

PD-ART-323  
87405

<b>AGENCY FOR INTERNATIONAL DEVELOPMENT</b> <b>PROJECT DATA SHEET</b>	<b>1. TRANSACTION CODE</b> <input type="checkbox"/> A = Add <input checked="" type="checkbox"/> C = Change <input type="checkbox"/> D = Delete	Amendment Number Four	<b>DOCUMENT CODE</b> 3
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<b>2. COUNTRY/ENTITY</b> PERU	<b>3. PROJECT NUMBER</b> 527-0335
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<b>4. BUREAU/OFFICE</b> LAC	<b>5. PROJECT TITLE (maximum 40 characters)</b> 05
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<b>6. PROJECT ASSISTANCE COMPLETION DATE (PACD)</b> MM DD YY 09 30 95	<b>7. ESTIMATED DATE OF OBLIGATION</b> (Under "B" below, enter 1, 2, 3, or 4) A. Initial FY <u>89</u> B. Quarter <u>4</u> C. Final FY <u>94</u>
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8. COSTS (\$000 OR EQUIVALENT \$1 = )						
A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	1,203	1,014.3	2,217.3	8,768	8,452	17,220
(Grant)	( 1,203 )	( 1,014.3 )	( 2,217.3 )	( 8,768 )	( 8,452 )	( 17,220 )
(Loan)	(        )	(        )	(        )	(        )	(        )	(        )
Other U.S.						
1.						
2.						
Host Country		1/			1/	
Other Donor(s)						
<b>TOTALS</b>	1,203	1,014.3	2,217.3	8,768	8,452	17,220

9. SCHEDULE OF AID FUNDING (\$000)									
A. APPROPRIATION	B. ACTIVITY CODE	C. ACTIVITY CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) PN	PNSD			10,284.8		4,950		15,234.8	
(2) HE	PNPD			1,985.2		-		1,985.2	
(3)									
(4)									
<b>TOTALS</b>				12,270		4,950		17,220	

<b>10. SECONDARY TECHNICAL CODES (maximum 5 codes of 3 positions each)</b>	<b>11. SECONDARY ACTIVITY CODE PNCN</b>
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12. SPECIAL INTEREST CODES (maximum 7 codes of 4 positions each)							
A. Code	PVL	PVX	CIT	TPV	TIC	PSD	WDI
B. Amount	17,220	10,332	9,299	10,332	10,332	3,100	8,266

**13. PROJECT PURPOSE (maximum 480 characters)**

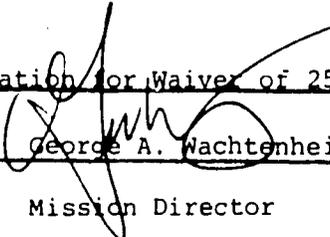
To maximize the availability of all family planning methods to women and men who wish to use them by increasing the capacity of the private voluntary sector to deliver long-lasting contraceptive methods while maintaining support for temporary supply methods and natural family planning.

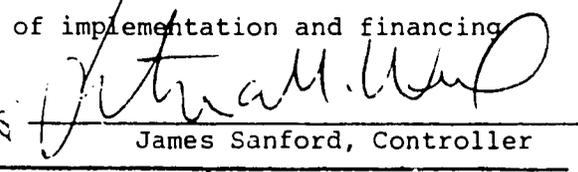
<b>14. SCHEDULED EVALUATIONS</b> Interim    MM YY    MM YY    Final    MM YY                                                                               	<b>15. SOURCE/ORIGIN OF GOODS AND SERVICES</b> <input checked="" type="checkbox"/> 000 <input type="checkbox"/> 941 <input type="checkbox"/> Local <input checked="" type="checkbox"/> Other (Specify) <u>Peru</u>
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**16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a 42 page PP Amendment)**  
 The purpose of this Amendment is to extend the life of project from fifty five months to seventy two months. This extension is consistent with DOA No. 752 dated 9/14/92.

Mission Controller has reviewed and concurs with the methods of implementation and financing included herein.

1/See Annex III. Justification for Waiver of 25% contribution.

<b>17. APPROVED BY</b>	Signature:  Title: Mission Director	Date Signed: MM DD YY 09 21 94	<b>18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION</b> MM DD YY 
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 James Sanford, Controller



**Project Paper Supplement**

**PVO Family Planning Service Expansion Project**

**(Project 527-0335)**

**Office of Health, Population and Nutrition**

**USAID/Peru**

**March 1994**

**Project Paper Supplement**

**PVO Family Planning Service Expansion Project**  
*(Project 527-0335)*

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## Project Paper Supplement

### PVO Family Planning Service Expansion Project

*(Project 527-0335)*

**Summary.** USAID Handbook 3, Chapter 13 states that if an approved project is being amended to facilitate the attainment of its original objectives through more funds or an extension of time, a Project Paper Supplement (PPS) is required. This document meets the requirement for a 17-month extension of the Project Assistance Completion Date (PACD) and the addition of funds for the Private Voluntary Organization (PVO) Family Planning Service Expansion Project (PVFP), project number 527-0335. The extension will enable all objectives to be successfully met, allowing continued support for institutional development and service provision to the best performers in the critical PVO family planning sector in Peru.

#### **1. Background**

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

The project, which began in 1989, was designed as a four-year activity, with initial authorization given only for the first year. Further authorization was contingent on the performance of the implementing agency in year one. This implementing agency is a Peruvian NGO known as A.B. PRISMA (Asociacion Benefica/Proyectos en Informatica, Salud, Medicina y Agricultura). PRISMA acts as an umbrella group in administering funds and overseeing the project-supported programs of the seven participating PVOs, which actually deliver the services, and offering them technical assistance and training in relevant areas. The seven PVOs are located in Lima, Cusco, Puno and Trujillo.

The project was originally authorized at a funding level of \$2,217,302, for a trial one-year cooperative agreement with PRISMA. An evaluation in 1990 found that sufficient progress had been made in fulfilling Project Year 1 objectives to recommend that PRISMA continue as the implementing agency. The cooperative agreement was extended for three years and funding increased to \$11,800,000, which included an OYB transfer of \$1,793,000 to AID/W

for contraceptives. At that time, PRISMA was assigned two additional tasks: (1) administration of the 1991 Demographic and Health Survey; and (2) consolidation and distribution of all USAID-donated contraceptives to public and private sectors. In 1993, authorized funding was increased to \$12,270,000.

The project has had four objectives: (1) to increase the capacity of selected PVOs to deliver family planning services; (2) to improve the availability of long-lasting contraceptive methods;<sup>1</sup> (3) to maintain support for temporary supply methods and natural family planning;<sup>2</sup> and (4) to enhance rural family planning coverage.

The original PACD was September 30, 1993. An evaluation completed in May 1993 recommended a two-year extension. Because the time during which the appropriate documentation for a long-term extension would have to be developed coincided with a complete turnover in USDH personnel, that timing would not have allowed for a thoughtful examination of future project directions. Thus, a five-month extension, followed by a two-month/no-cost extension, was enacted, bringing the current PACD to April 30, 1994. The five-month period has allowed USDH staff to review GoP policy, goals and objectives on population issues and acquaint themselves fully with the project, evaluating its accomplishments and identifying shortfalls in achievement of project objectives, as well as the reasons for those shortfalls.

**Participants.** A brief description of the umbrella group and the seven service delivery PVOs that participate in the PVFP Project follows:

- **PRISMA**, a multisectoral Peruvian PVO founded in 1986, implements a number of varied development projects, many through other USAID funding. For example, under the PL480 Title II program, PRISMA manages the PANFAR Program<sup>3</sup> with the MoH. This

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<sup>1</sup> *The term long-lasting methods refers to contraceptive technologies that, through their low reliance on patient compliance, provide substantial couple-years of protection (CYPs) once they are applied, independent of the behavior of the user. These methods generally have to be applied in clinical settings, since they require aseptic conditions, equipment and skilled personnel. The major long-lasting methods are the intrauterine device (IUD), voluntary surgical contraception (i.e., tubal ligation and vasectomy), and implants (NORPLANT<sup>®</sup>).*

<sup>2</sup> *Temporary supply methods are forms of contraception that must be applied on a regular basis to be effective. Further, these methods are generally applied by users themselves. They thus rely more on patient compliance, both to obtain resupplies and for self administration. Consequently, their effective use entails stronger educational and behavioral components. The major supply methods are oral contraceptives, condoms, and vaginal jellies, foams and tablets. The latter four contraceptives are also known as barrier methods, because they prevent the union of the egg and sperm.*

*Natural family planning refers to low-technology forms of contraception. These methods are completely under the domain of users and so require a strong educational component to be effective. They do not require clinical settings. The major forms of natural family planning are periodic abstinence, basal body temperature, cervical mucus and the lactational amenorrhoea method.*

<sup>3</sup> *Programa de Alimentación y Nutrición de la Familia en Alto Riesgo.*

program provides training, supervision and distribution of food commodities to over 2,600 health centers and posts nationally. Also under Title II funding, PRISMA implements special projects in 28 districts nationwide to create employment and upgrade community conditions by improving agricultural infrastructure, as part of efforts to enhance food security. Along with these activities PRISMA conducts nutrition surveillance and provides medical and family planning services to families in a *pueblo joven* of Lima. Still other projects deal with HIV/AIDS and cholera vaccine research.

PRISMA's responsibilities with the PVOs include administration of funds, training, assistance in development of information, education and communications materials, field supervision, and reporting. Of equal importance is another responsibility PRISMA has under this project: the importation, management and distribution of all USAID-donated contraceptive supplies, whether their end point be the Ministry of Health, the Instituto Peruano de Seguridad Social (IPSS) or the PVO sector.

- **Asociacion de Trabajo Laico Familiar (ATLF)** offers clinical and laboratory services in reproductive health, general health and pediatrics, as well as promoting natural family planning methods in Lima. The PVFP Project has supported its network of *Unidades de Trabajo Comunitario (UTC)*, which work with couples in educational activities key to the effective use of natural family planning. Under G/R&D/POP central funds, ATLF has an agreement with the Institute of Reproductive Health of Georgetown University to train midwives and other Ministry of Health personnel in natural family planning, in an effort to expand such services in the public sector.

- **Asociacion de Profesionales para la Promocion de la Salud Materno-Infantil (APROSAMI)** is a maternal/child health program that serves the northwestern sections of Lima. It offers both clinic-based services and community-based services, the latter through a series of posts in some of the northwestern *pueblos jóvenes* of Lima. The PVFP Project has supported both the central clinic and the community posts.

- **Centro Nor-Peruano de Capacitacion y Promocion Familiar (CENPROF)** is based in Trujillo and provides a wide gamut of reproductive health care, including childbirth and surgical services, as well as an array of family planning methods. The PVFP helps finance the clinic and totally supports seven itinerant posts.

- **Instituto Peruano de Paternidad Responsable (INPPARES)** is the Peruvian affiliate of the International Planned Parenthood Federation (IPPF) and provides services through a broad network of clinics nationwide. The PVFP Project has directly supported its Family Planning Community Action program,<sup>4</sup> which provides services to low-income clients through a network of five community clinics and thirty itinerant posts in *pueblos jóvenes* and other low-income neighborhoods in greater Lima. INPPARES receives additional AID

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<sup>4</sup> *ACPF, or Acción Comunitaria en Planificación Familiar.*

support through G/R&D/POP's Transition Project, which supports IPPF affiliates throughout the Americas.

- **Proyecto Planificacion Familiar (PLANIFAM/Cusco)** offers community-based distribution (CBD) and clinic-based services in Cusco and surrounding peri-urban and rural areas. It operates a network of seven community-based clinics in both the *pueblos jóvenes* of Cusco and the adjacent and outlying rural areas. The PVFP Project provides overall administrative support for this program and directly funds five of the seven clinics.
- **PLANFAMI/Puno** was incorporated into the PVFP as a newly independent organization previously operating as a sub-center of PLANIFAM/Cusco. The organization offers clinic-based and rural reproductive health services to a largely Aymara-speaking population on the Peruvian altiplano. The PVFP Project has provided overall support for PLANFAMI programs.
- **Promocion de Labores Educativas y Asistenciales en Favor de la Salud (PROFAMILIA)** offers family planning and other health services in the southern sections of greater Lima, through an organizational arrangement of a central clinic, a series of service-delivery modules, fixed posts and fairs. The PVFP Project has funded one permanent family planning/medical service clinic and six itinerant posts.

In addition to the services provided in clinics and posts, most of the participating PVOs also provide services through special events, most typically through *ferias* (fairs) or *campañas* (campaigns). These consist of providing services in either a portable (e.g., tent) or mobile (e.g., van) setting. The location is a place of congregation, such as a market, and the timing coincides with peak activity, such as a Sunday market day or a festival. For some of the NGOs, such fairs account for a large proportion of their service delivery.

## 2. Methodology of PPS

This Project Paper Supplement (PPS) has been developed following a deliberate methodology guided by USDH staff. It has encompassed:

- (a) Review of project documents, including the Project Paper (1989) and Amendment 1 (1990), the 1993 evaluation, PRISMA reports and documentation supplied by the participating PVOs;
- (b) Unannounced and announced visits to service facilities to evaluate production and quality of services.

- (c) Meetings with the senior management of five of the seven participating PVOs to learn their views on accomplishments, constraints and perspectives on the future of their institution.
- (d) Meetings with PRISMA staff to ascertain their perspective on extension issues.
- (e) Written analysis by the Project Monitor on PVO performance, together with recommendations for future directions.
- (f) A meeting of the full Project 527-0335 Committee and related Mission staff to debate and reach consensus regarding the project extension.
- (g) Technical assistance from G/R&D/POP to ensure consistency with Global Bureau policies and to provide information on worldwide experience with PVOs.
- (h) A cable to the Regional Bureau (LIMA 001035, dated 1/31/94) advising of this methodology and plans for the extension, with an invitation to offer comments.

### **3. Rationale for PACD Extension**

An external evaluation of the PVFP Project was conducted by the G/R&D/POP centrally-funded PROFIT Project in May of 1993. It found that although significant advances had been made since 1989 towards achieving project objectives, some outputs originally planned had not yet been accomplished. To allow all objectives to be fully met, the evaluation recommended a two-year extension. The principal findings of the evaluation were:

- (a) None of the PVOs were either institutionally nor financially self-sufficient. They ranged from total dependency with very low prospects for survival, to those with reasonably good prospects in the foreseeable future.
- (b) Achievements in institutional capacity and strengthening were multi-dimensional and varied considerably among agencies. In all cases, nevertheless, a clear awareness existed that this is a critical issue to their growth and independence.
- (c) All agencies appeared to have made significant advances towards increasing the use of long-term methods, with the logical exception of ATLF, which offers natural family planning exclusively.
- (d) Support of temporary supply methods has been variably affected by the reduction in funds for community-based distribution. Some agencies have continued support for these activities on their own.

(e) Expansion into rural areas and cooperation with public sector institutions have been attempted with very limited success.

(f) As an implementing agency, PRISMA has undertaken appropriate activities to accomplish project objectives. In general, it has been effective in establishing good working relationships with all participating PVOs.

Project Objective two (improving the availability of long-lasting methods) has had the greatest success; Project objective three (maintaining support for temporary supply methods and natural family planning) has been met, albeit less forcefully; objective one (increasing institutional capacity) has had varying success by PVO and sub-objective; and objective four (enhancing rural family planning coverage) has not been successful. The reasons for variation in achievement of project objectives are multifaceted. Much of the explanation lies in the hostile external environment during the life of the project, while another part relates to factors internal to the project.

**Hostile external environment.** It is well known that the period 1989-93 was an exceptional one in recent Peruvian history. Unfortunately, this meant that some of the assumptions upon which project design was based did not hold. For example, it was expected that through user fees for both family planning and related health services, the PVOs would recover costs and generate enough income to both enhance their financial sustainability and cross-subsidize services in rural areas. As the Economic Analysis in this document points out, during the four years of project implementation, Peru went through a very difficult structural adjustment that eroded real incomes and dramatically reduced purchasing power. This was not foreseen in 1988-89, when the project was designed and a different type of economic policy was being pursued under the government in power at that time. The effects of hyperinflation and the ensuing stabilization program on Peruvian real incomes meant that revenues accruing to the PVOs were much more limited than expected. Now in early 1994 Peru has resumed a pattern of positive economic growth, and realistic expectations are that incomes will rise in the mid-term.

The political climate has also improved over that of the first four years of implementation. Those years were ones of great civil strife all over Peru, but particularly in rural and marginal urban areas, where terrorism had its strongest hold. These are exactly the same areas targeted for expansion of services, since they are where the unmet need for contraception is greatest. Violence and fear of violence due to terrorism, then, limited the ability to extend services, even if funds for that expansion were adequate. That situation has also improved markedly over the past 18 months, now offering the real possibility of extension.

**Factors internal to the project.** In the case of the first project objective, that of increasing institutional capacity, another contributing explanation for lack of complete fulfillment deals with the long-term nature of the objective itself. Improving institutional capacity, or

institution building, is a slow, deliberate process if the strengthening is indeed to be internalized.

At the onset of the project in 1989, moreover, the participating PVOs had very little sense of their own responsibility to recover costs, since until then funding had been provided with scant regard for development of sustainability. There is now among the PVOs a high respect for this need, as well as moderate achievements in this regard. At the beginning of the project, the PVOs were recovering 10 percent of their total budget. They now recover 20-30 percent of that budget.

Further, PVOs worldwide tend to be associated, at least in their early phases, with strong charismatic leadership that makes the group viable, despite institutional weaknesses. The strengthening that the PVFP Project offers is intended to transfer some of that leadership from the person to the institution itself, so that it can be resident and diffuse throughout the PVO. Though this process takes time, it is progressing. The design proposed in this document intends to focus heavily on encouraging the PVOs to become more participatory, democratic institutions. This will be evidenced by more representative, democratically elected boards; clearer, more objective personnel policies; open, transparent hiring practices; and an equitable salary scale.

The relative success of project objectives two and three relates to where the project, under HPN guidance, chose to put its emphasis. In 1989, the most recent survey data available showed that only 13 percent of married women in union aged 15-49 were using the long-term methods then available (IUD and tubal ligation). This low prevalence of the more modern, effective contraceptive methods did not appear to be consistent with data from the same period showing that 64 percent of those same women wanted no more children. Thus, it seemed timely to emphasize greater availability and access to the more effective long-term methods, as a way of meeting imputed needs. Though these methods have high financial costs in their service delivery requirements, it was considered that over the longer-term they would be more cost-effective. Community-based distribution, which largely features supply methods, was discontinued. Natural family planning was considered the province of ATLF, which espouses a very time-intensive methodology for its application.

Project objective four, enhanced rural family planning coverage, was accorded a low priority because project managers decided to concentrate on institution building, in the sense of recuperating a proportion of each institution's operating costs, and long-lasting methods, which are generally delivered in central clinics. Rural family planning coverage was seen as a potential drain on these other efforts. Further, no funds were specifically allocated to the expansion of rural services. Indeed, the PROFIT evaluation went so far as to call the twin objectives of institution building and rural coverage a design contradiction. Given current Agency policy, as well as recognition of the tremendous need for family planning in rural areas, the assertion is unwarranted and untenable politically. More creative implementation strategies must be devised and executed in order to meet these twin objectives. Further,

rural coverage must be recognized as an element that will require long-term commitment and a certain amount of subsidization.

**Utility of the project.** Aside from the desire to complete all project objectives fully, there are several other strong arguments for extending this project. First is the importance of supporting the PVO/NGO sector itself. This is very much in line with recent Agency, Bureau and Mission policy.<sup>5</sup> Administrator Atwood has consistently emphasized the importance of collaboration with indigenous PVOs. Worldwide, PVOs have made a tremendous contribution to development, both specifically in the area of family planning and more generally in such areas as primary health care, rural development, microenterprise, environmental concerns and education. This project is the Office of Health, Population and Nutrition's principal vehicle for support to family planning PVOs. The PVFP was intended to consolidate the advances achieved in service delivery through more than two decades of USAID support to the Peruvian private voluntary sector. In order to complete this process, it is essential that all objectives be fully met.

Second, in line with that tradition, the participating organizations of the PVFP Project have played a pivotal historic role in USAID family planning assistance in Peru. Under military rule, for example, family planning services were not provided in public facilities, which *de facto* made the PVO sector the sole source of family planning services, aside from the private clinics that cater to upper-income groups. Despite provisions in law and policy, the GoP commitment to family planning remains fragile, dependent on political winds and the need for political support from conservative groups. Since PVOs are relatively insulated from the changes in government policy that often occur as heads of state change, or the ministers serving them change, they provide a useful, constant channel for supporting programs that might be vulnerable to the vicissitudes of government policy. Minimally, it is important to maintain the alternative route of service provision through PVOs until such time as family planning services are firmly established in all public sector agencies and thus immune to political decisions to limit or reverse.

Third, beyond the above, a strong PVO community is essential to the long-term sustainability of government programs, as it potentially decreases the client burden on the under-funded public sector. If users were not served by PVOs at their current lower-than-commercial-sector prices, they would have no recourse but to seek services from the public sector, which has responsibility for providing services to lower-income groups. At the same time, it appears that the budgetary restrictions of the Peruvian Ministry of Health will not improve in the immediate future because of the urgent need to comply with scheduled payments on the foreign debt. This situation is expected to continue for the foreseeable future.

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<sup>5</sup> See "Stabilizing World Population Growth and Protecting Human Health: USAID's Strategy" (1/6/94 draft); "The Strategic Role of U.S. Assistance in the Americas" (LAC Bureau strategy document, 1/94 draft); and "USAID/Lima: Partner in Development" (Mission Vision, 12/93).

Fourth, more recently, when the Peruvian government was under sanctions for non-payment of debt, USAID was nonetheless able to provide the Peruvian public with contraceptive supplies: Section 123e of the Foreign Assistance Act made it possible to continue support through PVOs. The PVFP Project provided those channels and can do so again in the future, if the need arises.

The PVFP Project has served a second major utility in a time of sanctions. The principal way in which the Mission evaluates the impact of its HPN projects is through the Demographic and Health Surveys (DHS),<sup>6</sup> a G/R&D/POP centrally-funded project that conducts national surveys in AID-assisted countries at five-year intervals. In this way, the Mission leverages resources by not putting dedicated evaluation funds into bilateral projects, yet has access to high-quality evaluation data at regular intervals that encompass both baseline and end-of-project indicators. Through the DHS, moreover, Peru participates in a worldwide undertaking with value for cross-country comparability. Systematic timing of the DHS is key, however, since utility of results would be undermined if the periodic surveys were too close or too far apart. The second DHS was scheduled for 1991, a time when Peru was in sanctions. PVFP was able to take on the management of the DHS, in collaboration with the National Statistical Institute, ensuring that the 5-year interval was observed.

Fifth, as noted above, this project has the challenging task of administering the importation and distribution of all USAID-donated contraceptives in Peru, whether their final destination be the public or private sector. The Agency is far and away the major source of donated contraceptives in Peru. PRISMA has undertaken this responsibility with great vigor and success, so that there is now great transparency and accountability in the management of contraceptives in Peru. This rationalization has allowed for greater efficiencies in contraceptive management. Indeed, if the project were not continued, the contraceptive supply line and distribution system that have been working so effectively, ensuring availability of supplies and minimizing losses, would also terminate. Establishing another supply mechanism could take months and would seriously affect USAID's family planning program, since there can be no program without contraceptives. It is clear that there is a continuing need for this type of management.

Finally, support to PVOs is also in line with Agency, Bureau and Mission objectives to promote democratic institutions. The capacity building that is undertaken under the PVFP Project seeks to promote participatory, grassroots involvement in the PVOs, as seen in such things as the selection of Executive Board members, the openness of recruitment for staff positions, and the level of involvement with the community. It also seeks to internalize the values of transparency, accountability and predictability in the culture of PVOs. Thus, our concern with PVOs has two dimensions: as unencumbered providers of quality family planning services, and as democratic institutions that invite grassroots Peruvians to participate actively in their own development.

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<sup>6</sup> *The DHS is known in Peru as the ENDES (Encuesta Demográfica y de Salud Familiar).*

#### 4. Nature of Proposed Extension

A 17-month extension of the project is sought to enable all objectives to be successfully met. The original project goal, purpose and objectives, as described in the Project Paper (PP), remain unchanged. At the same time, the assessment of the project that has been conducted to prepare this PP Supplement has allowed HPN staff to identify opportunities for reinforcement and finetuning. In summary, the additional period of time will permit the:

(a) Continued participation of PVOs in capacity-building activities that improve technical, administrative and management capability and enhance financial sustainability. These will include internalization of capacity to conduct periodic cost analyses; reforms in personnel and salary policies, with an emphasis on transparency and accountability; continued strengthening of cost recovery and income generation; and continued attention to enhancing quality of care.

(b) Funding of certain one-time capitalization costs, as a way of facilitating cost recovery and income generation. To be considered on a case-by-case basis, such capitalization would meet the test of either removing a major impediment to enhancing cost-recovery (*e.g.*, purchase of a building for a clinic) or underwriting creative ways to generate income (*e.g.*, purchase of a press that could provide printing services for a number of PVOs).

(c) PVO-specific qualitative studies, in each PVO's catchment area, of non-utilization of services and its relationship to quality of services and self-sufficiency. The results will help inform modifications in service provision, so that services become more acceptable to their intended beneficiaries.

(d) Continued availability and promotion of all contraceptive methods. Long-lasting methods need to receive continued support, while temporary supply methods and natural family planning need increased support. This is the cornerstone of quality of care in family planning. The composition of method mix must emanate from demand variables, and that can only occur if all methods are available and counseling on them is objective.

(e) Expansion of services in rural areas. Now that the political and economic climates are more favorable and long-lasting methods have a firm foothold in clinical settings, it is timely to give a high priority to the delayed expansion into rural areas. Marginal urban areas will also be a priority, since the problems of access faced by those residents are similar, albeit not identical.

(f) Increased attention to reaching the target group of low-income women and couples. The PVOs have not had an ongoing system of keeping statistics on users by any socioeconomic indicator. This needs to be instituted under the extension, so that data are readily available on whom the services are reaching.

USAID will continue to support all participating PVOs. Funding on the order of US\$ 4.950 million has been budgeted within Mission FY 94 OYB. Allocation of funding, however, will

be based on an assessment of each PVO's performance over the last 4.5 years, as well as its potential contributions to the extension sub-objectives described above. Good performance will be rewarded. Annex I presents: Table I, which contains the estimated budget for the revised life of project (LOP) funding by component; Table II provides the estimated LOP budget by component and sub-component; Table III contains the estimated budget for the project period extension; and Table IV the illustrative budget by period of obligation.

## **5. Analysis of Accomplishments and Needs by Objective**

This section describes the current status of activities by project objective and outlines the activities that need to be undertaken during the extension period to meet that objective fully.

### **Objective 1: Increase the Capacity of PVOs**

The institutional capacity of the participating PVOs has indeed been built over the 4.5 years of the project, albeit unevenly among them, due to the particular characteristics of each institution. Planned EOPS included improved administrative systems, improved cost-effectiveness of service delivery, and enhanced financial sustainability.

(a) Improved administrative systems. Administrative systems have been strengthened significantly. Manuals relevant to financial reporting and programming have been designed and distributed. A management information system (MIS) has been installed in most PVOs to track resource allocation, logistics, and service statistics. The MIS is intended to contribute to management decision-making, providing information to the different levels of the organization in a timely and accurate manner. This system should be expanded to include such elements as personnel (payroll), inventories and accounts receivable.

At the same time, there remains progress to be made. Utilization of the MIS system has been sub-optimal, some of the data collected have been flawed and frequent turnover has occurred among staff assigned to the MIS, reducing the benefits of investments made in MIS training. Further, it is not clear if the information collected has been adequately exploited within PVOs for management and decision-making. According to the PROFIT evaluation, PVOs have used the financial module to prepare and present budgets, to guide budget decisions, to detail income and expenses during the reporting period, and to report income and expenses by category, but the emphasis has been on reporting to PRISMA. In other words, these reforms have not been totally internalized by the PVOs. The MIS, while theoretically a useful management tool, will be made more relevant to participating PVOs in order to ensure their use of the system during the extension period. Thus, commitment to appropriate use of the MIS will be part of the provisions under the extension.

Another success has been the initiative in strategic planning. Each PVO prepared guidelines to design its strategic and operational plans. Most organizations subsequently prepared and presented strategic plans and all have operational plans for the fiscal year. Thus, the

importance of setting priorities, planning by objective and matching resources to needs and objectives has been institutionalized.

Strategic planning has encompassed lobbying as well. As a result of a high-level workshop, for example, a lobbying program was implemented by PVO directors to promote family planning and reproductive health issues among political leaders, national and community entrepreneurs. Under the extension, PVO strategic planning will be expanded to include plans for extending services in rural and urban marginal areas.

Another area where the PVOs have made some progress, but where continued efforts are warranted, is in reform of personnel systems and organizational structure. The objective here is to make PVO organizational structures and policies transparent, accountable and predictable. The PROFIT evaluation recommended that PVOs establish Executive Boards that are externally oriented toward the larger economic environment, providing access and contacts with financial and commercial leaders and institutions. This would help to broaden the base of the PVO Executive Boards, decentralizing power away from the senior management, which in some cases is overly centralized around a charismatic figure. Slates of candidates for Board membership should take this recommendation into account, as well as consider gender. Boards should be in office for a set period, and policies for elections, including candidate selection, should be set in writing.

Personnel policies should be transparent, with positions classified along an objective scale by their requirements. Staff should be paid according to the position they occupy, and the salary schedule should be made known to all staff. Equal work should merit equal pay, and personnel policies should be explicit about such matters as recruitment procedures and the circumstances under which relatives can be employed. All such policies should be subject to Executive Board approval.

#### **Extension targets:**

- PVOs will continue to operate under the guidance of a strategic plan. The plans already developed will be modified to target activities envisioned under the extension, particularly expansion into rural areas.
- PVOs will continue to develop yearly operational plans and follow those plans.
- The MIS will become further institutionalized among PVOs, enhancing its relevance for management and decision-making.
- The MIS will be expanded to encompass data from and for clinics and posts. This will include socioeconomic data on users.
- PVOs will establish written by-laws and internal policies for their organization. These will address, among other items, recruitment for and election of the Executive Board, powers

and limitations on powers of the Executive Director and other senior management, personnel policies and organizational structure. There should be written, accessible minutes of Board meetings, and these should be distributed routinely to PRISMA and USAID.

(b) Improved cost-effectiveness of service delivery. Cost and marketing studies were conducted to assist PVOs in determining the most appropriate and efficient service delivery strategies. To date, results of the studies have been used selectively by PVOs, partially due to the limited participation of the PVOs in the development and implementation of the studies. The PVOs have, in some cases, resisted participation in management development activities organized by PRISMA. This attitude was the result of an initially top-down approach that failed to instill a felt need for cost-effectiveness activities among the PVOs themselves. As the project continued, and relationships between PRISMA and PVOs deepened, PVOs began to identify cost-effectiveness activities with their institutions' long-term interests. As part of their strategy to offer more long-lasting methods, the PVOs have begun to establish the community clinics required for these methods. As a strategy for generating income, they have also expanded the services offered to include general medical as well as reproductive health services. This model will continue for urban areas, with added emphasis on counseling and promotion of temporary supply methods.

The model to be employed in rural areas will be on an itinerant basis, offering education in fertility awareness, integrated reproductive health services and community based distribution (CBD) of contraceptives. If demand increases, the itinerant health services will be offered more frequently and may be upgraded to a community clinic.

PVOs are beginning to utilize the cost and market study data to design IEC campaigns, but have yet to incorporate the findings into service delivery strategies. Selected PVOs have implemented cost saving and cost-effectiveness measures, such as fee-sharing with physicians and reducing costs associated with the delivery of IUDs and sterilization. Technical assistance in the improvement of cost-effectiveness will continue, especially as regards service utilization. Cost analyses will be conducted periodically, and expertise in this activity will be transferred to staff of the PVOs. Among other things, such analyses will calculate real institutional costs with respect to true revenues.

At the same time, cost-effectiveness will be considered as only one indicator of program monitoring. It must be clear that issues of quality of care and success in reaching project target groups take precedence over cost-effectiveness. In other words, the PVFP Project will strive for the most cost-effective ways to deliver high-quality services to its target groups of lower-income women and men, a portion of whom will be residents of rural areas.

**Extension targets:**

- By the new PACD, PVOs will be utilizing a minimum of 70 percent of their installed capacity for service provision.

- By the new PACD, PVOs will have identified and be delivering services in the most cost-effective ways that also meet the criteria of quality and outreach to rural areas.
- Expertise in conducting cost analyses will be institutionalized, with analyses being conducted systematically by PVO staff themselves.

(c) Enhanced financial self-sufficiency. The PP specified that PVOs should serve the economically needy that the public sector had not been able to reach. Concurrently, the groups were expected to initiate programs for cost recovery and income generation. There was also an expectation that the PVOs would attract a significant portion of middle-class clients, in addition to serving low-income women and men. In theory, the revenues generated from middle-class clients would be used to cross-subsidize services for low-income clients and rural expansion. PVOs charge a nominal fee for services, but waive fees if the client is unable to pay. But even while charging a fee for service, PVOs have been unable to recover the majority of their costs.

Currently, PVOs recover 20-30 percent of their costs. This accomplishment is far from insignificant, considering that at project initiation only about 10 percent of costs were being recovered and in view of the hostile economic environment of recent years. At the same time, there is now a more realistic appreciation among donors that certain activities serving social objectives, such as family planning services, are not likely to become completely self-sufficient in financial terms in the near future, if appropriate attention is given to access and quality of care for low-income groups. Nonetheless, current realistic expectations are that under the extension participating PVOs will increase notably the proportion of costs recovered, especially in view of the capitalization plans described below. Within the first three months of the extension period, PRISMA will work with each participating PVO to conduct an organizational diagnosis that identifies current levels of cost-recovery and sets realistic targets for an increase in that level during the 17-month period. That increase should reflect an organizational commitment to cost-recovery and should pave the way for possible future institutional development under any follow-on project. The organizational diagnosis will be preliminary to preparation of proposals by PVOs for capitalization.

A significant implementation problem lies in actual clinic attendance. Many PVOs are simply not attracting clients to their services. For example, although PLANIFAM/Cusco offers a range of services, the organization averages only eight visits a day in any of its eight delivery sites for consultations of any kind. PLANFAMI/Puno averages 13 consultations a day in all facilities. Other PVOs show similar statistics. According to the 1992 ENDES, only 7 percent of current contraceptive users obtain services through a PVO. Indeed, overall production of the PVOs has declined recently: Total CYP in 1994 is 80 percent of the 1990 level.<sup>7</sup> This trend is even more puzzling in view of the shift over the past several years

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<sup>7</sup> *There is the possibility that part of the decrease is artifactual, since service statistics before the PVFP Project began were likely inflated, due to poor information systems and scant supervision by donors. Under PRISMA, a much tighter control on contraceptives has resulted in more reliable service statistics; PRISMA also supervises the PVOs and*

from temporary supply methods to long-term methods, given that the later tend to provide more CYPs than the former.<sup>8</sup>

**Qualitative studies.** Since services are frequently offered free of charge or at nominal rates, such as s/. 3 (US\$1.40 equivalent) per visit, ability to pay should not be the only factor in clinic attendance, though it no doubt represents part of the explanation, as stated in Section 3 of this document. Yet worldwide experience has shown that lower-income groups have generally been able to pay some amount for services. Further, even when activities have been fully financed by the project, selected PVOs have not been able to attract clients. This situation warrants community-level research.

Attracting a larger volume of clients, nonetheless, is likely to be only a partial answer to the self-sufficiency problems of PVOs. PVOs need to examine why clients aren't in the clinics and use that information to plan how to make services more accessible and acceptable. The quality and dependability of services offered is undoubtedly a primary factor in low clinic attendance, along with weak outreach and insufficient IEC efforts. Many issues of quality of care have arisen during surprise clinic visits and in the course of project management. Worldwide, PVOs normally seek their niche in the market as high-quality purveyors of services. If this element is missing, the likelihood of a full client load or self-sufficiency is small.

For all these reasons, funds will be allocated under the extension to sub-contract with local universities or research groups, in the catchment area of each participating PVO, for qualitative studies on non-utilization of family planning services. Each study will seek to identify why women -- and men -- are not using family planning services available through the local PVO and how such services can be improved to attract more users. In addition, the results of these studies will inform the information, education and communication strategies that PVOs will draw up and implement during the extension period.

The qualitative studies, then, will focus on the perspective of users and non-users in the target area of each participating PVO. By contracting with a local university or research group to undertake each study, the probability will be heightened that the investigators will be sensitive to local concerns. Ideally, the studies will be carried out by medical anthropologists, that is, people who both are knowledgeable about family planning and have insight into local belief systems. Linguistic skills are also important. In Cusco, for example, Quechua-speaking investigators will be required, while in Puno, the investigators should know Aymara. The application of the findings of these studies should result in

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*conducts patient audits.*

<sup>8</sup> *International expert groups have assigned particular values in CYP units to each method of contraception. A tubal ligation, for example, is valued at 10 CYPs, while it takes 15 cycles of oral contraceptives or 150 condoms to equal one CYP. An IUD insertion is worth 3.5 CYPs. A trend toward long-lasting methods, thus, should be accompanied by an increased production of CYPs.*

higher-quality, more acceptable services, which in turn should result in greater utilization of services, more family planning production and more cost recovery.

**Working Capital Interventions.** As stated above, cost recovery from fees for service currently accounts for 20-30 percent of the average PVO's annual budget. Although far from self-sufficiency, this can be described as major progress towards long-term financial sustainability. It is not sound, however, to expect family planning associations to become completely financially self-sufficient through income generated exclusively through fee for family planning services, particularly if the expectation is also that they will serve low-income people and extend access in rural areas. Therefore, PVOs must focus on alternative forms of income-generation, within or outside of their current areas of expertise. The PROFIT evaluation also recognized this when it noted that there are probably absolute limits to cross-subsidization from the health sector itself and that other, non-health income-generating activities should be explored that can provide an ongoing source of revenue for serving the poorer populations targeted by the PVOs.

Several innovative income-generation and capitalization activities have been proposed by participating PVOs. Such endeavors are in line with the Project Paper, which refers in several places to a mandate to generate income in alternative ways.<sup>9</sup>

As each participating organization is able to identify major barriers to financial self-sufficiency, such as ownership of their service delivery locale or a one-time replacement of equipment, the PVFP extension will consider covering those costs as a one-time investment in the organization's long-term sustainability. Such activities will depend on the situation and characteristics of each PVO. PRISMA, in coordination with USAID/Peru, will study proposed options and offer recommendations for appropriate investments in capitalization.

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<sup>9</sup> For example, "The project also will assist the participating PVOs to acquire skills required to undertake income-generating activities: specifically, to increase local in-kind and cash donations, and to undertake profit-making activities" (p. 3); "Long-term financial sustainability is a goal of this project, although the Mission recognizes that self-sufficiency is impossible in four years. The project will further the sustainability goal in four ways:....(d) promoting cost recovery and income-generating activities (p. 16)"; "Where appropriate, PVOs will begin or expand income-generation activities, the profits from which will be reinvested in capital expenditures, staffing or program operating expenses" (p. 51); and "The project will also introduce profit-making activities into the family planning PVOs to further increase their levels of self-sufficiency. Peruvian law permits agencies registered as non-profit to produce profits as long as the income generated is reinvested in the agency and not distributed among its members" (p. 52).

### **Extension targets:**

- Within the first six months of the extension, a community-level qualitative study will be done in the catchment area of each PVO. A local university with ties to the community, or a similar entity, will be subcontracted to conduct the study. The research will be conducted among non-users in the target group, to identify reasons for low utilization of services. A certain proportion of users can also participate, as a way of soliciting suggestions for improvements in quality of care.
- By the end of the first nine months of the extension, the findings from these studies that can be feasibly implemented will be in place. Feasibility will be determined jointly by the PVO in question and PRISMA, with input from USAID. An IEC campaign will be conducted in the community to publicize the revamped services.
- Within the first two months of the extension, each PVO invited to do so will present a proposal to PRISMA for a working capital intervention that will give a one-time boost to cost recovery or income generation. The proposals accepted by PRISMA and approved by USAID will be funded. Each PVO will monitor closely the income that arises from this capitalization, so that the value of the activity can be evaluated.
- By the new PACD, participating PVOs will be recuperating at least 50 percent of their total budget. With appropriate working capital this is a realistic level, given the inherent constraints outlined above. Sources of cost recovery will be donations, fees for service and generated income.

### **Objective 2: Improve Availability of Long-lasting Contraceptive Methods**

This objective has had the greatest success, reflecting priorities established in project implementation, when some other objectives seemed less feasible because of reasons cited above. Attention to long-lasting methods addressed the need of Peruvian women for methods of contraception that allow them to limit total family size, as well as space births. This need was identified through the 1986 DHS, which found that 64 percent of married women aged 15-49 did not want more children. At that time, a large part of PVO efforts went toward community-based distribution programs, which provided only temporary supply methods. This category of long-lasting methods includes intrauterine devices (IUDs), implants (NORPLANT) and voluntary surgical contraception (tubal ligation and vasectomy). Over the 4.5 year period, there has been a 55 percent increase in client use of these methods, which is 116 percent of the increase envisioned in the PP.

Four years later, at least one long-lasting method is firmly established in Peru. The IUD is the long-lasting method most widely available in Peru and the most prevalent "modern"

method in Peru. The contraceptive prevalence rate<sup>10</sup> in Peru, according to the 1991 DHS, is 59. On a national level, IUD use represents 13 of the 59 points of the contraceptive prevalence rate, or 22 percent, and 39 percent of all modern method use. In PVO service statistics, it is far and away the most commonly-supplied method and the major source of CYP production.

Voluntary surgical contraception, though also available through participating PVOs, has just begun to take hold on a wider scale. Advances have been made in the policy environment for the methods, in training of personnel in high-quality provision and appropriate counseling, and in informing potential users of their availability. Implants (Norplant) have been available through one PVO that has staff adequately trained in the necessary procedures for quality care associated with that method. But since USFDA approval for implants is recent, adequate time has not elapsed to establish it on a wide scale. Under the extension Norplant will be made available on a limited basis dependent on the technical competence of service providers and fulfillment of the protocol justifying it as the method of choice for that individual. Thus, despite noteworthy success in improving the availability of long-lasting methods, continuing support in this area is called for. Ensuring the availability of a full range of methods that features long-lasting methods will continue to be a project priority.

There is some evidence, however, that pursuit of this project objective has caused a disproportionate emphasis on long-lasting methods on the supply side, an emphasis that may have implications for access and quality of services. At the project design stage of the PVFP, long-lasting methods were relatively new and unavailable. As pointed out earlier, their share of contraceptive prevalence was very low. Four years later, method mix is skewed towards the IUD, while pill use has declined over the length of the project. The share of long-lasting methods in total CYPs has increased from 37 percent in 1990 to 49 percent in 1994. In contrast, the share of supply methods in total CYPs has declined from 38 percent to 12 percent during this same period. A partial explanation might be that the elimination of community-based distribution has reduced the wider provision of supply methods.

More disturbing for quality of services, promoters and doctors in some PVOs have received incentive payments for referrals and services that differ by method. The IUD is more expensive, and as a result, health workers receive a larger payment for an IUD referral than one for, say, oral contraceptives. Health workers have sometimes received a percentage of the cost charged for services, which has resulted in the same phenomenon. It appears that these internal incentive systems have helped skew the method mix towards the IUD. PVOs will receive assistance under the PVFP extension to revamp incentive programs with an eye to eliminating incentive differentials by method.

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<sup>10</sup> *The contraceptive prevalence rate refers to the percent of women aged 15-49 currently in union who practice a form of contraception.*

A possible factor in the drop in supply-method use in PVOs is the commercial market's increasing share of supply methods during 1992-93. During that time, the commercial sector experienced a 5 percent growth in purchases of pills and a 15 percent increase in purchases of foaming tablets. A related hypothesis suggests that clients attend PVO clinics primarily to procure services unavailable from the for-profit private sector, such as pharmacies. Finally, another contributing factor may be that a larger percentage of PVO clients have a preference for the IUD, as virtually the only long-lasting method widely available to a population of Peruvian women of whom more than half want no more children.

As pointed out earlier, client volume has decreased over the project period. A skewed method mix may have had some bearing on this. Worldwide, quality of care and high contraceptive prevalence rates have been positively associated with the availability of the full gamut of methods. This points to the need to increase the attention paid to counseling and the concerns of non-users in the design of services and IEC, as well as to increase outreach and IEC efforts.

As an essential part of any family planning program, these methods need continued support, albeit not at a level that prejudices availability of other methods. USAID policy is not to reduce choice in family methods *a priori*: "Providing information about and access to a wide range of appropriate family planning methods not only remains the most effective means of reducing population growth rates to levels consistent with sustainable development, but also significantly improves the health of women and children."<sup>11</sup> This policy gives expression to the understanding that there is no one ideal method of contraception for all men and women at all times. Contraceptive choices depend on age, parity, health, lifestyle and reproductive intentions, among other factors. The method mix in contraceptive prevalence should reflect the sum of user demand. As such, PVFP's focus should remain on quality of counseling and services for a full range of contraceptive methods.

#### Extension targets:

- Within the first three months of the extension, incentive systems will be revamped, with any incentive differentials by method eliminated.
- The utilized level of installed capacity for IUD insertion will be maintained.
- A study will be conducted on the discontinuation rate for IUDs, with an appropriate strategy and target level for reducing discontinuations emanating from the study.
- The utilized level of installed capacity for voluntary surgical contraception will increase among the best performers from a current 35 percent to 50 percent.

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<sup>11</sup> USAID (1994). "Stabilizing World Population Growth and Protecting Human Health: USAID's Strategy," p.6.

- The proportion of voluntary surgical contraception that is accounted for by vasectomy will double for each participating PVO that provides this service.

### **Objective 3: Maintain Support for Temporary Supply Methods and Natural Family Planning**

(a) Temporary supply methods. To date, some financial support has been maintained for temporary supply methods and natural family planning, but a more appropriate level of attention will be paid to these methods under the extension. As outlined above, an equitable emphasis will be given to all methods during counseling and service provision by participating PVOs. In this way, imbalances in the achievement of project objectives can be corrected. Given increasing rates of HIV/AIDS and sexually transmitted diseases, barrier methods (supply methods) are ever more important to family planning and reproductive health programs. This is because the spermicides used in many barrier methods are often active against the pathogens that cause sexually transmitted diseases. They are therefore polyvalent in reducing risks of infection and providing protection against pregnancy. In view of this, barrier methods, especially condoms, have been revalued. Recent policies of USAID and other donors encourage the integration of these wider reproductive health concerns into family planning programs. Consequently, it will be necessary to revisit the CBD concept and develop a model that will be managerially feasible while avoiding the risk of leaks of donated supplies to commercial markets.

(b) Natural family planning. The availability of counseling and services for natural family planning (NFP) methods is essential to any family planning or reproductive health program. Natural methods may appeal to some couples for religious reasons, but are also seen as part of a wide choice of contraceptive methods. Some women and couples do not wish to use a technology-dependent method, preferring to regulate their fertility through their own knowledge of their body's physiology, modifying their behavior in times of heightened fecundability.

Periodic abstinence is the most widely used family planning method in Peru. It represents 21 of the 59 points that constitute the contraceptive prevalence rate, or 36 percent of all contraception. The basal body temperature and cervical mucus methods help women pinpoint the precise days of ovulation, thereby reducing the number of days of heightened risk.<sup>12</sup> This makes periodic abstinence a more acceptable method. Further, barrier methods can be combined with natural family planning methods, so that spermicides and/or condoms are used on risky or marginally-risky days. Such a combination makes both periodic abstinence and barrier methods more acceptable. For all these reasons, family

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<sup>12</sup> Similarly, these methods can also be used by couples that desire a pregnancy, by pinpointing when relations are most likely to result in a pregnancy. They are therefore part of any infertility program. In their true sense, reproductive health programs should advise on infertility as well as on contraception.

planning programs have a responsibility to provide information to women and couples that will maximize these methods' efficacy. One way to help do this is through a series of educational sessions on fertility awareness, where human physiology is discussed and relevant methods explained.

Finally, lactational amenorrhea as a contraceptive method should be highlighted in programs, as 96 percent of Peruvian children are ever breastfed. Further, infants are breastfed on average 17 months, and post-partum amenorrhea lasts on average 9.6 months. These data mean that breastfeeding is a tremendous inhibitor of fertility in Peru. As such, it should be supported and preserved for both its nutritional and its contraceptive value.

Under the PVFP, ATLF has been the only organization dedicated to counseling and education on natural family planning. Unfortunately, ATLF's nine-month training methodology for users is not conducive to reaching a large population. Given that the PP authorizes activities with other PVOs outside the initial groups<sup>13</sup>, USAID and PRISMA will investigate other alternatives for providing NFP services and training.

#### **Extension targets:**

- Within four months of the extension, all PVOs will be counseling objectively on the gamut of contraceptive methods they offer. Quality of care in counseling will be monitored periodically through mystery client or similar evaluation techniques.
- By PACD, the number of couple-years of protection that is accounted for by supply methods will double.
- The number of participating PVOs that actively support natural family planning, albeit within a gamut of methods, will be increased to three.
- Educational materials on natural family planning will be produced.
- At least one PVO will conduct a series of fertility awareness sessions for women. This may be in collaboration with non-family planning NGOs.

#### **Objective 4: Enhance Rural Family Planning Coverage**

Worldwide, differentials between urban and rural fertility rates are common. Urban rates tend to be lower for a number of reasons, including greater service availability, higher

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<sup>13</sup> *"Other Peruvian PVOs will be invited to participate in specific activities, such as training, research, and production of educational materials. These may include PVOs involved in non-family planning development activities that wish to collaborate with the public sector to offer family planning services." (p. 46)*

quality of care and lower desired family size. In Peru, however, these differentials are particularly great. The 1991/92 DHS revealed that the total fertility rate (TFR) of women in rural areas, at 6.3 births, had remained virtually unchanged over the preceding five years. During this same period, total fertility in urban areas decreased by some 10 percent. The rural TFR of 6.3, moreover, is three times that of the 2.1 TFR of Lima. The overall urban fertility rate for Peru is 2.8, also a low figure.

Logically, the same imbalance is reflected in contraceptive prevalence rates. The CPR for Lima is 73, for all urban areas 66, while for rural areas it is only 41 percent, with 26 of those 41 points representing use of traditional methods, such as periodic abstinence<sup>14</sup> and withdrawal.

These statistics underscore the importance of extending and improving services in rural areas for two major reasons. First, with fertility in Lima, where one-third of Peru's population lives, at almost replacement level,<sup>15</sup> further declines in fertility on a national scale are dependent on future declines in rural areas. Second is a matter of equity. Recently-elaborated Agency, Bureau and Mission policies, cited elsewhere in this document, emphasize broad-based participation in development and considerations of equity. For this reason as well, then, the great need for family planning services in rural, as well as marginal urban areas, can no longer be considered a low priority.

Further, all indications are that maternal mortality in Peru is extremely high, estimated at over 300 deaths per 100,000 live births. Much maternal mortality is associated with inadequate care at the time of delivery. Per the 1991/92 DHS, 83 percent of women in rural areas give birth at home, while that figure is only 29 percent in urban areas. Since family planning is key to avoiding unwanted pregnancies, an increase in its use in rural areas should help reduce maternal mortality substantially.

During project implementation to date, however, it was considered difficult both to target unserved or underserved rural populations and implement cost recovery and income-generation activities. In particular, the strategy of expanded coverage through PVO collaboration with the public sector did not prove feasible. Additionally, the emphasis on the promotion of clinic-based, long-lasting methods was considered incompatible with usual modes of rural and peri-urban service delivery, such as community-based distribution.

At one point in the project design, urban community-based distribution (CBD) was envisioned to become self-sufficient and even free up funds to support rural expansion

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<sup>14</sup> *The high TFR would indicate that this method is probably applied incorrectly quite often, underlining the need for education on how to use it effectively.*

<sup>15</sup> *Replacement level refers to the number of births a woman would have if she were only to replace herself in the childbearing population, without adding to population increase. Considering that, on a population level, two births translates into one boy and one girl, a TFR of 2.0 is considered replacement level.*

activities. These programs did not survive during the project period for two reasons: 1) urban CBD posts were not attracting clients commensurate with costs associated with providing services; and 2) CBD was not able to achieve any measure of self-sufficiency. In order to achieve the expansion of rural services, the project's fourth objective, funds must be explicitly allocated for this purpose, rather than depend on income generation from other project components. Some percentage of costs are already being recovered through a variety of schemes, but these are not of enough significance to cover a necessarily subsidized activity such as the expansion of services in rural areas. Novel approaches must be tried and old models re-examined for their potential contributions.

In order to achieve expansion into rural services, the project's fourth objective, funds must be explicitly allocated for this purpose, rather than depend on income generation from other project components. Some percentage of costs are already being recovered through a variety of schemes, but these are not of enough significance to cover a necessarily subsidized activity such as the expansion of services in rural areas. The PVFP will provide the basic means to maintain and expand rural services. This can include both fixed-site service delivery and support for community-based activities, including fairs. Such support might come in the form of means of transportation (bicycle or moped), boots, ponchos, tents, folding examination tables, etc.

Some PVOs have already drafted expansion plans for the rural areas. These will need to be updated and refined with assistance from PRISMA. The plans will then be submitted to USAID for approval for funding, within two months of the project extension.

As general guidelines, it is estimated that fixed service-delivery sites will be supported in 16 rural areas, in four rural areas adjacent to each of the four cities represented by the PVOs: Cusco, Lima, Puno and Trujillo. These sites will offer all methods except voluntary surgical contraception and implants, which will be available via referral to a central clinic. Mobile service delivery will be supported in the rural areas surrounding each of the four cities. This can take the form of mobile medical units, tents for fairs, motorcycles and/or bicycles. The fixed service delivery sites will carry out educational activities in their community catchment area; these activities will be designed with the full participation of the local community.

Over and over again, the PP states that the primary target group of the PVFP Project is lower-income groups. Unfortunately, no mechanism was adopted to measure whether this is the group that is actually being reached. This may not be such a problem in analyzing service statistics from posts in *pueblos jóvenes* or other low-income areas, since it is hardly logical that large groups of middle-income clients would seek their services in those areas. It is more problematic, however, in analyzing the production of central clinics, many of which are located in middle-class neighborhoods. To enable monitoring of the project in relation to its objective of reaching lower-income groups, routine service statistics under the extension will include socioeconomic data on users. PRISMA and the PVOs will suggest to USAID non-invasive, reliable variables to serve this purpose. Some suggestions are educational

level, occupation of user or spouse, construction material of dwelling, and ownership of certain material goods.

**Extension targets:**

- Within two months of the project extension, relevant PVOs will submit, with assistance from PRISMA, refined plans for extension into rural areas. These plans are subject to approval from USAID.
- Within four months of the project extension, mobile service delivery and community-based activities will have commenced in the 16 rural priority areas.
- Within six months of the project extension, fixed service-delivery sites will be supported in 16 rural areas, equally distributed among the rural areas adjacent to Cusco, Lima, Puno and Trujillo.
- Costs of (and funding for) rural sites will be monitored in such a way that data can be disaggregated, so that by PACD there will be data on which to judge the cost and cost-effectiveness of this delivery mode.
- PVOs will continue their network of health posts in marginal urban areas.
- Within two months of the project extension, service statistics will routinely include socioeconomic data on users.

## **6. Analyses**

**Economic Analysis.** Peru has undergone a profound change in economic policies during the life of this project -- from the "populist" policies of the Alan Garcia Government to an orthodox market approach under the current Fujimori Government. The hyperinflation associated with the Garcia Government and the ensuing stabilization program have had a direct bearing on the ability of the NGOs to recover costs in family planning. This section focuses on the economic framework that has influenced the NGOs' ability to achieve financial sustainability.

From July 1985 to July 1990, the Garcia Government implemented "heterodox" economic policies directed at raising the rate of economic growth by increasing domestic demand through credit expansion, tax reductions, and government-mandated wage increases. Following a short-lived boom with real GDP growth rates averaging nearly 7 percent a year in 1985-1987, real GDP decreased by an average of 8 percent a year in 1988-1990; inflation climbed steadily from 100 percent during 1987 to 1,700 percent in 1988, eventually reaching 12,000 percent during the 12 months ending in August 1990. Inflation was caused by budget

deficits in excess of 8 percent per year, on average, during 1987-1990 and the resulting financing of these deficits by the Central Bank. During this period tax revenues fell substantially, domestic savings fell and the external current account rose to a deficit of nearly 5 percent of GDP in 1990.

Public sector deficits were the result of widespread subsidies (through low public sector tariffs and prices) and reductions in tax revenues (due to the government's tax reductions). In turn, central bank quasi-fiscal losses stemmed from multiple exchange rates, financial subsidies, and monetary transfers to development banks. The consolidated public sector deficit, including the Central Bank's foreign exchange and financial losses, exceeded 10 percent of GDP in 1987 and 1990.

Policy during the latter half of the 1980s reversed financial liberalization: convertibility of dollar deposits into foreign currency deposits was suspended; ceilings were reduced on interest rates; legal reserve requirements were increased to finance subsidized public sector credit, primarily to agriculture; and monetary expansion was out of control. The result by 1990 was a dramatic reduction in financial intermediation in the formal banking system: broad money and credit to the private sector in real terms were only 27 percent and 20 percent, respectively, of their 1985 levels.

Hyperinflation and the decreases in real GDP led to a severe deterioration in real wages. By 1990 real wages were equivalent to 43 percent of their 1988 level. Consumption declined and income distribution, already one of the most unequal in Latin America, worsened.

The new government, which took office in July 1990, implemented a comprehensive stabilization program and structural reforms aimed at rectifying the macroeconomic imbalances, improving competition and achieving an efficient allocation of resources, setting the foundations for long-term growth.

The new economic program has had the following objectives: a) reduce inflation through fiscal and monetary discipline; b) promote efficiency by privatization, deregulation and trade liberalization; c) promote foreign and domestic investment by establishing clear rules and equality of treatment; d) encourage employment by making the labor market more flexible; and e) re-insert Peru into the international financial community.

In order to achieve these objectives, the economic measures taken have included tight monetary and fiscal policies and the removal of price controls and subsidies, with a view toward eliminating the budget deficit; market determination of the exchange rate and interest rates; and trade liberalization through the reduction and consolidation of tariff rates and elimination of quantitative restrictions on imports. Domestic markets have been deregulated, and legal restrictions to private sector employment have been eliminated. Other reforms include: simplification of the tax system and strengthening of tax-collecting institutions; reduction in public sector employment; and removal of state monopolies and the beginning of a process to privatize public enterprises.

The results of this stabilization program have been impressive on the macroeconomic front: The annual inflation rate has declined substantially -- to 40 percent in 1993, with a rate of 27 percent estimated for 1994. Further, international reserves have increased because of an inflow of external capital, and the budget deficit has declined to about 2 percent of GDP and is currently financed through external borrowing. Tax revenues are presently about 10 percent of GDP. The Peruvian Government has re-scheduled its official debt through the Paris Club and is beginning negotiations with its commercial bank creditors. As a result, real GDP grew by almost 7 percent in 1993. Growth arose mainly in the primary sectors of mining, fishing and industrial processing of primary products.

Serious economic problems still remain: the underemployment rate has increased from 37 percent in 1988 to 76 percent in 1992 (data for Lima), and real wages are at 50 percent of their 1988 levels. Though real growth rates of 5 percent are estimated for the next two years, at that rate real GDP per capita in 1996 would still be below its 1988 level. Also, tight monetary policies have led to an overvalued exchange rate, which limits the medium-term growth of non-traditional exports; these tend to labor-intensive and thus could generate significant gains in employment. Therefore, growth during the next two years is likely to focus on primary sectors, which are capital intensive, with small gains in employment. Furthermore, since labor income in Peru is approximately 23 percent of national income, it is unlikely that the benefits of growth will trickle down in terms of higher disposable incomes for the poor in the very near future.

The ability of the Peruvian Government to increase social expenditures is constrained by the still low (by international standards) tax burden in relation to GDP and the high percentage of the budget allocated to payments on the external debt. In the next two years, budgetary social expenditures (*i.e.*, health, nutrition and education) will be financed mainly by borrowing from international financial institutions.

In short, the economic program has set the foundations for sustained growth of the Peruvian economy with increasing incomes in the long run. Nevertheless, in the short run the ability to pay for family planning services is limited by the previous five-year deterioration in disposable incomes for a majority of the population.

**Financial Analysis.** All PVOs involved in the project have taken steps towards achieving some sort of financial sustainability, albeit with varied degrees of success. During the first semester of fiscal year 1993, the percentage of cost recovery by PVO was the following:

PLANFAMI	9 %
PROFAMILIA	14 %
CENPROF	22 %
APROSAMI	24 %
ATLF	25 %
INPPARES	25 %
PLANIFAM	26 %

The main sources of revenue (measured as a percentage of total revenues) were:

- (a) Clinics: PLANFAMI (100%); APROSAMI (86%); CENPROF (59%);  
INPPARES (56%)
- (b) Posts: PROFAMILIA (87%); PLANIFAM (54%)
- (c) Laboratory services: ATLF (86%)

With the support of local consultants, the PVOs have made some progress in cost control and marketing strategies. They charge a unified set of fees and in some cases payment of this fee is waived.

Regarding prospects for cost recovery by raising user fees, it is necessary to weigh the effects on enhanced financial self-sufficiency versus the effects on use of services by lower-income groups, who are the intended target group of the PVFP Project.

The PVOs participated in a price committee to standardize prices and test price elasticity. In committee work it became apparent that some increases in user fees resulted in a reduction of demand for services, although it could not be concluded whether this was due to the price increases themselves or to the economic situation. As long as demand is downward sloping, which is the case for health services, an increase in price will reduce quantity demanded, all else constant. This decrease in quantity demanded could be offset if other factors intervene (*i.e.*, if all else is not constant), such as an increase in incomes or an improvement in the quality of care. The issue, therefore, is not whether a price increase is going to reduce use of the facilities, but by how much use will fall. The response of demand to a change in price will determine the desirability of raising prices and the extent to which they can be raised. To measure this response, elasticities need to be estimated.

Econometric evidence on the price elasticity of demand in developing countries for health services gives a coefficient of -0.2 and an income elasticity of 1.33.<sup>16</sup> This is an average for the country, and the income elasticity is likely to be biased upward. Although the demand for family planning services is likely to be more elastic than that for health services in general, the value of -0.2 is used to illustrate what would happen with an increase in fees. This figure means that if fees were doubled (*i.e.*, a 100 percent increase), for example, the demand for family planning services would fall by 20 percent on average, resulting in an increase of 80 percent in total revenues for the PVOs.<sup>17</sup>

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<sup>16</sup> Over, Mead. *Economics for Health Sector Analysis*. Washington, DC: The World Bank, 1991.

<sup>17</sup> Demand for family planning services by PVOs is also more elastic than demand for family planning services in general. The former has close substitutes: an increase in fees could lead users to switch to commercial or government services. In this case, the effect of a price increase would lead to a loss in market share for the PVOs, and the effect on revenues might be negative.

The elasticity estimate is for all types of services (private, public and NGOs) and all incomes. A recent study<sup>18</sup> shows that the poor are more responsive to a change in prices than people with higher incomes. The price elasticity for a clinic visit in rural Peru rose from -0.02 (highly inelastic) for the highest income quartile to -0.96 for the lowest quartile. This means that in the case of the lowest quartile, a doubling of the price would decrease quantity demanded by 96 percent, increasing total revenue by only 4 percent.

Therefore, pricing services to recover costs would imply a decrease in use by the poor, and this decrease would not be offset by increases in incomes throughout the economy, as pointed out in the above Economic Analysis. Given that one of the objectives of the PVFP Project is to provide services to the poor, the option to charge prices to reflect costs is not feasible nor desirable. A study on demand elasticities may be required to look at the possibilities and trade-offs the PVOs face in this area and to set an optimum pricing strategy for the future.

Given the limitations on achieving financial self-sufficiency by raising user fees, all PVOs are seeking diversification and opportunities for profit-making activities. Most of these activities are health-related, *e.g.*, clinical laboratory services, birthing centers, sonograms, obstetric and gynecological care, and pharmacy services. One of the PVOs, INPPARES, has suggested some interesting ideas in the areas of health education and administration of private sector health programs that, properly managed, might be very profitable. Technical assistance could be provided to the PVOs in the design phase of these alternative sources of income generation, via pre-feasibility studies for example, and these alternatives might not be limited to health activities. However, any new activity will undergo a shake-down period and will need an initial investment by the PVOs, capitalization that would have to be provided by USAID. The extra income from these activities could then be used to cross-subsidize family planning services to the poor.

In summary, the PVOs have made significant improvements towards enhanced self-sufficiency. Although complete self-sufficiency is impossible in the next two years and prices reflecting real costs are not a feasible option, in the long run the PVOs could achieve financial sustainability by diversifying into other income-generating areas. A first step in this direction would be for USAID to provide the means for their capitalization.

**Administrative and Financial Analysis.** As part of the PP Supplement development the USAID reviewed PRISMA's administrative capacity to manage effectively the increased responsibilities for the proposed level of financing and time frame. It has been determined that as an institution it has a satisfactory administrative structure. The internal controls are adequate and effective. The Internal Auditor verifies compliance on a continuous basis.

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<sup>18</sup> Gertler, Paul and van der Gaag, Jacques. *The Willingness to Pay for Medical Care: Evidence from two Developing Countries*. Baltimore, MD: John Hopkins University Press, 1990.

Their annual audit reports reaffirm adequate internal controls and acceptable accountability for Grant funds.

The Grantee was requested to develop an estimated budget based upon the objectives to be reached in the Cooperative Agreement extension. The methodology of budget development was reviewed by Controller staff and found to be reasonable. Costs have been separated by inputs for program implementation and administrative support. The basis for separation is rational and well supported. The basis of development of the proposed overhead rate was also reviewed and found that it followed approved criteria.

In sum, the review conducted by USAID has found that the extension is administratively feasible if handled through PRISMA.

**Gender Considerations.** Gender is taken into consideration in this PP Supplement in several ways. First, its emphasis on offering the full gamut of contraceptive methods<sup>19</sup> in a high quality way does not pre-judge women's and men's needs or desires. Though the state-of-the-art of contraceptive technology is imperfect and continually evolving, programs that offer the full gamut of methods in a non-biased way are more likely to meet the needs of individual women and men, since life situations, gender relations between couples and other determinants of method choice vary greatly and cannot be generalized. By taking the broad view, then, the PVFP Project can best meet specific needs.

Second, to the extent that the project targets men, as well as women, it does two things that are gender-sensitive. It helps meet the needs of men for contraception and/or ways to reduce the risk of sexually-transmitted diseases and HIV/AIDS. It also helps distribute the burden of contraception a little more equally. Though it is clear that contraception is a tremendous advantage to women who wish to postpone, space or limit births, the practice of contraception also has its costs, be they psychic, financial, health-related or social. Increased male responsibility for contraception helps share these costs while accomplishing the same family planning objectives. The extension will therefore promote condoms and vasectomy appropriately, train counselors in skills for counseling men and target men to an appropriate degree in its IEC materials and educational activities. Men also need stronger knowledge on human physiology, the female menstrual cycle and contraceptive mechanisms of all methods in order to be more effective users of contraception with their partners.

Third, the PVFP Project has focused greatly on quality of care and will deepen this thrust even more under the extension. A large part of quality of care refers to educational activities and counseling in ways that are sensitive to the particular needs of women and men. A full

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<sup>19</sup> *The obvious exceptions to this are the diaphragm, which USAID does not presently offer, and depo-provera, whose procurement is currently under negotiation by the AID/W office responsible for centralized purchase and supply of all contraceptives.*

knowledge of their physiology, for example, helps women regulate fertility in non-invasive ways, if they so desire, or choose a contraceptive technology that will not have negative effects on the social relationship with their partner.

Fourth, the PVFP Project contains a substantial training component, encompassing such areas as IEC, clinical services, management, quality of care and information systems. Selection of participants for the various training opportunities will consider gender, so that opportunities in non-traditional roles will be wider for both women and men.

Fifth, in institutional development activities, participating PVOs will be encouraged to consider gender in the make-up of candidates for their Executive Boards, their management staffing and their overall staffing. Consideration should be given to both absolute numbers and location in the organizational hierarchy. To the extent possible, work performed should be remunerated or compensated in kind, rather than relying on volunteerism. This is particularly true if the workers are at a relatively low level; participation in Executive Boards and other top-level jobs may more appropriately be unpaid. Finally, personnel policies should be transparent, with jobs classified according to a scale and equal pay provided for equal work.

## **7. Audit**

PRISMA is a recipient of USAID funds through a Cooperative Agreement as well as a Farm Bill grant; additionally they receive PL-480 Title II and III generated local currencies. To satisfy the audit requirements of each funding source PRISMA contracts annually a comprehensive audit meeting OMB Circular A-133 standards. The auditor is selected from the USAID listing of approved audit firms.

This Agreement has funding provided separately for the audit of the Cooperative Agreement and the sub-grantees whose annual budget exceed \$25,000. The overhead base includes the cost of their institutional audit requirements. The agreement will finance partially the cost of this audit on a provisional overhead rate basis.

## **8. Implementation Strategy**

The basic implementation strategy will remain unchanged. PRISMA will continue as the umbrella group responsible for coordinating and monitoring the project-funded activities of participating PVOs. PRISMA will provide training in needed areas, convene working groups on relevant topics such as IEC, and provide technical assistance as needed. PVOs will submit their operational plans to PRISMA, as well as their proposals for capitalization and for expansion of services to rural areas, as well as the other documents called for in this PP Supplement. PRISMA has final responsibility for implementation and achievement of project

objectives. PRISMA will also continue with the responsibility for importation, management and distribution of all USAID-donated contraceptives.

A brief description of specific activities to be undertaken in the extension period specific to PRISMA and each PVO follows:

**PRISMA.** PRISMA, in collaboration with USAID, will be responsible for developing provisions to the continued funding of PVOs as specified below within thirty days of the beginning of the extension period. This measure will ensure the greatest efficiency possible in USAID's investment.

PRISMA, in collaboration with appropriate PVOs and USAID, will also articulate a rural expansion plan within 60 days of the beginning of the extension period. Provision has been made to subsidize rural expansion within the PVO support line item. PRISMA will consider the institutional capacity of the PVOs in planning for the expansion of rural and marginalized peri-urban programs.

PRISMA will oversee participating PVO IEC workplans as currently planned, under the policy and technical guidance of USAID. PRISMA will review plans and collaborate with PVOs with attention to issues of equity and gender. In general, materials should not assume a derogatory attitude towards women's beliefs by labeling them ignorance, myth or rumor. Family planning and reproductive health IEC should attempt to portray positive images of women and their beliefs. General posters and leaflets should consider the range of methods, rather than focus on one method exclusively. More attention should also be given to explaining how the method actually prevents conception. To date, the focus has overwhelmingly been making women good compliers, with insufficient attention to their full educational needs.

Materials to date have also focused on the economic benefits of smaller families. Under the extension, the IEC committee should consider focusing on the health rationale behind family planning and reproductive health programs. Worldwide, providing women with the information they need to keep themselves and their children healthy has proved a powerful motivator in the adoption of family planning. In past materials, contraindications of certain methods, such as the IUD, are not elaborated. There is no mention of possible side effects or the health benefits of contraceptive use in the general information on methods. Studies show that women are less likely to discontinue method use when fully cognizant of side effects.

The key staff that will be required for PRISMA to satisfactorily meet these expectations follows. All key staff and consultants are subject to the approval of the USAID Project Officer.

- (a) Project Administrator (full time): This person will have day-to-day responsibility for all aspects of the project. He/she will be the primary liaison between the project and USAID and with the Ministry of Health and IPSS for the contraceptive component. He/she should have relevant experience and/or education in institutional development, management, administration, economics and family planning.
- (b) Family Planning Specialist/Program Coordinator (full time): This person will have primary responsibility for the family planning programs, including quality of care, supervision and monitoring. He/she will identify training needs and organize fora to meet those needs. He/she should have strong experience in the delivery of family planning services and, preferably, have training as a nurse, midwife or physician.
- (c) Assistant to the Program Coordinator (full time): This person will assist the family planning specialist in monitoring and supervision of programs and in preparation of training fora, among other responsibilities. He/she should have substantial experience in family planning service delivery and have training as a nurse or midwife.
- (d) Logistics and Systems Chief (full time): This person will have responsibility for working with the PVOs in finetuning and utilization of the management information system. He/she will also have responsibility for tracking the contraceptive supplies that enter the country under USAID auspices. He/she will have first-line responsibility for statistical reporting on the projects. This person should have training and experience in computer systems and management information systems.
- (e) Project Accountant (full time): This person will have responsibility for monitoring all project expenditures, by type and by PVO. He/she should have a degree, preferably a graduate degree, in accounting and should have several years of work experience in the field.
- (f) Communications Specialist (one-third time): This person will work with the PVOs in developing information, education and communications (IEC) materials, and will work with the family planning specialist to develop materials for training fora. He/she should have training in communications and/or anthropology and should have work experience in the field, preferably in relation to public health generally or family planning particularly.
- (g) Rural Services Advisor (full-time): This person will work with the PVOs in planning and implementing their expansion into rural areas. He/she should have direct experience in managing and delivering services in rural areas and should have clinical training as a nurse, midwife or physician.
- (h) Income-generation Advisor (half-time): This person will work with the PVOs in devising plans for and implementing their individual schemes for income generation, including their proposals for capitalization. This person should have direct experience in income generation for non-profits, as well as demonstrated success in such undertakings.

The income-generation advisor may be a consultant rather than a staff position, as long as the time commitment remains the same and the cost does not exceed that of a half-time staff person.

Further, the project may support up to one-fourth of the time of the Executive Director of PRISMA. The proportion of time depends on the results of the administrative analysis now underway. The Executive Director will have overall responsibility for project implementation, liaison with USAID, the Ministry of Health, IPSS and the PVOs. He/she should have graduate training in public health or a related area and substantial work experience in the field.

**Rewarding good performance.** While some level of support will be continued for all seven PVOs, levels will not necessarily be consistent with the past 4.5 years. Good performers will be supported more actively. In the development of this PPS, good performance has been measured by several indicators taken as a whole. Prominent among them:

- a good record in reporting to PRISMA and participating in training and other opportunities for institution strengthening offered under the project;
- evidence of effort to reform and internalize reforms;
- attainment of at least a minimum threshold of service provision;
- demonstrated ability to generate income to recover at least a certain portion of costs;
- evidence of commitment to serving rural and marginal urban areas;
- commitment to quality of care, including client-oriented counseling and education on the range of contraceptive options.

Following is an outline of the major activities to be supported with each PVO under the project extension. The final description of activities to be supported and the level of support for each PVO will be developed by PRISMA, in consultation with and subject to approval by USAID, within the first sixty days of the extension period. PRISMA, in consultation with USAID, will also draw up the provisions that each PVO must meet in order to qualify for the types of support illustrated below during the extension.

**APROSAMI.** Due to management and supervision problems, funding for APROSAMI will be reduced significantly during the extension period. APROSAMI may continue to receive donated commodities and equipment and will be eligible to participate in in-service training. Consideration will be given to requests for technical assistance that can help APROSAMI make the transition to an institution not directly supported by USAID.

**ATLF.** ATLF operates a well-equipped laboratory and clinic, but these facilities suffer from underutilization. ATLF will be eligible to request a qualitative study on non-use of their facilities, with the objective of identifying ways to promote and increase use of the services offered. Some measure of support will also be continued for their *Unidades de Trabajo Comunitario*, which work with low-income populations in promoting natural family planning. Consideration will also be given to requests for technical assistance in the area of administration, a current institutional weakness.

**CENPROF.** CENPROF has made great strides towards self-sufficiency and has consistently taken advantage of technical assistance. Activities with CENPROF will minimally be maintained during the extension period, with the strong possibility of additional resources, if appropriate proposals for their use are presented. Discussion and analysis will center on determining CENPROF's capability and willingness to undertake expansion into underserved rural areas outside of Trujillo. Requests for appropriate types of one-time capitalization will also be considered.

**INPPARES.** Work with INPPARES will focus on institution strengthening. Assistance in supervision and logistics will be maintained. PRISMA will work with INPPARES to promote more open management and personnel practices. In order to maximize the possibility of success, this work will be carried out with the IPPF's Transition Project. USAID/Peru will help facilitate this cooperation. If provisions for increased support are met, INPPARES may receive funding to expand its community-clinic model to cover additional areas in greater Lima. PRISMA will also explore with INPPARES its ability to expand services to rural areas outside of Lima and in provinces where INPPARES has a foothold. Requests for appropriate types of one-time capitalization will also be considered.

**PLANFAMI/Puno.** PVFP activities with PLANFAMI/Puno will be strengthened and rural outreach programs expanded. Though the youngest PVO, PLANFAMI is perhaps the organization that is currently best positioned to increase access in chronically underserved rural areas, given the demographics and other characteristics of Puno. Technical assistance will continue to help strengthen PLANFAMI's institutional base and for developing a broader strategy for rural extension. Requests for appropriate types of one-time capitalization will also be considered.

**PLANIFAM/Cusco.** As the only PVO provider of family planning services in Cusco, assistance to PLANIFAM/Cusco will minimally be maintained and even increased, if provisions are met and sound plans for extension are presented. PLANIFAM needs to develop more formal organizational policies in a number of management and administrative areas. The organization is currently providing services in some rural sites, and there is opportunity for further rural outreach, under the appropriate circumstances. Requests for appropriate types of one-time capitalization will also be considered.

**PROFAMILIA.** Due to internal management problems, assistance to PROFAMILIA will be limited to donated contraceptive commodities and some equipment. Requests for appropriate

types of technical assistance will be considered, and PROFAMILIA staff will also be eligible to participate in training fora. PROFAMILIA has recourse to sources of support outside this project to help maintain the modest amount of service delivery it currently provides.

Budgets for the extension period are contained in the Annex I.

## **9. Method of Implementation**

The method of implementation outlined in the PP is presented in Annex II. These procedures are repeated in this document for reference. USAID/Peru will obligate and implement the project extension through a 17-month amendment to the existing cooperative agreement with a Peruvian non-profit organization, Asociacion Benefica/Proyectos en Informatica, Salud, Medicina y Agricultura (A.B. PRISMA). Planned funding to the participating PVOs will be channeled through the cooperative agreement.

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

(a) Contraceptive Commodities. The Implementing Agency will request USAID to transfer funds to purchase contraceptives distributed under the Project. USAID will review commodity requests and issue the necessary cables to A.I.D./W. The Implementing Agency will be responsible for receiving, storing, and distributing contraceptives to the public and private sectors once the commodities are in country. The Implementing Agency will keep USAID informed of stock levels, sub-grants with recipients of supplies and any problems that may occur related to contraceptive supplies.

(b) Project Personnel. USAID approval will be required prior to selection and contracting of key Project personnel by the Implementing Agency. These include the Project Administrator, Family Planning Specialist/Program Coordinator, Assistant to the Program Coordinator, Logistics and Systems Chief, Project Accountant, Communications Specialist, Rural Services Advisor, and Income-generation Advisor. Any deviation from the number of support personnel will require the prior approval of USAID, as will any changes in level of effort of PRISMA'S Director during life-of-project.

(c) Local Contracts for Technical Services and Consultants. USAID will review the scopes of work for all sub-contracts issued by the Implementing Agency under the Cooperative Agreement for local technical services, studies, and consultants. This will include, but not be limited to, institutional financial audits of the Implementing Agency and participating PVOs and technical studies planned. Prior approval from USAID will be required for all contracting actions, and for selection of sub-contractors and consultants.

(d) PVO Sub-grants. USAID will review PVO workplans and sub-grant budgets for institutional support and technical assistance. Prior approval from USAID will be required for all PVO sub-grants under the Cooperative Agreement.

(e) Evaluation of PRISMA. With the possible assistance of a consultant, USAID will conduct an in-house evaluation in October 1994. An external final evaluation of the Project will be conducted in July 1995. Funding for both activities will come from the Cooperative Agreement.

(f) Evaluation of Participating PVOs. USAID will participate with the Implementing Agency in end-of-period evaluations of progress made by the participating PVOs in achieving their institutional and service delivery goals. All decisions regarding continuation or discontinuation, inclusion or non-inclusion of PVOs in the Project and/or Project activities will require the prior approval of USAID.

(g) Working Capital Interventions. USAID will participate in all aspects of the capitalization activities, from the design and selection of projects by PVOs to the actual contracting actions for carrying out any resulting decisions (e.g. purchases).

(h) USAID Monitor. USAID will issue the PIO/T for direct contracting of the USAID Monitor.

## **10. Monitoring and Evaluation Plan**

**USAID Monitoring and Evaluation.** Monitoring and evaluation under the project extension will include all objectives, but will emphasize those objectives not fully accomplished during the first four years of project implementation. The Health, Population and Nutrition Office in USAID/Peru will have responsibility for managing the project. The Deputy Chief of that office will serve as the Project Officer and will be responsible for the administrative approval of all project inputs and for overall project monitoring and coordination.

The Project Officer will be assisted by a personal services contractor (PSC) contracted from funds reserved under the Cooperative Agreement. The major responsibility of the PSC will be to assist PRISMA in carrying out its responsibilities under the cooperative agreement, including ensuring compliance with project objectives and USAID procedures. The PSC monitor will also be the point of day-to-day contact between USAID and PRISMA. Other project monitor activities will remain unchanged as described in the PP (pages 64-65).

Evaluation will be based on indicators as stipulated throughout this document, *i.e.*, those that are critical to the purpose of the extension. With the possible assistance of a consultant, USAID will conduct an in-house evaluation of extension activities and indicators in October 1994, six months after the extension implementation date. Results of this evaluation may

alter some of the activities laid out in the PPS. A final evaluation of the project will be conducted in July 1995.

**PRISMA Monitoring and Evaluation.** USAID/Peru will complete its administrative analysis of PRISMA before the negotiation of a follow-on cooperative agreement. This analysis will determine follow-on actions with regard to financial management under the extension.

Within PRISMA, monitoring and evaluation will be conducted in several ways. PVO performance will be monitored and evaluated via supervisory announced and unannounced visits to service points. PVOs will be required to report service statistics and other information to PRISMA every three months. PRISMA, in turn, will compile this information and submit a monitoring and evaluation report to USAID four times a year.

## **11. USAID/Peru Procedures**

**Twenty-five Percent Contribution Requirement.** Waiver of the A.I.D. policy of a 25 percent contribution to total life-of-project costs is justified, among other reasons, by the service PRISMA provides to the Mission by channeling funds to the PVO sector, which is an important element of USAID/Peru's family planning service delivery strategy, and by ensuring the use of these funds to advance the availability of services to Peruvian couples who desire them. Additionally, in accepting the task of handling all USAID donated-contraceptive supplies for distribution to public and private sectors, the amount of money saved through the logistical system established to avoid losses and waste represents thousands of dollars per year. Over the life of the project these savings may even exceed the 25 percent contribution in a PVFP Project with no budget for contraceptives. See Annex IV Justification for Waiver of 25 Percent Contribution Requirement.

**Technical Notification.** Technical Notification 291 expired without objection on March 29, 1994. Budget allowance in the amount of \$3,300,000 has been received via STATEs 049386 dated February 26, 1994 and 063171 dated March 11, 1994.

## Annex I - Table I

Estimated Budget  
Revised Life of Project by Component  
(US\$)

	Prior Amount Obligated	This Amendment		LOP Estimated Budget
		Adjustments	PP Supplement NOA	
<b>A. <u>Program Costs</u></b>	<b><u>11,797,232</u></b>	<b><u>2,768</u></b>	<b><u>4,750,000</u></b>	<b><u>16,550,000</u></b>
1. PVO Institutional Support	2,973,108	(203,108)	1,890,000	4,660,000
2. Technical Assistance	751,611	28,389	570,000	1,350,000
3. Commodities & Management	6,824,063	305,937	340,000	7,470,000
a. Supplies	6,544,441	559	115,000	6,660,000
b. Logistics	279,622	305,378	225,000	810,000
4. Working Capital Interventions	---	---	770,000	770,000
5. Program Management	926,185	(126,185)	580,000	1,380,000
6. Audits and Financial Reviews	156,828	3,172	20,000	180,000
7. Direct Administrative Costs (Provisional Overhead 13.78%)*	165,437	(5,437)	580,000	740,000
<b>B. <u>Administrative Costs</u></b>	<b><u>472,768</u></b>	<b><u>(2,768)</u></b>	<b><u>200,000</u></b>	<b><u>670,000</u></b>
a. USAID Monitoring	412,768	(2,768)	160,000	570,000
b. Evaluations	60,000		40,000	100,000
<b>TOTAL COOPERATIVE AGREEMENT</b>	<b><u>12,270,000</u></b>	<b><u>---</u></b>	<b><u>4,950,000</u></b>	<b><u>17,220,000</u></b>

(\*) Provisional Overhead Rate applicable to this Amendment period (May 1, 1994 through September 30, 1995)

Note: It is anticipated that there will be an allowance for 15 percent flexibility between line items. Any amount in excess will require formal Cooperative Agreement amendment.

Estimated LOP Budget  
By Component and Sub-Component  
(US\$000)

Annex I - Table II

	Amendment No. 10	This Amendment	LOP Estimated Cost
<b>I. PROGRAM COSTS</b>			
<b>A. PRISMA Implemented</b>			
1. PVO Support (Basic)	2,785	820	3,595
- ATLF	193	70	263
- CENPROF	249	81	330
- INPPARES	574	488	1,062
- PLANIFAM/Cusco	275	135	410
- PLANFAMI/Puno	148	56	204
- Other	1,326	--	1,326
2. PVO Support (Expansion)	---	1,065	1,065
- Improved Services		44	44
- Equipment and Instruments		257	257
- Rural Areas		764	764
3. Technical Assistance	776	575	1,351
- IE&C	62	141	203
- Training	91	134	225
- Research	623	150	773
- Other	--	150	150
4. Commodities & Management	469	340	809
- Supplies	--	115	115
- Logistics	469	145	614
- Inventory Costs	--	80	80
5. Working Capital Interventions	--	770	770
- Investment		670	670
- Research	--	100	100
6. Program Management	813	570	1,383
- Wages and Benefits	455	491	946
- Office Expenses	99	22	121
- Vehicle Costs	120	13	133
- Local Travel	83	30	113
- Office Equipment	56	14	70
7. Audits and Financial Reviews	157	20	177
<b>TOTAL PROGRAM DIRECT COSTS</b>	<u>4,980</u>	<u>4,170</u>	<u>9,150</u>
Provisional Overhead Rate 13.78%	158	580	738
<b>TOTAL PRISMA COSTS</b>	<u>5,138</u>	<u>4,750</u>	<u>9,888</u>
<b>B. USAID Implemented (Contraceptives)</b>	<u>6,659</u>	---	<u>6,659</u>
<b>TOTAL PROGRAM COSTS</b>	<u>11,797</u>	<u>4,750</u>	<u>16,547</u>
<b>II. USAID SUPPORT COSTS</b>			
1. Monitoring	473	200	673
2. Evaluation	413	160	573
	60	40	100
<b>TOTAL COOPERATIVE AGREEMENT</b>	<u>12,270</u>	<u>4,950</u>	<u>17,220</u>

Estimated Budget  
Project Period Extension  
May 1, 1994 through September 30, 1995  
(US\$000)

Annex I - Table III

	PRISMA Cost <u>Estimates</u>	USAID Adjustments <u>          </u>	Proposed Estimated <u>Costs</u>
<b>PRISMA IMPLEMENTED COSTS</b>			
<b>I. <u>PROGRAM DIRECT COSTS</u></b>			
A. <u>PVO Support (Basic)</u>	<u>832</u>		<u>832</u>
- ATLF	70		70
- CENPROF	83		83
- INPPARES	488		488
- PLANIFAM/Cusco	135		135
- PLANFAMI/Puno	56		56
B. <u>PVO Support (Expansion)</u>	<u>1,063</u>		<u>1,063</u>
- Improved Services	42		42
- Equipment and Instruments	257		257
- Rural Areas	764		764
C. <u>Technical Assistance</u>	<u>498</u>	<u>77</u>	<u>575</u>
- IE&C	141		141
- Training	134		134
- Research	161	(11)	150
- Other	62	88	150
D. <u>Commodities and Management</u>	<u>226</u>	<u>115</u>	<u>341</u>
- Supplies	--	115	115
- Logistics Management	146		146
- Inventory Costs	80		80
E. <u>Working Capital Interventions</u>	<u>668</u>	<u>100</u>	<u>768</u>
- Investment	668		668
- Research	--	100	100
F. <u>Program Management</u>	<u>571</u>		<u>571</u>
- Wages and Benefits	492		492
- Office Expenses	22		22
- Vehicle Costs	13		13
- Local Transportation	30		30
- Office Equipment	14		14
G. Audits and Financial Reviews	<u>21</u>		<u>21</u>
<b>TOTAL PROGRAM DIRECT COSTS</b>	<u><b>3,879</b></u>	<u><b>292</b></u>	<u><b>4,171</b></u>
Provisional Overhead Rate 13.78%	<u>535</u>	<u>40</u>	<u>575</u>
<b>TOTAL PRISMA IMPLEMENTATION</b>	<u><b>4,414</b></u>	<u><b>332</b></u>	<u><b>4,746</b></u>
<b>USAID Implemented Costs</b>	<u><b>200</b></u>	<u><b>---</b></u>	<u><b>200</b></u>
- Monitoring	160		160
- Evaluation	40		40
<b>TOTAL PROPOSED AMENDMENT</b>	<u><b>4,614</b></u>	<u><b>332</b></u>	<u><b>4,946</b></u>

Note: PRISMA cost estimates were developed based upon objectives provided by the USAID for the 17 month extension period.

**ILLUSTRATIVE BUDGET BY PERIOD OF OBLIGATION**  
(PRISMA Cooperative Agreement No. 527-0335-A-00-9373-00)

	12 mo.	5 mo.	Total
<b>I. <u>PROGRAM DIRECT COSTS</u></b>			
<b>A. PRISMA Implemented</b>			
<b>1. PVO Support (Basic)</b>	<b><u>485,000</u></b>	<b><u>345,000</u></b>	<b><u>830,000</u></b>
a. ATLF	40,000	30,000	70,000
b. CENPROF	50,000	30,000	80,000
c. INPPARES	280,000	210,000	490,000
d. PLANIFAM/Cusco	80,000	55,000	135,000
e. PLANFAMI/Puno	35,000	20,000	55,000
<b>2. PVO Support (Expansion)</b>	<b><u>740,000</u></b>	<b><u>325,000</u></b>	<b><u>1,065,000</u></b>
a. Improvements	30,000	15,000	45,000
b. Equipment	150,000	105,000	255,000
c. Rural	560,000	205,000	765,000
<b>3. Technical Assistance</b>	<b><u>400,000</u></b>	<b><u>175,000</u></b>	<b><u>575,000</u></b>
a. IE&C	100,000	40,000	140,000
b. Training	100,000	35,000	135,000
c. Research	100,000	50,000	150,000
d. Other	100,000	50,000	150,000
<b>4. Commodities &amp; Management</b>	<b><u>200,000</u></b>	<b><u>140,000</u></b>	<b><u>340,000</u></b>
a. Supplies	60,000	55,000	115,000
b. Logistics Management	100,000	45,000	145,000
c. Inventory	40,000	40,000	80,000
<b>5. Working Capital Interventions</b>	<b><u>600,000</u></b>	<b><u>170,000</u></b>	<b><u>770,000</u></b>
a. Investment	500,000	170,000	670,000
b. Research	100,000	---	100,000
<b>6. Program Management Costs</b>	<b><u>390,000</u></b>	<b><u>180,000</u></b>	<b><u>570,000</u></b>
a. Wages and Benefits	330,000	160,000	490,000
b. Office Expenses	15,000	5,000	20,000
c. Vehicle Expenses	10,000	5,000	15,000
d. Local Transportation	20,000	10,000	30,000
e. Office Equipment	15,000	---	15,000
<b>7. Audits &amp; Financial Reviews</b>	<b><u>10,000</u></b>	<b><u>10,000</u></b>	<b><u>20,000</u></b>
<b>TOTAL PRISMA PROGRAM COSTS</b>	<b><u>2,825,000</u></b>	<b><u>1,345,000</u></b>	<b><u>4,170,000</u></b>
PRISMA Overhead 13.78%	<b><u>389,285</u></b>	<b><u>185,341</u></b>	<b><u>574,626</u></b>
<b>TOTAL PRISMA COSTS</b>	<b><u>3,200,000</u></b>	<b><u>1,550,000</u></b>	<b><u>4,750,000</u></b>
<b>USAID Support Costs</b>	<b><u>100,000</u></b>	<b><u>100,000</u></b>	<b><u>200,000</u></b>
1. Monitoring	100,000	60,000	160,000
2. Evaluation	---	40,000	40,000
<b>TOTAL GRANT AMENDMENT</b>	<b><u>3,300,000</u></b>	<b><u>1,650,000</u></b>	<b><u>4,950,000</u></b>

**METHOD OF IMPLEMENTATION BY  
TYPE OF ASSISTANCE AND FINANCING METHOD  
(\$000)**

INPUTS	METHOD OF IMPLEMENTATION	METHOD OF FINANCING	LOP ESTIMATED AMOUNT
<b>I. <u>PROGRAM COSTS</u></b>			
A. PRISMA Implemented			
1. PVO Basic Support			3,595
2. PVO Expansion	PIL-type documents	Reimbursement	1,065
3. Technical Assistance	under Cooperative	and/or Periodic	1,350
4. Supplies and Logistics	Agreement with PRISMA	Advances	925
5. Working Capital Interventions			770
6. Program Management			1,380
7. Audits and Financial Reviews			180
8. Overhead (indirect costs)		Reimbursement	740
B. USAID Implemented			
1. Contraceptives	Funds transfer to	AID/W Direct Payment	<u>6,545</u>
TOTAL PROGRAM COSTS			16,550
<b>II. <u>ADMINISTRATIVE COSTS</u></b>			
1. USAID Monitoring	PSC (PIO/T)	Direct Payment	570
2. Evaluation	Contract (PIO/T)	Direct Payment	<u>100</u>
TOTAL ADMINISTRATIVE COSTS			<u>670</u>
<b>TOTAL PROJECT</b>			<b><u>17,220</u></b>

**Justification for Waiver  
of 25 Percent Contribution Requirement**

Per standard USAID policy, PVOs with operational program grants (OPGs) or operational program cooperative agreements (OPCAs) should make a 25 percent contribution to total life-of-project costs from non-USAID sources. Although this provision is not mandated by legislation, USAID has administratively determined to establish the requirement. This non-USAID contribution may include cash and in-kind contributions from PVOs, local collaborators and other non-governmental donors, as well as from host governments, other governments and international organizations.

The PVFP Project is not the typical project in which USAID receives a proposal from a PVO requesting assistance to carry out a program. In this case, rather, USAID approached PRISMA in 1989 and requested that it become the umbrella organization for funding and technical assistance to the six indigenous PVOs who actually deliver the family planning services. At that time the PVOs lacked the administrative and financial maturity to control and monitor USAID funds. Thus at that time the 25 percent requirement was waived.

During the past 4.5 years, the participating PVOs have improved their income-generation, so that they are now recovering some 20-30 percent of their costs. Though as sub-grantees they are technically not required to contribute to the total life-of-project costs, this recovery is tantamount to the 25 percent requirement, since PRISMA channels USAID funds to the PVOs. Since PRISMA does not deliver services, it does not have the potential to recover costs directly.

Further, during the past 4.5 years, PRISMA has worked without an overhead rate, with USAID sharing a limited portion of indirect costs directly. The net effect of this situation is that PRISMA has been contributing to life-of-project costs, since the PVFP Project has benefitted from PRISMA institutional support in office facilities and technical expertise.

Third, a major part of the PVFP Project budget is devoted to the acquisition of contraceptive commodities. PRISMA is the channel for all USAID-donated contraceptives in Peru, whether their distribution be through the public or private sector. The large volume of funds required for this critical logistical task inflates the PVFP Project budget beyond the real scope of its technical assistance and service delivery activities. The rationalized distribution system that PRISMA has developed, moreover, results in savings in losses and waste that may even exceed the value of a 25 percent contribution in a PVFP Project with no budget for contraceptives.

Under the extension, PRISMA will again be channeling funds to the PVOs and handling all USAID-donated contraceptives. It will work with the PVOs to continue to enhance their income-generation and cost-recovery activities. Realistic expectations are that the PVOs might be recovering as much as 50 percent of costs by the end of the 17-month extension.

In view of the above, waiver of the requirement that PRISMA directly make a 25 percent contribution to life-of-project costs is justified.