FPAs visited had done a good job in developing charts and other visual aids and audiovisual materials. The emphasis has been on materials that depend on a written text to convey the message; use of graphics tended to be of secondary importance. This is appropriate for literate clients, but does not serve well for the women who cannot read.

Equipment and Supplies. In both Mexico and Chile, basic equipment, instruments, asepsis control, and stocks of commodities were all considered adequate.

Drop-out Rates. Drop-out rates are not documented, and therefore it was impossible to detect whether sufficient attention was being accorded to continuing users. Clinic visits suggested that prime attention was directed to new acceptors, although in many cases, a follow-up component was included in service delivery protocols for specific methods. The existence of difficult conditions (e.g., crowded clinics, poor scheduling, etc.) may, however, be influencing clients not to conform to the recommended return visits, and cost constraints may be cutting into planned provider follow-ups. This entire issue deserves further study.

Method Mix. As a group, the FPAs are providing primarily orals and condoms in MG II funded activities, with a far lower percentage of new acceptors using IUDs and voluntary surgical contraception (VSC) (see Table 3). Because of the long-lasting effectiveness of VSC, however, this method accounts for nearly 50 percent of all the CYPs provided through the project (see Table 4).

As might be expected from the above, most FPAs are providing primarily temporary methods. Method choices for new acceptors in 1989 were as follows: in Brazil, 92 percent of new acceptors received either pills or condoms; in Mexico, 86 percent; in Paraguay, 39 percent, in Peru, 65 percent; and in Trinidad and Tobago, 59 percent. There were only two exceptions to this pattern: in Chile, the FPA is providing mostly IUDs (55 percent of new acceptors in 1989) and in Colombia, the FPA provides mainly female VSC (73 percent of all new acceptors in 1989) (see Table 5).

On a national level, the method mix in many Latin American countries is skewed toward one method or another. For example, in Brazil, female VSCs and oral contraceptives are very popular, whereas there is virtually no use of IUDs or condoms. This pattern reflects a number of factors: government policy (e.g., pills are subsidized and available without prescription); the prejudices of the health establishment (medical workers are highly skeptical of IUDs); and cultural preferences (males here -- and in most Latin American countries -- resist use of condoms). Likewise, in Chile, government policy is responsible for the predominance of IUDs (women who want long-term methods have access only to IUDs since the Ministry of Health prohibits use of VSC, except for high-risk women). In Colombia, on the other hand, there is a very limited government program and PROFAMILIA, the IPPF affiliate, provides a considerable proportion of the services. Here, therefore, the high use of VSC reflects a conscious decision on PROFAMILIA's part to promote this method.

The issue is whether FPAs should be attempting to offset some of the lack of balance in method mix in the countries in which they are operating. To a considerable degree, this has not proved practical. The primary focus of MGs I and II has been expansion of family planning services. It is understandable, therefore, that the method mix of the FPAs has often mirrored national patterns.

Table 3
Percentage Distribution of New Acceptors by Method
All MG FPAs

Contraceptive	1988	1989
Orals	40	38
Condoms	34	38
IUD	11	10
VSC (male/female)	8	8
Other	7	7

Source: 1989 MG Annual Report, Diagram 1.

Table 4
Percentage Distribution of CYPs by Method
All FPAs

Contraceptive	1988	1989
VSC	48	47
Orals	26	24
IUD	15	16
Condoms	9	11
Other	2	2

Source: 1989 MG Annual Report, Diagram 2.

Table 5
New Acceptors by Country, 1989

Country	Percentage Distribution of New Acceptors by Method, 1989					
	Oral	IUD	Condom	Female VSC	Male VSC	Other
Brazil	43	1	49	1	*	5
Chile	32	55	5	—	—	8
Colombia	5	19	—	73	*	4
Mexico	43	7	43	1	*	6
Paraguay	79	9	10	—	—	2
Peru	37	22	28	—	—	14
Trinidad & Tobago	27	5	32	11	*	25
Uruguay	36	24	28	1	—	11
Venezuela	39	47	8	3	*	3

Source: Matching Grant 1989 Annual Report.

* Countries not reporting percentages for male/female VSC by sex.

For example, in Brazil, the method mix provided by BEMFAM through MG II has been shaped in large part by the existing infrastructure that the IPPF affiliate is utilizing, namely outlying clinics and fieldworkers who can provide only temporary methods (pills and condoms). On the other hand, BEMFAM should be credited with having attempted to increase the use of IUDs, although the national suspicions about this method have made these efforts largely unsuccessful. In Chile, as in Brazil, the available delivery system has tended to dictate the method mix provided in its MG II program: in this case, the IPPF affiliate, APROFA, utilizes Red Cross clinics which it staffs with midwives trained to insert IUDs. In line with national policy, APROFA has not attempted to promote VSC in these clinics, although it could conceivably suggest to the government that it loosen its restrictions on the use of VSC. In Colombia, the matching grant funds are used mostly to provide PROFAMILIA's VSC services. These funds enable PROFAMILIA to subsidize this procedure and thus to make it available for a minimal charge to low-income women (see Section 4.1.3). Here the issue is whether, at some point in the future, the government should not begin to take over more responsibility for delivery of this method.

Although, to date, FPAs have given principal attention to providing services and increasing numbers of acceptors, their service delivery efforts may now be well enough established that they can turn their attention to providing a better-balanced array of methods. Given that MG workplans are increasingly emphasizing the leadership role of FPAs (see Section 2.2 below), it seems appropriate for FPAs to give increased attention to method mix in their own programs, in collaborative programs, and nationally.

Recommendations

- (6) IPPF/WHR should ensure that the recently prepared IPPF medical guidelines are made widely available throughout the region and that FPAs are encouraged to incorporate into their own medical standards for all MG-supported activities, the applicable and appropriate worldwide IPPF guidelines.
- (7) FPAs should continue to seek opportunities to improve the quality of public sector programs through, among other approaches, increasing efforts to provide training to public sector service providers.
- (8) IEC materials for populations who are not highly literate should have less text and more graphics.
- (9) Studies should be initiated of both the rate and reasons for dropping out of programs.
- (10) FPAs should give increased attention to method mix in their own programs as well as nationally. To this end, the MG should fund studies of method mix, initially in those countries where method mix is particularly unbalanced.
- (11) APROFA should be encouraged to explore how VSC can be made more widely available both in its own program and in public and private programs.
- (12) PROFAMILIA in Colombia should explore the feasibility of encouraging the government to offer more VSC in its family planning services.

2.2 Issues Relating to Leadership Role of FPAs

2.2.1 Leadership Role for FPAs

A theme underlying a number of the objectives in MG II is the policy or advocacy role of FPAs. The MG implicitly, and to some extent explicitly, addresses this issue by encouraging FPAs to move from their traditional role of serving a limited clientele through a small number of independent facilities to a broader role of seeking ways to influence the larger family planning scene through development of collaborative service delivery programs. The hope is that over the five-year span of the MG, FPAs will be in "a stronger position to accelerate the long-term spread of family planning in their countries."

Some FPAs are using MG support to play this strategic role in their countries. MEXFAM is probably the prime example. MG resources have enabled MEXFAM (1) to help some public sector agencies (e.g., the Health Secretariat, the Mexican Institute for Social Security, and the Social Security Institute for Government Employees) to strengthen their family planning services; (2) to develop increased interest in family planning on the part of the private sector (in particular, in factories); and (3) to design new ways of providing family planning services to unserved or underserved populations in both urban and rural settings (community doctors program). Most FPAs, however, have yet to articulate just how they might take on a more prominent national role in family planning. The USAID representative in Chile, for example, believes that APROFA could work with industry to ensure that young workers — e.g., in the fruit packing industry — have information about and ready access to contraceptives. It is highly likely that there are other opportunities of this sort in the region. Moreover, given that public support for family planning is not increasing, the need is growing for FPAs to lead the way.

Recommendation

- (13) Senior MG staff should view assistance to FPAs to provide leadership as one of their highest priorities.

2.2.2 FPA Mobilization of Resources of Other Organizations

Involving other organizations in service delivery represents the most obvious way for FPAs to exert leadership in the region, and the MG has been extremely successful in this respect. Mobilization of resources of other organizations was spelled out as a prime objective in the MG II unsolicited proposal. Involving other organizations was viewed, in particular, as a way to "avoid the classic dilemma of either absorbing high recurring service costs or passing most of those costs on to clients who can ill afford them."

FPAs have initiated collaborative efforts with the private sector, the public sector, and with private voluntary organizations (PVO).

One of the most interesting private sector schemes is the MEXFAM community doctor initiative in which MEXFAM supplies the initial investment needed for the establishment of a private practice for doctors willing to locate in communities without access to family planning services (and, frequently, medical services, as well). Once these doctors are self-sufficient, they not only deliver family planning services at no cost to MEXFAM (except the cost of contraceptives and

their delivery) but they are expected to reimburse MEXFAM for a portion of the original investment. Another collaborative effort with the private sector, also a MEXFAM initiative, involves provision of family planning services in factories. MEXFAM has convinced the management of these industrial sites to provide family planning services for male employees. MEXFAM's input has been relatively low cost, consisting of providing talks to employees, IEC materials, and organization of a contraceptive distribution system. The factory covers the cost of contraceptives and educational materials.

Collaborative projects with public sector agencies are functioning in Mexico, Brazil, Uruguay and, as of this year, Trinidad and Tobago. For example, the FPA of Trinidad and Tobago is cooperating with the Ministry of Health in two respects: it provides the government with A.I.D.-donated contraceptives for distribution throughout the Ministry's 95 health centers and it has reached a cost-sharing agreement with the government to equip two of the latter's health centers, train staff of these centers in family planning service delivery, and supply the centers with contraceptives. In Uruguay, although the Ministry of Health has included family planning in its five-year plan for primary health care, there is little actual provision of services in MOH clinics. With MG support, however, the Uruguayan FPA provides family planning information and services in many of these facilities through a network of government physicians, nurses, midwives and health visitors who serve as volunteers for the FPA while carrying out their responsibilities in the government health services.

FPA collaboration with PVOs occurs in Chile, Mexico, and, as of this year, in Trinidad and Tobago. In Chile, the PVO is the Chilean Red Cross, which makes space available in its clinics for provision of family planning by one or two midwives, hired with MG II funds.

An issue in this area relates to dissemination of successful models and programs. To some degree, other FPAs are learning about each other's program successes through technical assistance (see Section 2.2.4 below). Furthermore, MG semi-annual and annual reports amply document these accomplishments. These materials, however, have not been widely disseminated and the documentation itself has not been carried out in a systematic manner or in a form that makes it useable by larger audiences. A.I.D. and IPPF/WHO agree that a major effort is needed in this area. Progress has been limited mostly by difficulties in filling the MG evaluation position with a properly qualified individual.

Recommendation

- (14) As soon as the evaluation position is filled, MG staff should develop plans for documentation and dissemination of innovative service delivery models that involve collaboration between FPAs and other organizations.

2.2.3 Real Cost of Contraception

The unsolicited proposal introduced the concept of the real cost of contraception (RCC), in part as a new way of conceptualizing barriers to contraceptive use and in part as a component of the strategy of initiating collaborative efforts with other sectors.

With respect to the issue of non-use of contraception, the proposal voiced the conviction that a variety of factors (ranging from high cost of contraceptives to long waits in line) are probably responsible for much of the gap between expressed interest in contraception and actual use. These barriers, which together constitute the "real cost of contraception," can be both monetary and

non-monetary. Monetary costs may be of two types: the real and necessary monetary outlay for services or commodities and the artificially high or otherwise avoidable outlays that may be incurred due to government policies. For example, a government policy to tax the imported chemical components of oral contraceptives may result in artificially high prices for those contraceptives in the commercial market. Non-monetary costs are inconveniences like the time spent waiting in inefficiently run clinics. Many of these costs are avoidable.

The proposal anticipated that FPAs would apply the concept of RCC at two levels: internally, within their own operations and nationally, in a dialogue with the government. Within their own operations, FPAs were to be encouraged to identify their monetary and non-monetary operational costs and take appropriate steps to reduce them. As part of their collaborative efforts with other organizations, FPAs were to attempt to influence other providers to reduce the costs of services borne by their clients, where this might be feasible.

Neither of these efforts has been initiated, primarily because IPPF/WHR has yet to refine the concept of RCC and to develop a methodology to apply it in specific situations. The unsolicited proposal had viewed identification of the "costs" within a variety of MG II-supported FPAs as a high priority. This effort was to have been spearheaded by the evaluator to be hired through the MG, but because this position has not been satisfactorily filled, the effort has yet to begin. Some patient flow analyses and client satisfaction studies have been carried out in six countries (see Section 3.4.2), but almost nothing has been done to translate the findings into the broader context of the concept of RCC. In addition, there is no accepted methodology to be applied by FPAs to identify the components of RCC. Thus, to date, FPAs have not begun to devise strategies for lowering or removing the avoidable components of real costs.

Recommendation

- (15) The evaluation specialist should refine the concept of RCC and develop a methodology to apply to specific FPAs. The methodology should not ignore the more mundane elements of RCC that are the responsibility of the FPA, despite the appeal of focusing on high visibility costs in the public policy arena. Likewise, the effort should not be over complicated or involve a great many studies, each of which demonstrates the same phenomena. Rather, the methodology should be kept simple and inexpensive.
- (16) FPAs that have successfully applied the concept of RCC to their own operations should be encouraged to disseminate this approach to government programs.

2.2.4 Technical Assistance among FPAs

FPA efforts to assist one another in improving their operations are another aspect of the FPAs' playing a leadership role in the region. From every aspect, this activity has been successfully implemented. At an average cost of under \$2500 per person-visit, FPA managers and technical staff have been exposed to innovations that entail collaboration with other groups, such as the community doctors program in Mexico and the Red Cross clinics in Chile. Their exposure has resulted in the spread of new service delivery models among various FPAs in the region. For example, Peru and Ecuador have developed programs of community doctors (like MEXFAM's) and Colombia has also tested this delivery model. Paraguay has implemented the concept with both doctors and paramedics.

Also, this project component enables technical staff from more advanced FPAs to provide assistance to FPAs that wish to initiate program and administrative improvements. The assistance usually has highlighted priority program and management issues, e.g., service delivery models that mobilize resources of other organizations, evaluation, development of MIS, etc. A substantial portion of the MIS development in FPAs has been supported by technical assistance among FPAs (see Section 2.3.3 below).

In 1987, 32 persons participated in the program. In addition to visits to MEXFAM to study collaborative efforts, FPAs either provided or received technical assistance in evaluation, IEC, finance, male clinics, and CBD. Eight FPAs were represented in these visits. In 1988, 13 staff from 12 FPAs participated in this project component. In 1989, there were 18 scheduled visits: staff from 8 FPAs participated, with MEXFAM receiving 4 visits and APROFAM, 3. Twenty visits were scheduled for 1990.

WHR considers this project component to be one of the most effective of the MG because it has accelerated the diffusion of program and administrative innovations among FPAs.

2.3 Improved Management

2.3.1 Introduction

The unsolicited proposal foresaw as an important offshoot of the MG an increased rigor in the relationship between IPPF/WHR and the FPAs, which would be reflected in better managed activities and a higher degree of accountability. The improvement in management would be effected in two ways: (1) cost controls and cost accounting for FPAs for MG II funds would be more exacting than those required for funds received directly from IPPF headquarters in London; and (2) an MIS would be introduced that would assist FPAs to carry out the new reporting and budgeting functions as required.

2.3.2 Improved Reporting

The MG requires FPAs to provide monthly financial reports to the New York staff. This initially put a strain on some FPA administrators, accustomed to the less frequent reporting requirements of IPPF/London. To assist FPAs to complete these reports and to check on the quality of the work done, an MG II staff accounting expert travels frequently to FPAs, auditing their reports and, to some degree, giving technical assistance in budgeting. These efforts appear to have had salutary results: the MG has enabled IPPF/WHR to insist on more carefully planned projects and frequent reporting, and the financial reporting appeared to be timely and sound (see Sections 5.5 and 5.6).

2.3.3 Management Information Systems

The MG included among its prime objectives the development and installation of computerized MISs in FPAs. In addition to their role in improving FPA management, these systems were viewed as essential to undertaking cost-effectiveness studies, RCC, redirection of efforts to lower-prevalence/low-income clients, and collaborative efforts with other providers.

Technical Assessment. Following a couple of false starts, IPPF/WHR has adapted a set of accounting and administrative "modules" developed by a Costa Rican software firm called TECAPRO. This was coupled with the development of a special clinic management module, for use specifically in FPAs. Together, these represent a viable, flexible set of computer programs capable of addressing the most pressing short-term administrative needs of the FPAs as well as some of their longer-term needs for data to support strategic planning. The MG has also supported training of FPA staff in use of the resulting system and the provision of technical support in its use, once installed. The implementation of systems using this computer software has gained momentum in the last year and, before the end of MG II, most of the participating FPAs should be using and relying on the TECAPRO system.

The system centers around a program designed to maintain accounts. Linked to this accounting module is a series of modules designed to simplify the *administration* of the FPA, including a budget module, a check-writing module, a bank reconciliation module, a personnel/payroll module, and a fixed asset module. These modules are applicable in any business environment — they are not designed specifically for FPAs. For the FPA, they serve primarily to simplify everyday operations such as report generation for multiple donors, voucher preparation for multiple donors, cash flow control, inventory control, and procedures as mundane as check writing. In addition, they have the potential to provide some of the information needed for medium- and long-term planning.

The clinic management module was designed specifically for FPAs. As with the business modules, its primary purpose is to simplify the everyday operation of a clinic, reducing the time spent by staff on record keeping while, at the same time, shortening the waiting time of clients seeking service. It is also capable of creating and storing client information as well as tracking revenues derived from clients for service and/or contraceptive supplies. In addition, an inventory and sales module, adapted from commercially available modules, tracks commodities (not necessarily limited to contraceptive commodities) in a multiple warehouse environment. Fully linked, these modules support the *operations and service* functions performed by FPAs, further reducing the time spent on administration while increasing the accuracy and completeness of the information available for management.

Technical Support. Thus far, the technical support provided to FPAs by IPPF/WHR, TECAPRO and, in some cases, from the staffs of other FPAs further along in system installation, has been adequate. Due to its excellent design, the system is easily understood by its users following a relatively short training period. In the future, as momentum for more extensive and more rapid installation of the full TECAPRO system increases, the demands placed on IPPF/WHR and TECAPRO may grow to levels beyond those that can be managed by the current staff. The use of staff from the FPAs whose systems are fully operational may help meet this need; however, those very same individuals may continue to be needed at home to support system use and thus may not be available for prolonged, frequent consultant missions.

Installation Strategy. IPPF/WHR has adopted a strategy calling for the installation of one or two modules in an FPA, followed by a period of acclimation before the installation of additional modules. The accounting module is the first installed, followed by other administrative modules and, finally, the operations and service modules. In FPAs, such as MEXFAM, with experience in computerization and a strong demand for improved management systems, this strategy is perceived as too gradual. In Peru, where the USAID mission felt the need for logistics management was paramount on a national (not FPA) basis, the progressive strategy adopted by

IPPF/WHR delayed the installation of the inventory module, causing some tension between the mission and the FPA.

Potential Uses. A great advantage of this program is that it can be modified to carry out a variety of tasks, some simple and some more complicated. It can manipulate a wide range of data, depending on the program needs identified during the system design process that is conducted by IPPF/WHR for each FPA. All that is needed is a simple modification of the parameters of the system to accommodate whatever data are required to answer specific questions.

For most programs, the needs are relatively simple: the typical case is the FPA that is having difficulty meeting cash-flow requirements due to inefficiencies in preparing vouchers. In such an instance, the primary need may be no more complicated than automating the voucher preparation process. In the MIS systems observed, the data collected and used were appropriate to assist FPAs with their administration and routine management of their service operations.

On the other hand, some FPAs may well be ready for more sophisticated data analysis that would lay the groundwork for strategic planning. This would involve cost accounting, i.e., collection and manipulation of detailed information about the true costs of each component (fixed and marginal) of their operations as well as the true costs, currently not borne by the FPA due to donor contributions, of such items as contraceptive commodities. Armed with these cost data, an FPA could determine the optimal investment of its resources subject to the constraints established by its other objectives; for example, it could more easily estimate the possible return (or drawdown of cash reserves in a subsidized program) from increasing voluntary sterilization services in poor neighborhoods. It could also make difficult management decisions regarding issues such as optimal method mix, the opening and/or closing of clinics based on their efficiency, and the allocation of staff to tasks.

In addition to these kinds of analyses, the system is capable of storing and analyzing data for special studies. For example, if a more detailed exploration of the socioeconomic characteristics of FPA clients were desired, the clinic management module could be easily modified to accept additional data on each client for as long as the study required.

The system is fully capable of handling such analyses. The issue is whether an FPA is ready to carry them out. Until FPAs have developed fundamental management skills, it would not be appropriate for them to begin tackling these more complex issues. In general, the current approach of IPPF/WHR to configure MIS systems in the FPAs to eliminate pressing everyday problems is a sound one, especially if viewed as a step towards using management information for more strategic planning. Over the long term, however, if resources available for the subsidized delivery of family planning services decrease, the importance of preparing all FPAs to do such analyses will, in all likelihood, grow.

Overlap among CAs. There appears to be considerable overlap of responsibilities among CAs in the area of MIS. In addition to IPPF/WHR, several other CAs are involved in this area. Management Sciences for Health (MSH), for example, was involved in efforts to develop an MIS for BEMFAM, the Brazilian affiliate. Even more pronounced is overlap in the area of logistics management; two other CAs are designing computerized MIS's, John Snow, Inc. and the Centers For Disease Control, to forecast contraceptive needs. Due to the importance of developing an effective MIS, the involvement of a number of CAs can be justified, since each brings its own set of experiences and expertise to bear on the problem. On the other hand, such involvement requires

that special attention be given to coordinating these efforts so that the experiences of one can be shared by all others.

Recommendations

- (17) With respect to MIS installation and training, IPPF/WHR should remain sensitive to the balance between demand for technical assistance and its ability to meet that demand in a timely way and take whatever steps are necessary to retain a favorable balance.
- (18) IPPF/WHR should continue and accelerate, if possible, its program to install the TECAPRO system in all participating FPAs. The current practice of installing the system a few modules at a time should be reviewed on a case-by-case basis, especially for the larger FPAs which have the capacity to implement the system in its entirety.
- (19) In providing continuing support to FPAs in MIS development, IPPF/WHR should be sensitive to their perceived needs as these evolve. As soon as an FPA is using the system routinely to streamline operations and to facilitate reporting, IPPF/WHR should be prepared to help that organization take the next step in system evolution — the use of and analysis of data for better resource allocation.
- (20) A.I.D. should consider convening a workshop or meeting in which the various CAs involved in MIS development present their work with the objective of sharing their respective strengths and exchanging information on lessons learned.

3. Project Design Issues

3. Project Design Issues

3.1 Balance among Activities

The MG currently includes funds for three kinds of program activities: (1) subgrants to Mexico, Colombia and Brazil, representing approximately 80 percent of total MG funds provided to FPAs; (2) subgrants to other, smaller FPAs; and (3) regional activities including MIS, evaluation, technical assistance among FPAs, and assistance in the area of contraceptive commodities. The appropriateness of this balance among categories of activities is discussed below.

3.2 Focus on Three Large Countries

With respect to the division among subgrant recipients, the emphasis on the three advanced developing countries of Mexico, Colombia, and Brazil for expansion and improvement of services is in accord with A.I.D.'s priorities, as well as with the unsolicited proposal. The rationale, well founded, for emphasizing these three countries rests on three facts: (1) These countries do not have bilateral population programs with A.I.D. and therefore this project serves as an alternative conduit for population-related funds; (2) the FPAs in these countries are well established and comparatively well run and reach a substantial clientele; and (3) each of these countries has underserved pockets of populations with need for services (see Section 2.1.2).

Under the MG, funding levels have remained stable in Colombia and Mexico. There has, however, been a decline in Brazil because the program there has encountered problems of various kinds (see Appendix C for a description of MG II activities in Brazil, Mexico, and Colombia and Appendix D for a history of funding levels for all MG countries).

3.3 Smaller Subgrants

It is appropriate that the MG provide opportunities for subgrants for FPAs in other countries, in particular to those FPAs with innovative projects that help expand and improve services offered by other organizations (Chile is a prime example). IPPF/WHR does a competent job in assessing proposals from FPAs, selecting only the more dynamic organizations for support. A total of nine countries have received subgrants: Chile, Guatemala, Jamaica, Panama, Paraguay, Peru, Trinidad and Tobago, Uruguay, and Venezuela. (See Appendix C for a description of MG II activities supported through smaller country subgrants.)

One country subgrant deserves special mention, since it is in fact regional in its purposes rather than country-specific: regional training activities in voluntary surgical contraception (VSC) provided by APROFAM, the IPPF affiliate in Guatemala. This program is designed to provide training in VSC for teams that include a physician, a social worker and a nurse. Because the effort is organized and run locally, the activity is funded as a country subgrant, but the intent is to make possible a wider dissemination of VSC skills to staff from other FPAs.

There is some question as to the cost effectiveness of this particular regional approach to VSC training. Bringing persons to Guatemala from distant Latin American countries, particularly

given that training programs do exist closer to home, may not be the most economical approach. In addition, the capacity of APROFAM is limited; under its current two-week training program, it probably cannot accommodate more than 20 persons per year for VSC training. Some problems were also identified in the execution of the program. The plan that countries would send teams does not seem to be working out in practice; a majority of the persons trained are doctors, with few nurses and social workers included (see Table 6). Other issues relate to current practices of selection: whether criteria for screening candidates are adequate, particularly with relation to surgical training and skills; whether the program should begin to accept general surgeons or general practitioners with training in basic surgical techniques; and what the best arrangements are for training social workers and nurses and what the criteria should be for their selection.

Table 6

**APROFAM - Guatemala
Trainees 1987-1989**

Year	Medical Doctors	Social Workers	Nurses	Total
1987	20	7	8	35
1988	12	6	3	21
1989	17	4	2	23
Total (%)	49 (62%)	17 (22%)	13 (16%)	79 (100%)

Source: MG Annual Reports, 1987-1989.

Recommendation

- (21) The MG staff should take the leadership in organizing an assessment of training requirements in VSC, taking into account the requirements of the FPAs of Latin America for VSC training, the availability and appropriateness of existing training sites, and the performance, relative cost, and potential role of APROFAM in providing VSC training to other countries.

3.4 Regional Activities

3.4.1 Overview

With respect to regional activities, although these do not absorb a large proportion of total MG funds, they represent an important dimension to the grant. In particular, they ensure that the MG supports not only selected affiliates, but rather that it is available to all members of the federation. The only concern is that, because these are much more labor intensive than are the subgrants, regional activities could absorb a disproportionate amount of staff time and resources, if expanded unduly.

Of the four activities, discussion of two — MIS and technical assistance among FPAs — is found above, in Chapter 2 (Sections 2.3 and 2.2.4). The following sections deal with the two other regional activities — evaluation and activities related to commodities.

3.4.2 Evaluation

The evaluation component was viewed as pivotal in the implementation of a number of the objectives in the MG, and thus, the very long delay in hiring an individual with the requisite evaluating skills is viewed as a serious omission. Specifically, without an evaluator (or systems analyst) on staff, it has been impossible to undertake the kind of analysis of targeting that was anticipated, to implement a program for dissemination of innovative service delivery models, or to begin the implementation of the RCC as envisioned. An evaluator will also be essential in conceptualizing the kinds of links that will be needed to use the MIS in analyses related to cost effectiveness, which would help determine appropriateness of various models of service delivery (see discussion of MIS in Section 2.3.3 and of cost-effectiveness and sustainability in Section 4.1.3). Specifically, these efforts should enable program managers to make such decisions as these:

how to determine which market segments it will attempt to reach, and how;

what is the appropriate method mix in a program, taking account of such factors as client preference, client characteristics, required resources, cost, etc.; and

at what level should family planning services be priced, taking into account clients' ability to pay as well as needs for program sustainability.

IPPF/WHR is fully aware of the need to take action in this area. At the time of this evaluation, a search for a qualified candidate was under way and one or two individuals had been identified.

The unsolicited proposal had called for two specific types of evaluation activities: (1) 12 client surveys that would reveal client likes and dislikes about FPA services and identify determinants of client satisfaction; and (2) clinic profiles in a number of the same countries that would serve to alert clinic managers to problems before they became chronic.

The evaluation component has evolved quite differently from the way that had been envisioned. Although no clinic profiles were undertaken, client satisfaction studies were carried out in six countries, coupled in some cases with patient flow analyses. In addition, three unanticipated activities were completed: (1) studies of socioeconomic status of clients to determine whether MG-supported programs are reaching the poor; (2) program evaluations of MEXFAM; and (3) papers on evaluation topics prepared by MG staff.

The client satisfaction surveys, mostly undertaken in 1989, used two different methodologies — exit interviews and focus groups. The patient flow analyses were originally envisioned as part of these studies but now they are being viewed as separate activities. The studies of socioeconomic status were initiated as a result of A.I.D.'s interest in confirming whether the MG was reaching low-income, low-prevalence clientele (see Section 2.1.2). The program evaluations of MEXFAM have been undertaken principally by the Mexican Institute of Social Studies (IMES) and have focused on the process and tools for selecting areas for placing community doctors, characteristics of effective community doctors, and costs of the community doctor program. A review

of a sample of the IMES reports indicates that they have not always produced information that could readily be used by a program manager in making decisions about future program design.

In the late spring of 1990, IPPF, with A.I.D.'s agreement, changed the title of the evaluation position from evaluation officer to program analyst. Although the change is largely semantic, it does suggest that IPPF anticipates a more active role for the evaluator, with a greater emphasis on economic analysis.

Recommendation

- (22) As soon as the evaluation specialist (or program analyst) is recruited, the MG staff should develop a strategy and an agenda for increased activity in the area of evaluation. The strategy should recognize that the MG staff must take the initiative in this field and will have to provide encouragement and technical and other assistance to FPAs (especially since managers understandably tend to give primary attention to immediate operating problems). The priorities for evaluation activities should be based on assessments of the needs of program managers (and planners). It should also give increased attention to issues that relate to targeting, quality, cost, and cost-effectiveness.

3.4.3 Contraceptive Commodities

The MG funds a number of areas related to the contraceptives that are provided to the FPAs from A.I.D. (FPAs also receive contraceptives from IPPF and may purchase some locally. No MG II funds are used to purchase contraceptives.) Most important among the contraceptive-related activities is assistance to FPAs in estimating their contraceptive needs for A.I.D. commodities. In addition, funds are provided to help monitor the warehousing and shipping of the A.I.D. contraceptives and for a variety of equipment and supplies (such as medical kits and laparoscopes).

One issue of concern to A.I.D. has arisen lately in the context of increasing demand and more-or-less stable resources. Specifically, some FPAs are providing A.I.D.-supplied contraceptives to government family planning programs in countries that are a lower priority for A.I.D. (Chile and Trinidad and Tobago).

In Chile, the justification appears strong for the FPA to serve as the principal supplier of contraceptives for the public sector since, without subsidized contraceptives, the government family planning program would have little hope of being viable. Senior officials of the Ministry of Health recognize that, in the longer term, the government will have to purchase contraceptives, rather than rely on APROFA. For the next four years, however, the Ministry's priority is to use the limited resources available to rehabilitate the government's basic health services. (A complicating issue is the Ministry's current policy of providing contraceptive services free of charge, which makes it difficult if not impossible to pursue some cost recovery strategies.) APROFA has recently won the agreement of the Ministry to play a larger role in the monitoring of storage, distribution, and use of commodities it supplies. Similarly, in Trinidad and Tobago, economic conditions are such that if the FPA did not supply the Ministry of Health centers with contraceptives, the Ministry would not be able to make up the shortage and many clients would simply have to do without.

By contrast, in Mexico, another country in which the IPPF affiliate provides commodities to the government program, the transfers occur only on an emergency basis, when

government service facilities do not have adequate supplies available. Although this situation occurs with some frequency, the practice is justified in light of the extreme disruption in services that would occur if these backup supplies were not available. There is, of course, limited control of monitoring the storage and use of contraceptives in such an arrangement.

Recommendations

- (23) In Chile, APROFA should continue to supply contraceptives for the next several years, but the government should be encouraged to address the issue of how it will assume this responsibility over time. APROFA should continue to increase its participation with the Ministry in joint monitoring of storage, distribution, and use of APROFA-supplied contraceptives.
- (24) As long as the Mexican public sector's contraceptive distribution system continues to result in stockouts in family planning service centers, MEXFAM should be allowed to continue its present practice of selectively filling gaps when the need arises.
- (25) In the case of any FPA that supplies contraceptives to public sector programs, the FPAs should institute a dialogue with the public sector regarding methods of cost recovery for contraceptive supplies.

4. Financial Issues

4. Financial Issues

4.1 Performance with Respect to Objectives (as set forth in proposal)

4.1.1 Reduce the Annual Level and Proportion of MG Support

The unsolicited proposal from WHR identified two closely linked financial goals for the five-year duration of the MG. The first was to reduce gradually the annual level of MG support required. The second (which would be expected to follow) was that, by the end of the period, MG resources should represent "a substantially smaller portion of total resources" Both objectives have been realized.

Over the period of the MG, the level of MG support has dropped, although there has not been the steady decrease envisioned in the unsolicited proposal (see Table 7 below).

Table 7

Total Annual MG Expenditures and Targets

Calendar Year	Actual Expenditures US\$ (millions)	Target (unsolicited proposal) US\$ (millions)
1986	5.929	5.0
1987	6.413	7.0
1988	5.958	6.3
1989	6.090	5.8
1990 (est.)	5.222	5.4
1991 (est.)	—	4.9
1992 (est.)	—	4.6

Source: Annual Reports for 1987, 1988, and 1989 and Unsolicited Proposal.

There has also been a reduction in WHR's relative dependence on the MG. In 1986, the first full year of the MG, MG funds accounted for 23.7 percent of subgrantee income whereas in 1989, the MG accounted for only 16.6 percent of total subgrantee income (see Table 8 and Figure 1).

4.1.2 Maintain or Increase Non-Federal Income

The MG contained specific matching requirements, which called for MG inputs to be matched by funds from other sources ("non-Federal funds") both at headquarters level (two to one ratio) and at the local FPA level (one to one ratio). A.I.D. decided to keep the match ratio constant throughout the MG life, although the unsolicited proposal had called for a modest increase.

The match at the FPA level has been increasingly easily met. Among "non-Federal funds" that have grown, the fastest-growing has been local income, or income received by FPAs in return for services performed. This has risen from \$5.5 million to \$9.1 million over the four-year period. Over the same period, support from IPPF increased from \$6,565,800 to \$7,927,300 and

support from "other donors" increased from \$700,200 to \$2,193,100 (see Table 8 and Figures 1 and 2 — also Appendix D).

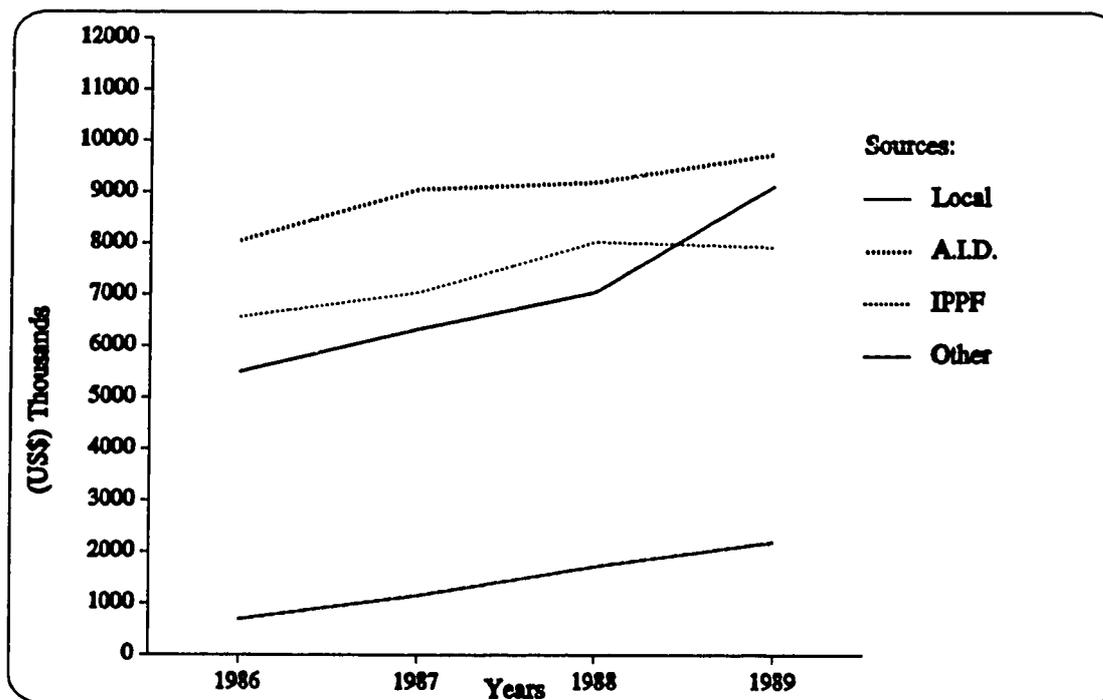
Table 8
Total Income of MG Subgrantees, by Source
1986-1989

Year	Local Income		From A.I.D.		From IPPF		From Other Donors		TOTAL	
	Amount US\$ (millions)	Percent								
1986	5.5	26.4	8.0	38.5	6.6	31.7	0.7	3.4	20.8	100
1987	6.3	26.9	9.0	38.5	7.0	29.9	1.1	4.7	23.4	100
1988	7.0	27.0	9.2	35.5	8.0	30.9	1.7	6.6	25.9	100
1989	9.0	31.5	9.7	33.6	7.9	27.3	2.2	7.6	28.9	100

Source: Tables D1-4.

Note: Local Income represents funds raised by local FPAs through sale of family planning or related services.

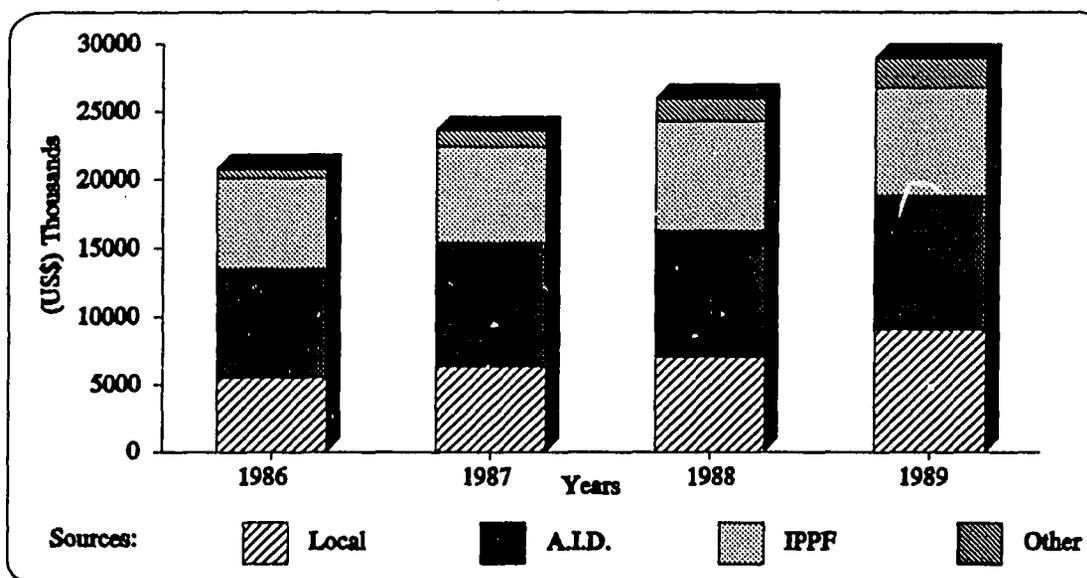
Figure 1
Increases in Subgrantee Income, by Source, 1986-1989



Source: Derived from Table 8

Figure 2

Sources of Subgrant Income, 1986-1989



Source: Derived from Table 8

4.1.3 Make FPA Programs More Cost Effective and Sustainable

In anticipation of reduced levels of MG funding, the unsolicited proposal called for FPAs to increase the cost effectiveness of their operations and, insofar as possible, their self-sufficiency. At the same time, the proposal cautioned that a fee structure should not be imposed that would act as a barrier to lower-income clients. Overall, the FPAs have done a good job in reducing costs, both per new acceptor and per couple of year protection (CYP) (see Tables 9 and 10).

Theoretically, there are four ways FPAs might improve the cost-effectiveness and sustainability of their programs. Of those listed below, the FPAs have had some successes with the first and second approaches, and a few successes with the third.

- (1) Collaborative schemes with other providers, through which some other organization carries part of the cost of service provision (see Section 2.2). The MEXFAM community doctor scheme, for example, requires MEXFAM to provide contraceptives and initial subsidies for doctors only until they become self-sufficient.
- (2) Better management using, *inter alia*, the MIS.
- (3) Offering services that will most likely produce cash income for the FPA. Some FPAs are experimenting with provision of services beyond family planning that generate income and that can help to sustain family planning services. For example,

Table 9

Cost per New Acceptor during Matching Grant II

Country	Jan.-Sept. 1986 ¹	1987 ²	1988 ³	1989 ⁴
Argentina	\$ 42.05	\$ —	\$ —	\$ —
Brazil	11.52	6.06	5.45	3.87
Chile	47.46	15.51	11.33	14.35
Colombia	29.28	31.28	27.26	29.55
Jamaica	—	—	11.38	—
Mexico	10.48	6.04	6.18	5.11
Panama	—	62.22	—	—
Peru	5.88	2.58	4.03	3.85
Trinidad	107.31	15.87	16.10	18.41
Uruguay	2.63	3.83	4.21	3.92
Venezuela	—	—	409.95	36.99
All:	\$ 14.20	\$ 8.53	\$ 7.93	\$ 7.24

Sources:

- 1) Compilation based on tables appearing on pages 1 and 43 of the Matching Grant Quarterly Report, July 1-September 30, 1986.
- 2) Matching Grant Annual Report, January-December 1987, page 2.
- 3) Matching Grant Annual Report, January-December 1988, page 2.
- 4) Matching Grant Annual Report, January-December 1989, Attachment A, page 1.

Note: These costs were computed using total FPA expenditures of MG funds as the numerator and number of new acceptors as the denominator. There are obvious drawbacks to this methodology: Costs are not comparable, as some FPAs have more cost-sharing activities than others, and costs vary according to methods provided and maturity of effort. In particular, the unusually high values in the table reflect the overwhelming effect of start-up costs in a new program of an experimental nature. None of the factors mentioned is captured in these computations.

Table 10

Cost per Couple Year of Protection during Matching Grant II

Country	Jan.-Sept. 1986 ¹	1987 ²	1988 ³	1989 ⁴
Argentina	\$109.32	\$ —	\$ —	\$ —
Brazil	4.68	5.06	5.99	4.12
Chile	27.82	10.99	4.65	5.85
Colombia	2.45	2.65	2.24	2.42
Jamaica	—	—	47.81	—
Mexico	10.28	7.25	7.72	7.75
Panama	—	68.84	—	—
Peru	3.92	2.86	4.87	4.47
Trinidad	6.71	3.59	1.15	1.33
Uruguay	2.04	2.68	2.59	2.53
Venezuela	—	—	335.42	21.00
All:	\$ 3.99	\$ 3.98	\$ 3.71	\$ 3.56

Sources:

- 1) Compilation based on tables appearing on pages 1 and 43 of the Matching Grant Quarterly Report, July 1-September 30, 1986.
- 2) Matching Grant Annual Report, January-December 1987, page 2.
- 3) Matching Grant Annual Report, January-December 1988, page 2.
- 4) Matching Grant Annual Report, January-December 1989, Attachment A, page 1.

Note: The computation was done as in Table 9, with FPA expenditures of MG funds the numerator and the CYP the denominator. The same proviso with regard to the comparability of resulting costs per CYP holds true here.

in Guatemala, APROFAM provides revenue-generating services, such as sonograms, in their larger clinics in an effort to recover part of the costs of running those clinics. Another approach is to offer special treatment (e.g., scheduled appointments) for middle class clients who can pay for such services.

(4) **Charging for a service or product without inhibiting use by low-income clients.** MG reports provide little information on the bases for establishing prices for various contraceptive services. It is known, however, that PROFAMILIA is charging the equivalent of \$1 or \$2 for VSC although the real cost for the organization is in the order of \$35. PROFAMILIA is charging these very low fees consciously, to ensure that target populations with few financial resources will be able to use these services. It is likely, however, that there may be room for charging higher fees without discouraging clients who are very poor. A fair summation is that, if FPAs are attempting to provide services for those who cannot afford private physicians and for whom public services are not available or are inadequate, then it is unlikely that 100 percent sustainability can be achieved. Nonetheless, there may be room for more cost recovery than some programs are currently achieving.

Some current family planning service models are clearly more sustainable than others. Thus, the community doctor scheme in Mexico entails only an initial investment by MEXFAM, whereas the APROFA-Red Cross program in Chile calls for continued salary support of midwives by APROFA. Furthermore, Red Cross policies require that services in Red Cross clinics be free. Although boxes have been placed in clinics for voluntary contributions for family planning services, the amounts collected do not begin to meet full costs. Additionally, Ministry of Health policy is that all preventive care, which includes family planning, is free in government facilities. These are all serious obstacles to establishing sustainability in this program. On the other hand, some of the Red Cross clinics have arrangements whereby they defray some of their operating costs through fees paid by doctors and dentists who have practices in the clinics. These doctors and dentists pay the clinic a percentage of the fees charged to clients (which enables the clinic to buy medical and other supplies).

Any assessment of the overall cost-effectiveness of these two operations, however, must take into account their relative effectiveness in reaching clients. The average patient load of a community doctor in Mexico is on the order of 15 persons per day, of whom perhaps only one-third to one-half come for family planning. Midwives in Red Cross clinics in marginal areas of Santiago, on the other hand, may have a patient load of 50, three-fourths of whom come for family planning.

Recommendations

(26) The MG should continue to address the issue of how family planning services can be made more cost effective. The MG staff should also encourage FPAs to carry out cost-related studies of family planning services and to experiment with new ways of providing more sustainable services. The development of improved MISs should facilitate this task. In such efforts, due regard should always be accorded to such competing objectives as appropriate method mix, the need to reach the underserved, etc.

- (27) FPAs should be encouraged to continue testing ways of subsidizing family planning services through offering additional services (e.g., sonograms) and middle class services.
- (28) IPPF/WHR should explore with PROFAMILIA the possibility of charging more than \$1 or \$2 for VSC.
- (29) APROFA should begin to look for ways to make its collaborative program with the Red Cross more sustainable. One possibility would be to extend to midwives a variation of the practice now applied in some clinics to doctors and dentists practicing there; the clinic could share with midwives a percentage of income generated from client fees, rather than paying them salaries. This might be tested in a high-performing clinic.

4.2 Project Funding

As A.I.D. has come to face greater uncertainty regarding funding levels available to it, funding for this project has become an issue. In the past, although it was always understood that MG allocations were subject to annual availability of funds and A.I.D. program priorities, funds were abundant, unspent funds in any given year were available to "forward fund" the following year's activities at the start of IPPF/WHR's fiscal year (January 1), and obligations could be made largely on an as-needed basis. This situation eliminated any uncertainty with regard to programming efforts that had been identified in annual workplans. IPPF/WHR relied on this flexible arrangement to keep funds flowing in an uninterrupted fashion to its FPAs. This arrangement was very satisfactory from IPPF/WHR's perspective: As the headquarters, it feels considerable responsibility to its FPAs, which have payrolls to meet and programs that could founder if expected funds are not forthcoming on schedule.

Elements of uncertainty have entered the picture in recent years. One of the most disruptive is that A.I.D. has become less ready to forward fund, instead dispensing funds in the course of the year as they become available to the Office of Population. A second problem surfaced in 1989 when the Office of Population did not inform IPPF/WHR in advance of a sharp cut in the level of funding it was requesting for IPPF/WHR in its Congressional Presentation (CP) for the upcoming calendar year. The cuts in IPPF funding were part of a general reduction in the request for the central population account that year. Moreover, funding levels proposed in the CP are not controlling; they tend to change during the appropriation process. Nonetheless, this represented a lapse in what should be the normal process of communication between the Office of Population and one of its CAs and raised a real concern about the availability of funds for the FPAs. A third weak link in the budgeting/planning continuum is the timing of IPPF/WHR's workplan submission to A.I.D. Currently, in accordance with the grant agreement with A.I.D., this is provided to A.I.D. in November for a program year that begins two months later, in January. Given that USAID missions must concur for each country budget, this leaves very little time for in-depth discussions among concerned parties.

IPPF/WHR has resisted efforts to accept the possibility that it will not receive full funding, timed as needed, for its programs; it does not husband its resources by keeping a funding reserve in the pipeline in case of delays or shortfalls. Rather, apparently in the expectation that it *will* receive a full obligation by the start of each fiscal year, IPPF/WHR makes plans to spend funds

accordingly. Moreover, IPPF/WHR invites the FPAs to submit annual workplans assuming full funding of the MG. This creates a situation that is jeopardizing sound planning of country activities. If there is a shortfall in the total level of funds allocated, workplans cannot be implemented at the desired level and a reprogramming exercise will be required. Delays in the receipt of obligations may also threaten a cessation of activities under the MG.

A.I.D. has made several suggestions regarding how IPPF/WHR might change its planning process to reflect better current funding realities. Among these are the adoption and implementation of a multi-year workplan and/or the preparation of annual workplans for the FPAs for different funding levels.

These suggestions, while reasonable, do not constitute a complete solution. A multi-year workplan would avoid the necessity of obtaining the mission clearances required annually. On the other hand, once the funding level were known for a given year, the multi-year plan would have to be modified to fit that funding level. Similarly, workplans at multiple levels could be approved prior to the determination of actual funding levels, but further modification might be necessary to fit the final funding level if it were to differ substantially from those assumed in the workplan. Although both of these steps would reduce the amount of time required for MG staff to respond to the actual funding level once it is announced, neither changes the reality that IPPF/WHR cannot assure its FPAs that it can keep its commitments to them in any fiscal year until it knows the actual funding level available to it.

Recommendations

- (30) The steps set forth below are suggested as an approach to resolving the funding issue:
 - (30-1) Discussions between IPPF/WHR and A.I.D. regarding funding levels should begin as early as possible and, insofar as possible, the Office of Population should keep IPPF/WHR abreast of developments that might result in marked deviations from expected funding patterns (i.e., in conformance with proposed MG II funding levels). In particular, A.I.D. should attempt to provide IPPF/WHR as accurate a forecast as possible of the funds it will receive following the CP budget review.
 - (30-2) Workplans and budgets should be prepared several months earlier than they currently are in order to give A.I.D. more time to review plans and to allow for approval prior to the beginning of the MG fiscal year (January 1). Alternative versions should be prepared, anticipating both the possibility of shortfalls and supplementary allocations. The supplementary program and budget and the shortfall program and budget should be set at figures agreed upon by the Office of Population and IPPF/WHR.
 - (30-3) A resumption of forward funding is the best solution to the problem of maintaining continuity of activities. If this is not possible, IPPF should pace the rate of expenditures in the MG to attempt to have adequate cash on hand between the end of one fiscal year and the release of funds during the next fiscal year.
 - (30-4) When MG funds for approved and budgeted activities are not spent by an FPA because one or more activities were not carried out, the funds should be reallocated as needed: either to meet any shortfall between annual workplan level and A.I.D. allocations to the MG or to support the supplementary program (see [30-1] above).

- (30-5) When MG funds are not spent by an FPA because it has received more funds than expected from other than the MG source, the FPA should be encouraged to propose to the MG staff alternative uses for the unspent MG funds.
- (30-6) Given the uncertainty regarding funding, WHR should attempt to be more flexible in planning and budgeting.

4.3 Debt Swap

In Latin America, with its frequent periods of rampant inflation, the continual and diligent monitoring of the flow of U.S. dollars to countries is a critical element of financial management. IPPF/WHR appears to handle this obligation extremely well, enabling the FPAs to get the full value of the foreign currency component of their budgets.

In this regard, IPPF/WHR has made diligent efforts to capitalize on debt swaps throughout the region. Debt swaps are transactions in which an organization working in a country with substantial foreign debt purchases notes held by banking institutions in the United States for a fraction of their stated value. It then sells these notes back to the country for local currency in excess of the value of the dollars advanced by the organization to buy the notes. These debt swaps are encouraged by A.I.D., because, in theory, everyone gains. The bank gets some return for notes that might not otherwise be repaid, the country has a portion of its debt retired, and the organization benefits by receiving more local currency for its dollars than it would receive through a direct exchange on the currency market.

Despite A.I.D.'s overt encouragement of the use of debt swaps, IPPF/WHR has found that the bureaucratic regulations that A.I.D. has developed for these transactions are too laborious to permit the rapid action that is essential.

Recommendation

- (31) A.I.D. should consider ways to streamline the process of approving a debt swap transaction to enable IPPF/WHR to generate additional local currency for its grant.

5. Project Management

5.1 Office of Population Relationship with IPPF/WHR

IPPF/WHR and A.I.D.'s Office of Population Family Planning Services Division (FPSD) have had some disagreement as to the roles and responsibilities of each party vis-a-vis the operation of the MG. This has led to miscommunication on a number of critical issues and has had an adverse effect on the functioning of the project. To be specific, at times IPPF/WHR has not been forthcoming with the kind of information that the Office of Population felt it needed. Perhaps in reaction, the Office has exercised what appears to be an increasing — and inappropriate — tendency to act as if it were a full partner in the detailed planning and management of the MG. Because this grant was made on the basis of an unsolicited proposal from an organization seeking to enhance a set of ongoing activities, it should be dealt with differently from contracts or cooperative agreements for which A.I.D. has defined the objectives and outputs. The potential for remedying the situation seems good, however, since there is no fundamental disagreement regarding the project's goals and objectives.

Recommendations

- (32) Both FPSD and IPPF/WHR should recognize the need for all those with project responsibilities to have timely and adequate information on project matters — especially those that may imply emerging or future problems.
- (33) MG staff should make a greater effort to have effective communication with A.I.D. staff.
- (34) FPSD should recognize that it has in IPPF/WHR an experienced and competent organization in the field of family planning and should therefore avoid the tendency to take too active a role in the management of MG activities.

5.2 USAID Mission/WHR Relationships

Relationships between the IPPF/WHR staff and the USAID missions are generally very good. In all three countries visited, USAID staff remarked that MG staff always maintained contact with them when visiting the countries. USAID staff in Mexico and Guatemala were particularly positive regarding MG activity. On the other hand, in a few countries, there have been problems. The most frequently cited case occurred in Peru where the USAID mission and the MG staff appear to have had differing views on program priorities. In addition, this mission feels that the MG staff have not worked closely enough with it in preparing MG plans.

Recommendation

- (35) IPPF/WHR staff and USAID missions should be alert to the need to have effective communications with each other.

5.3 Organization and Management

The role of senior MG staff has been mainly to guide, review, and approve MG-supported activities of FPAs. To augment its resources, the staff has been able to use other WHR staff (e.g., from the Program Coordination Unit, the Program Support Unit, and Finance Department) for various activities related to the MG. In 1987, for example, 10 non-MG staff helped with MG work, including providing technical assistance to FPAs in MIS development and development of annual workplans and assistance to senior staff in review of financial implementation of MG subgrants, and in review of implementation of MG activities. In 1988, 8 staff members had significant participation in MG work. Thanks to their ability to use other WHR staff, the MG has succeeded in maintaining a lean organization and staffing pattern. This achievement is most commendable. On the other hand, the lean staffing pattern has meant that MG senior staff have not had the time to provide in-depth technical assistance in the areas of strategic planning and management.

Recommendation

- (36) MG senior staff should spend more time in the field assisting FPA managers with strategic planning and management issues.

5.4 Staffing

MG staff are well qualified and knowledgeable regarding the region. Other than the failure to recruit and retain a well-qualified person for the evaluation position (see Section 2.1.2), there are no problems in this area.

5.5 Planning and Budgeting

The quality of MG planning and budgeting has generally been very good. Workplans, however, have not always given enough attention and detail to issues of strategy. This is true also of workplans prepared by FPAs. One reason for inadequate attention to strategy in FPA plans may be that IPPF/WHR senior staff have not spent sufficient time in the field providing assistance in this area, due to the press of their duties at headquarters, including fulfilling A.I.D. reporting requirements. The creation of the position of deputy project manager is designed in part to give senior project management more time to work with FPA management in the field.

It is well understood that all planning must go on within the limits set by the overall design of the MG, and IPPF/WHR has done a good job in adhering to the terms therein. The governing factors are as follows: (1) IPPF/WHR's unsolicited proposal, which lays out an overall five-year strategy; (2) the agreed emphasis on FPAs in three advanced developing countries (Mexico, Colombia, and Brazil); (3) WHR and A.I.D.'s interest in encouraging a limited number of other FPAs to propose innovative projects; (4) both agencies' interest in supporting a component of regional activities which enables the larger WHR network of FPAs to participate in activities supported by the MG and which accelerates the diffusion of innovations; and (5) the need to keep the total activity load manageable in relation to the existing MG staff.

Recommendation

- (37) The MG staff should give increased support to the FPAs in the area of strategic planning. This would include better use of improved MIS, more attention to use of evaluation findings, and more access to and use of operations research. One way to facilitate this would be if the Office of Population and WHR staff were to explore ways to reduce the volume of reporting.

5.6 Financial Management

Financial management of the MG has been very effective. IPPF/WHR has in general been able to obtain funds budgeted in MG annual workplans, even in the face of uncertainty within A.I.D. as to the overall availability of funds for the Office of Population. MG expenditures have generally been closely in line with budgets, except in those circumstances in which factors beyond program control have disrupted planned program activities. When this has occurred, WHR has shifted funds to other MG project activities, with A.I.D. concurrence. For example, PROFAMILIA received substantial additional funds in 1988 and 1989 (some \$250,000 and \$179,000 respectively) to expand VSC services. MEXFAM received an additional \$250,000 in 1988 to cope with a budget shortfall caused by an unexpected change in the currency exchange rate.

Financial reports on MG activities have usually been complete and on time. Reports on expansion of contraceptive services have included information on costs per new acceptor and costs per CYP. The work currently under way on MIS in a number of FPAs will provide more opportunities for FPAs to strengthen their financial management, including giving attention to such issues as cost-effectiveness of various services and sustainability. In the one or two cases in which questions have arisen regarding proper use of and accounting for funds, WHR appears to have taken appropriate action and has provided pertinent information to A.I.D.

Financial management of the MG will be a greater challenge for WHR from now on. With the increased uncertainty about availability of funds for the Office of Population for projects such as this, financial management performance in the future may have to be evaluated in terms of an additional criterion, viz., the ability of IPPF/WHR and participating FPAs to adjust promptly in the course of the fiscal year to changes — presumably mostly decreases — in available funds.

5.7 Reporting

Reporting on MG activities has generally been timely, complete, and in accordance with requirements. An apparent exception is trip reports, which have not been sent to A.I.D. in accordance with the required schedule.

Recommendation

- (38) IPPF/WHR staff should take steps to comply with requirements regarding trip reports.

6. Issues of Special Concern to A.I.D.

6. Issues of Special Concern to A.I.D.

6.1 Relevance of MG to IPPF's and A.I.D.'s Long-Term Strategies

The IPPF long-term strategy document sets forth, *inter alia*, three service objectives and three service priorities and also emphasizes the importance of quality of service; resource development and cost recovery; advocacy; and institutional development and management capability. The three service objectives are (1) to provide models of service delivery that other organizations can replicate, expand or continue to support; (2) to support elements of service delivery such as training; and (3) to complement service delivery of others by reaching unserved sectors or by providing services not offered by others. The three service priorities are (1) people living in marginal urban areas, (2) young people, and (3) individuals in need of long-lasting forms of contraceptives.

The MG reflects nearly every aspect of the strategy. All three of the strategy's long-term goals are incorporated in the MG, as are two of the service priorities. The MG also focuses on quality, resource development, and to some extent, cost recovery, advocacy, and management. The only priority area not addressed is service to adolescents, although some FPAs, notably MEXFAM, have developed imaginative strategies and materials in this area (see Section 2.1.2).

A.I.D.'s long-term strategy is embodied in the report *Preparing for the Twenty-First Century: Principles for Family Planning Service Delivery in the Nineties*, prepared by FPSD. This report proposes six principles to guide service delivery in this decade: (1) expansion of services to meet the needs of a growing and changing population; (2) changes in service delivery programs to incorporate a larger array of modern methods; (3) improvements in quality of care; (4) increased cooperation among service providers; (5) greater attention to sustainability; and (6) more attention to comparative advantage, coordination of efforts and better management, including on the part of donors and CAs.

A review of MG II workplans indicates that all of these principles are being addressed to a significant degree. Review of MG II annual reports suggests that more progress has been made in relation to some principles than to others. Specifically, work on quality of care and on the issue of sustainability warrant increased effort.

6.2 Work in Bilateral Countries/Buy-Ins

A.I.D. has made a policy decision that, in countries with bilateral family planning programs, such programs will be required to buy into centrally funded population activities. This would supersede the practice whereby centrally funded projects have used their own funds to carry out activities in bilateral countries.

With respect to MG II, A.I.D. maintains that \$2 million of the grant funds should be provided through buy-ins, in accord with a stipulation included in the A.I.D. approval document. The MG II staff contest the relevance of this stipulation. In IPPF/WHR's view, the approval document was an internal A.I.D. document about which the MG II staff were not consulted or informed and with which, therefore, they should not be expected to conform.

Even if IPPF/WHR were inclined to pursue this stipulation, the prospects that it could generate \$2 million in buy-ins for this grant are slight. Currently, subgrants go to only two countries that have bilateral population programs: Guatemala and Peru. The MG provides support in Guatemala for the regional training activity at APROFAM (\$65,000 for FY 1990) and in Peru, for a variety of activities (\$200,000 for FY 1990). Because the APROFAM training program largely serves countries other than Guatemala, it is unrealistic to expect the USAID mission there to buy into the MG to support this activity. In Peru, on the other hand, it is plausible that the USAID mission might buy into the MG in future, although the mission claims it is already overextended and might not have sufficient funds.

With respect to the regional activities, A.I.D. does not expect missions to buy into these small activities for the duration of this grant. Regarding a future grant, IPPF/WHR maintains that requiring countries to buy into regional activities would have a negative effect, since the scale of paperwork involved could discourage participation of FPAs from bilateral countries. This is a valid point.

It is not clear that buy-ins will ever represent an important option in the FPA Latin America environment. Since the ultimate recipient of buy-in funds would be the local FPA, USAID missions — if they so chose — could provide funding directly to these operations, without using IPPF/WHR as an intermediary. In this same vein, the institutional infrastructures in Latin America, including in the health and family planning fields, typically are sufficiently developed that they may not need appreciable amounts of the technical assistance normally provided through buy-ins. Finally, most FPAs in Latin America are of relatively small size, and thus the bureaucratic effort required for the buy-in mechanism would not be justified. On the other hand, a large-scale project activity in a sensitive area (adolescents, for example) in which the mission did not want to have to seek agreement with the host government might represent an excellent opening for the buy-in mechanism.

Recommendation

- (39) Where feasible, MG staff should seek opportunities for buy-ins through dialogue with USAID missions in bilateral countries.
- (40) A vigorous regional component, funded from central sources, should be maintained.

6.3 Cooperation among Cooperating Agencies

In general, IPPF/WHR has worked well with other CAs, using the skills of these centrally funded projects to strengthen MG activities. With the exception of the area of MIS (see Section 2.3.3), there appears to be no duplication or overlap. Rather, other CAs, for example, The Pathfinder Fund and the Association for Voluntary Surgical Contraception, have complemented MG activity through their support to various FPAs in Latin America. Likewise, in the area of forecasting contraceptive needs, the efforts of John Snow, Inc., in forecasting national needs, both those of the government and those of private programs, are viewed by MG staff as complementary to their role. No problems were evident in the estimating work and cooperation was good. In Mexico, IPPF/WHR staff and the head of MEXFAM believe that support from several CAs serves to strengthen the FPA. In the area of operations research (OR), on the other hand, opportunities may exist for further cooperation (see Section 6.4 below).

Recently, the attention of the Office of Population has begun to shift to Africa with consequently fewer funds for Latin America. As a consequence, the level of CA support to the region has begun to drop and the chances of overlap or duplication are therefore fewer.

6.4 Operations Research

An area that warrants further attention is operations research (OR). The issue was raised principally with respect to MEXFAM and the possibility that it might get assistance from the A.I.D.-funded INOPAL project, which operates in Latin America. MEXFAM has been seeking support for an OR project -- prepared by another organization -- designed to strengthen MEXFAM's management. To date, MEXFAM has not been successful in securing support for the effort. Moreover, it is questionable whether this particular OR proposal would have its intended impact. Because of its experience in OR in the family planning field, INOPAL might be better positioned to assist MEXFAM to explore how it could address its management concerns.

OR can be a useful complement to MG evaluation activity. It would seem useful, therefore, for MEXFAM and other FPAs to tap INOPAL expertise. MG staff, however, may need to assist FPA managers in Mexico and elsewhere to explore opportunities to receive assistance and support for OR.

Recommendation

- (41) MG staff should help FPA managers explore opportunities to receive assistance and support for OR. Any OR that is undertaken should be focused on priority program issues; should be of relatively short duration and produce findings that can be translated into changes in program design and/or operation; and should not represent an undue burden on program managers or operating programs.

**7. Overall Conclusions and Summary of
Recommendations for MGs II and III**

7. Overall Conclusions and Summary of Recommendations for MGs II and III

7.1 Overall Conclusions

The foregoing analysis suggests that there are many advantages (and no real disadvantages) in the MG from A.I.D.'s perspective.

The advantages that arise are of three sorts.

First is the opportunity the MG offers A.I.D. to work with IPPF/WHR. This experienced organization is excellently positioned to expand and improve family planning services throughout a large geographic area. Furthermore, there are economies of scale in carrying out regional activities through a federation such as IPPF; the modest MG staff size, together with use of WHR staff to assist the MG staff, has kept management costs at reasonable levels and has helped integrate MG-funded activities into the larger set of activities of WHR and the FPAs.

Secondly, the unsolicited proposal itself conforms to important A.I.D. priorities. It offers A.I.D. a way of supporting advanced developing countries in a way that is consistent with A.I.D. objectives to extend family planning services to the underserved, and it is generally congruent with FPSD's strategy for the nineties.

In its execution, the MG has succeeded in accomplishing many of the goals incorporated in the proposal. It has substantially increased the number of family planning acceptors in participating FPAs. It has encouraged FPAs to play new strategic roles in their countries. It has developed links with government and PVO programs that have stimulated more and better quality services by both types of organizations. It has encouraged FPAs to diversify and strengthen their resource bases — and some have been quite successful in this effort. It has accelerated dissemination of innovations. It has enabled IPPF/WHR to require FPAs to send forward projects that are well planned and monitored. Overall, these successes constitute a commendable record.

7.2 Recommendations for MG II

7.2.1 Programmatic

Service Delivery

Increases in Family Planning Services

- (1) To promote comparability of the indicators over time and across projects, IPPF/WHR should continue to impress upon the FPAs the importance of defining both a new acceptor and CYPs according to IPPF/WHR guidelines.
- (2) IPPF/WHR should consider adopting a method of calculation of CYP from female sterilization that would take into account the age of the acceptor.

Targeting Lower-Income, Low-Prevalence Populations

- (3) FPA's should continue their efforts to target low-prevalence, low-income clientele.
- (4) MG staff should urge the FPA's to attempt to influence other providers to focus their efforts on underserved populations.
- (5) Consideration should be given to funding innovations in the area of adolescent fertility, under a future MG. To some degree, FPA's could learn from one another from such efforts, but program design and activities should respond primarily to country situations.

Quality of Service

- (6) IPPF/WHO should ensure that the recently prepared IPPF medical guidelines are made widely available throughout the region and that FPA's are encouraged to incorporate into their own medical standards for all MG-supported activities, the applicable and appropriate worldwide IPPF guidelines.
- (7) FPA's should continue to seek opportunities to improve the quality of public sector programs through, among other approaches, increasing efforts to provide training to public sector service providers.
- (8) IEC materials for populations who are not highly literate should have less text and more graphics.
- (9) Studies should be initiated of both the rate and reasons for dropping out of programs.
- (10) FPA's should give increased attention to method mix in their own programs as well as nationally. To this end, the MG should fund studies of method mix, initially in those countries where method mix is particularly unbalanced.
- (11) APROFA should be encouraged to explore how VSC can be made more widely available both in its own program and in public and private programs.
- (12) PROFAMILIA in Colombia should explore the feasibility of encouraging the government to offer more VSC in its family planning services.

Leadership Role

- (13) Senior MG staff should view assistance to FPA's to provide leadership as one of their highest priorities.
- (14) As soon as the evaluation position is filled, MG staff should develop plans for documentation and dissemination of innovative service delivery models that involve collaboration between FPA's and other organizations.
- (15) The evaluation specialist should refine the concept of RCC and develop a methodology to apply to specific FPA's. The methodology should not ignore the more

mundane elements of RCC that are the responsibility of the FPA, despite the appeal of focusing on high visibility costs in the public policy arena. Likewise, the effort should not be over complicated or involve a great many studies, each of which demonstrates the same phenomena. Rather, the methodology should be kept simple and inexpensive.

- (16) FPAs that have successfully applied the concept of RCC to their own operations should be encouraged to disseminate this approach to government programs.

FPA Management Issues

- (17) With respect to MIS installation and training, IPPF/WHR should remain sensitive to the balance between demand for technical assistance and its ability to meet that demand in a timely way and take whatever steps are necessary to retain a favorable balance.
- (18) IPPF/WHR should continue and accelerate, if possible, its program to install the TECAPRO system in all participating FPAs. The current practice of installing the system a few modules at a time should be reviewed on a case-by-case basis, especially for the larger FPAs which have the capacity to implement the system in its entirety.
- (19) In providing continuing support to FPAs in MIS development, IPPF/WHR should be sensitive to their perceived needs as these evolve. As soon as an FPA is using the system routinely to streamline operations and to facilitate reporting, IPPF/WHR should be prepared to help that organization take the next step in system evolution — the use of and analysis of data for better resource allocation.
- (20) A.I.D. should consider convening a workshop or meeting in which the various CAs involved in MIS development present their work with the objective of sharing their respective strengths and exchanging information on lessons learned.

Regional Training in VSC

- (21) The MG staff should take the leadership in organizing an assessment of training requirements in VSC, taking into account the requirements of the FPAs of Latin America for VSC training, the availability and appropriateness of existing training sites, and the performance, relative cost, and potential role of APROFAM in providing VSC training to other countries.

Evaluation

- (22) As soon as the evaluation specialist (or program analyst) is recruited, the MG staff should develop a strategy and an agenda for increased activity in the area of evaluation. The strategy should recognize that the MG staff must take the initiative in this field and will have to provide encouragement and technical and other assistance to FPAs (especially since managers understandably tend to give primary attention to immediate operating problems). The priorities for evaluation activities should be based on assessments of the needs of program managers (and planners).

It should also give increased attention to issues that relate to targeting, quality, cost, and cost-effectiveness.

Contraceptive Management

- (23) In Chile, APROFA should continue to supply contraceptives for the next several years, but the government should be encouraged to address the issue of how it will assume this responsibility over time. APROFA should continue to increase its participation with the Ministry in joint monitoring of storage, distribution, and use of APROFA-supplied contraceptives.
- (24) As long as the Mexican public sector's contraceptive distribution system continues to result in stockouts in family planning service centers, MEXFAM should be allowed to continue its present practice of selectively filling gaps when the need arises.
- (25) In the case of any FPA that supplies contraceptives to public sector programs, the FPAs should initiate a dialogue with the public sector regarding methods of cost recovery for contraceptive supplies.

7.2.2 Financial Issues

Cost Effectiveness and Sustainability

- (26) The MG should continue to address the issue of how family planning services can be made more cost effective. The MG staff should also encourage FPAs to carry out cost-related studies of family planning services and to experiment with new ways of providing more sustainable services. The development of improved MISs should facilitate this task. In such efforts, due regard should always be accorded to such competing objectives as appropriate method mix, the need to reach the underserved, etc.
- (27) FPAs should be encouraged to continue testing ways of subsidizing family planning services through offering additional services (e.g., sonograms) and middle class services.
- (28) IPPF/WHR should explore with PROFAMILIA the possibility of charging more than \$1 or \$2 for VSC.
- (29) APROFA should begin to look for ways to make its collaborative program with the Red Cross more sustainable. One possibility would be to extend to midwives a variation of the practice now applied in some clinics to doctors and dentists practicing there; the clinic could share with midwives a percentage of income generated from client fees, rather than paying them salaries. This might be tested in a high-performing clinic.

Project Funding

The steps set forth in Recommendations 30-1 through 30-6 are suggested as an approach to resolving the funding issue:

- (30-1) Discussions between IPPF/WHR and A.I.D. regarding funding levels should begin as early as possible and, insofar as possible, the Office of Population should keep IPPF/WHR abreast of developments that might result in marked deviations from expected funding patterns (i.e., in conformance with proposed MG II funding levels). In particular, A.I.D. should attempt to provide IPPF/WHR as accurate a forecast as possible of the funds it will receive following the CP budget review.
- (30-2) Workplans and budgets should be prepared several months earlier than they currently are in order to give A.I.D. more time to review plans and to allow for approval prior to the beginning of the MG fiscal year (January 1). Alternative versions should be prepared, anticipating both the possibility of shortfalls and supplementary allocations. The supplementary program and budget and the shortfall program and budget should be set at figures agreed upon by the Office of Population and IPPF/WHR.
- (30-3) A resumption of forward funding is the best solution to the problem of maintaining continuity of activities. If this is not possible, IPPF should pace the rate of expenditures in the MG to attempt to have adequate cash on hand during the period bounded by the end of one fiscal year and the release of funds during the next fiscal year.
- (30-4) When MG funds for approved and budgeted activities are not spent by an FPA because the activity was not carried out, the funds should be reallocated as needed: either to meet any shortfall between the annual workplan level and A.I.D. allocations to the MG or to support the supplementary program (see [30-1] above).
- (30-5) When MG funds are not spent by an FPA because it has received more funds than expected from other than the MG source, the FPA can propose to the MG staff alternative uses for the unspent MG funds.
- (30-6) Given the uncertainty regarding funding, WHR should attempt to be more flexible in planning and budgeting.
- (31) A.I.D. should consider ways to streamline the process of approving a debt swap transaction to enable IPPF/WHR to generate additional local currency for its grant.

7.2.3 Project Management

FPSD/WHR Relationships

- (32) Both FPSD and IPPF/WHR should recognize the need for all those with project responsibilities to have timely and adequate information on project matters — especially those that may imply emerging or future problems.
- (33) MG staff should make a greater effort to have effective communication with A.I.D. staff.
- (34) FPSD should recognize that it has in IPPF/WHR an experienced and competent organization in the field of family planning and should therefore avoid the tendency to take too active a role in the management of MG activities.

USAID Mission/WHR Relationships

- (35) IPPF/WHR staff and USAID missions should be alert to the need to have effective communications with each other.

Organization and Management

- (36) MG senior staff should spend more time in the field assisting FPA managers with strategic planning and management issues.

Planning and Budgeting

- (37) The MG staff should give increased support to the FPAs in the area of strategic planning. This would include better use of improved MIS, more attention to use of evaluation findings, and more access to and use of operations research. One way to facilitate this would be if the Office of Population and WHR staff were to explore ways to reduce the volume of reporting.

Reporting

- (38) IPPF/WHR staff should take steps to comply with requirements regarding trip reports.

7.2.4 Issues of Special Concern to A.I.D.

- (39) Where feasible, MG staff should seek opportunities for buy-ins through dialogue with USAID missions in bilateral countries.
- (40) A vigorous regional component, funded from central sources, should be maintained.
- (41) MG staff should help FPA managers explore opportunities to receive assistance and support for OR. Any OR that is undertaken should be focused on priority program issues, should be of relatively short duration and produce findings that can be translated into changes in program design and/or operation; and not represent an undue burden on program managers or operating programs.

7.3 A Possible MG III

Based on the assessment of the achievements of MG 2 to date, and taking into account the advantages of the MG for A.I.D., it is recommended that A.I.D. give favorable consideration to a future unsolicited proposal from IPPF/WHR for an MG III. Listed below are recommendations of a programmatic, financial, and administrative character which should guide A.I.D.'s assessment of and response to a future request.

7.3.1 Programmatic

- (1) The balance between subgrants and regional activities should remain about the same as in MG II, with the qualification that regional activities should be increased to the extent that this is feasible without an increase in the size of the MG staff. The

proportion of the total grant earmarked for Mexico, Colombia and Brazil should not be increased. The principal reasons for this recommendation are as follows: These three countries already receive about 80 percent of total funds for FPAs; thus, the grant should represent an opportunity to strengthen family planning services of other affiliates of WHR.

- (2) Equal attention should be accorded to improving existing services as to starting services for additional areas or populations. This would include looking at such issues as whether there is adequate targeting of populations to be served (client needs, client socioeconomic status, availability of services by other family planning providers, etc.); cost effectiveness of services; and quality of services (appropriate method mix).
- (3) Priority should be given to assisting FPAs to develop the capability to play a more strategic role in family planning in their countries. This would include helping FPAs to define the character and scope of their own programs and their relationships with other relevant institutions.
- (4) Priority should remain on forging cost-sharing partnerships with government, PVOs, private firms and private doctors.³
- (5) Testing should be continued of the feasibility of providing medical services beyond family planning that can represent a source of income that could be used to support family planning services.
- (6) Management of FPAs, including through further MIS development, needs continued emphasis.
- (7) Emphasis should remain on documentation and dissemination of successful models of service delivery.
- (8) Work on the real cost of contraception should continue.
- (9) Technical assistance among FPAs should remain focused on priority MG activities.

7.3.2 Financial

- (1) MG III should be funded at approximately the current level, or at a modestly increased level if this is feasible from FPSD's perspective. Increased funding can be justified on the grounds of the success of MG II; the obvious need in the region for more family planning services, including services of better quality; the current and potential capability of FPAs to play a more strategic and collaborative role in their countries — which means that MG funds can have a multiplier effect; and the potential of the regional activities component to diffuse innovations through the region.

³The USAID representative in Chile has recommended that APROFA work with industry to ensure that contraceptive information and supplies are available — e.g., to young workers in the fruit packing sector.

- (2) An increase should be considered in the matching requirement. (The MG has easily met the matching requirements of MG II. FPSD and WHR should consider whether a higher match is feasible.)
- (3) Debt swap opportunities should be exploited wherever possible.
- (4) Insofar as possible, buy-in possibilities should be built into a MG III. There should, however, be adequate central funds to ensure support for subgrants in non-bilateral countries and for a vigorous regional activities component. In the latter context, a buy-in from the Latin American Regional Bureau should be explored that could be used to support regional activities directly involving bilateral programs.

7.3.3 Administrative

- (1) MG staff should be maintained at its currently approved level and the current practice of tapping WHR staff for MG work should continue.
- (2) Opportunities should be explored for increased delegation of authority to WHR to build greater administrative flexibility into the MG. Areas that should be considered include permitting reallocation of MG resources among approved budget items of an FPA subgrant up to a specified limit or percentage; permitting reallocation of MG resources among FPA subgrants, up to a specified limit or percentage; and permitting reallocation of MG resources among approved regional activities, up to a specified amount or percentage.⁴ In addition, WHR should be permitted to seek local USAID mission or USAID representative travel concurrence directly for any international travel already described in the annual workplan, as approved by A.I.D., except in those countries where the security situation dictates otherwise.

⁴This flexibility would be subject to whatever decision A.I.D. makes regarding these three recommendations.

Appendices

Appendix A
Terms of Reference for the Evaluation

Appendix A

Terms of Reference for the Evaluation

The scope of work for this evaluation states that its purpose is "to assess progress to date and make recommendations about follow-on activities which reflect the current family planning environment in Latin America." More specifically, the evaluation was expected to address these issues:

1) performance to date — How successful has the project been in increasing access to safe, affordable services and improving the management of services?

2) future role within A.I.D. population assistance portfolio — What is IPPF/WHR's particular niche and comparative advantage in family planning service delivery and should S&T/POP continue to support the matching grant?

3) allocation of resources and emphasis for a follow-on project if recommended.

The complete scope of work can be found in Attachment 1.

This evaluation uses as principal reference points: (1) the programmatic and financial OBJECTIVES set forth in the unsolicited proposal from WHR and the objectives and targets of MG annual workplans, which are based largely on the proposal; (2) a number of ISSUES which were identified either by A.I.D., WHR or the evaluation team.

Evaluation team members Robert Wickham (team leader), Roy Miller, and Alberto Rizo were in Washington from July 9 to 12 for briefings by staff from the Population Technical Assistance (POPTECH) Project, staff of A.I.D.'s Office of Population, the Bureau for Latin America and the Caribbean, and the MG Project Director. The team spent July 13 through 17 in New York City meeting with IPPF/WHR staff and reading documents.

This team was in Mexico from August 20 through 25, principally assessing the MEXFAM program in Mexico City, Queretaro, and the area between Tampico and Tuxpan. The team traveled to Guatemala City August 26 and spent August 27 visiting and being briefed about APROFAM's management information system (MIS) and its regional training program in voluntary surgical contraception (VSC). Roy Miller remained in Guatemala in order to study further the MIS, while Robert Wickham and Alberto Rizo traveled to Santiago, Chile on August 28 and spent August 29 through September 1 visiting APROFA's programs and meeting with officials of the Chilean Red Cross and the Ministry of Health.

The team spent September 3 through 7 in Washington, developing its tentative conclusions and recommendations, preparing a preliminary briefing paper, and having debriefing meetings with A.I.D. staff and with the MG Project Director.

Team members prepared materials for the report during the balance of September, and Robert Wickham and Roy Miller had a final debriefing meeting with A.I.D. staff October 3 in Washington and with IPPF/WHR staff October 4 in New York. A fourth team member, Dorothy B. Wexler of POPTECH, assisted in editing and preparing a final draft of the report.

A list of persons met is included as Attachment 2.

The team was given a substantial number of documents by IPPF/WHR, A.I.D., MEXFAM, APROFAM and APROFA. A list of these materials is included in Attachment 3.

The team would like to thank staff of the Office of Population, POPTECH, IPPF/WHR, MEXFAM, APROFAM and APROFA for the very substantial assistance that they provided.

Scope of Work (Attachment 1)

DRAFT

International Planned Parenthood Federation Western Hemisphere Region (IPPF/WHR)

Evaluation

I. Summary

Project 936-3043, Expansion and Improvement of Family Programs in Latin America and the Caribbean (LAC), is a seven year project implemented through two successive cooperative agreements with IPPF/WHR. The first two year \$12 million cooperative agreement was approved in August 1985. The second five year \$27 million cooperative agreement was approved in August 1987.

The current agreement is scheduled to finish in August 1991. The purpose of this evaluation is to assess progress to date and make recommendations about follow on activities which reflect the current family planning environment in Latin America. The major issues are:

- 1) performance to-date - How successful has the project been in increasing access to safe, affordable services and improving the management of services?
- 2) future role within A.I.D. population assistance portfolio - What is IPPF/WHR's particular niche and comparative advantage in family planning service delivery and should S&T/POP continue to support the matching grant?
- 3) allocation of resources and emphasis for a follow-on project if recommended

II. Background

A. A.I.D./IPPF Relationship in Latin America

A.I.D. and IPPF have shared a mutual mandate to make safe, effective family planning services available since the 1960's. In 1985 a separate matching grant (MG) with IPPF/WHR for the Latin America region was signed. This is the only Office of Population activity directed solely at Latin America. With other cooperating agencies (CAs) shifting their operations to Africa and other low prevalence areas, the IPPF/WHR grant has become increasingly important in providing assistance to LAC.

Organized in 1953, IPPF/WHR was incorporated as a private U.S. voluntary organization in 1955. It currently has 43 member organizations of which 35 receive funds and technical assistance from IPPF/WHR. The family planning associations (FPAs) which are the IPPF affiliates in Latin America are among the oldest and best established private family planning groups in the world. There is however considerable variation in mandate, size, and experience of the IPPF/WHR affiliates. For example, Colombia's PROFAMILIA has been the major provider of national services in this high prevalence (69%) country for more than 25 years. With \$1.39 million in MG funds, PROFAMILIA expects to provide 548,457 couple years of protection (CYP) at an average cost of U.S. \$2.61 in 1990. On the other hand, Paraguay's CEPEP has only been receiving MG support for a few years and targets its efforts at areas where contraceptive prevalence was estimated as 38% in 1987. In 1990 with \$70,000 in MG support, CEPEP expects to provide 6,900 CYP at a cost between U.S. \$10 to \$14 per CYP.

B. Matching Grant

In August 1985 A.I.D. approved the initial two year \$12 million matching grant with IPPF/WHR. The purpose of the grant was to increase the delivery and use of acceptable, affordable family planning services throughout Latin America and the Caribbean region. The grant was based on an unsolicited proposal submitted by IPPF/WHR and is targetted primarily at those Latin American countries without an A.I.D. bilateral population program. The grant specifies that "special assistance" will be provided to Brazil, Colombia, and Mexico which amounts to 75% of the MG. Assistance at a lower funding is provided to other LAC countries. The first grant included an in-cash cost sharing arrangement where IPPF/WHR would match 200% of A.I.D.'s contribution to the IPPF/WHR New York Office and 100% of A.I.D.'s contribution to the affiliates.

In August 1987 the second grant was signed for five years based on an unsolicited proposal. Total planned funding was up to \$27,000,000. Of this, \$25 million was to be S&T funding and \$2 million in add-ons. The grant has three objectives:

- .increase substantially the number of new acceptors;
- .improve the management of family planning services to reduce cost; and
- .manage a gradual decline in MG support without hindering the quality of services or coverage.

In the second grant, the matching requirement is modified annually. The ratio of non-A.I.D. to A.I.D. funds rises from 1.0 in CY1986 to 1.5 in CY1992 for country activities and from 2.0 in CY1986 to 2.5 in CY1992 for New York activities.

To date, A.I.D. has provided \$12 million under the first grant and approximately \$13 million under the second grant. Currently, 10 countries receive matching grant support, an eleventh, Costa Rica, is proposed for 1990. These and five additional countries will receive assistance with management information systems in 1990.

C. Results of 1989 Management Review

The most recent A.I.D. management review, June 1989, was positive. It found that IPPF/WHR was meeting the matching requirement; that there had been progress in improving systems to collect client and cost data; and that with the addition of a senior deputy director IPPF/WHR would be able to increase technical assistance and communication.

III Purpose and Scope of the Evaluation

In reviewing performance as a basis for recommendations for future activities, the evaluators should look at project impact and project management. They should also consider the changing environment for family planning in Latin America and consider what the implications are for future assistance through the matching grant in the nineties. While many LAC countries have achieved high rates of contraceptive prevalence, there is some evidence of erosion of public support because of the adverse economic situation. In thinking about future emphases, the evaluators should consider whether the present matching grant supports the priorities outlined in IPPF/WHR's long range strategy and in S&T/POP/FPSD's paper, "Preparing for the Twenty-First Century: Principles for Family Planning Service Delivery in the Nineties". Listed below are a series of suggested questions to assist the evaluators in reviewing performance and making recommendations for future assistance.

A. Project Impact

In assessing project impact, the evaluators should look at those factors identified in the original design such as program quality and coverage; management efficiency and cost per acceptor; and progress toward local support including matching requirements. Among the questions that need to be asked are: What have been the project outputs and achievements? Have the expected targets been met in reaching new acceptors and providing couple years of protection? In addition, to the service statistics, what evidence is there of qualitative achievements in both program and management? Are there better use, management and reporting on financial and other resources? Why and what has been the role of the MG in influencing improvements in service delivery and management?

What is the quality of data? Can informed judgements be made about program coverage, quality, cost and local sustainability? Some activities have not been direct support for family planning service delivery. How have these non-family planning activities contributed to overall success? Should they be continued?

1. Program Coverage

This has several important dimensions: the quality of services; the clients being served and the numbers reached. Have there been changes in what and how services are provided? Are there for example changes in method mix, types of information or counselling services provided, and/or training of providers, etc.? Are there new standards, new procedures for service delivery, etc.? How are these monitored and reported? MG resources are to assist FPAs in better targetting their programs at low income populations who could not otherwise obtain services. For example, MG resources in Colombia are specifically directed at providing sterilization to low income women. Is there documentation that verifies this? What information do IPPF studies and information systems provide on client characteristics, numbers, and satisfaction as well as changes overtime in numbers and in method mix and the process for monitoring appropriate care standards?

2. Cost Per Acceptor

IPPF/WHR has been collecting information on cost per new acceptor and cost per CYP. Is the right information collected? For example, what costs are being included and is this consistent from one FPA to another? How good are the data that are being used to estimate these costs? Have the costs per acceptor and per CYP decreased over time and how significant have the changes been? Are there ways that the affiliates could continue to serve low income populations and reduce costs? What are these? A major emphasis of the new MIS is improved cost data. What is the interface between cost and program data? Will the current MIS design ensure the collection of the necessary information needed for monitoring service costs?

3. Increased Local Support (and Matching Grant Contribution)

The matching grant provision was designed to ensure that A.I.D. resources would augment not replace local or IPPF/London funds. Are the matching requirements being met? Are these requirements sufficient to promote local cost awareness and attention to local fund-raising options?

Do the FPAs understand that A.I.D. support is designed to diminish and eventually cease overtime? Is the MIS being designed to provide information on current financial viability and alternative approaches to increasing local sustainability?

FPA affiliates have pioneered in a range of cost sharing service delivery arrangements with local governments, the non-profit sector and the commercial sector. What are the most successful of these and what are the lessons learned both for increased emphasis within the MG and for more general sharing with the population community? What types of collaborative programming have been least effective? Why?

B. Project Management

In addition to addressing the management concerns relating to financial management, records and reporting, the evaluators should look at the provision of technical assistance by IPPF/WHR staff; recommendations and management of contraceptive commodities; program evaluation and data collection systems; reporting; and design and implementation of FPA management information systems.

1. Technical Assistance Role of IPPF/WHR Staff

A. General Assistance

How important is the technical assistance role of the IPPF/WHR MG staff? Where is this assistance most effective and what are some of the benefits? Is the amount of technical assistance sufficient? Are there areas where additional assistance is required? Do MG staff have the appropriate skill mix? If yes, what are these? Other IPPF/WHR staff provide technical assistance, how appropriate is this? Has IPPF core staff provided adequate support in substantive areas such as communications? Has IPPF mobilized adequate technical assistance resources with substantive skills, language skills and monitoring capacity?

B. Assistance with Management Information Systems

An important initiative under the MG has been the development and implementation of MIS for the local affiliates. Currently approximately 15 FPAs are receiving assistance with MIS. What is the quality of the assistance and of the systems being provided? What evidence is there that appropriate information is being collected and used? What is the interface between financial and program data sets?

What data is being collected on a routine basis on client characteristics, method mix and cost per CYP and new acceptor? What are the benefits for decision making on program management and program performance? Who uses the MIS for what purposes? What are some of the limitations of the system? How important are these?

2. Recommendations and Use of Commodities

IPPF/WHR has responsibility for working with the affiliates to estimate and make recommendations on contraceptive supplies. How well has this function been carried out? Is there any need to change procedures or staffing to respond to the diminished availability of contraceptive supplies? What records exist on the storage and use of contraceptives? Are these adequate and up to date?

3. Data Collection and Management including Evaluation and Reporting

The MG places particular emphasis on the collection of improved data to target services at those most in need and to measure the quality and extent of services provided. How well are these functions being performed? What is the quality and timeliness of data? How well do local managers understand and use this data? Are sufficient resources being allocated to this process?

The IPPF affiliates have pioneered in a number of approaches to family planning service delivery, cost sharing and monitoring evaluation. How important are these approaches and is adequate information available? Should IPPF/WHR be collecting more information and disseminating it more broadly? How?

Is the appropriate information being shared between the FPAs and IPPF/WHR; between the FPAs (and IPPF/WHR) and the Missions; and between IPPF/WHR and A.I.D./W? If not, can the evaluation team make recommendations?

C. Recommendations for a Follow-on Project

With both the increased acceptance of family planning in Latin America and the demographic profile of the population, the projected number of users is expected to increase significantly. Government resources to provide family planning to these growing numbers are inadequate and in some cases diminishing.

In the countries where FPAs receive assistance through the matching grant, other A.I.D. and IPPF assistance is provided to the FPAs and other organizations.

The evaluators should look at the role of the grant within the overall context of A.I.D. population assistance and especially centrally-funded assistance for the region. What is IPPF/WHR's particular niche and comparative advantage in family planning service delivery?

How does the MG complement IPPF core support for the FPAs? In cases where the FPAs receive other donor support, how is this coordinated with MG support?

Increasingly, the FPAs are working with private for profit groups, other NGOs and governments. What are the benefits of such a collaborative approach? Are there examples of new approaches or innovative service delivery mechanisms that should be reported and shared with the larger population community? Are there better ways of targetting services?

Many of the non-bilateral countries where IPPF/WHR works are A.I.D. graduate countries with reported high contraceptive prevalence rates. Is it appropriate to continue the matching grant in these countries? Why? The evaluators should also look at the differences in matching grant investment in countries overtime. While ten countries receive assistance under the matching grant, the majority of project funds go to three countries: Brazil, Colombia and Mexico. Only, two other countries: Chile and Peru, will receive more than \$100,000 in 1990. What is the impact of these varying levels of support? How important and how appropriate is the major support provided to Brazil, Colombia and Mexico? What is achieved for the more modest investment in higher income LAC countries like Uruguay and Venezuela? What priority should be given to low prevalence countries?

Do changes need to be made in the configuration and the level of support for the MG? Are there particular types of activities that should be emphasized? Are there others that should be dropped? How important is the matching component? Would increasing the matching requirements lead to greater local efforts to raise resources or would it shift services away from those least able to pay? Are the existing management and reporting systems adequate? If not, what changes are recommended?

List of Persons Contacted (Attachment 2)

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Marcial Orellana, Director, Maternal Health Program
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Ms. Alvear, Director
Teresa Rodríguez, Study Director
Teresa Chadwick, Head, International Affairs

PERU

USAID
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Appendix B

Strengths and Weaknesses of the TECAPRO System

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Appendix B

Strengths and Weaknesses of the TECAPRO System

The evaluation team observed the operation of the TECAPRO system in two FPAs, MEXFAM (Mexico) and APROFAM (Guatemala). The system is most fully developed in APROFAM, where a skilled and talented team has successfully automated most of the key administrative functions of the office. An early initiative to automate administrative functions in MEXFAM, prior to the Matching Grant initiative to introduce the TECAPRO system, has left MEXFAM in the unenviable position of making a transition from earlier, poorly integrated systems, to the TECAPRO system. Further, due to personnel turnover, the transition has been slower and perhaps more painful than desired by the top level management of the Association. The two case studies provide contrasting stories regarding the automation of a Family Planning Association.

The system is written in a computer language called PASCAL. The "business" modules are marketed by TECAPRO worldwide in much the same way as other commercial software, such as DBASE, LOTUS or WORDPERFECT. Anyone can purchase the modules. The source code (the program itself) is unavailable to the purchaser; therefore, the program cannot be modified by the user. However, the program is largely "generic." A generic program is one that allows the user to define all of the parameters necessary to customize the system without having to change the program. Thanks to the generic nature of most of the modules, the information collected and used in each installation may be quite different. For example, if an FPA wishes to gather income data on its clients, it can configure the clinic management system so that income is recorded for each client. If the FPA feels that education is more important or indicative of socioeconomic status, the clinic management system can be configured to record data about education or, in fact, any other piece of information deemed relevant by the FPA. Over time, as TECAPRO has worked with the FPAs, more and more of the system has been made "generic" to suit the special needs of individual FPAs.¹

Because the program is written in the computer language, PASCAL, early versions of the system did *not* allow the user to retrieve the data for uses not anticipated by the system designers. Unlike a system written in a language such as DBASE, where the user need only know the structure of the data base files to retrieve the data independently of the "front end" system normally used to access the data, a system written in PASCAL is closed to the user (unless the user is given the file structure and knows how to write his/her own computer programs). This inflexibility regarding data retrieval was a serious shortcoming in the early TECAPRO design. However, TECAPRO has now written a new module, called INFOTECA, which enables the user to retrieve not only the data in the TECAPRO system but also auxiliary data stored in DBASE files or LOTUS files. Moreover, INFOTECA allows the user to define reports using the data from all of the sources without needing to know how to use any of the other underlying software packages. INFOTECA is best used by a systems specialist; however, it is possible for any user to master the module and to apply it.

Given the flexibility provided by the INFOTECA module, the drawback to using TECAPRO modules as they were first presented to FPAs, namely, that the data bases created by the different modules could not be integrated, has been overcome. Still, "off-the-shelf" systems can be less flexible and more limiting than custom systems; however, the expense of developing a custom system is almost always greater than the expense of installing a well-designed "generic" system and adapting that "generic" system for the particular installation. On balance, an FPA with limited resources to expend on system development is better off with an off-the-shelf system such as TECAPRO with two exceptions: the FPA already has all or part of its own system and need only upgrade it as demands for automation grow or the FPA has very special management needs requiring customized system development.

¹An example of what is meant by "generic" is the recent modification of the payroll module made, in part, to enable MEXFAM to use the module. The early version of the payroll module had a simple function built in to calculate payroll taxes — too simple for the sophisticated taxing system of Mexico. The revised "payroll" module allows the user to define a complex function (and to modify it later as well) which is then "input" to the system for calculating payroll tax. The program itself need not be modified — only the user supplied function.

Appendix C

Activities Funded through MG II Country Subgrants

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Appendix C

Activities Funded through MG II Country Subgrants

Activities Funded through Three Major Subgrants (Brazil, Mexico, and Colombia)

Brazil. In Brazil, MG funds support community-based and clinical family planning programs in four states of the Northeast and the state of Rio de Janeiro. The five states have more than 1,000 distribution posts in all. MG funds are used principally for salaries, training, supervision, promotion and supplies. This BEMFAM-supported program operates on the basis of agreements signed with state, municipal, private and community organizations.

Mexico. In Mexico, the MG supports MEXFAM activities in 17 states. Family planning services and information are provided through five major service delivery strategies:

MEXFAM's family planning centers;

Intensive promotional areas: These are areas of low contraceptive prevalence with little or no access to family planning services. They are usually marginal urban areas in which MEXFAM provides family planning services through a combination of private doctors and community promoters, supervised by MEXFAM's local coordinators;

Institutional support programs: Through this strategy, MEXFAM provides training, promotion, contraceptive supplies, and IEC as required to enable a number of public and private health services organizations to provide family planning services;

Rural activation programs: This strategy is the rural counterpart to intensive promotional areas and institutional support programs described above, modified to take account of lower population densities. In this effort, MEXFAM enlists the support of private doctors, midwives and community leaders and provides, inter alia, training, IEC, supplies and supervision; and

Industrial programs: The industrial program provides family planning information and services to workers through agreements with private sector organizations. Services are normally incorporated into existing company health facilities and services.

Colombia. PROFAMILIA is the major provider of family planning services in Colombia, offering an estimated 65 percent of all contraception in the country. The MG has supported clinical services, VSC, and community marketing programs in Colombia since 1986, enabling PROFAMILIA to expand services to poor and underserved populations.

Activities Funded Through Smaller Subgrants

Chile. In the APROFA-Red Cross project, APROFA supplies family planning and related services in 44 Red Cross clinics. APROFA provides funds for one or two midwives for each clinic together with supplies, training of community promoters, and supervision of family planning related activities. In addition to family planning, the clinics provide pregnancy testing, postpartum exams, examinations and testing for breast, cervical and uterine cancer, referrals for high risk OB/GYN cases and treatment for STDs. APROFA also supplies contraceptives for the Chilean government health program.

Jamaica. The Jamaica Family Planning Association received a grant for a CBD project.

Peru. The MG has supported CBD programs in the interior of Peru as well as a family planning clinic in Lima.

Trinidad and Tobago. The MG supports two efficient and high-quality clinics of the FPA in Trinidad and Tobago (FPATT), a community outreach program, and a program of supplying contraceptives to the government's health centers. The community outreach program consists of associate doctors (patterned after the MEXFAM program) and community depots, in effect CBD outlets located in industrial sites, community organizations, youth centers, and government offices.

Uruguay. The MG has supported two types of family planning services: (1) Services are provided through a network of Ministry of Health doctors, rural health promoters, mobile clinics, nurses, midwives, teachers and social workers. The FPA's responsibility is to oversee and coordinate the provision of family planning services by the above-mentioned staff (who in effect serve as FPA volunteers while carrying out their regular jobs); train government health teams and community leaders in family planning information and services; offer on-going technical assistance; and provide contraceptive and other family planning supplies; and (2) family planning services to women in areas of extreme poverty in the outskirts of Montevideo. Six social workers and midwives make home visits and provide counseling on family planning, MCH and social problems. Women are screened and provided contraceptives and instruction in their correct use or are referred to the FPA's central clinic -- for example, for IUDs.

Venezuela. The FPA, PLAFAM, receives MG support for operation of its headquarters clinic in Caracas. The clinic, which opened in 1988, is expanding its program to reach the poor and underserved populations in Caracas. MG support is critical for the clinic's operation, given that patient fees cover only one-fifth of service costs in 1990.

Appendix D

**Tables Showing Income of Matching Grant Subgrantees
1986 - 1989**

Table D1

1986 Income of Matching Grant Subgrantees, by Source, in \$1,000's

Association	Local Income	Income from A.I.D.				International Income		Total Income
		Bilateral	Other CAS	Match. Grant	Total	I.P.P.F.	Other Donors	
Brazil	\$ 997.7		\$ 518.8	\$1,780.1	\$2,298.9	\$2,111.4	\$370.5	\$ 5,778.5
Chile	80.5			100.5	100.5	617.4		798.4
Colombia	2,939.3		800.2	1,737.4	2,537.6	1,569.2	107.6	7,153.7
Guatemala	477.7	\$1,064.8	482.4	.0	1,547.2	450.3		2,475.2
Mexico	366.2		99.2	1,149.1	1,248.3	796.1	158.2	2,568.8
Panama	54.1		8.2	.0	8.2	127.3		189.6
Paraguay	50.8		49.8	.0	49.8	222.2		322.8
Peru	93.8	18.1	68.7	103.5	190.3	270.7	25.5	580.3
Trinidad & Tobago	354.0		.1	30.5	30.6	205.5	38.4	628.5
Uruguay	82.6			37.6	37.6	195.7		315.9
Total:	\$5,496.7	\$1,082.9	\$2,027.4	\$4,938.7	\$8,049.0	\$6,565.8	\$700.2	\$20,811.7

Source: Prepared by IPPF/WHR for Evaluation Team.

Tables Showing Income of Matching Grant Subgrantees
1986 - 1989

Appendix D

Table D2

1937 Income of Matching Grant Subgrantees, by Source, in \$1,000's

Association	Local Income	Income from A.I.D.				International Income		Total Income
		Bilateral	Other CAS	Match. Grant	Total	I.P.P.F.	Other Donors	
Brazil	\$1,596.3		\$ 758.6	\$1,514.7	\$2,273.3	\$2,384.3	\$ 106.8	\$ 6,360.7
Chile	170.5			258.2	268.2	681.0	5.8	1,125.5
Colombia	2,730.8		918.1	1,891.7	2,809.8	1,607.1	265.0	7,412.7
Guatemala	545.8	\$1,291.0	489.6	.0	1,780.6	475.6	41.3	2,843.3
Mexico	747.3		181.4	1,176.6	1,358.0	979.4	483.1	3,567.8
Panama	49.9			35.0	35.0	139.0		223.9
Peru	30.0		175.8	160.0	335.8	326.3	12.2	704.3
Trinidad & Tobago*	344.9			101.7	101.7	225.2	158.4	830.2
Uruguay	123.6			83.1	83.1	226.9	78.2	511.8
Total:	\$6,339.1	\$1,291.0	\$2,523.5	\$5,231.0	\$9,045.5	\$7,044.8	\$1,150.8	\$23,580.2

Source: Prepared by IPPF/WHR for Evaluation Team.

Table D3

1988 Income of Matching Grant Subgrantees, by Source, in \$1,000's

Association	Local Income	Income from A.I.D.				International Income		Total Income
		Bilateral	Other CAS	Match. Grant	Total	I.P.P.F.	Other Donors	
Brazil	\$2,076.5		\$ 498.9	\$1,253.1	\$1,752.0	\$2,473.5	\$ 83.6	\$ 6,385.6
Chile	136.6		.0	197.9	197.9	747.7	.0	1,082.2
Colombia	3,166.4		1,125.2	1,598.8	2,724.0	1,985.0	1,226.9	9,102.3
Guatemala	658.6	\$1,961.9	111.5	56.8	2,130.2	470.0	55.1	3,313.9
Mexico	497.9		90.2	1,339.9	1,430.1	1,201.7	324.3	3,454.0
Paraguay	82.8	1.4	99.4	.0	100.8	219.4	.0	403.0
Peru	66.4		327.3	257.4	584.7	349.8	.2	1,001.1
Trinidad & Tobago*	236.1		38.4	100.7	139.1	254.1	24.6	653.9
Uruguay	120.4		.0	99.5	99.5	234.8	.0	454.7
Venezuela	11.0		3.3	25.8	29.1	87.5	.5	128.1
Total:	\$7,052.7	\$1,963.3	\$2,294.2	\$4,929.9	\$9,187.4	\$8,023.5	\$1,715.2	\$25,978.8

Source: MG 1990 Annual Workplan.

Table D4

1989 Income of Matching Grant Subgrantees, by Source, in \$1,000's

Association	Local Income	Income from A.I.D.				International Income		Total Income
		Bilateral	Other CAS	Match. Grant	Total	I.P.P.F.	Other Donors	
Brazil	\$2,333.8		\$ 686.7	\$ 846.1	\$1,532.8	\$2,467.9	\$ 559.0	\$ 6,893.5
Chile	196.2			271.7	271.7	787.4		1,255.3
Colombia	3,894.8		769.2	1,772.2	2,541.4	1,826.4	331.6	8,594.2
Guatemala	878.2	\$2,783.0	126.6	60.5	2,970.1	490.4	21.4	4,360.1
Mexico	978.4		253.5	1,321.3	1,574.8	1,099.4	862.9	4,515.5
Paraguay*	121.3	33.7	65.0	39.2	137.9	226.8	7.1	493.1
Peru*	381.4		207.0	249.1	456.1	433.4	64.8	1,335.7
Trinidad & Tobago	179.4			104.4	104.4	260.5	298.7	843.0
Uruguay	130.5			105.7	105.7	266.6	35.2	538.0
Venezuela*	24.4		2.8	36.8	39.6	68.5	12.4	144.9
Total:	\$9,118.4	\$2,816.7	\$2,110.8	\$4,807.0	\$9,734.5	\$7,927.3	\$2,193.1	\$28,973.3

Source: Prepared by IPPF/WHR for Evaluation Team.