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**PROJECT PERFORMED FOR**  
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**Development *(Office of Population)***

**Deloitte &  
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**EVALUATION OF  
USAID/PERU PROJECT NO. 527-0335**

**PRIVATE VOLUNTARY FAMILY  
PLANNING SERVICE EXPANSION  
PROJECT**

**APRIL 18-MAY 8, 1993**

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**THE PROFIT PROJECT  
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## ACRONYMS

APROSAMI	Asociacion Profesional para Promotores de la Salud Materno-Infantil
APF	Asociacion de Planificacion Familiar
AQV	Anticoncepcion Quirurgica Voluntaria
ATLF	Asociacion de Trabajo Laico Familiar
AVSC	Association for Voluntary Surgical Contraception
BCR	Banco Central de Reserva
CA	Cooperating Agency
CBD	Community-Based Distribution
CE	Coordinating Entity
CEDPA	Center for Development and Population Activities
CENPROF	Centro Nor-Peruano de Capacitacion y Promocion Familiar
CPT	Contraceptive Procurement Tables
CSM	Contraceptive Social Marketing
CYP	Couple-Year-Protection (Años de Proteccion Pareja)
DHS	Demographic and Health Survey
EOP	End-of-Project
FP	Family Planning
IA	Implementing Agency
INPARRES	Instituto Peruano de Paternidad Responsable
IPSS	Instituto Peruano de Seguridad Social
IPPF	International Planned Parenthood Federation
IUD (DIU)	Intra-Uterine Device (Diapositivo Intra Uterina)
LAC/DR	AID Bureau for Latin America & the Caribbean
LOP	Length of Project
LT	Long-Term Anticonceptive Methods
MIS	Management Information Systems
MOH	Ministry of Health
NGO	Non-Governmental Organization
PF	Planificacion Familiar
PLANIFAM	Proyecto Planificacion Familiar
PRISMA	Proyectos en Informacion, Salud, Medicina y Agricultura
PROFAMILIA	Promocion de Labores Educativas y Asistenciales en Favor de Salud
PVFP	Private Voluntary Family Planning Project (527 - 0335)
PVO	Private Voluntary Organization
S & T	Bureau of Science and Technology
SPF	Private Sector Family Planning Project (527 - 0269)
ST	Short-Term Anticonceptive Methods
STD	Sexually Transmitted Diseases
TAG	Technical Advisory Group
UDES	Ministry of Health Department Health Units
USDH	U.S. Direct Hire
VSC	Voluntary Surgical Contraception

**SECTION 1**  
**EXECUTIVE SUMMARY, MAJOR FINDINGS, PRINCIPAL RECOMMENDATIONS**

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**1. EXECUTIVE SUMMARY, MAJOR FINDINGS AND PRINCIPAL RECOMMENDATIONS**

**1.1 Purposes of the Evaluation<sup>1</sup>**

The principal purposes of the evaluation are to review progress towards the goals and objectives of the PVFP, with emphasis on the financial sustainability of the NGOs involved; and, to make recommendations regarding the possibility of a one or two year extension.

**1.2 Main Focus and Objectives of the Evaluation**

While virtually all evaluations assess the multiple components of a project and its intervention results or progress, it was emphasized by USAID/Peru/HPN that the major concern was on the aspects of and progress towards financial sustainability of the NGOs participating in the PVFP. This component was stated explicitly as a goal or objective in the Project Paper, and it is clear in that document (and concordant with A.I.D./Washington-R&D/POP philosophy<sup>2</sup>), that the formal objectives stated below should establish conditions that would lead to this meta-goal. Accordingly, the specific project objectives to be assessed are:

- ◆ To assess progress towards institutional capacity by the NGOs;
- ◆ To assess progress towards shifting to long-term contraceptive methods;
- ◆ To assess on-going support for short-term methods and natural family planning;
- ◆ To assess progress towards expansion into rural areas by the relevant NGOs and cooperation with Public Sector (MOH, IPSS) through the private utilization of public service facilities during public sector "down time".

In the initial briefing with Mission HPN Staff, the emphasis on financial and institutional sustainability was reinforced. Specific questions asked included:

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<sup>1</sup> A.I.D. Peru Scope of Work and related relevant correspondence is in Appendix I.

<sup>2</sup> See, for example, Gillespie, Duff, 1987 and 1988. In addition A.I.D. has established phase-down/out policies for several countries whose current programs are designed specifically towards self-sustaining activities by NGOs.

- ◆ Is self-sustainability a viable option?
- ◆ How can the NGOs (given their individual missions and characteristics) prepare for and strive towards self-sustainability?
- ◆ How can (financial) dependence on A.I.D. be reduced?
- ◆ Of the NGOs participating in the PVFP Project how many should continue and which ones? Is the concept of merger(s) viable?

It is of major importance to note, both for this evaluation and for A.I.D. (and the international development community in general) that there is no clear, nor commonly accepted definition of "sustainability". The concept runs the gamut from relatively "soft" - diversification of donor funding sources (spreading dependency risk), to "hard" - virtual independence from donors through mechanisms of self-generated income, with donations viewed as a welcome, but not an operationally necessary, addition.

### 1.3 Major Findings (generalizations from all agencies)

1.3.1 At this time, none of the NGOs involved in the PVFP are either institutionally or financially self-sufficient. They range from total dependency (and insufficient support) with very low prospects of survival (PLANFAMI - Puno; ATLF), to those with reasonably good prospects in the foreseeable future (APROSAMI, INPPARES, and PROFAMILIA). CENPROF and PLANIFAM, probably because of their geographical location have high institutional prospects but severe economic limitations.

In agencies which do generate significant income from other health-sector activities, this income very often must be used to support either PVFP or overhead costs which reduces capital available for income generating investment.

1.3.2 Institutional capacity and strengthening results are multi-dimensional and vary considerably among and between agencies. Nevertheless in all cases a clear awareness exists that this is a critical issue to their growth and independence. One good indicator of this is the understanding of the vocabulary associated with institutional capacity: strategic planning; cost analyses; market segmentation, etc. Nevertheless the translation of these concepts into operational activities is generally weak in most cases.

1.3.3 All agencies (except ATLF) appear to have made significant advances towards increasing the use of long-term contraceptive methods.

- 1.3.4 Support for short-term methods has been affected variably by the reduction in funds for community based distribution (CBD) activities in some agencies. Some agencies have continued support for CBD promotional activities on their own.

Natural family planning (NFP) information is variably provided by all agencies during counselling activities. However, NFP itself will not generate income, and must be supported by aggressive income generating activities in both the health and non-health sectors.

- 1.3.5 Expansion into rural areas and cooperation with public sector institutions has been attempted with very limited success. Principally, the Evaluation Team believes this is a project design contradiction, in conflict with objectives towards building institutional capacity and financial self-sustainability.

Given the economic situation in Peru, rural services (i.e. focused on traditional *campesinos*) result in net financial losses to agencies, and must depend on cross-subsidies from other income sources. Hence goals for rural expansion (which often rely on some form of community based promotion) are in apparent conflict with goals of institutional capacity and self-sustainability. That is, whatever income that may be earned from delivery of urban services seems to have been siphoned-off to support rural extension.

Attempts to coordinate services by having agencies provide services in under-utilized public sector facilities has met with two principal problems. The first is confusion on the part of the populations served as to why services (which are apparently the same or similar) are charged-for during NGO activities, and free during public sector service schedules. The second deals with reported resentment on the part of MOH physicians who are not paid on a fee-for-service basis.

- 1.3.6 PRISMA as an implementing agency, has undertaken appropriate activities to accomplish the goals of the PVFP Project. In general, it has been effective in establishing good and effective relationships with all NGOs. This is no mean task given the heterogeneity of the NGOs and the circumstances inherited from the PVFP predecessor, the SPF.

Shortcomings noted that have considerable effect on the NGOs relate especially to initial involvement and follow-up on studies and recommendations done by private technical consultants. This is coupled with a paucity of transfer of technology or methodology for the

NGOs to conduct studies of their own in cost analysis, marketing and pricing. The work done on strategic planning is an exception.

**1.4 Principal Recommendations**

- 1.4.1 That the PVFP be extended for a two-year period.
- 1.4.2 That the first year focus specifically on institutional capacity building by updating (or re-doing) the technical assistance aspects of: MIS, Cost Analysis, Market Analysis, Strategic Planning, and, Investment Opportunities - and incorporating these into the NGOs at the institutional level.
- 1.4.3 That specific goals and targets with respect to institutional capacity be defined in conjunction with the NGOs.
- 1.4.4 That participation of the NGOs in the second year financing be contingent upon satisfactory achievement of the first year goals.
- 1.4.5 That budget modifications include the inclusion of an Income Generating Coordinator for PRISMA.
- 1.4.6 That budget modifications in Year-One include provision for basic equipment and instruments for the NGOs.
- 1.4.7 That budget modifications include a Year-Two Capitalization budget for the NGOs.

**SECTION 2**  
**PRIVATE VOLUNTARY FAMILY PLANNING PROJECT (PVFP)**

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**2. THE PRIVATE VOLUNTARY FAMILY PLANNING SERVICE EXTENSION PROJECT (527-0335)**

The Private Voluntary Family Planning Project (PVFP), (527-0335), supplanted the Private Sector Family Project (SFP), (527-0269), when that project was prematurely terminated for program direction policy, management and other reasons.

In September, 1989, a non-competitive award was made to A.B. Proyectos en Informática, Salud, Medicina y Agricultura (PRISMA) to implement the PVFP for a one-year period. Contingent on satisfactory performance (evaluated at the eight-month mark), the PVFP would be awarded to PRISMA for the completion of the project.

Based on satisfactory evaluation in 1990, an amendment to the PVFP was made on October 3, 1990, in which PRISMA was awarded the contract for the remaining three years, and the budget was amended to \$11.8 million.

**2.1 Summary of Purpose of the PVFP**

"The project goal is to improve the quality of life for Peruvian families through increased access to the means to achieve the desired number and spacing of their children. The project purpose is to maximize the availability of family planning services to women and men who wish to use them by strengthening the capacity and improving the performance of the private voluntary sector to deliver quality and efficient services, focusing on long-lasting contraceptive methods, and maintaining support for temporary supply methods and natural family planning methods." (Project Paper [PP], p. 2.)

**2.2 Four Main Goals of the PVFP**

The project paper specifies that the PVFP has four main goals:

- ◆ To increase the capacity of selected PVOs to delivery family planning services (institution building);
- ◆ To improve the availability of long-lasting contraceptive methods;
- ◆ To maintain support for temporary supply methods and natural family planning; and,
- ◆ To enhance rural family planning coverage through PVO-public sector collaboration. (PP, p. 43.)

In addition to these four goals, it is clearly indicated that a main focus is on the "Sustainability of PVO Operations" (PP, p. 16). This paragraph states:

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

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

"Sustainability of PVO operations is an important goal in and of itself and becomes more urgent in light of decreasing availability of OYB funds in the USAID population account and decreased emphasis on Latin America within A.I.D./W centrally-funded population projects. While sustainability ultimately depends on larger economic factors and clients' ability to pay, the economic and financial analyses performed as part of the development of this project suggest that significant income could be generated through the sale of donated commodities, which account for more than half of the direct institutional support provided to the PVOs." (PP, p. 16).

### 2.3 A.B. PRISMA

PRISMA, a legally registered Peruvian NGO, was established in 1986. Since its founding, it has pursued activities in accord with its charter in a variety of undertakings, including maternal and child health, scientific research, family planning, development of MCH training materials, and other technical assistance activities.

According to PVFP documentation, PRISMA at the time of the award, received high marks during an Administrative and Management Review. PRISMA, according to this review "...exhibits the positive attitude toward change, appropriate management capability and congruency with the A.I.D. strategy needed to implement the PVFP Project." (PP, p. 87)

In addition to the PVFP and other projects managed or conducted by PRISMA, the organization has been awarded a USAID contract to manage the distribution of contraceptives to both the public and private (non-commercial) sectors throughout

Peru. This has been based on its successful experience in management and oversight, since 1988, of the USAID "Food for Development" program (527-0323).

One deficiency, noted in the Project Paper (p. 88), is that, "From a business perspective, the only structural weakness observed is PRISMA's self-sufficiency. Efforts are being made to generate income." The only significance of this is that with the emphasis in the Project Paper placed on self-sustainability, PRISMA suffered from the same problem, according to that Management report. While admittedly speculative, the Evaluation Team must consider that PRISMA's own lack of experience in developing its own self-sufficiency may have occluded its view of the complexity of fomenting sustainability in other, less sophisticated, NGOs.

PRISMA is administered by an ex-patriot Executive Director with considerable experience in developing countries. A Board of Directors of 14 (nine of whom are external members) serves an oversight and policy function. Although not in the by-laws, the Chairperson traditionally is an external member. The majority of the Board are technically oriented individuals, not business or financial representatives.

The PVFP is directly administered by an "Administrator" who manages the routine functions of the project and coordinates with the Executive Directors of the NGOs. He is supported by coordinators for accounting, systems, and family planning, and appropriate supporting staff.

PRISMA has been pro-active and enthusiastic in the pursuit of the objectives of the PVFP. It is aware of some of the short-falls that are mentioned in the findings of this document. It is keenly aware of the "leakage" of contraceptive methods to the informal and commercial markets, and has taken steps to identify the source of these leaks and is preparing action to ensure that this does not reoccur.

PRISMA has taken a pro-active role towards the continuation and improvement of this project. A draft paper entitled, "A New Role for the Family Planning PVOs", was prepared and submitted to USAID/Peru in December, 1992. This paper presents an objective overview of the NGO progress since the beginning of the PVFP (with some comparative data since 1987).

Some of the assertions in this paper appear to the Evaluation Team to be on the optimistic side. For example, the general assessment of institutional capacity differs considerably from the findings of this evaluation, as does the optimism expressed for public sector collaboration.

Nevertheless, the important point is that PRISMA is clearly aware not only of the internal aspects of the NGOs, the intent and direction of the public sector, but also of the general external economic and social environments in which family planning services must operate.

One critical remark is important to note here. The "Role" paper tends to treat the NGOs involved in the PVFP as relatively homogeneous, although some variation is noted. The Evaluation Team, in the section dealing with "Investment Opportunities" stresses that this is not necessarily the case. One theme which reoccurred in a number of interviews with senior NGO staff, was a concern (or even a fear) that the PVFP was designed to establish a centralized control over them. Thus, a strategy which is perceived to co-opt their own independence and individual strategies will be viewed with considerable suspicion and probably met with resistance. Statements which appear in the "Role" paper may tend to reinforce this concern. For example, "PVOs will..." imply central control (page 18). They further imply that the NGOs have "bought into" this strategy, which as far as the Evaluation Team can discern, is not necessarily the case, even though the NGOs clearly have been exposed to such ideas as changing market segments and public sector involvement.

While it is clearly the case that some aspects of the PVFP need to be re-assessed, and PRISMA should be complimented on its own efforts in this behalf, the Evaluation Team believes that the definition of roles should be conducted jointly with each NGO as part of their own strategic plan, and not give the appearance of being imposed either by USAID/Peru or PRISMA.

#### 2.4 NGOs participating in the PVFP<sup>3</sup>

The PVFP was designed to support six primary NGOs. Presently, seven NGOs are afforded support through this project. The seventh NGO, PLANFAMI<sup>4</sup>, located in Puno, is a newly independent organization previously operating as a sub-center of PLANIFAM Cuzco. These organizations are:

- ◆ APROSAMI (Asociacion de Profesionales para la Promocion de la Salud Materno-Infantil). Based in Lima.
- ◆ ATLF (Asociacion de Trabajo Laico Familiar). ATLF works only in natural family planning methods, is recognized by the Episcopate of the Catholic Church. Based in Lima.
- ◆ CENPROF (Centro Nor-Peruano de Capacitacion y Promocion Familiar). Based in Trujillo.

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<sup>3</sup> Descriptions of each NGO are provided in the Section "Shift from Short- to Long-Term Methods".

<sup>4</sup> PLANFAMI, located in Puno, was not scheduled as part of the Evaluation since it is relatively newly independent (about 2 years). However the Team did have the opportunity to interview the Administrator, in Lima, and the findings from that interview are interspersed throughout the evaluation where relevant.

- ◆ INPPARES (Instituto Peruano de Paternidad Responsable). Based in Lima with an extensive network nationwide. IPPF affiliate.
- ◆ PLANIFAM (Proyecto Planificacion Familiar). Based in Cuzco.
- ◆ PROFAMILIA (Promocion de Labores Educativas y Asistenciales en Favor de la Salud). Based in Lima. Sub-center in Huancayo.

Each of these agencies has its unique history and process of development. Even PLANIFAM and PLANFAMI, while stemming from the same roots, have experienced considerable differences in their development. All have their unique strengths and weaknesses, as will become apparent throughout this evaluation report. All agencies have very strong and positive leaders. Interviews and observations with staff show that these personalities have clearly left their mark on their organizations and staff. All agencies visited have developed their own "institutional mystique" or "mistica" which nourishes both the staff and the institution.<sup>5</sup>

Ostensibly, the Lima-based NGOs have defined mutually-exclusive working zones. This "zonificacion" system came about in the late-1980's as a solution to agencies' overlapping and duplication of services and commodities in the same areas. In other words, it was designed to establish zones of influence and reduce competition between NGOs. This has not always worked out in practice, according to some NGO Executive Directors (also, see below - Marketing). However, they claim that "violations" of these zoning arrangements are generally worked out at the senior staff or executive level, and are not currently a problem. Verification of overlap and the degree to which it might affect operations (and inter-agency cooperation), could not be determined in the evaluation.

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<sup>5</sup> The concept of "mystique" or "mistica" is not unique to these agencies, Peru, nor family planning. NGO staff throughout the world often describe their work in these terms. It can best be described as an individual's internalization of the "vision" of the organization as demonstrated or expressed by its leadership.

## SECTION 3 ENVIRONMENT

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### 3. THE FAMILY PLANNING ENVIRONMENT IN PERU

Three major elements shape the current Family Planning environment in Peru. These are the current population trends, the political and the economic environments. These elements combine to create a structural situation which both stimulate and constrict family planning activities.

#### 3.1 Population Issues<sup>6</sup>

The population of Peru has doubled over the past thirty years to its present size of around 23 million. Of this total, roughly 70 percent live in areas defined as urban. The population growth rate is estimated at 2.0 percent, and a population doubling time of 35 years at this rate. The total fertility rate is 3.5 country wide, with an urban rate of 2.8, and 6.2 in rural areas.

##### 3.1.1 Contraceptive Knowledge

About 96 percent of all women know of contraceptive methods, and roughly 89 percent indicate that they know where modern methods can be obtained. For this study, it is important to note that the second lowest regional level of knowledge of sources of modern family planning methods is in the INKA Region (76.2%), in which both PLANIFAM and FAMPLANI are based. In those areas defined as "rural" (less than 2000 inhabitants), only about 71 percent know where to obtain modern contraceptive methods. Of those women with no formal education, about 84% knew of modern methods, but only 56 percent could identify where to obtain methods. For those with primary education, 96 percent know of modern methods and 84 percent know where to obtain them.

##### 3.1.2 Contraceptive Use

Of women of fertile age (15-49) currently in union, 82.9 percent have used some form of contraceptive method, and 55.6 percent have tried a modern contraceptive method. According to DHS, at the time of the survey, 59% of all women of fertile age in current union used some form of contraception; and 32.8 percent indicated that they used a modern method. Of those using

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<sup>6</sup> Data are based on the 1991-92 Demographic and Health Survey

modern methods, 13.4% use an IUD, and 7.9% have had sterilization procedures. Male sterilization, on the other hand, is only 0.1%.

Differences between 1981 and 1991 are marked. In 1981, only 41% indicated any contraceptive use versus 59% in 1991. Method mix has changed remarkably over the last decade: IUD use has increased threefold; and sterilization procedures have doubled. The pill has remained about the same.

### **3.1.3 Sources of Contraceptive Methods**

According to the DHS, the public sector (MOH and IPSS) accounts for about 48.3% of all modern methods in Peru; the private sector accounts for 50.5%. According to the survey, which has been challenged by the PVO community, NGOs account for 6% of modern methods.

## **3.2 Family Planning and Population Policy Situation<sup>7</sup>**

Population and demographic issues officially became a focus of attention only as recently as 1965, when the Center for Population and Development Studies (CEPD) was established by the Government of Peru. USAID/Peru assisted in the establishment of CEPD by the funding of a number of demographic studies. Further, funds from CEPD were used to assist early family planning associations including one for natural family planning and an IPPF affiliate, Asociacion Peruana de Planificacion Familiar (APPF).

Under the presidency of Belaunde a family planning program was initiated for the sector. However, all legitimate activities were halted with the military coup of October, 1968. Under the regime of General Juan Velasco Alvarado, an order was issued that no family planning activities were to be permitted in public clinics.

Some private agencies who were engaged in family planning activities continued to operate with very low profiles. A.I.D./Washington, through its Collaborating Agencies, began to fund NGOs willing to work in family planning.

When the military regime was overthrown in 1975, Peru once again took a positive stance with respect to family planning. In 1980, Belaunde was returned to power, and established the Consejo Nacional de Poblacion. In 1985, the Population Policy Law was established which affirmed the right of couples to determine the number and timing of their children.

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<sup>7</sup> Acknowledgements to Ms. Gloria Nichtawitz, USAID/Peru, PVFP Project Manager, "History of Family Planning in Peru", Draft copy, May, 1993.

Currently all forms of family planning are legal, albeit with some restrictions. Sterilization is legal only under certain conditions relating to the health and status of the mother. The parameters for approval include regulations regarding the woman's age, number of children, and health risk for further pregnancies.

### 3.3 Economic Environment<sup>8</sup>

The 1980s were not a prosperous decade for most developing countries, and Peru was not an exception. In 1985, the newly inaugurated government of Alan Garcia inherited an economy which had not overcome the debt crisis. The government designed and implemented a "heterodox" stabilization program based on reduced foreign debt payments, a price freeze, and economic reactivation. The new government planned to redirect funds from foreign debt payments and the accumulation of foreign exchange reserves toward reactivation of the economy, giving priority to the needs of the poorest segments of the population via wage increases, job programs, and investment in education and health.

The first reactivation program, introduced in October 1985, stimulated consumer demand, establishing a trend which would continue through August, 1988. Major policies included an increase in the minimum wage, interest free loans to public sector employees, preferential interest rates for highland farmers, job programs in city slums, and subsidized production of basic foods to be sold in major cities, while interest rates and the payroll tax were reduced. The minimum wage was again raised in the February 1986 program and the sales tax was reduced by 50 per cent to insure continued growth in consumer demand.

While these policies encouraged economic growth in the short run, they proved to be unsustainable by leading to very strong inflationary pressures and deep budget deficits. In the face of mounting inflation, rapidly declining Central Bank reserves and growing public sector deficit, the government committed itself to maintaining real wages increases. Interest rates, already negative in real terms, were further reduced. Tax credits and exemptions were granted to manufacturers who added work shifts or increased installed capacity, yet at the same time taxes on luxury consumption goods were raised and key prices, such as gasoline and electricity, were increased to raise government revenues.

In September 1988, the government announced "El Paquetazo," a severe readjustment of prices representing a 114 per cent increase in the consumer price index. Ad hoc adjustment, composed mainly of price increases without wage increases and rapid decline in production, continued throughout the last two years of the Garcia

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<sup>8</sup> Summary of the paper prepared by Glewwe, Paul Gillette. Hall: "Poverty and Inequality during an Orthodox Adjustment: The case of Peru, 1985-1990. October 1991. Mimeographed Paper, World Bank.

Administration. The annual rate of inflation was 1,720 per cent in 1988, 3,400 per cent in 1989, and the monthly rate of inflation was still accelerating when the change of government occurred in late July 1990. From 1987 to 1990 the total decline in production is estimated to have been 20 per cent, the real wages on average are thought to have fallen 75 per cent over the same period.

Two Living Standards Surveys have been conducted in Peru. The 1985-86 Peru Living Standards Survey (PLSS) took place between June 1985 and July 1986, providing data for 5,000 households nationwide. The 1990 Peru Living Standards Survey was conducted in June and July 1990, and covers only 1,500 households in metropolitan Lima. The results of the two surveys show an average drop in consumption of over 50 per cent during 1985-1990, which is without doubt one of the most rapid and severe peace-time deteriorations in living standards ever recorded. The GDP per capita dropped 30 per cent from 1980 to 1990, and the average real minimum wage, Lima represented in 1990 the 21 per cent of the average in 1980.<sup>9</sup>

Net international reserves declined from \$1.4 billion to minus \$189 million. Tax revenue as a percentage of GDP dropped 21 per cent since 1987, and real wages were equivalent to 43 per cent of their 1988 level. Personal income and its distribution worsened. GDP per capita in 1985 was about equal to that of 1968, while current level is even lower than the levels reached at the end of the 1950s.

President Alberto Fujimori assumed office in July 1990, and immediately took action to address Peru's unprecedented economic crisis. His government initiated a bold and comprehensive economic stabilization program which included drastic cuts in public spending together with tax reforms and the elimination of subsidies. Results achieved are encouraging, with a substantial reduction in inflation, and the government proceeding with negotiations on a medium term economic program with the IMF and the World Bank aimed at restoring financial flows, macroeconomic equilibrium, and sustained growth.

These measures were followed in March 1991 by a comprehensive series of structural reforms aimed at strengthening stabilization and laying the basis for sustained growth. Initial measures included: (i) elimination of subsidies of basic foods and other products; (ii) jumbo increases (3,000 per cent) in fuel prices to restore the financial viability of the public sector's oil company (PETROPERU) and to generate the equivalent of 2.5 per cent of GDP in additional tax revenues to the Central Government; (iii) substantial increase in electricity, water, and telephone rates; (iv) elimination of most exemptions of the sales tax and reduction of the rate from 18 per cent to 14 per cent; (v) the adoption of a temporary 1 per cent on net wealth and insured assets, and increase in the selective consumption tax on luxury goods; (vi) a

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<sup>9</sup> PAAD, Economic Stabilization and Recovery Program (527-0344), USAID/Peru, 1992.

temporary 10 per cent tax on the f.o.b. value of exports, and substantial reduction in other export taxes and subsidies; (vii) elimination of almost all quantitative restrictions on imports and of all tariff exemptions, and reduction of import tariffs; and (viii) the adoption of legal and administrative measures to reduce lags in tax collection and increase penalties for tax evasion, among others.

The economy responded strongly to the emergency stabilization and structural reform measures. The rate of inflation fell from over 7,000 per cent in 1990 to 139 per cent in 1991, and 57 per cent in 1992. After contracting for three years, real GDP grew by 2.6 per cent in 1991. For 1992, real GDP is estimated to have declined by 3 per cent.

The fiscal and monetary policies since mid-1990 have played a major role in achieving a sharp deceleration in inflation. The consolidated public sector fiscal deficit declined from 6.5 per cent of the GDP in 1990 to 6.3 per cent in 1991, and further to 2.5 per cent during 1992.

In short, the process of stabilization, which started in August 1990, has been accompanied by remarkable achievement, but has yet to be consolidated.

#### 3.4 Political Environment

With the election of President Alan Garcia in 1985, not only had the APRA party, after forty years of struggle, finally consolidated its power, but it had done so in the personage of a young engaging and charismatic new leader who promised to bring change and lift Peru out of the mercantilist society it had inherited as a legacy from its European forbearers. Instead, Garcia introduced a modern-day sacking of the economy, plunging the country into a further state of despair, as foreign investment stopped and capital flight accelerated. Large scale populism was soon seen as a means to cover-up the mounting corruption and abuse. Aided by the growing discontent, the *Sendero Luminoso* and MRTA terrorist groups expanded their operations, gaining momentum and aggressiveness as Garcia's popularity declined. Token political support was provided by the likes of Carlos Andres Perez in Venezuela, and the equally discredited military junta in Argentina. Otherwise, Peru was slowly cutting itself off from the outside, with virtually no international credit, sour relations with the US, and a growing state of "malaise" at home.

By 1990, the stage was set for a change, and it was generally accepted that the FREDEMO candidate, novelist and well known international speaker, Mario Vargas Llosa, would be the next President. Incredulous at the time, and totally unexpected, a dark horse candidate began to emerge, growing from week to week, until finally it was apparent that Alberto Fujimori, the leader of *Cambio 90*, a new political group, was in a position to win the race. Elected on a platform of change and development, the "Tsunami President" brought a wave of changes to Peru. The APRA was

discredited, Vargas Llosa and the mercantilists of the "old Peru" were un-nerved by their loss, and a President of Japanese heritage had taken power.

With strong populist support, President Fujimori's mandate coincided with an escalation of terrorist activities. To compound the problem, Peru's external reserves were almost non-existent, and the country had few relationships on which to draw support. In April of 1991, President Fujimori announced the closure of Congress and the Supreme Court, in an act justified at the time as being necessary to preserve democracy in the advent of chaos and the growing terrorist threat. The measures were well received, and have enhanced the President's popular support. In the meantime, steps have been taken to draft a new constitution, and it is expected that the democratic process will be respected and maintained. The Government has also succeeded in capturing the leader of the *Sendero Luminoso* and a number of his key supporters, as well as several of the top leaders of the MRTA. This and a number of economic/financial moves, has started to restore investor confidence, and for the first time in years foreign capital is beginning to be interested in Peru.

If the process continues to improve, President Fujimori will be in a position to select his successor, who may very well be another unknown, in that the traditional political parties have little opportunity under the current conditions to re-group and gain national prominence. The political environment is therefore in a state of transition, with the hope that democracy will prevail and the economy will continue to show signs of improvement.

## SECTION 4 PVFP EVALUATION

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### 4. INTRODUCTION TO THE EVALUATION

The PROFIT Project was requested by A.I.D./Washington, Bureau of Research and Development, Office of Population, Department of Family Planning Service Delivery, to undertake the evaluation of the USAID/Peru Private Voluntary Family Planning Expansion Project (527-0335). PROFIT was chosen because of its mandate to undertake and fund projects with special emphasis on sustainable investments in Family Planning.

#### 4.1 Team members

The Evaluation was undertaken during the period 19 April - 8 May, 1993. The Evaluation Team fielded in Peru included the following members:

Donald R. Nicholson, II - Project Manager, The PROFIT Project; Team Leader (Investment, Finance, Marketing)

W. Timothy Farrell, Ph.D. - Director of Evaluation, The PROFIT Project; Deputy Team Leader (Evaluation, Maternal Child Health, Anthropologist)

E. Croft Long, M.B.,B.S., Ph.D. - Public Health Expert, Project HOPE; (Health Manpower, Health Management Systems, Integrated International Development)

Gustavo Vega, MBA - Coordinator for Latin American Projects, Deloitte & Touche/ILA (Finance, Accounting, Management Information Systems)

In addition, a Peruvian Research Assistant was contracted in the field:

Rosario Aquije, B.A. - Research Assistant - National Supervisor for Demographic and Health Survey (1991) and other national Health, Population and Family Planning surveys.

#### 4.2 Time frame

USAID/Peru requested an Evaluation Team of three members for a one month in-country period. Competing time commitments made a full month on-site visit impossible, and a compromise arrangement was made for a four member team for 10 days and a 3 member team for the remainder of the three week period.

The Evaluation was scheduled for one week preparation and three weeks on-site in Peru. This was modified to include at least one week of write-up on return to the United States.

Effective in-country dates were 18 April, 1993 through 8 May, 1993. It is important to note here that the in-country time frame was inadequate (even with the addition of an additional team member) given the nature of the task and the number of NGOs to be reviewed. The Team requested an additional four days in Peru, but this was denied due to security regulations which currently permit only forty-five TDY personnel in-country at any point in time.

The request was made due to the fact that two of the NGOs to be evaluated are not located in Lima. Trips to both Trujillo (CENPROF) and Cuzco (PLANIFAM) resulted in roughly a day each "down time" due to travel.

In addition, PLANFAMI (Puno) originally had not been included in the evaluation. Nevertheless, late during the second week, a PLANFAMI representative was invited to Lima for inclusion in the interview (but not observation) phase of the evaluation. There was no opportunity to physically observe operations or perform a detailed review of systems and records.

## SECTION 5 METHODOLOGY

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### 5. METHODOLOGY OF THE EVALUATION

Based on the A.I.D./Peru Scope of Work and continuing discussions both with USAID/Washington, R&D/POP and A.I.D./Peru, it was decided that the most appropriate evaluation methodology to employ was what is known as a formative evaluation.

The main purposes are:

- ◆ To provide a current assessment of the PVFP to date especially with respect to financial and institutional sustainability; and
- ◆ To provide recommendations for strategies and approaches which would assist PRISMA and the local NGOs in their quest for financial sustainability.

In addition, due attention was to be paid to the NGOs' progress and performance along more traditional lines of service delivery and operations.

It became particularly evident during the team's initial meetings with USAID/Peru/HPN that the emphasis was to focus on those elements relating to self-sustainability.

#### 5.1 Overall evaluation strategy and procedures

With these purposes foremost in mind, the strategy employed focused on qualitative interviews with appropriate representatives of A.I.D., PRISMA and the six principal NGOs<sup>10</sup>.

A qualitative approach was selected as most appropriate for this type of evaluation, relying principally on group and individual interviews and on primary agency documents.

An important element in all aspects of the evaluation is the concept of utilization of information and technical assistance provided on the part of the NGOs, and PRISMA's systematic follow up of studies conducted by technical consultants in cost analysis and pricing of services; marketing; strategic planning; investment opportunities; and MIS.

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<sup>10</sup> It is noted here that a seventh agency, PLANFAMI located in Puno, was not included in the original agenda due to its distant location and relative recent inclusion as an independent entity in the PVFP.

**With the exception of PLANFAMI, interviews and data collection took the following general form:**

- 5.1.1 Introductions (with the participation of USAID/Peru Project Monitor)**
- 5.1.2 Presentation of the purposes and methods of the evaluation, i.e. the structure of the evaluation and the kinds of information and data to be obtained. These included:**
  - **Formal open-ended interviews**
  - **Systematic data collection<sup>11</sup>**
    - **Managerial Questionnaires**
    - **Operational (base) Staff Questionnaire**
    - **Client intake observations**
    - **Client exit interviews**
    - **Review of administrative, accounting and inventory procedures.**
- 5.1.3 Initial briefings and discussions with NGO senior managerial staff. This included an institutional overview: brief history and institutional philosophy; management structure; range of services; location of services; and verbal reviews of plans for and progress towards sustainability.**

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<sup>11</sup> See Appendices IIIA-E for questionnaires and forms used for data collection.

#### **5.1.4 Establishment of appointment for in-depth technical interviews for**

- Administration
- Family Planning Service Delivery
- Strategic Planning
- Income Generation
- Marketing
- Cost Analysis
- Management Information Systems

#### **5.2 Technical Assistance Consultants Interviews**

PRISMA contracted a number of consultants to provide technical studies and assistance regarding a number of managerial issues. These included the following:

- Cost Analysis - Francisco Verdera
- Marketing - Dina Li
- Strategic Planning - Roberto Tirado
- Investment Opportunities - SASE Group
- MIS

#### **5.3 Interviews with Government Officials**

- Ministry of Health - Dr. Mongrut
- Instituto Peruano de Seguro Social

#### **5.4 Interviews with Other Knowledgeable Sources**

- Dr. Jack Fiedler - Consultant to USAID/Peru: Health Economist
- APROPO (Social Marketing) - Carola de Luque
- Karen Foreit, The Futures Group

## **5.5 Main Focus and Objectives of the Evaluation**

While virtually all evaluations assess the multiple components of a project and its intervention results or progress, it was emphasized by A.I.D./Peru/HPN that the major concern was on the aspects of and progress towards financial sustainability of the NGOs participating in the PVFP. This component is stated explicitly as a goal in the Project Paper, and is concordant with USAID/Washington/R&D/POP philosophy<sup>12</sup>). The specific project objectives to be assessed are:

- 5.5.1 To assess progress towards institutional capacity by the NGOs;
- 5.5.2 To assess progress towards shifting to long-term contraceptive methods;
- 5.5.3 To assess on-going support for short-term methods and natural family planning;
- 5.5.4 To assess progress towards expansion into rural areas by the relevant NGOs and cooperation with Public Sector (MOH, IPSS) through the private utilization of public service facilities during public sector "down time".

In the initial briefing with Mission HPN Staff, the emphasis on financial and institutional sustainability was reinforced. Specific questions asked included:

- ♦ Is self-sustainability a viable option?
- ♦ How can the NGOs (given their individual missions and characteristics) prepare for and strive towards self-sustainability?
- ♦ How can (financial) dependence on A.I.D. be reduced?
- ♦ Of the NGOs participating in the PVFP Project how many should continue and which ones? Is the concept of merger(s) viable?

It is of major importance to note, both for this evaluation and for A.I.D. (and the international development community in general) that there is no clear, nor commonly accepted definition of "sustainability". The concept runs the gamut from relatively "soft" - diversification of donor funding sources (spreading dependency risk), to "hard" - virtual independence from donors through mechanisms of self-generated

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<sup>12</sup> See, for example, Gillespie, Duff, 1987 and 1988. In addition A.I.D. has established phase-down/out policies for several countries whose current programs are designed specifically towards self-sustaining activities by NGOs.

**income, with donations viewed as a welcome, but not an operationally necessary, addition.**

## **SECTION 6 MAJOR FINDINGS**

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### **6. MAJOR FINDINGS (generalizations from all agencies)**

- 6.1** At this time, none of the NGOs involved in the PVFP are either institutionally or financially self-sufficient. They range from total dependency (and insufficient support) with very low prospects of survival (PLANFAMI - Puno; ATLF), to those with reasonably good prospects in the foreseeable future (APROSAMI, INPPARES, and PROFAMILIA). CENPROF and PLANIFAM, probably because of their geographical location have high institutional prospects but severe economic limitations.

In agencies which do generate significant income from other health-sector activities, this income very often must be used to support either PVFP or overhead costs which reduces capital available for income generating investment.

- 6.2** Institutional capacity and strengthening results are multi-dimensional and vary considerable among and between agencies. Nevertheless in all cases a clear awareness exists that this is a critical issue to their growth and independence. One good indicator of this is the understanding of the vocabulary associated with institutional capacity: strategic planning; cost analyses; market segmentation, etc. Nevertheless the translation of these concepts into operational activities is generally weak in most cases.
- 6.3** All agencies (except ATLF) appear to have made significant advances towards increasing the use of long-term contraceptive methods.
- 6.4** Support for short-term methods has been variably affected by the reduction in funds for community based distribution (CBD) activities in some agencies. Some agencies have continued support for CBD promotional activities on their own.

Natural family planning (NFP) information is variably provided by all agencies during counselling activities. However, NFP itself will not generate income, and must be supported by aggressive income generating activities in both the health and non-health sectors.

- 6.5** Expansion into rural areas and cooperation with public sector institutions. Efforts at this have been attempted with very limited success. Principally, the Evaluation Team believes this is a project design contradiction, in conflict with objectives towards building institutional capacity and financial self-

sustainability. In addition, the team believes that using the demographic/political definition of "rural" (nuclear centers of 2000 or less) and "urban" are not relevant to this project. For example, Chinchero (PLANIFAM) whose nucleated population is over 2000, is clearly not an "urban" center in any commercial or infrastructural sense.

6.5.1 Given the economic situation in Peru, rural services (i.e. focused on traditional campesinos) result in net financial losses to agencies, and must depend on cross-subsidies from other income sources. Hence goals for rural expansion (which often rely on some form of community based promotion) are in apparent conflict with goals of institutional capacity and self-sustainability. That is, whatever income that may be earned from delivery of urban services seems to have been siphoned-off to support rural extension.

6.5.2 Attempts to coordinate services by having agencies provide services in under-utilized public sector facilities has met with two principal problems. The first is confusion on the part of the populations served as to why services (which are apparently the same or similar) are charged-for during NGO activities, and free during Public Sector service schedules.

The second is that in some areas, notably Trujillo, public sector (MOH) physicians and staff are said to be jealous (celo) that NGO staff are allowed to charge for services.

6.6 PRISMA as an implementing agency, has undertaken appropriate activities to accomplish the goals of the PVFP Project. In general, it has been effective in establishing good and effective relationships with all NGOs. This is no mean task given the heterogeneity of the NGOs and the circumstances inherited from the PVFP predecessor, the SPF.

Shortcomings noted that have considerable effect on the NGOs relate especially to follow-up on studies and recommendations done by private technical consultants. This is coupled with a paucity of transfer of technology or methodology for the NGOs to conduct studies of their own in cost analysis, marketing and pricing. The work done on strategic planning is an exception, however its technical aspects could be strengthened (see below).

PRISMA generally opted initially for a strong managerial staff as opposed to individuals highly qualified in the technical aspects of family planning. NGO interviews revealed that this was resented early-on, but that PRISMA staff quickly learned the fundamentals of family planning. An obvious exception

was the first Program Coordinator who had specialized in the family planning field.

A comment worth including in this section is that PRISMA has had considerable experience in Primary Health, Child Survival and Family Planning prior to its selection for the PVFP. This fact is understated in project documentation and should be noted for the record.

## **6.7 Principal Project and Managerial Recommendations**

**6.7.1** That the PVFP be extended over a two year period to accomplish the following major goals in service of developing an essential platform for achieving institutional and financial self-sufficiency.

During the first year extension, it is strongly recommended that A.I.D. and PRISMA, in conjunction with the NGOs, establish clear, objectively measurable goals consonant with the following project-wide recommendations.

**6.7.2** That the first year extension focus on institutional capacity building and consolidation. As noted above, there is a push-pull project design contradiction that requires the NGOs to both develop capacity to become self-sufficient while expanding services in costly (and minimal cost-recovery) areas.

**6.7.3** Reinforce Institutional Capacity, giving special emphasis to establishing external and independent Boards of Directors. Most of the NGOs do not have external Boards, or do not make effective use of them. Boards should be externally oriented towards the larger economic environment, providing access and contacts with financial and commercial leaders and institutions. Ideally they should provide linkages to other service-oriented institutions such as Lions, Rotary, Optimists, etc.

Parallel with this is the need to shift institutional mentality, especially among staff, from one of pure social service orientation to one which balances a social service perspective with a more business focused and entrepreneurial approach. Such balance will provide more fertile ground among the executives and staff of the NGOs with respect to pursuing financial and institutional self-sustainability.

**6.7.4** Undertake and operationalize, implement and use a new cost analysis which calculates real institutional costs with respect to true revenues. As noted above, the groundwork for this has been laid. The NGOs recognize the need for cost studies, however these have generally not been acted upon nor has the technical methodology been institutionalized. Some of the reluctance seems to be rooted in the social orientation of staff at all levels, as well as mirrored or reinforced by the current economic environment.

**6.7.5** Undertake, operationalize and use market analyses that are based on individual NGO mission self-definitions and strategic plans. Linked with other recommendations and in concert with the Peruvian population's response to an ailing economy, the NGOs should define new (additional) market segments as targets. The disruption of the previously determined health tariff system provides an opportunity to explore new markets.

**6.7.6** Formalize a process for seeking revenue generation both within, and especially outside of, the traditional health service provision sector. To many health workers, health in all its aspects, is considered a basic human right, and services should be provided at costs accessible to all. Clearly some service revenues generated in the health sector (e.g. laboratory services, levels of facilities, etc.) do generate income to cross-subsidize other services. However, there probably are absolute limits to cross-subsidization from the health sector itself.

This evaluation recommends that other, non-health income generating activities be explored which can provide an on-going source of revenue for serving the poorer populations targeted by the NGOs.

**6.7.7** That all Technical Assistance Activities include components to transfer not only the findings of the specific studies and activities, but the methodologies employed. This is an essential element in institutional sustainability. Individuals in NGOs should be identified and incorporated as active, participatory elements in the conduct of studies and TA activities.

This will serve three indispensable criteria for NGO use of TA. First, it will serve as a training component for institutionalizing methodologies employed. Second, it will cause an institutional investment in the findings of the TA activities, enhancing the

probability of long-term buy-in and institutionalization. Third, and by no means least, it will serve to ensure relevance of the TA to the NGOs.

- 6.7.8 That the objectives of the original PVFP be modified so that there is operational recognition on the part of USAID/Peru and PRISMA of the heterogeneous nature of the participating NGOs and the populations that they serve.
- 6.7.9 That all NGOs participate actively in the definition of the goals and objectives of the extension
- 6.7.10 That PRISMA design its activities in accord with the individual needs and priorities of each NGO
- 6.7.11 That each NGO be required to develop a detailed strategic plan principally oriented to institutional and financial self-sustainability. This will require considerable direct Technical Assistance and technology transfer from PRISMA and/or its consultants.
- 6.7.12 That a new personnel item for PRISMA be included for an Income-generation Specialist/Coordinator. The organizational structure of this position would be similar to the Project (FP) Coordinator, and would take on a role of direct support and supervision of financial and (non-family planning) institutional TA.
- 6.7.13 That funds be made available for some form of community Based Distribution of short-term methods as a form of promoting long-term acceptance; not as a form of revenue generation for the NGOs. Especially important is that the system be designed with adequate controls to prevent the CBD system from "leaking" into the commercial and non-formal markets.
- 6.7.14 That PRISMA develop and systematically employ TA supervisory systems which ensure that all elements of TA are in concurrence with both the letter and spirit of the contracts. This would include detailed Scopes of Work (SOWs) and financial penalties for consultant non-compliance.

- 6.7.15 That USAID develop and systematically employ a monitoring system based on PRISMA's annual work plan which ensures satisfactory completion of project milestones.
- 6.7.16 That the extension budget be modified in such a way that addresses significantly and directly the recommendations presented in this evaluation. Specifically:
- 6.7.16.1 A program/operational budget structured around direct support to NGOs for family planning services;
  - 6.7.16.2 An operating equipment budget structured to address immediate shortcomings observed in a number of NGOs (outlined below) which brings them up to minimal standards. This is not intended as a budget for luxurious or state-of-the-art technology, but for purchase or replacement of essential items. There is no excuse, for example, for oxidized instruments or use of a bunsen-burner for sterilization of equipment due to lack of resources.
  - 6.7.16.3 A capitalization budget based on seriously developed strategic plans for income generation, both within and external to the health sector.
- 6.7.17 That the second year extension of the PVFP be considered at this time be oriented principally towards nurturing income generation based on institutional consolidation and strategic income planning achieved during FY93-94.
- 6.7.18 Specific NGO participation in the second year extension should be contingent upon successful completions of the first year extension work plans.
- 6.7.19 No recommendation is made at this time with respect to mergers or consolidation. The Evaluation Team believes that, while possibly economically efficient, the "mystique" and identity of each NGO will mitigate against this.

In addition, the Evaluation Team believes that given the diversity and size of the family planning markets in Peru, centralized services (laboratories, birthing centers, clinics, etc.) will discourage each NGO from finding and exploiting niches

**(market segments) towards which they can direct their services in search of institutional and financial self-sustainability.**

## SECTION 7

### PROGRESS TOWARD FINANCIAL SUSTAINABILITY

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#### 7. PROGRESS TOWARD FINANCIAL SUSTAINABILITY

##### 7.1 Introduction and Definitions

In the field of international development, the basic concept of sustainability is an outgrowth of the environmental movement which postulates that economic developmental efforts, especially in agriculture, needed to be critically concerned with environmental sustainability. In business, commerce and finance, sustainability is normally linked to profitability, strong institutional capabilities, vision and responsiveness to market, economic and political changes.

For Family Planning agencies, the concept of sustainability links both these general definitions. Population pressure is inextricably related to environmental issues, both substantively and economically. This is true at both the macro and micro (i.e. family) levels. Consequently, population issues are highly politicized, and encouragement for family planning has generally been included in national goals. As such, its financing has been viewed as a responsibility of the State, and services and commodities have been made available for free or for nominal costs, especially for the poorer segments of the populations of countries in the process of development.

Thus services and commodities have been provided to the large majority of populations through the public and private (not-for-profit) sectors. Upper- and middle-classes have generally had access to family planning services through the private health (commercial) sector whether through physicians, pharmacies or other commercial sources or providers.

In the public and private (non-profit sector) this has resulted in a considerable degree of dependence on international donor and State financing for services and commodities. In recent years, studies have indicated that the demand for contraceptive commodities and services will outstrip the financial capacity of international donors, resulting in what has been termed the "resource gap" (cf Gillespie, 1987, 1988). As a consequence of this projection, A.I.D. has undertaken a series of strategies designed to encourage financial sustainability of family planning activities in developing countries.

##### 7.2 Conceptual Definition of Sustainability

One of these strategies is designed to assist NGOs take the steps necessary to become financially sustainable. In this evaluation, we have designed a general concept of sustainability which includes three principal components or dimensions. These are:

**institutional capacity; management and service quality; and, revenue generation and financial soundness.**

### **7.2.1 Institutional capacity**

**This domain consists of structural, managerial and organizational components which serve to ensure the continued operational effectiveness of the organization. Critical elements reviewed in this evaluation include:**

- 7.2.1.1 An external Board of Directors which exercises governance and sets global policy including oversight and approval of strategic planning.**
- 7.2.1.2 An internal organizational management system with clearly delineated lines of authority and responsibility; no, or minimal, overlapping of supervisory functions; and reporting.**
- 7.2.1.3 A financial/accounting system with cost-assessment capabilities; projection capacity; division of purchasing and inventory functions from accounting functions; reporting capacity; control functions for sub-offices, cost centers, etc.**
- 7.2.1.4 Administrative systems and clearly established norms: accounting; personnel; supervision; purchasing; inventory; etc.**
- 7.2.1.5 Access to legal counsel.**
- 7.2.1.6 Appropriate and necessary legal authorizations. Government agreements formalized; agreements with other entities formalized; labor code compliance; etc.**
- 7.2.1.7 Institutional identity.**

### **7.2.2 Service management and quality**

- 7.2.2.1 Range of services appropriate to the market served. This includes method mix in family planning services.**
- 7.2.2.2 Non-family planning services available in support of family planning - other diagnostic and treatment services;**

support services - eg pharmaceutical products, clinical laboratories, etc.

- 7.2.2.3 Technical Service Standards - Supervision norms/checklists
- 7.2.2.4 On-going staff technical assessment and training norms
- 7.2.2.5 Social Service Standards - Client/Patient relations
- 7.2.2.6 Facilities standards
- 7.2.2.7 Information, Education and Communication (IEC): Activities appropriate to market; cultural and linguistic relevance.
- 7.2.2.8 A quality management process which continually seeks to improve services and products.

### **7.2.3 Revenue generation and financial soundness**

Because of the predominance of donor- and State-generated funding for family planning, and the limited financial amounts the lower economic strata in developing countries can (or are willing to) pay for family planning commodities and services, it is generally the case that NGOs serving this population must look elsewhere to establish a sustainable financial base which acts as a resource to cross-subsidize family planning activities.

Revenue generation depends to a large degree on the political and economic environment in which an NGO operates. Further it depends on the alertness of the Board and senior executives to opportunities. Whatever the environment, however, there are certain pre-existing conditions that apply. These include:

- 7.2.3.1 An investment strategy
- 7.2.3.2 Capital reserve
- 7.2.3.3 Human resources specialized in business management
- 7.2.3.4 A re-investment strategy which will assure growth to the income-generating entity while providing funds to the NGOs' non-revenue producing activities

- 7.2.3.5 A determination of where the income generated from the business venture will go: e.g. to administration and overhead, or to service delivery

### 7.3 Roles of the NGOs

#### 7.3.1 **Rationale for Financial Sustainability**

Within the broad field of international development, NGOs - both international and local - most often occupy a niche somewhere between the public and the private (commercial) sectors. Regardless of their mission, NGOs usually target their activities and services towards the lower socio-economic strata of the societies in which they operate. Most NGOs operate under a not-for-profit charter recognized by the governments of the countries in which they work, usually through some decree or authorization of the Ministry which most closely shares their goals. NGOs are almost always dependent on some sort of external support from both private (charitable parent fund-raising organizations) or from government agencies of more affluent countries. While the range of dependency varies from total to minimal, it is always a factor in determining not only what services the NGO will provide, but also the amount. If international donors, for example, decide (for political or other purposes) not to fund certain activities, or not to support a particular set of policies, NGOs must choose to accept those conditions or face the financial consequences.

Nevertheless, macro-level donor policies may not often be optimum for populations served by small NGOs, yet they must often "chase" money in order to survive. Chasing money very often means that very dependent NGOs must modify their fundamental purposes or target populations in order to survive. This is especially true of those NGOs which are primarily dependent on a single-donor funding source.

Therefore, aside from donor-driven policies for self-sustainability, it is in the NGOs' own self interest that such a course should be pursued.

#### 7.3.2 **NGOs involved in the PVFP Project**

Of the six (now seven) NGOs involved in this project, one (FAMPLANI - Puno) is one-hundred percent dependent on project funds. Others form up along a continuum from high to moderate financial dependency. All of the NGOs are "vertical" in that their principal service is family planning, with maternal and child health services seen as ancillary or as income resources. They also vary considerably in maturity, having operated as "independent" entities from two to 25 years.

In addition, most have multiple sources of funding at the project level. This can result in an administrative burden since each funding source demands its own reporting and accountability procedures. A consequence of this is that NGO Directors and Administrators often are forced to think in "Project", rather than "Institutional", terms, balancing this reality with their overall Mission statements and goals.

### **7.3.3 Recognition of Dependence and Need for Self-Sufficiency**

All seven NGOs recognize their relative dependency on donor resources. In interviews with the Executive Directors and other senior staff, this is a factor which is clearly on their minds, and is substantiated through content analysis of self-administered interview schedules.

In addition, all but one have taken steps to reduce this dependency by establishing some form of revenue-producing activities. These vary in nature and scope, but virtually all are within the health sector. Some examples include: clinical laboratories; birthing centers; sonograms; OB/GYN care; minor surgery; pharmacies; sales of IEC materials; etc. One, INPPARES, has established majority ownership in a commercial pharmaceutical distribution venture.

## **7.4 Constraints on Progress towards Self-Sufficiency**

There appear to be three categories of constraints on the NGOs with respect to achieving financial self-sustainability. These are: the economic situation in Peru; structural and operational aspects of the PVFP and its implementation; and, NGO organizational factors.

### **7.4.1**

The economic chaos that Peru has suffered in recent years mitigates against NGOs charging prices that will cover their costs, much less yield a return. The target populations for virtually all of these organizations is the very low end of the economic scale. While Central Clinics may be located in middle-class areas, operational posts are located in areas of severe poverty (*pueblos jóvenes*) in Lima, Cuzco and Trujillo, and in economically depressed rural areas in Cuzco and Puno. In many instances, service fees are waived for persons who obviously cannot afford them, and in some cases services are provided for goods. As one field service provider put it, "How can we refuse services when she so badly needs them but has no money?".

Expenses, especially rent and utilities, are having a negative impact on capital accumulation. In CENPROF/Trujillo, the Central Clinic was originally rented

for about \$400 per month. The cost is now \$3,000 per month and the contract is adjusted annually. The bind for CENPROF is to find another suitable locale which is difficult, since the Central Clinic also has surgical facilities and an eight-bed birthing center, both of which generate revenues for the NGO.

Similar problems are faced by the other NGOs. Some, for example PLANIFAM (Cuzco) have sought other rent-free spaces for their peripheral centers with some success. INPPARES is working on a strategy in which the municipal governments will provide space and pay some expenses in exchange for locally situated services.

#### 7.4.2

The structural and operational aspects of the PVFP at times also operate against the NGOs' efforts towards sustainability. The budget, for example, does not allow for equipment purchase. Instruments are often in very poor condition, or are replaced at the NGOs own costs<sup>13</sup>, which results in capital flight. Similarly, when fund disbursements are late, the NGOs must float PVFP activities on their own accounts or use high interest overdraft accounts to fund legitimate project operational costs.<sup>14</sup>

#### 7.4.3

NGO organizational and attitudinal factors also tend to mitigate against activities towards self-sufficiency. While most Executive Directors must be classified as entrepreneurial since all but one has founded and nurtured their agencies, the overriding concern is one of service to the poorer populations. This laudable attitude provides the "mystique" that allows the NGOs to accomplish their missions even with economic restrictions. This leadership quality needs to be complemented with a concrete business approach. As will be noted below, inadequate attention has been given to technical assistance activities provided through PRISMA designed to enhance this business approach: cost analysis; market survey; strategic planning; and MIS.

In addition, Boards of Directors/Advisors, where these exist, seem to focus on internal operational and technical issues. Such bodies, however constituted in the Peruvian cultural milieu, need to link to the external economic

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<sup>13</sup> It is recognized that part of self-sufficiency is the ability to pay certain costs. However, the lack of a minimal budget for instrument replacements, in this economic environment, does not permit capital accumulation for investment in real income generating activities.

<sup>14</sup> It is recognized that this is the exception, not the norm. However, all steps necessary must be taken to inadvertently cause capital loss to the NGOs.

environment, seeking opportunities for expansion and diversification, as well as to the internal realm of the NGOs in terms of cost control, pricing policies, staff ratios (i.e. administrative to program staff ratios<sup>15</sup>), and other management and governance issues.

The following sections describe the efforts undertaken by PRISMA, local consultants and the NGOs to study and implement critical elements necessary to strengthen institutional capacity and self-sustainability.

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<sup>15</sup> Generally speaking, during this evaluation exercise, and as cited in the recent SASE report, it was found that about 30 - 40% of the budget goes into administrative (i.e. non-productive) costs, and in one case this was estimated to be as high as 60%. The acceptability of this ratio should be a Board or policy concern.

## **SECTION 8 MANAGEMENT INFORMATION SYSTEM (MIS)**

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### **8. MANAGEMENT INFORMATION SYSTEM**

A key objective of the Institutional Capacity Strengthening aspects of the PVFP project is to improve the NGOs' ability to measure and control their administrative and program effectiveness. To achieve this objective, the PVFP included the development, installation, and use of a management information system (MIS) to track staffing, resource allocation, logistics (commodities), and service statistics. The main objective of the MIS' design is to contribute to the NGOs' management decision-making process, providing information to the different levels of the organization in a timely and accurate manner.

In 1990, PRISMA with the collaboration of The Population Council, designed and implemented an integrated information system called FPCONTRO, to assist the NGOs generate information as requested in the PVFP project. The system includes a program to prepare and present monthly financial reports of resources employed by the NGOs.

The system consists of three modules:

- Logistics, which allow the NGOs keep track of inventories, distribution, and consumption of different contraceptive methods;
- Service statistics, which list the number of new and ongoing patients, medical services provided by each outlet, activities carried out on Information, Education, and Communication (IEC), and the sale of contraceptives, and
- Administration of financial resources, which lets the NGOs manage the income and expenses generated under this project and their own programs. (This module is also known as ASIGNA.)

In 1990, PRISMA found that the NGOs could not easily assimilate changes in technologies because their multiple donors may have implemented different control or reporting systems. Initially, PRISMA found some resistance from some of the NGOs.

The main problems identified included:

- Utilization of the system was incomplete.
- Lack of compliance with the established procedures to manage the information.
- Inconsistency of the information, and

- Turnover of the staff assigned to manage the system.

PRISMA considered it necessary to carry out a series of training courses for each NGO to strengthen their computer knowledge and to facilitate system implementation by PRISMA. Initially, the lack of equipment and trained personnel delayed the implementation of the system. In order to guarantee the utilization of the system, PRISMA provided financial support to PLANIFAM, CENPROF, and PROFAMILIA to contract part time staff to maintain the system and provide the information requested by PRISMA. This precedent may have resulted in another NGO subsequently asking for the same support to implement the cost model promoted by PRISMA.

To ensure the proper utilization of the system, PRISMA in conjunction with the NGOs, formed the Service Statistics Committee. This committee improved the utilization of the system and the presentation of reports.

As of August 1992, based on the final evaluation prepared by The Population Council, APROSAMI, CENPROF, and PROFAMILIA/Lima reached higher skill level in terms of: (a) better knowledge of the system, (b) involvement by users in different parts of the organization, (c) clear procedures, and, (d) more accurate information.

PLANIFAM in Cuzco, PLANFAMI in Puno, and PROFAMILIA in Huancayo, regularly use of the system. In PLANIFAM/Cuzco the development is slow. INPPARES recently installed the system.

Following is a review of the MIS' modules' use by each organization.

### 8.1 The Logistics Module

- 8.1.1 Only PLANIFAM/Cuzco, PROFAMILIA/Huancayo, and PLANFAMI/Puno are using the system;
- 8.1.2 CENPROF in Trujillo is not using the system because of recent changes, and the person in charge conducts manual inventory management;
- 8.1.3 APROSAMI and PROFAMILIA/Lima have their own system; PROFAMILIA/Lima controls inventory only at the central warehouse;
- 8.1.4 FPCONTROL does not include "average cost" for valuing inventories; rather, it uses the FIFO methodology, which is not acceptable in Peru. In order to value the inventories at the end of the fiscal year, the NGOs have to keep a manual control of their inventories. PRISMA is aware of the NGOs' needs and this is one of the reasons PRISMA is working

with INFOSERV on the design and implementation of an institutional management information system.

- 8.1.5 Every six months, PRISMA conducts an inventory control of each NGO. The last round of inventory supervision was January 1993. At that time, the Logistics Unit at PRISMA decided not to carry out the semi-annual inventory at INPPARES/Lima.<sup>16</sup>
- 8.1.6 At INPPARES, ATLF, PROFAMILIA, APROSAMI, and CENPROF, the person responsible for the warehouse is also responsible for keeping the manual kardex control. In terms of control this practice is not recommended. In the past, the auditors have recommended this practice be changed.
- 8.1.7 In the inventory control performed last July 1992, at INPPARES, the PRISMA supervisor noticed that INPPARES did not have the expiration date control card visible for each method at the warehouse. He also observed that the kardex control was not handled at the INPPARES' main office (at Jesus Maria site), and he confirmed that the control of kardex is operated by the warehouse guard and his assistant. However, in his report to PRISMA he did not report these anomalies.
- 8.1.8 APROSAMI utilizes its own system named SUMI, which is a data base developed under the Dbase III program. PRISMA has asked APROSAMI to change the program to include the inventories at the central warehouse as well as intermediate warehouses.

## 8.2 The Service Statistics Module

The statistics module is used by the NGOs to report to PRISMA the fulfillment of their goals, new users obtained, medical services provided, contraceptives consumption, and the IEC's goals.

### Findings:

- 8.2.1 ATLF is not using the system. ATLF gathers the information in a Quattro Pro spreadsheet. The Evaluation Team learned at ATLF that they got a copy of Quattro Pro software from PRISMA. This program was installed without respecting U.S. copyright law.

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<sup>16</sup> Because PRISMA has overall responsibility for commodity distribution and control throughout Peru, it is very important that inventories be conducted on a regular basis without fail. Recent investigations of commodity diversion to the informal commercial markets underscore this need.

- 8.2.2 INPPARES did not install the module and has tried to install and operate the TECAPRO system provided by IPPF. INPPARES has been trying to make this program workable. PRISMA has offered assistance to INPPARES to implement the TECAPRO system.
- 8.2.3 The NGOs utilize FPCONTRO to report monthly service statistics. This information is accumulated weekly and in some cases monthly; therefore, it is not used by the NGOs' top management as a management tool. They have their own forms and reports to inform the executive directors and staff of daily changes. PRISMA is working with INFOSERV to design a new MIS that responds to these information needs.
- 8.2.4 The service statistic module has the capability to track staffing and resource allocation, as demanded in the project paper. Currently, this feature is not being used.
- 8.2.5 PLANIFAM/Cuzco, PLANIFAM, and CENPROF mentioned that they would like to receive assistance to control billing and cashier processes, as well as inventory and statistical services. PRISMA is discussing with INFOSERV the design and implementation of an institutional management information system to integrate a program that involves the accounting process, logistics, and service statistics.
- 8.2.6 The PRISMA system coordinator mentioned that he recommends the NGOs improve the coordination between the people who collect the information and the people who introduce and process the information. He thinks the NGOs staff need some assistance in collecting information. The Evaluation Team observed this same deficiency. However, the problem is not only collecting information but in other operational areas such as accounting, management, and warehousing. Since the NGOs are not generating enough income to cover their basic costs, it is not feasible for them to contract additional personnel to collect the information for reporting purposes.

### 8.3 The Financial Module: ASIGNA

The financial module presents the budgets, level of budget's execution, detailed income and expenses, and the report by accounting schedules by income and expenses category. It provides a wide range of information such as:

- ◆ Zones in which the NGOs operate
- ◆ Staff by each NGO
- ◆ Level of education of staff

- ◆ Staff hours worked in the project
- ◆ Number of ongoing and potential projects
- ◆ Staff activities for the reporting period
- ◆ Contraceptive consumption by project, promotor, user, and gender
- ◆ CYPs generated
- ◆ Products being handled in each warehouse
- ◆ Institutional stock by product
- ◆ Funds received by donor under the project
- ◆ Funds spent under the project
- ◆ Funds generated under the project

The financial module is used by the NGOs to prepare and present budget, budget execution, detailed income and expenses during the reporting period, and income and expenses by category. PRISMA has set up a coordination unit in charge of reviewing the reports prepared and presented by the NGOs. This unit is comprised of two people who evaluate the budgets prepared by the NGOs. They also review the financial reports presented by the six NGOs for presentation to USAID/Peru. This unit is also responsible for preparing a quarterly report summarizing the expenses and costs covered with the income generated by the NGOs under the project.

#### **Findings:**

- 8.3.1 Some NGOs indicated that they would prefer to prepare the financial reports every quarter rather than monthly, because their preparation takes too much time. PRISMA does not see any problem with this as long as USAID/Peru also agrees that PRISMA presents those reports on a quarterly basis, too. In previous projects, other donors have asked them to present quarterly reports. The Evaluation Team found that those NGOs asking for the change do not enter all their operations daily; rather they wait until the end of the month to enter the information in the computer module.
- 8.3.2 PRISMA indicated that the module does not total monthly operations. To prepare the quarterly report for USAID/Peru, this unit has to manually add line by line and report by report. This is a lengthy process which consumes considerable time.
- 8.3.3 This module is also used by the NGOs to report the income generated by the services provided under the same project. This information is gathered by PRISMA to establish the total costs of the project and, based on the number of CYPs obtained during the same reporting period, to calculate the cost per CYP.

8.3.4 Other NGOs, such as INPPARES, are using other computer programs to report their expenses to PRISMA. One such program is TECAPRO which was donated by IPPF. Last February, PRISMA changed to TECAPRO to control its inventories. This change allowed PRISMA to have a better control of the contraceptives delivered to each NGO.

#### 8.4 New MIS Proposal by INFOSERV, S.A.

Recognizing that there are a number of inconsistencies and potential for improvement in the MIS, PRISMA has requested a local systems firm, INFOSERV, S.A., to review the system and present a proposal for a new system. The Evaluation Team has had access to the documents relating to this proposal and it is relevant to include them in this review.

The proposal presented by the local firm INFOSERV consists of a general document in which they explain the scope of the proposal. Also included is an individual document for each NGO, PRISMA, CENPROF, APROSAMI, and PROFAMILIA. The general document indicates on Page 3, that the development of an integrated system would strengthen the relation of the three organizations and there would be a reduction in terms of costs and time, not only for the development of the system but its maintenance.

There is an apparent contradiction as noted on page 14. INFOSERV mentions the cost to develop and implement the system is \$24,600. This figure does not concur with the total amount presented in the individual proposals (\$96,000).<sup>17</sup>

In the proposals presented by INFOSERV, the evaluation Team did not find a cost/benefit analysis. This company does not mention how many operations each organization processes every day, and if it is necessary to implement a sophisticated and expensive computerized system. In addition to the \$96,600 mentioned above, INFOSERV has budgeted about \$65,350 for hardware (computers, printers). They are proposing, for example, the purchase of laptop computers for some of the medical posts. APROSAMI has commented that the volume of operations do not justify the acquisition of laptops for the posts.

In INFOSERV's reports they mention that the three organizations have almost the same type of services and that would make possible the designing of a standardized system. As was noted in the eight - month evaluation, one issue is compatibility between and among systems, not necessarily standardization. The experience in this

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<sup>17</sup> For example, for PROFAMILIA, the budget to design the system is \$24,000, CENPROF \$26,000, APROSAMI, \$26,000, and PRISMA \$20,600. In total the cost for the four organizations is \$96,600. PRISMA should discuss and confirm with INFOSERV what are they proposing to develop with the \$24,600 and what are they proposing to develop with the \$96,600.

evaluation indicates that each NGO views itself as unique (at least from their perspective), and hence may not welcome a standardized system. Similarly, recent experience has shown that the six organizations are reluctant to use a study or model if they are not useful for them. If the new MIS happens to be inappropriate for them, it is possible they will react the same way.

On the other hand, the financial benefits of standardized systems of this nature are considerable.

One of the general problems facing both the PVFP and PRISMA as well as the NGOs, is that the NGOs are sometimes restricted by vertical, project-bound thinking, especially in the financial sense. It is important to note that the new MIS should be built as a flexible and accommodating "horizontal", institutional structure which can account for multiple project-specific (i.e. donor) reporting requirements. The Team believes that any system designed in support of a particular project will not satisfy the reporting needs of any other project, thus resulting in more and costly overhead structures to support vertical project reporting.

## **8.5 Recommendations**

- 8.5.1 Before proceeding further with INFOSERV (or any other vendor) on a new MIS, all NGOs should be consulted specifically on the acceptability of a standardized system. It must be made very clear that the new MIS is not going to be designed only to satisfy PVFP and PRISMA requirements, but to improve necessary and useful management information on an NGO institutional (not project) basis.
- 8.5.2 Verify INFOSERV's price quotations. Do these refer to the entire system, or to individual NGO systems? Clarify specifications before putting the contract out for bid.
- 8.5.3 Formalize the training procedures for MIS. It is apparent that these have been done on an ad hoc basis. The amount of money and time, and the amount of diversity expressed by the NGOs, warrant the development of an on-going training program for all NGO staff using any of the critical systems.
- 8.5.4 At the NGO level, cross-training should occur for critical systems (one person is insufficient to know how to operate the various programs).
- 8.5.5 Regular back-ups of data sets need to be made. One copy of the most recent back-up should be kept off-site in case of fire, theft, etc.

- 8.5.6 Previous audit recommendations should be followed, or if over-ridden by the Executive Director, such over-ride and reasons should be clearly noted and available for review.**
- 8.5.7 Software copyright laws should be respected, especially anything purchased or copied through the USAID PVFP Project funds.**
- 8.5.8 Due consideration should be given to shifting to quarterly vs. monthly financial reporting.**
- 8.5.9 Disbursement of Requests for Funds should be made promptly. Failure to do so causes NGOs to lose money through high interest on overdraft accounts; decapitalize to meet PVFP covered costs, etc.**

## SECTION 9 MARKETING STUDY

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### 9. MARKETING STUDY

#### 9.1 Introduction

The market study was intended to help the NGOs determine the size of their markets, to estimate the size of their target population, and to design the most efficient service strategy to serve those targets. The study was to help determine the nature of community preference and other factors which may influence contraceptive use, such as kinds of services, fee adjustments, and expansion into new geographical areas, socio-economic levels, and/or contraceptive methods.

Another important support to be provided to the NGOs through the Market Study was the determination of fair prices and pricing policies for goods and services. Price elasticity studies were also planned to determine the ability of target communities to pay the services rendered by the NGOs.

To meet this objective, PRISMA contracted the services of "BM&G Consultores Asociados S.A.," to prepare the marketing study of the services and products sold by the NGOs.

#### 9.2 Objectives of the marketing study:

- 9.2.1 To identify and evaluate attitudes and preferences of current and potential users;
- 9.2.2 To determine market size and forecast its demand;
- 9.2.3 To determine market characteristics so as to identify factor that influence the use of family planning services;
- 9.2.4 To identify the unmet needs in term of family planning; to identify the area of influence for each NGO, and detect possible area of duplications;
- 9.2.5 To establish a range of prices in which the current and potential users would be willing to pay for family planning services and products;
- 9.2.6 To establish the most distribution channels to reach users; and,

### 9.2.7 To understand the most proper forms and media to promote family planning programs.

The study was undertaken during April-June 1990. The findings were presented to NGOs in a workshop promoted by PRISMA during the period October-December 1990. The reports met the requirements requested in the scope of work. However, due to some concerns presented by the NGOs<sup>18</sup>, it was necessary to hold several complementary working meetings to define the required adjustments to this study. The final version was presented by the consultants during the period January-March 1991, and sent to each NGO shortly thereafter.

The Evaluation Team met with the consultant who led the market study. Some members of the NGOs challenged their participation in the market of family planning. The consultant thinks that the information contained in this study was accurate and provided information that the NGOs did not have. The team that prepared this study did not transfer techniques and methodology on market analysis to the NGOs' staff.

## 9.3 Findings

- 9.3.1 The study found that there exists an overlap among the zones assigned to each NGO in Lima: APROSAMI has the Northern and Western zones, INPPARES downtown Lima and Eastern zones, and PROFAMILIA the Southern zone.
- 9.3.2 PRISMA reported in June-September 1991 that study results were being used by the IEC team and by program coordination area for specific planning activities. This utilization is minor compared to the expectations reflected in the design.
- 9.3.3 In terms of pricing policies, PRISMA began an effort to promote a Price Committee among the three main organizations in Lima. The purpose of this committee was to standardize prices for services and contraceptives methods. This committee started in October 1991 and stopped functioning in September 1992. When the Price Committee decided to increase the prices, the demand for services decreased and so did the production of CYPs.<sup>19</sup> The Price Committee decided that the production of CYPs was more important, and therefore voted to lower prices to increase the production of CYPs. At the beginning they

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<sup>18</sup> Two NGOs disagreed with the size of the market being served; they also disagreed with the findings of the DHS surveys of 1986 and 1991. In addition a number of other minor issues were raised.

<sup>19</sup> There is debate about whether this decrease in production is due to price increases or to the economic situation in general. See Section on Shift to Long Term Methods, Graph I.

accepted a floor price and that PRISMA would monitor the accomplishment of the agreements. Overall, this control mechanism never worked out as planned.

9.3.4 Another effort by PRISMA and the NGOs to coordinate the action under different projects was to define "zones of influence" for each NGO. This was done in a meeting attended by USAID/Peru, Pathfinder, Population Council, and the NGOs. During 1990, PRISMA reported that the NGOs were honoring the agreements reached with the different donors. However, the market study prepared by BM&G reflected the opposite: there was an overlap in the four zones assigned to the three NGOs. After the presentation of this study, the zoning was never mentioned.

9.3.5 The study falls short of presenting price elasticity studies.

9.3.6 Problems with standardized prices and zoning will remain as long as the organizations continue to receive subsidies. If they were operating in a true market environment, they would look for market niches and define prices that the consumer could afford to pay, thereby allowing the organization to grow. The organizations would set their prices based on the installed capacity, productivity, their services offered and the quality of these services, financial resources and capital available, technology utilized, market size, competition and market share, consumer incomes and product and services preferences, human resources available to the organization, etc.

#### 9.4 Recommendations

9.4.1 Since the emphasis on self-sustainability is an important objective, a revision of this study is necessary. This time, however, the emphasis should not solely be on family planning activities, but also on commercial investment opportunities that the NGOs might pursue.

9.4.2 PRISMA must involve the NGOs at the very beginning of the new or revised Market Study. Since NGO disagreement came about over relatively minor issues, these should be discussed and agreed upon with the consultant and incorporated in the design.

9.4.3 Executive Directors should commit themselves to support the implementation of the results. They should also agree that a member from their staff should become involved in the entire process of the study.

- 9.4.4** A new study should not discard the information available in the market study. PRISMA and the selected consulting firm should use this information as a reference. The Evaluation Team learned that the Ministry of Health, in conjunction with other private sector organizations, are preparing a survey on family planning, which will be ready soon. This information could be used to up-date the market study in term of population data and other related information.
- 9.4.5** PRISMA should assist in the definition of price policies<sup>20</sup> for the services offered by the NGOs. The market study prepared for PRISMA and the NGOs does not include a pricing strategy. It only presents a collection of information concerning the range of prices the users and potential users are paying or are willing to pay.
- 9.4.6** Through the addition of an Income Generation Specialist to the PRISMA Staff, Technical Assistance in interpreting and using the results of the market studies, and updating these, should enhance NGO efforts in this direction.

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<sup>20</sup> To recommend an appropriate price policy to the NGOs, PRISMA and the NGOs should understand all the elements needed in a timely manner. The existing MIS and the one proposed by INFOSERV do not collect and provide the majority of this information. However, INFOSERV acknowledged that it is possible to include it in the system.

## SECTION 10 COST ANALYSIS

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### 10. COST ANALYSIS

#### 10.1 Introduction

In the PVFP project design, USAID/Peru included the preparation of a cost analysis to identify administrative and program costs, both direct (program) and indirect (capital, administrative, and support). The study was also to identify capital and other indirect costs, and establish a basis for allocating a fair share of these costs to the direct cost associated with each service delivery project.

To comply with this objective, PRISMA contracted an independent local consultant, (Francisco Verdera), in 1990 to prepare, in conjunction with the six NGOs and PRISMA, an analysis of each organization, staff, services, clients, expenses, costs, and assets, and establish a methodology to determine unit costs for the services and contraceptive methods offered by the NGOs.

#### 10.2 Purposes of the Cost Analysis

- ◆ To assist the NGOs to improve the recuperation of their service and product costs through a proper price policy, cost reduction (rationalize the uses of their resources), and better utilization of their installed capacities;
- ◆ To elaborate a program to adjust periodically the basic costs included in the model designed under the cost study.

The cost study was begun in April-June 1990. During this period PRISMA contracted the service of an independent consultant. During October-December 1990, an official presentation of the results of the study was made and a seminar was held to train accountants in the methodology to be used for the determination of cost, in each NGO. Based on initial findings, PRISMA and the consultant designed a work plan to institutionalize the cost model developed in the study of each organization. In January-March 1991, PRISMA and the consultant defined a work plan oriented toward cost estimation and specially, transferring the methodology to each NGO. The first step of this activity was carried out in PROFAMILIA, INPPARES, and APROSAMI.

Three elements were central to this follow-on activity: adaptation of the methodology, cost estimation, and the incorporation of the methodology to the administrative system at each NGO. By September 1991, these three elements had been completed in PROFAMILIA and APROSAMI, and had started at INPPARES. By January-March

1992, PRISMA and the three participants NGOs (APROSAMI, INPPARES, and PROFAMILIA) were able to update unit costs through December 1991.

### 10.3 Incorporating the Elements of the Cost Study into the NGOs

Three elements were defined to follow up on the study with the NGOs:

#### 10.3.1 **Adapt the methodology to the NGOs for their use**

The model was installed in APROSAMI and PROFAMILIA in June 1991 and in INPPARES during the period October-December 1991. The other NGOs participating in the family planning project postponed the installation of the model for different reasons: PLANIFAM was interested in its program service first; CENPROF was revising its contraceptive logistic management; and ATLF was re-defining its service scheme. PRISMA and these three NGOs agreed to postpone the installation of the model until late 1992.

#### 10.3.2 **Estimate unit costs and prices**

The cost study developed a computerized (Lotus 1-2-3) model to assist NGOs to adjust prices periodically. The model includes direct costs such as personnel at the clinics, posts, material, direct services, equipment, furniture, medical instruments, and other direct costs. Indirect costs corresponds to home office overhead, expenses incurred by the IEC program, any other operating expenses of the home office and support offices.

The information required to derive prices is:

- (a) the unit cost per service
- (b) weighted value of each service's cost elements
- (c) price of the cost elements.

The only information the computer model needs to calculate the unit cost is price of the element of costs during the analyzed month. With this information, the NGOs would be able to determine the cost recovery against prices, cost variations, and the percentage of cost recovery compared to a "base" month. The Lotus model is provided with instructions on how to enter this information into the model.

Results obtained from the model show that in March 1991, at a clinic level in PROFAMILIA, the unit cost for a gynecological service was 1.63 million Intis and the price for the service was .5 million Intis.<sup>21</sup> This means that the organization was recovering only 31 percent of its cost, and therefore it was losing money. At APROSAMI the situation was different, the unit cost for the same service was 1.058 million Intis and the price was 1 million Intis: they were recovering 95 percent of their costs. The only exception was INPPARES, where the unit cost was 1.255 million Intis and the price was 2.379 million, which represents a cost recovery of 187.9 percent.

### **10.3.3 Incorporate the methodology into the management system of each NGO.**

The consultant trained the administrator and other personnel on how to access and operate the Lotus files and how to adjust the model's parameters (cost components, weighted values, data for the base period). The NGOs' accountants seem to assimilate with no major problems the techniques for entering the information as requested in the model.

However, they did not learn the methodology to up-date the parameters utilized by the consultant to calculate the unit costs. The lack of monitoring of the results of this activity and the apparent inertia and lack of interest of the NGOs made it difficult for the NGOs to utilize this important tool. As a result, any new activity contemplated by PRISMA and USAID/Peru should receive the full commitment from the NGOs' top management.

The consultant mentioned to the Evaluation Team that during 1992 and 1993 there was no effort to update the model designed in 1990 and 1991. As the economic conditions during the those two years have changed, the model should be adjusted accordingly.

## **10.4 PRISMA's Findings on Follow-up - March, 1993**

In March 1993, the Financial Unit's coordinator at PRISMA met with APROSAMI, INPPARES, and PROFAMILIA to evaluate the status of the cost study. Specifically, the following questions were addressed: (a) are you using the cost study, (b) what personnel did you assign to implement the study, (c) what inconvenience or observations do you have, (d) do you consider that in

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<sup>21</sup> The Inti was devaluated and re-denominated in new soles in 1991. Because of exchange rate differences, the U.S. dollar value cannot be calculated with accuracy, hence the Inti will be used for illustrative purposes.

the current circumstance it is applicable, (e) if not, why and what suggestion do you have.

The findings of this review were:

- ◆ None of the NGOs interviewed is using the cost study. Only APROSAMI has assigned a person to apply the methodology, and this is sporadic.
- ◆ The main obstacles are: (i) lack of a full time dedicated person to implement the model; (ii) parameters are outdated; (iii) excessive components to determine the cost; (iv) the base of goods (cost elements) is inflexible, i.e., one cannot change elements that are no longer utilized for other that are utilized; (v) the program calculates the number of average medical consultations based on historic data and installed capacity, and not on real number of medical consultations; and (vi) in general, the study is based on historic costs.

#### 10.5 NGO Issues and Concerns on incorporating the Cost Study

At the beginning of the study, the NGOs did not collaborate as requested in the letter sent by PRISMA. Their main concern was fear of the control PRISMA might exert on them.

With some of the NGOs, no full time dedicated staff were available to implement the model. This made it difficult for the consultant to train people on how to enter the information and how the change the parameters necessary to adjust the base month.

#### 10.6 Recommendations

The Cost Analysis should be re-vitalized. It is an essential element to NGO Self-sufficiency. The following actions should be taken by PRISMA:

- 10.6.1 **Establish a Cost Analysis Forum** consisting of the Executive Directors of each NGO together with a Consultant. This Forum would:
  - 10.6.1.1 Establish a framework for the consultation - beyond the broad Scope of Work
  - 10.6.1.2 Establish a time table for stages of incorporating the analysis and its methodology into each NGO

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- 10.6.1.3 Ensure the commitment of each NGO to the use of the Cost Analysis by naming a senior management staff member as Representative. A core of three individuals already exist who could fill this role. These individuals were sent to Quito, Ecuador, to attend a special course in Cost Effectiveness. The PVFP should take advantage of these resources.
  - 10.6.1.4 Provide for on-going follow up by PRISMA and the Forum with respect to maintaining the fundamental parameters current.
  - 10.6.1.5 Develop a clear and step-by-step USERS' Manual for operating and up-dating parameters. This should be a bound, loose-leaf manual which is readily amenable for Technical Updates and related correspondence.
- 10.6.2 **Technical Recommendations (Addresses PRISMA's Findings in 10.4)**
- 10.6.2.1 Use medical consultations as a way of including real data;
  - 10.6.2.2 Costs should be determined based on production; for that purpose the NGOs should have accurate information;
  - 10.6.2.3 Include depreciation;
  - 10.6.2.4 Establish a minimum holding of furniture that each post or clinic should have, because each NGO has different infrastructure;
  - 10.6.2.5 Change the elements related to post because the modality has changed;
  - 10.6.2.6 Permit the user to change the cost elements as needed in the program;
  - 10.6.2.7 Up-date the elements that have changed.

## SECTION 11 STRATEGIC PLANNING

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### 11. STRATEGIC PLANNING

#### 11.1 Introduction

The general objective of the strategic planning technical assistance is to improve the planning capabilities of the NGOs. To do this, PRISMA contracted an external consultant (Roberto Tirado) to design and present a workshop with the NGOs and PRISMA to improve the perception of the group of the environment they are working and its perspectives. One goal was to design and prepare Strategic Planning Manual and Operational Plans Guide, and to develop project profiles to be defined by the consultant and the NGOs to investigate potential activities.

#### 11.2 Specific objectives of the strategic planning assistance:

- 11.2.1 To design and coordinate a workshop for the participating NGOs and PRISMA, to improve the level of perception of the environment they are working and its perspectives
- 11.2.2 To elaborate an administration program of the environment or lobbying for PRISMA and each NGOs.
- 11.2.3 To design and elaborate a Strategic Planning Manual and an Operational Plans Guide, which would be implemented in each organization, gathering a common experience methodology, but maintaining the idiosyncrasy of each organization.
- 11.2.4 To develop a workshop on creativity to reinforce and improve this vital aspect for the strategic planning
- 11.2.5 To find, design, and develop project profiles which will be done by the consultant with the collaboration of teams defined by the NGOs to build within the NGOs this capabilities to be developed in the future.
- 11.2.6 To formulate, develop, and elaborate the strategic plans for each institution. This includes technical assistance, training, consulting, and support to the organizations.

- 11.2.7 To formulate, develop, and elaborate Operational plans. This include technical assistance, training, consulting, and support to the organizations.

In April 1991, the technical assistance for strategic planning started under the guidance of a consultant. This assistance included an initial workshop, followed by individual NGO consultations in which the consultant spent several days in each NGO to work with them to develop NGO-specific plans, and, finally, follow up and on-the-job training was carried out by the same consultant.

The Evaluation Team had the opportunity to discuss with the consultant and to receive a copy of the final report, in which he presents the objectives and results of the consultancy.

APROSAMI and PROFAMILIA, with the assistance of the consultant prepared their strategic plans in January-March 1992; manuals were also developed with the assistance of the consultant. The NGOs prepared their strategic plans and operational plan, and profiles of potential activities.

### 11.3 Findings

According to the final report presented by the consultant, the following results were achieved as a result of the strategic planning activities.

- 11.3.1 In January 1992, a workshop was presented on the Peruvian economic and political environment by a congressman and an economist associated to the Ministry of Economy. This meeting helped the directors and top management of the seven NGOs to understand the changes occurred months later.

In the same workshop, the directors of the NGOs with the assistance of Mr. Tirado, presented the market evolution of family planning.

- 11.3.2 A lobbying program was implemented by the NGOs' directors to implement a joint effort to sell the family planning topics effectively among the political leaders, national and community entrepreneurs.

- 11.3.3 Each NGO prepared guidelines to design its strategic and operational plan. These guidelines were prepared with the intention of general dissemination throughout the organizations.

- 11.3.4 A workshop on creativity was implemented with the participation of the board of directors and top management of the NGOs. The group prepared a case study in which the participants applied the skills learned at the workshop to anticipate the change in the donors' behaviors.
- 11.3.5 For project management a common methodology was developed for all the organizations. This represents a base for a programmed market study of information and the preparation of the study itself.
- Additionally, the group revised and modified an Evaluation Guide, which now is part of the management system.
- 11.3.6 All but CENPROF, PLANFAMI, and INPPARES prepared and presented their strategic plans. CENPROF's final version was pending a final discussion with the administrator. PLANFAMI, needs to consider rural areas and the need to maintain subsidies. INPPARES continued its own programs and the recommendations provided by another consultant.
- 11.3.7 All the organizations have operational plans for the fiscal year 1992-1993.
- 11.3.8 The consultant provided some assistance out of the scope of work in the areas of: guide to evaluate the services, workshop on service sales, technical support for the 1991-92 and 1992-1993 agreements.
- 11.3.9 The assistance provided by this consultant is the most appreciated by the NGOs. They feel they learned something applicable to their organizations.
- 11.3.10 The consultancy techniques involved a high degree of participation. Significant use was made of working groups. This had the effect of incorporating all staff into the process and enhancing their understanding of the problems and opportunities facing the NGOS. It also allowed individual staff members to participate in the planning process and how they could contribute to the achievement of these goals.
- 11.3.11 The organizations were highly motivated to work with the consultant and prepare their own plans. One of the organizations mentioned that it has prepared its own strategic

and operation plans manuals to train its personnel on a continuous basis.

- 11.3.12 A review of two NGO operational plans revealed that the complete concept of planning has not been totally absorbed or incorporated into practice.

One theme, oft repeated throughout this evaluation, is that NGO Directors are "Project-focussed", not Institutionally focussed. Documents reviewed treated the plans as relating specifically to the PVFP, rather than to their institutions as entire entities.

A second problem is level of detail to implement operational plans. In two instances these were buried in the narrative rather than presented as objectives and activities, timeframes, etc., with monitoring and control points

#### 11.4 Recommendations

The recommendations made by the consultant regarding Strategic Planning are basically shared by the Evaluation Team with some modifications. These are:

- 11.4.1 Future projects must take cost/effectiveness targets into consideration. It is necessary, however, to establish what is the real cost of the services provided. (See Cost Analysis Section.)
- 11.4.2 In order to develop and complement self-sustainability, a market study and project profiles should be implemented. (See Market Study Section.)
- 11.4.3 Consider the creation of a revolving fund to finance the projects. (The evaluation team agrees strongly with the need for a capital fund (see General Recommendations on budget for the extension).

However, a revolving fund is a difficult mechanism to implement successfully. It depends on participants' good will and commitment to pay-back terms, and the skillful investment of their share of the fund. Further, it is questionable whether PRISMA is either technically prepared or institutionally inclined to act as a broker-banker-enforcer to a revolving fund. And, if commercial sources are engaged to administer the fund, what will be the cost? Are NGOs willing to commit their meager

capital assets, i.e. their means of survival, as collateral for a loan to invest in some other enterprise?

The Evaluation Team recommends that a serious study be conducted before proceeding with a revolving fund scheme. Similarly it recommends that any such scheme be established under commercial conditions but with credit terms more favorable than market-rates.

Conceivably PROFIT itself might be in a position to be of assistance in this endeavor.

11.4.4 Implement workshops for programming and supervision of targets for field personnel and supervisors.

11.4.5 Provide follow-on training in project management. The Evaluation Team recommends that the assistance provided by Roberto Tirado should be complemented with an assistance in project management and implementation. It is important for them to know how to keep the project or activities on track.

This same recommendation applies to PRISMA, and to USAID/Lima. The Evaluation Team had the opportunity to review the annual plans and the quarterly reports presented by PRISMA. In some activities, PRISMA did a good job of monitoring activities, but in others there appears to have been slippage.

In PRISMA's quarterly reports, there is no mention, for example, that the NGOs had not applied the findings of the Cost and Market studies, nor that there was some serious resistance to the market study. Formal monitoring of program implementation activities should be made a part of the systematic management systems of USAID/Lima, PRISMA and the NGOs.

11.4.6 It bears emphasis that special attention to Strategic Planning for rural areas should be a priority for those NGOs with rural programs. As mentioned elsewhere in this evaluation, the definition "rural" as employed in political and demographic definitions, needs reconsideration. More relevant definitions would include such factors as accessibility, infrastructure, occupational characteristics, linguistic characteristics, etc.

**Both Strategic and Operational plans will differ markedly for these populations. In the short- to medium-term, it is doubtful that these populations will contribute much to cost-recovery, and probably will require ongoing subsidization.**

## SECTION 12 INVESTMENT OPPORTUNITIES

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### 12. INVESTMENT OPPORTUNITIES STUDY

#### 12.1 Introduction

As discussed in the general Introduction, one of the main concerns of the PVFP is the acquisition of skills by the NGOs to become reasonably self-sufficient. This is of concern not only at the USAID/Peru level, but also at the A.I.D./Washington level. Further, financial self-sustainability is in the NGOs' own best interests.

The PVFP, through the agency of PRISMA, has attempted to provide the NGOs with some of the means to achieve some degree of sustainability. As noted in the previous sections, studies have been conducted and applied with varying degrees of success in cost analysis, marketing, MJS, and strategic planning. All of these elements are essential in pursuing institutional strategies of sustainability. The introduction of profit-making activities into family planning will further increase the NGOs' level of self-sufficiency. These activities should be introduced only after the other institutional development outputs have been achieved. The project will also assist the NGOs to identify their marketable skills and products, market, and prices. Second, the project will assist in the development of business plan that clearly specify the product of services to be sold, the market, start-up costs, and cash flow projections.

#### 12.2 Commercial Market Study (SASE)

In order to systematically explore income-producing ventures, an investigation commissioned to a local consulting firm "Seguimiento, Analisis y Evaluacion para el Desarrollo" (SASE), was undertaken. SASE delivered its first draft on April 30, 1993, during the period of the Evaluation. Because of this, no actions have been taken with respect to the SASE findings as yet. The specific objectives of this study are:

- ◆ To predict and identify investment opportunities and the commercialization of family planning services,
- ◆ To identify and value different market strategies viable for the NGOs, and
- ◆ To gather a portfolio of potential investment opportunities for the NGOs.

To achieve the objectives of this study, SASE determined the services currently offered by the NGOs, the costs and income structure for each organization, the

outreach and diffusion of services provided by the NGOs, and the market environment in which the NGOs operate.

### **12.2.1 Findings**

The report by SASE is a 115 page document which attempts to comprehensively survey the current organizational, operational and financial status of all the NGOs, and succeeds to a significant degree. In addition, its technical findings triangulate well with the findings of this evaluation.

It is relevant to note here that considerable tension seems to have been generated by the study. Some NGOs have indicated that they were not advised, and not consulted, with respect to the purposes of the study nor its design. In the Final Report, SASE indicates that the study was limited due to lack of collaboration and coordination between PRISMA and the NGOs (SASE report, pp. 2-3). PRISMA, on its part, has documentation that indicates that the NGOs were in fact involved and notified prior to the study. In any case, the fact that this has been raised as a major issue by SASE, reinforces other recommendations of this evaluation that the NGOs need to be consulted and involved directly in the design of any major TA activity. In addition to this issue, SASE also reports a deficit of information in that either it was not organized or simply did not exist.

This is particularly disturbing, and should be of considerable alarm to both PRISMA and USAID/Lima, given the amount of time and money spent on the other studies and MIS. Information, methodologies, and systems that are not used are a serious drain on precious resources. The single instance of the SASE experience would be of less import had it occurred early-on in the PVFP, and if some of these findings were not triangulated by the findings of this evaluation. However for a project three and a half years down the road, this is a red-flag indeed regardless of where the basic responsibility lies.

### **12.2.2 Technical Findings by SASE**

12.2.2.1 NGOs lacked information. In some organizations, SASE found some difficulties obtaining the information, because it was not systematized or the NGOs did not have it.

12.2.2.2 The organizations did not have a costing system that could provide disaggregated, current information by type of service. The data on gross expenditures was not provided in detail. (This evaluation recommends that the cost study be reactivated and implemented.)

- 12.2.2.3 There is no price policy based on costs, market, and other technical parameters. (This evaluation recommends that pricing policies be reactivated and implemented.)
- 12.2.2.4 All NGOs have a high level of financial dependency. The range varies from 42 per cent to 78 per cent.
- 12.2.2.5 The majority of "own income generated" comes from services offered at the clinics. This represents between 75 per cent to 95 per cent.
- 12.2.2.6 Community posts' income represents approximately between 5 per cent and 21 per cent of revenues (across all organizations).
- 12.2.2.7 In the majority of the organizations, the number of people directly involved to providing services in family planning and health are approximately 60-70 per cent and 30-40 percent are involved in the administration of these services. At INPPARES, the reverse is the case, with 60% of staff in administrative activities.
- 12.2.2.8 Overall, the six NGOs are only operating at 51% of installed capacity. Peru's economic conditions are cited as partially responsible for this.
- 12.2.2.9 The NGOs cannot survive on the basis of their own income generation.
- 12.2.2.10 Family planning services do not produce significant incomes to each organization to permit self-sustainability.

### **12.2.3 Recommendations by SASE**

- 12.2.3.1 To reach some level of self-sustainability, the NGOs should redefine: (a) their target populations; and, (b) the services offered. SASE recommends targeting another strata more likely to be able to afford cost-effectively priced services, and to make general medical services available.
- 12.2.3.2 To develop a joint health insurance system to attract funds

The evaluation Team learned that the government of Peru is in the process of establishing the regulation to implement a private health service that can offer alternatives services to employees currently being served by the social security system. Health insurance programs are not new in Peru, and some private clinics are currently offering this type of service.

The Evaluation Team met with Dr. Jack Fiedler (Health Economist), an independent consultant to USAID/Peru who is assessing the current services and programs being implemented by the private sector. The results of this study should be shared with PRISMA and the NGOs.

However, the Evaluation Team views this recommendation from SASE with considerable skepticism at the present time. None of the NGOs currently have the management, financial, marketing, sales or other skills necessary to support such an endeavor. Second, establishing an insurance group presupposes a collaborative will and mutual trust and interest among all players. At this point, these factors cannot be said to exist among the NGOs.

12.2.3.3 To promote the establishment of an information network among the NGOs. This network should gather administration, logistic, medical services offered, and promotion.

Sharing information on costs, market, and prices has been difficult to realize under this project. For the Evaluation Team this network seems to be good idea if the six organizations were willing to work together and share information that they consider basic and in some cases private. As mentioned above, this is not presently the case.

12.2.3.4 To invest in the implementation of new services, improve the existing, and the installed capacity.

Here again, the Evaluation Team noted that the lack of communications between PRISMA, SASE, and the NGOs inhibited the opportunity for SASE to explore some good ideas that the NGOs may have. In almost

every organization, the Evaluation Team has heard of some projects that are not presented in the profiles prepared by SASE.

- 12.2.3.5 To invest in promotion and change of image of the organizations. This recommendation should be part of a new business strategy, i.e. as cited above in terms of targeting a new/different population and emphasizing general medical services.

### 12.3 Observations and Discussion

Findings from all sources triangulate to reinforce the observation that the NGOs are not currently financially self-sustainable. It is even questionable as to whether or not they form a "group" in the sociological or anthropological sense. Their main common threads seem to be few: a genuine belief in family planning; their dependency on donor subsidies and commodities from USAID/Peru; and, their inclusion in the PVFP Project. All, except perhaps INPPARES (due to its IPPF affiliation), are concerned with survival. The Evaluation Team seriously questions any current recommendation that would require fiscal collaboration and shared identity for these NGOs in a quest for efficiency or even income-generation. Each of the six major organizations is headed by a strong leader, each with his/her specific strengths and talents. In effect, they are the organizations.

- The successful development of an income project which would merge all or some of the NGOs is considered premature. Issues of leadership, financial investments, distribution of risk profits, etc., are all considered problematic at this time.

On the other hand, much can be said in favor of pooling of resources. Some suggestions that have been offered by various parties during the course of this evaluation include the establishment of a major clinical laboratory with considerably greater range of services and volume than any individual NGO now possesses; a common OB/GYN center; maternity center; centralized administrative services; and so forth. One problem with these concepts is that many of the NGOs already have invested in some or all of these activities, and depend on them for their own income sources. Thus, relinquishing control and ownership of their own revenue centers in favor of a common facility is probably not in their own (short-term) interest. In addition, the geographical distribution of the current target populations in Lima, not to mention the NGOs in Trujillo, Cuzco and Puno, reduce the probability that their clients and patients could avail themselves of centralized services.

It may be more feasible to organize a common effort on the part of the NGOs if a new income strategy could be developed outside the specific health services delivery sector. Consideration could be given to health support or related services, where the

**expertise and contacts of the health personnel in all NGOs might be tapped. Without journeying into fantasy, one might consider such enterprises as clinic catering with attention to special dietary and nutritional requirements; linen services; janitorial services; health food and nutrition retail stores, etc. These are ventures in which all NGOs could participate without fear of losing control of their current array of services.**

**Whatever specific strategy for income generation is finally adopted, if it is to involve more than a single NGO, the Evaluation Team recommends:**

- 12.3.1** That both the NGOs and PRISMA commit themselves to work hand-in-hand to implement plans, studies, and recommendations. Without complete participation, any plan is likely to fail to be implemented. Over last three years ample opportunity to strengthen their organizations has been provided. Some of them have taken advantage of this assistance and some have not. For the two-year extension, such cooperation and communication is essential.
- 12.3.2** Generalizing from the SASE experience, and without casting blame, it should be clear that the best intentioned efforts require clear communications among all parties. PRISMA has made an admirable effort in providing resources for the development of necessary skills for self-sufficiency (as well as good basic management). The evaluation team views multiple-breakdowns in the communication and follow-up process as a critical impediment to their successful incorporation by the NGOs.
- 12.3.3** Both PRISMA and USAID/Lima and the NGOs should develop and monitor Gantt Charts on each project activity. Critical milestones need to be agreed to in advance. Reports of failure to meet milestones should be reported as they occur, and not wait till the quarterly report. The USAID/Lima Project Manager should document "action-taken" on these reports.
- 12.3.4** In the extension budget an item for "Income Generation Specialist" should be included. While PRISMA has a sound management team, it has no specialist in entrepreneurial activities. This two-year contract position should assume the direction and responsibilities of all studies undertaken towards sustainability. The position should be parallel to that of the Program Coordinator for Family Planning. Both these positions should be viewed as support consultants to the NGOs.

Administrative oversight and accountability should be divided for these technical support functions.

**12.3.5** The NGOs should also designate an individual as Coordinator of Income Generation as counterpart to the PRISMA position. It is recognized that this is a budget issue and that funding must be made available. Nevertheless a solution (part-time, contract positions) must be found if the NGOs are to successfully incorporate sustainability technical assistance into their organizations and apply that technology.<sup>22</sup>

Their functions should include income project development in conjunction with the executive directors. They should be involved more in the management of the organization in such areas as:

- price and cost analyses
- market trends and opportunities
- development of business plans
- analyze the monthly financial statement and prepare recommendations to the Executive Directors
- follow up with PRISMA the implementation of studies and investigations undertaken

**12.3.6** Any effort to diminish the dependency on outside donors, should respond to an institutional strategy that includes training; a Board of Directors that includes local entrepreneurs; and a focus on pro-actively obtaining the financial resources to invest in new business opportunities.

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<sup>22</sup> Once the new MIS is installed, the current need for some redundant activities such as multiple data entry will probably be eliminated. PRISMA and the NGOs should begin to consider re-training programs for personnel now in some of these positions. For example some administrative and accounting staff might be trained in activities regarding cost analysis and other financial functions.

## SECTION 13 FAMILY PLANNING GOALS

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### 13. INTRODUCTION

This section of the evaluation report focusses focus on the progress made by the NGOs in the substantive area of Family Planning. It incorporates findings relative to the three PVFP goals:

- ◆ Improved availability of long-term methods (PVFP Goal 2)
- ◆ Maintenance of supply of temporary and natural family planning methods (PVFP Goal 3)
- ◆ Expansion in rural areas and collaboration with the public sector (PVFP Goal 4)

#### 13.1. Contraceptive Method Mix: Shift to Long Term Methods and Continued Support for Temporary and Natural Family Planning Methods

For the purposes of this evaluation report, this Section "Shift to Long-Term Methods" is interpreted to indicate the increased emphasis on availability and use of IUD and sterilization methods and wider dissemination of information and knowledge regarding their advantages

In addition, it covers the degree to which temporary and natural family planning methods are maintained and supported by the NGOs.

#### 13.2 NGO Policies on Method Mix

Each NGO is emphatic that during counselling a comprehensive range of family planning methods is presented to the client with a full explanation of the advantages, disadvantages and appropriateness of each to the user, and no attempt is made to use persuasion toward any particular method. It is axiomatic, according the philosophy of each NGO, that such influence would undermine the principles of freedom of choice and would be inconsistent with their goals and objectives.

In the central clinics of all NGO's visited, registration of new and continuing users and extraction of records, is followed by a counselling session and a physical examination by a physician of new users and of continuing users where preexisting medical conditions so indicate. In peripheral clinics and posts, full counselling and physical examinations are desirable, but not always possible due to personnel shortages. If long term methods are desired in these cases, referral to a central clinic, or an appointment with a rotating team (including a physician) is made.

### 13.3 Summary: Performance Findings - Shift to Long Term Methods

Analysis of performance statistics of seven NGO's<sup>23</sup> indicates that, despite the progressive decline in total number of CYPs from 1990 to the first six months (ending March 31) of 1993, the CYPs for all Long-Term methods expressed as a percentage of the accumulated total of both Long- and Short-Term methods shows a progressive and dramatic increase. In 1990, 49% of all CYPs were accrued from Long-Term methods. This figure increased to 52% in 1991, 59% in 1992 and 80% in the first six months of FY 1993, (Graph 1).

The cumulative total number of CYPs provided by the seven NGO's were 75,517 (1990), 69,953 (1991), 56,941 (1992) and 55,000 (estimated 1993).

Graph 2<sup>24</sup> indicates CYP's for NGO's and totals expressed as a percentage of 1990 activity (taken as 100%). While a net decrease in total CYP's is evident, estimated 1993 activity does not appear significantly different from 1992. Thus the decrease since 1990, possibly attributable to the depressed economic status of Peru, appears to have stabilized. It is not known whether MOH family planning statistics indicate a compensatory increase in activity since 1990 as a result of users selecting less expensive alternative services.

Graphs 3-7 show the distribution of temporary and long-term methods by agency for the years 1990-1993, and the cumulative 1993 totals.

### 13.4 Short term Maintenance

During the first three months of 1993 the cumulative figures for all seven agencies in rank order of choice for short-term family planning methods shows: use of contraceptive pills 734 CYP's (41%), condoms 521 (29%), vaginal tablets 264 (15%), other methods including implants 198 (15%).

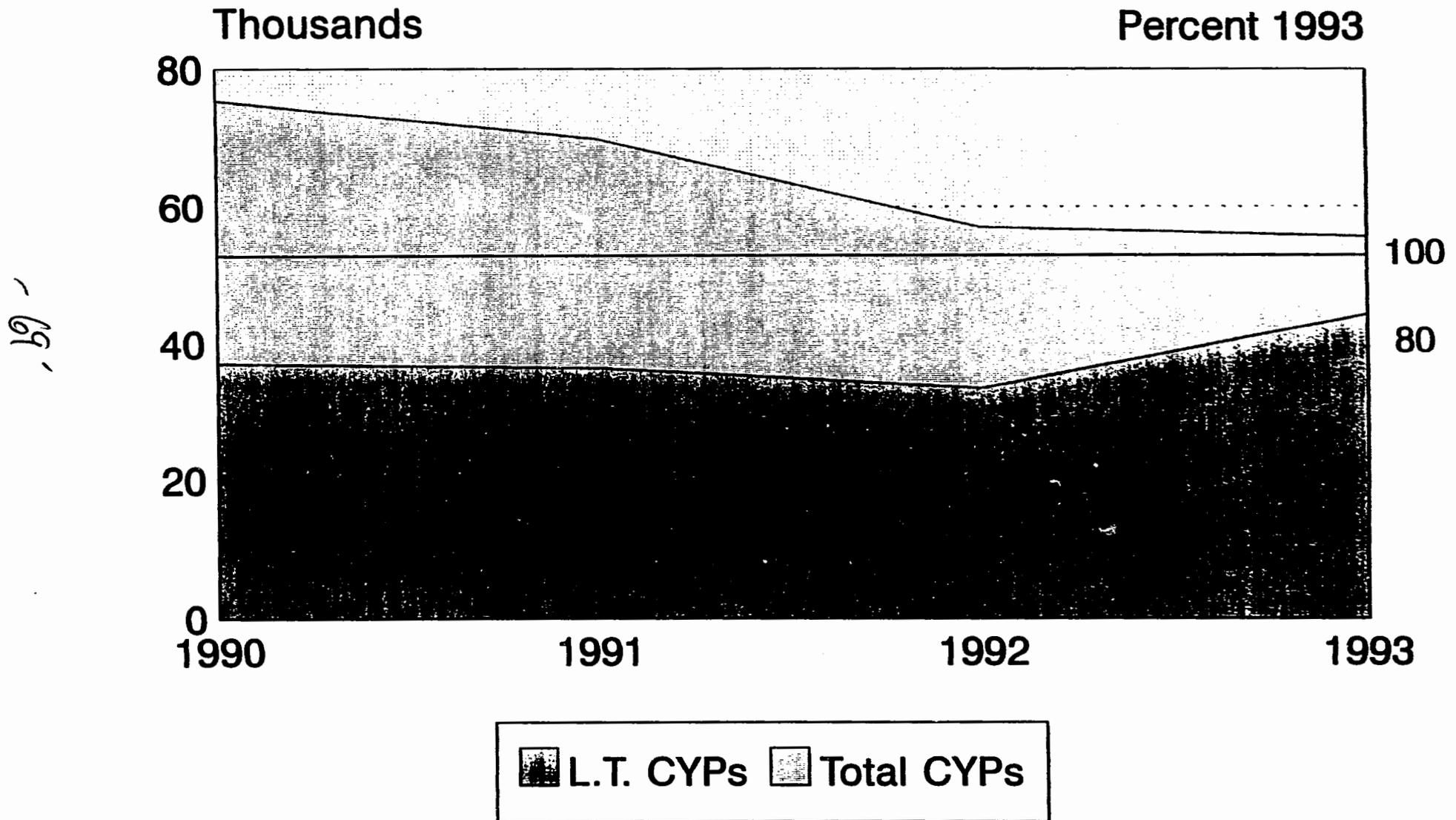
It is notable that following the change of policy regarding the role of promoters and their utilization as informational sources rather than distributors of commodities (with percentage payment) that became effective on 1st October, 1992, the cumulative numbers of CYPs was anticipated to fall significantly. While the downward trend appears to have stabilized, the change in role of the promoters does not appear to have affected the program precipitously. On the other hand, the percentage of CYPs

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<sup>23</sup> Includes: APROSAMI; CENPROF; PROFAMILIA (Lima and Huancayo); INPPARES; PLANIFAM; PLANFAMI(Puno). ATLF is excluded since it engages only in Natural Family Planning methods.

<sup>24</sup> PLANFAMI - Puno figures are not included in this Graph since their starting point is zero, their significant performance since that point distorts the graph. It should be borne in mind, nevertheless, that PLANFAMI has made remarkable strides towards CYP production.

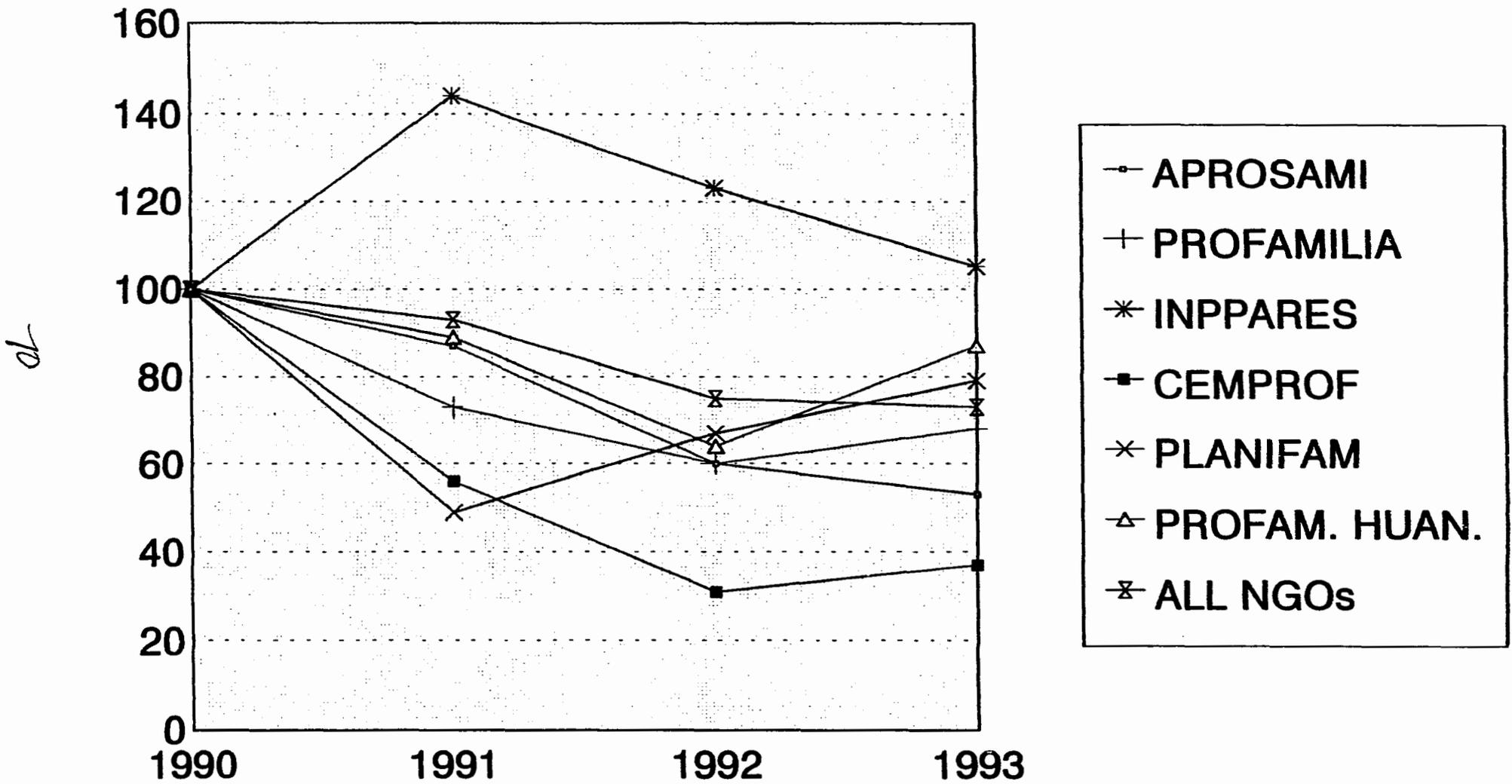
# Total and Long-Term CYPs for NGOs FY 1990 - 1993 (est.)



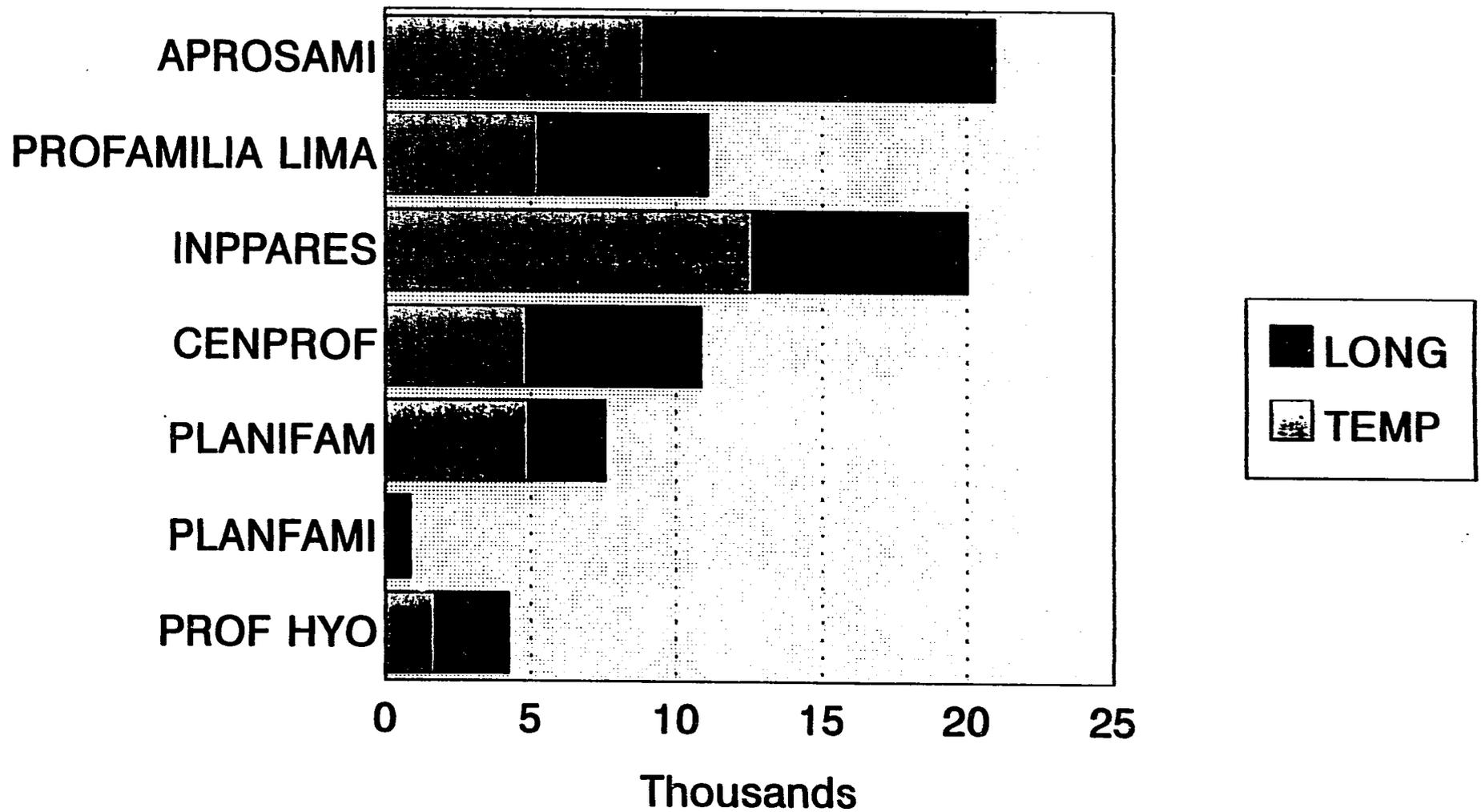
Graph 1

# CYP Activities of NGOs, FY 1991 - 1993 (est.)

Expressed as % of FY 1990 levels

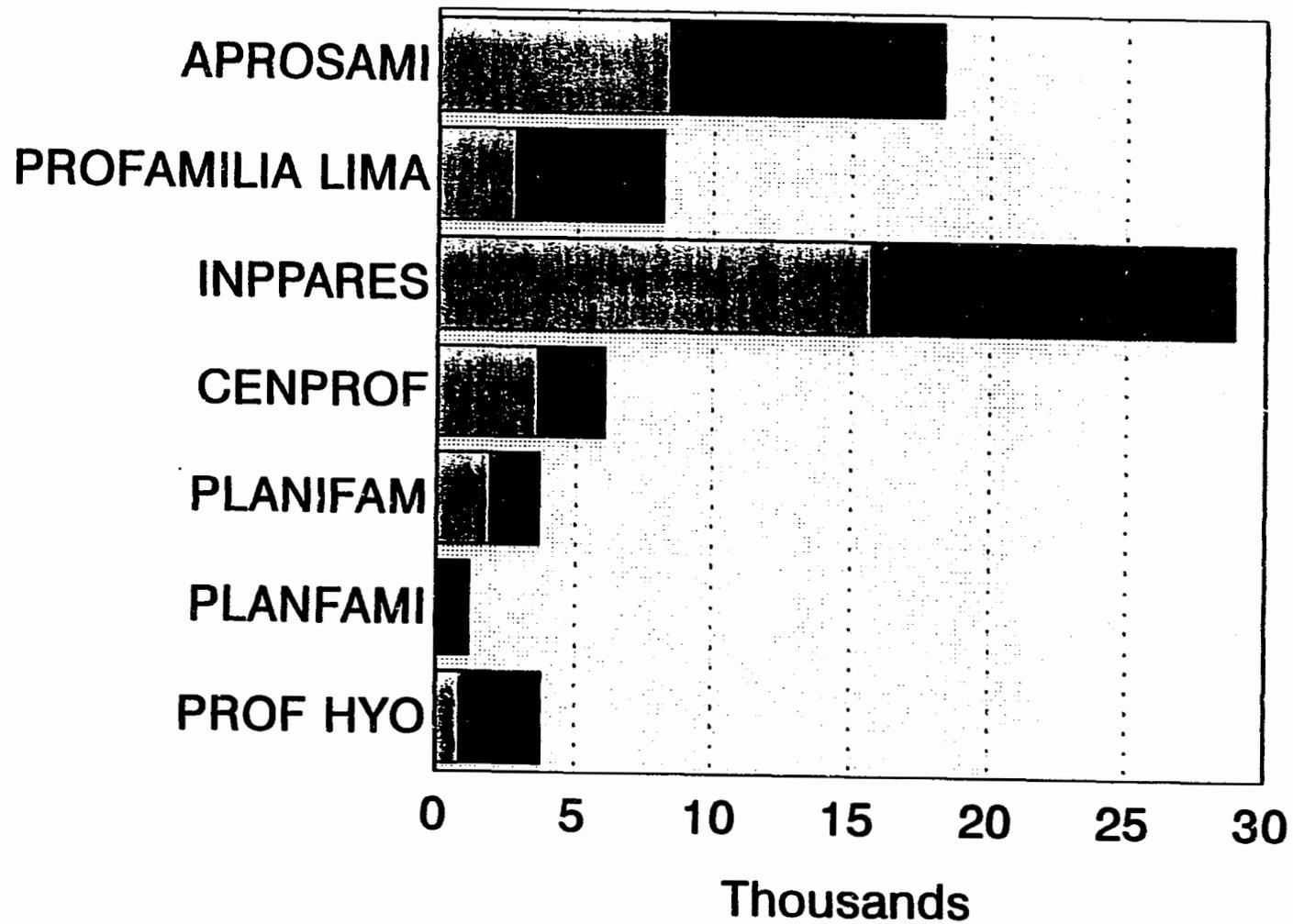


# CYP Production by NGO 1990



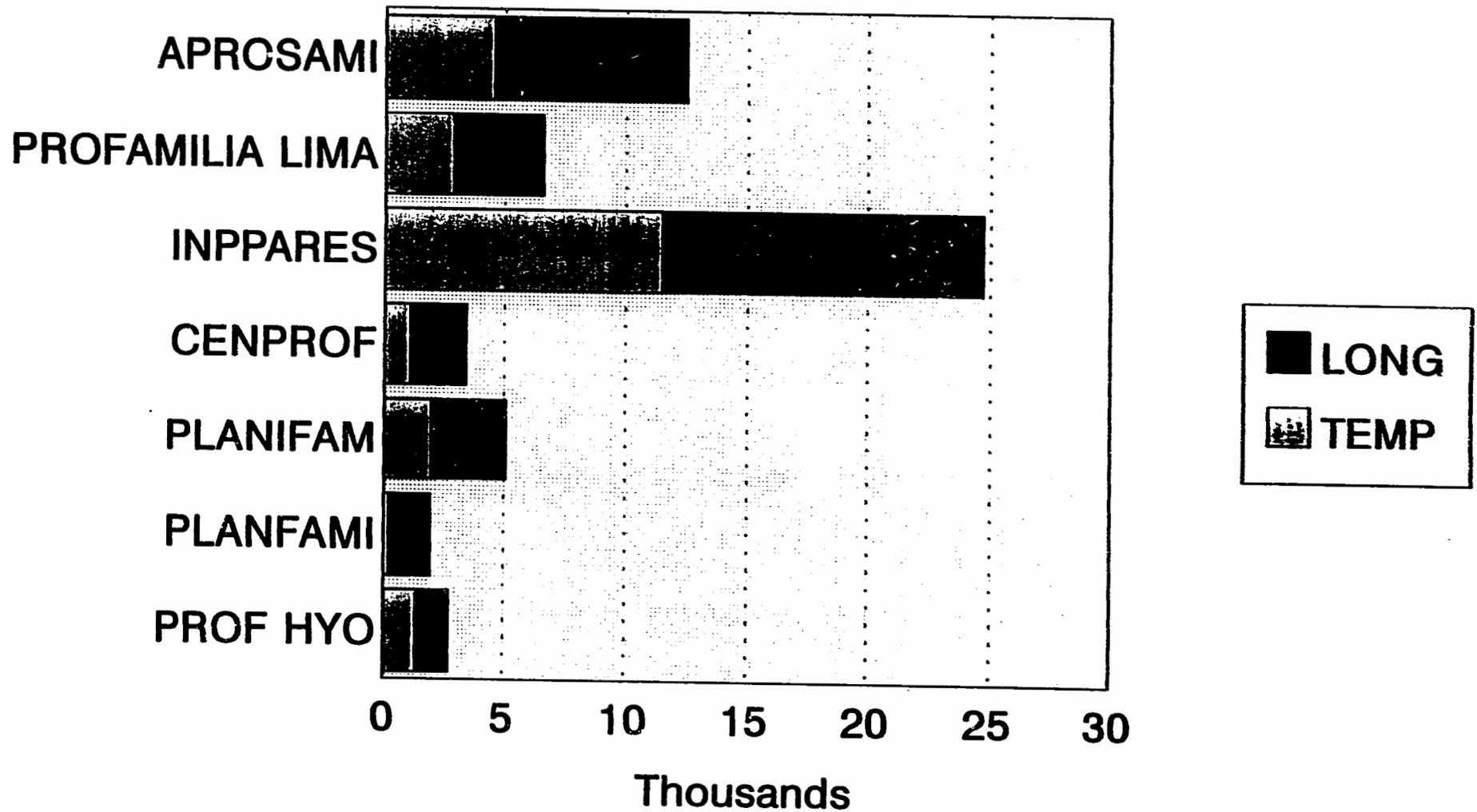
Graph 3

# CYP Production by NGO 1991



Graph 4

# CYP Production by NGO 1992

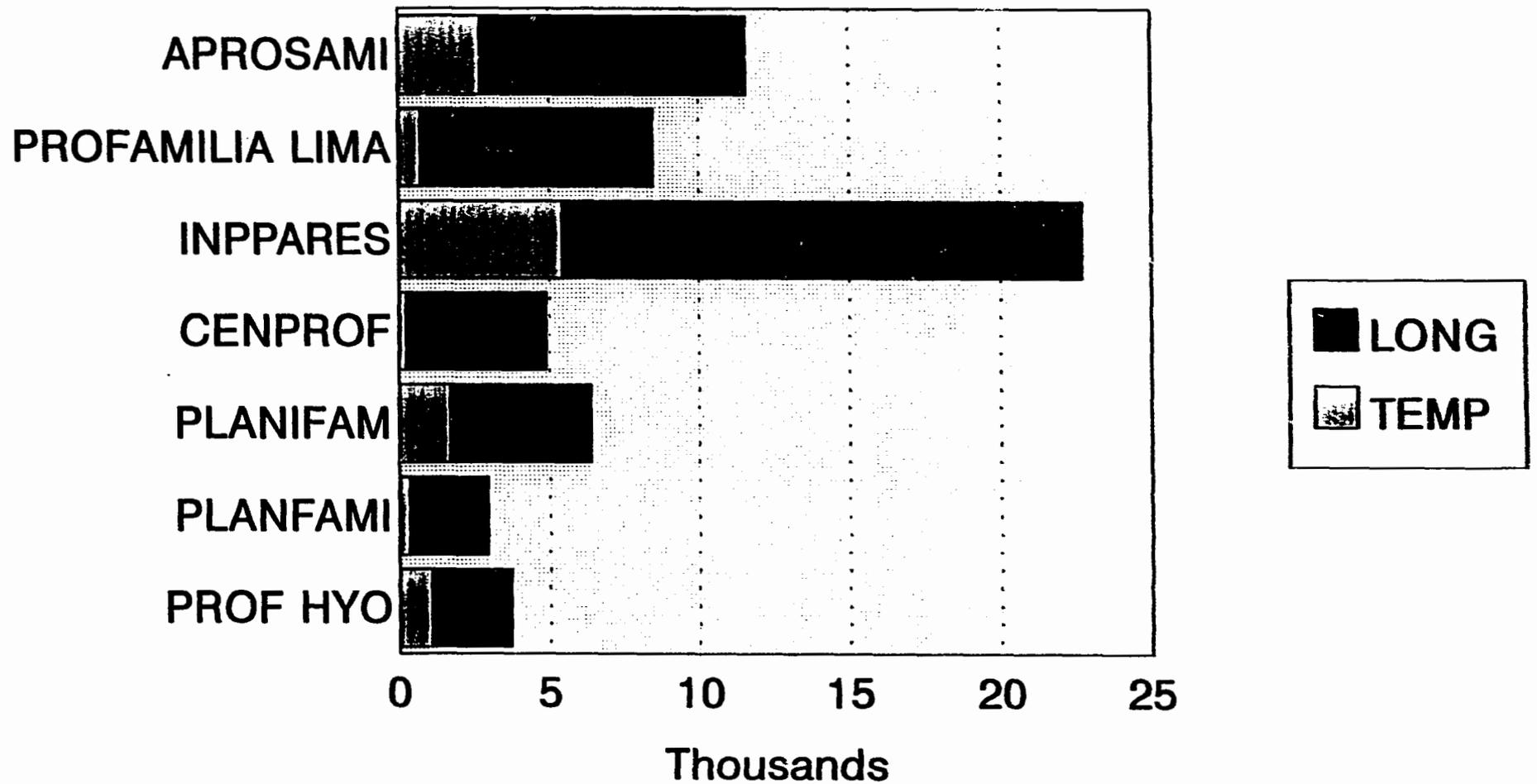


Graph 5

# CYP Production by NGO

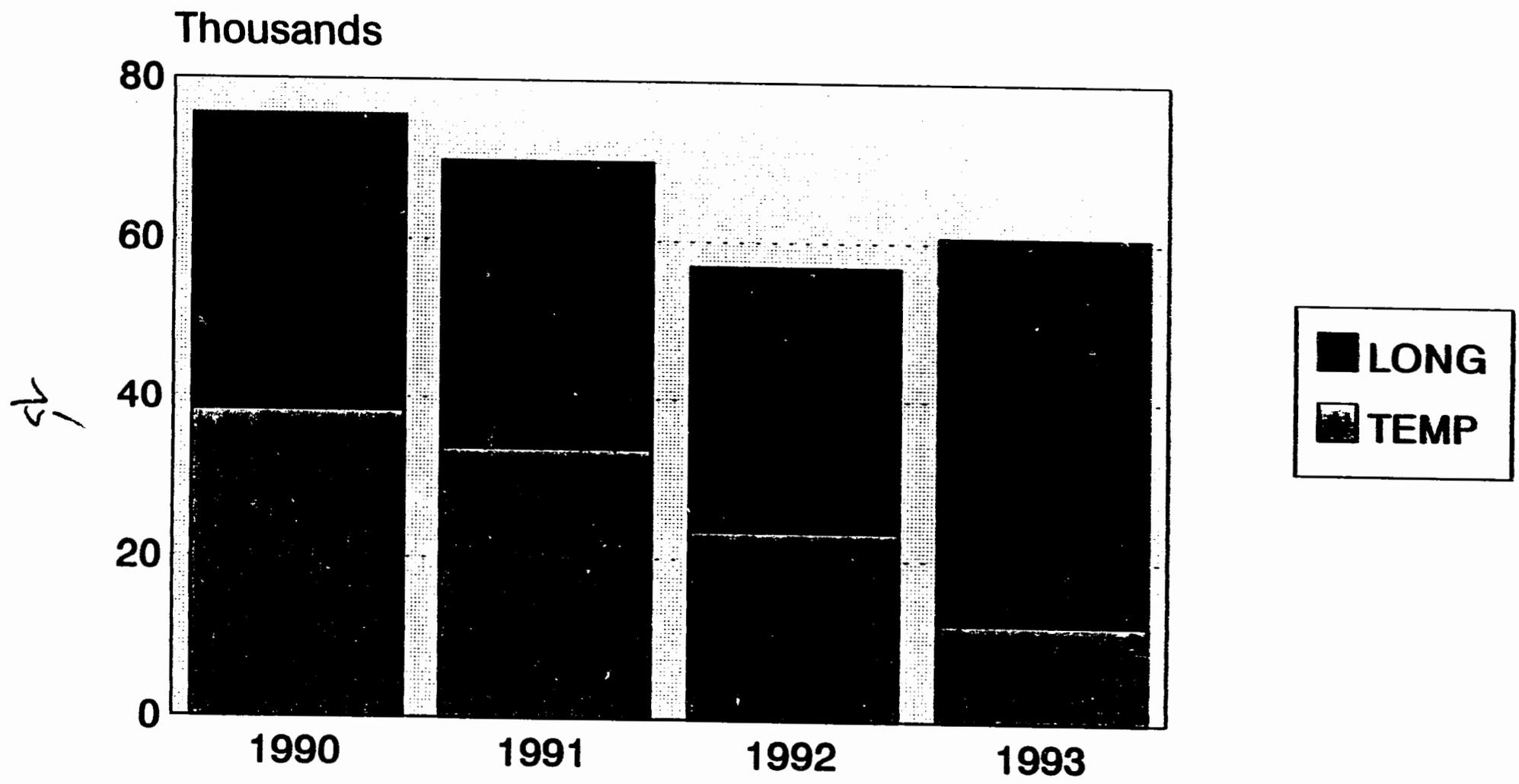
## 1993

### Graph 6



Note: 1993 projections based on first 6 months' data multiplied by 2 plus 10% anticipated growth

# NGO CYP Production 1990-1993



Graph 7

for Long-Term methods has shown a highly significant anticipated increase. Thus it can be stated that the change in policy toward the promoters has had no observable adverse impact on the program and its progress toward Long-Term methods.

### 13.5 Review by NGO

#### 13.5.1 APROSAMI

This institution, beginning in 1978, claims to be the first organization undertaking community educational program in health and family planning in Lima. The organization began informally and provided education and services to peri-urban zones in greatest need.

A reorganization took place in 1992 when the foundation undertook to provide both clinic and community-based services.

Emphasis is placed on community education through a variety of media and focuses on health, sex education, responsible parenthood and family planning. Educational activities also take place in the university and among women's groups (Club de Madres, Vaso de Leche and others).

The central clinic offers a range of for-pay services including pediatrics, maternal and child care, general medicine, OB/GYN and family planning services including laparoscopy, Minilap and vasectomy. It is noteworthy that some 80% of tubal ligations are performed by laparoscopy under local anesthesia and 20% by Minilap.

The agency operates four community clinics in the north-eastern peri-urban section of Lima, each staffed by an obstetric paramedic, a doctor, an auxiliary nurse and administrative staff. Visiting professionals from the central office provide counselling and other services.

These clinics receive referrals from a total of 16 posts throughout the 6 districts served. Twelve of these so-called "Itinerant Posts" provide services to the local community once weekly. Two "Intermediate Posts" provide services twice weekly and two additional "Fixed Posts", staffed by a doctor and auxiliary nurse provide services daily. Provision of family planning information and recruitment at each site is conducted by three or four community "orientadores" (promoters) who reside in the communities adjacent to each clinic and post. These individuals receive an incentive award, paid monthly by the agency, of 27% of the value of the services provided to clients they recruit. Four educators provide information to the communities on a rotating basis and organize group meetings and other promotional activities in

family planning. Two supervisors, heads of the medical and educational service components, provide monitoring of the program.

A formalized reporting system aggregates family planning and health activities at the clinic and post level and information is sent daily to the central office. Accounting records are prepared by the auxiliary nurses and forwarded to the central office, together with financial receipts.

In addition to visits to the central offices, a representative of the Evaluation Team visited the center in Carmen de la Legua and an itinerant post "Daniel Alcides Carrion".

The agency also conducts a program in association with the MOH directed to the urban population of Chimbote. An obstetric paramedic and auxiliary nurse provide family planning services during the afternoons in two Health Centers. Counselling and family planning services are available and recruitment and sale of contraceptives through a Community-Based Distribution System is conducted by 40 orientadores at each post. Community educational and informational activities take place periodically by a coordinator who supervises activities.

Following discussion of problems with other NGO's in establishing zones of activities, APROSAMI now serves the northern part of peri-urban Lima through the services of some 200 volunteers, decreased from 400 after reduction of financial contributions. A program to provide services to communities in and around Chimbote is financed by IPPF.

The program emphasizes long-term methods and, during the first three months of 1993 provided a total of 2,727 CYP's of service - 82% of total CYP's generated in the overall program. Of these, IUD insertion was the method in greatest use - comprising 69% of the 82% long-term methods. Other methods that consist of tubal ligation and vasectomy made up the remaining 13%

Of the short-term methods, the contraceptive pill (308 CYP's) made up 55% of all short-term methods, followed by vaginal tablets 142 (25%). Condoms account for the balance of 113 CYP's (20%).

During 1990 APROSAMI provided 12,023 CYP's (57% of total services) of long-term services; 9,858 (54%) in 1991; 7,920 (64%) in 1992; and, an estimated 8,500 (77%) in 1993. Although the total CYP's of all services provided has consistently diminished since 1990 - 20,941 to an estimated 11,000 in 1993, the trend toward long-term methods is clearly demonstrated.

### **13.5.2 ATLF**

**This institution is generally accorded special status since natural family planning services are provided uniquely. The organization operates in accordance with philosophy of the Roman Catholic Church but is not formally affiliated with it.**

**The program began in San Justin, a poor region in the peri-urban area of Lima, and services were provided by a US physician aided by local volunteers. The organization became an entity in 1970 and receives external support from Pathfinder, Family Health International, U.N.F.P.A. and Georgetown University in addition to assistance through the PVFP program.**

**The organization operates a small clinic at which charges are made and where a range of general medical, cardiology, OB/GYN, maternal and child and natural family planning services are provided. The facility has a small laboratory, X-Ray unit and pharmacy.**

**General medical and family planning services are provided to the community by seven field units ("Unidades de Trabajo de Campo" - U.T.C.) where training and follow-up activities in family planning can be conducted.**

**Information regarding all family planning methodologies are presented at large group meetings. Those couples interested to pursue the natural method are provided with information and instruction on a personal, often "home visit" basis. Those interested in other methods are referred to MOH clinics and not to other NGO's.**

**Since success of the natural methods depends almost exclusively on the knowledge and motivation of the couple, informational materials are available to instruct illiterates.**

**A group of seven instructors have been trained in the natural methods - several in the U.S. and in other countries. These instructors teach educators who in turn provide intensive motivational presentations and follow-up visits to the homes of users in the evenings and at week-ends. Their instruction includes family values, sexual education as well as natural family planning techniques. No charge is made for these services.**

**Following some nine to eleven months of instruction and sustained motivation, successful couples are designated as "Autonomous" and are deemed capable of continuing practicing family planning independently, with reinforcement by a house visit from an educator every one to three months. These "Autonomous Couples" are also considered to be capable of recruiting and training others.**

The thrust of the program is towards consolidation of the family unit through mutual respect and consideration, morality and responsible parenthood. Natural family planning methodology is considered to be an important, but not an exclusive, contributor to this objective.

It was estimated by the Director that of audiences of a total of 10,000 persons attending initial presentations, some 100 (1%) would graduate as "Autonomous Couples" approximately one year later. However, the Director was adamant that in Peru, women prefer the use of natural methods because of the alleged complications associated with "modern" methods.

Wastage, or drop-outs, in the system are high and are deemed to be due to deficient instruction, misuse or misunderstanding of the selected natural method and to failure of motivation of the couples. To diminish wastage due to instructional failures, structured interview outlines have been prepared and are carefully adhered to by the educators. Much success depends upon an accurate comprehension by the couple of a complex set of anatomical structures and physiological phenomena.

Since formal record-keeping began in 1980 it is estimated that there are now some 2000 autonomous couples within the targeted populations. However this figure does not take into account the multiplier effect of others taught by successful couples, assuming that this effect is indeed valid. According to the Director, the ideal is to have a multiplier effect of 6 new couples for each couple formally trained.

According to the Director, the natural methods should be deemed to be of "short-term" since their efficacy is from menstrual cycle-to-cycle. However the methods can also be considered "long-term" in the sense that they can be maintained for as long as the methods are practiced successfully. For these reasons, statistical data, expressed in unit activities and CYP's are not considered appropriate instruments by which to measure productivity, and data regarding ATLF are therefore not incorporated in the data-base and analyses conducted by the PRISMA MIS.

### 13.5.3 CENPROF

The precursor to what is now the CENPROF institution began in 1979 with a staff of two professionals and a secretary who provided family planning services in the Regional Hospital. The organization moved to their present rented headquarters in central Trujillo in 1989 where the central clinic provides a range of out-patient and in-patient care.

Family planning and ancillary services (general medicine, pediatrics, gynecology, obstetrics including Caesarian sections and normal deliveries, Papanicolaou, family planning including vasectomy, and laboratory examinations) are available in the central clinic supported by community posts. In these locations short-term methods are available and IUD insertions take place. Clients are referred for other services not available locally.

The programs of CENPROF include projections to the marginal communities surrounding Trujillo through the staffing and operation of 7 posts in 4 districts operated under the PVFP program and 8 operated under the PATHFINDER project. In the PVFP program three field supervisors oversee the operation of the posts which provide services from one to two times weekly during the afternoons on a rotating basis. They are assisted by 3 to 5 volunteer health promoters from the local community who provide information regarding the post activities in health and family planning.

Three physicians provide general medical, pediatric, OB/GYN outpatient care including family planning services and placement of IUD's. Two representative posts were visited by the Evaluation Team (Wichanzao and Pueblo Libre) as well as the central clinic.

It is noteworthy that out of a total of 33 promoters trained in November 1992 and selected for training in June 1993, 21 (64%) had received secondary education and 5 (15%) were auxiliary nurses. A serious level of unemployment has required auxiliary nurses, among other professionals, to work in small businesses, as street vendors and in markets.

The numbers of CYPs provided by the peri-urban posts during the first six months of FY 1993 was 1055 with a range of 226 (Buenos Aires) to 84 (Manuel Arevalo). Of these 983 CYPs (93%) were from placement of IUDs. Seventy-two CYPs (7%) were from the provision of short-term methods.

In terms of selection of short-term methods, requests for the contraceptive pills represented 35 CYP's (65%), followed by vaginal tablets 13 (24%), other methods (NORPLANT not provided) 6 (11%).

The total number of CYPs provided annually has decreased from 1990 to 1992: 10,846 (1990); 6,026 (1991); 3,413 (1992); and, 4,000 (estimated 1993). In terms of Long-Term CYPs as percentages of all family planning services, the indicators have shown an overall increase - 55% (1990), 40% (1991), 69% (1992) and 95% (first six months of FY 1993).

#### **13.5.4 INPPARES**

The Peruvian Association for the Protection of the Family, founded in 1966, was the progenitor of INPARRES which began activities in 1976 following the publishing of a governmental decree outlining the population policy. INPPARES became affiliated with IPPF and International Associates for Maternal and Child Health. During the military government the program was closed temporarily but was resuscitated after the change of administration.

This agency, the largest NGO providing health including family planning services, conducts a series of related programs with financial assistance from a variety of local and international sources.

Through the PVFP program, supplemented by other organizations, five clinics provide services in the Lima area. Client recruitment is conducted by some 400 promoters who direct users to 30 posts at which a range of medical and family planning services are provided. The promoters receive from 50-70% of the value of family planning care provided as incentive awards.

The newly-opened Community Clinic Augustino and a post loaned by the Asociacion Pachacutec in the Santa Anita district were visited by a representative of the Evaluation Team.

The Clinic is staffed by a physician who provides services during the afternoons and an obstetric paramedic paid on the basis of production. Counselling and general medical consultations, Ob/Gyn, MCH, Papanicolaou, NORPLANT, IUD services are provided. Vasectomy will be available at the clinic shortly and patients for Minilap are referred to the Central Clinic of INPPARES.

Patients are recruited by some 15 promoters whose activities account for some 50% of clients attending. A further 50% of clients attend as a result of community informational activities as direct entries.

Each post is directed by a local supervisor who receives incentive awards. Four zonal supervisors monitor from ten to fifteen posts and report to a program coordinator at the central level. Following the closure of 40 posts of

low productivity eight doctors previously providing care there, now staff four clinics and serve the fixed posts.

INPPARES is a unique example of a program in which the numbers of CYP's provided since 1990 has undergone some annual fluctuations but has not demonstrated a major decrease since 1990.

In 1990, a total of 20,010 CYP's of service were provided, 28,879 in 1991; 24,709 in 1992; and an estimated 21,000 in 1993. Of these, 7,420 (39%) were for long-term methods in 1990, 13,170 (46%) in 1991, 13,227 (54%) in 1992, and an estimated 16,000 (76%) in 1993.

Of a total of 519 CYP's of short-term services provided during the first three months of 1993, 224 (43%) were for contraceptive pills, 108 (21%) for condoms, 78 (15%) for foams, 60 (11%) for implants, 30 (6%) for vaginal tablets and 19 (4%) for injectable. Of the NGO's providing family planning services within the PVFP program, INPPARES is the only one providing injectable and implant methods.

#### 13.5.5 PLANIFAM

PLANIFAM with its former affiliate, PLANFAMI, was established some 12 years ago in Cuzco in the INKA Region. This region, comprising the departments of Apurimac, Cuzco and Madre de Dios, has been identified as one of the poorest regions of Latin America, 80% of the population of which are stated to live in "extreme poverty". Infant mortality (129 per 1000 live births) is almost twice the national average and population growth is estimated to be 3.4% per year. With a large indigenous population speaking Quechua and some Amayra, the INKA zone poses unique problems in information transfer and provision of services.

Because of the seriousness of the problems of health and population growth, the regional government, at the urging of PLANIFAM, established in early 1993 a Regional Council on Population to coordinated public and private sector family planning activities.

The agency operates a central clinic in Cuzco, 6 community posts including the Ciudad Universitaria de Perayo, Cuzco and provides medical and obstetrical services including family planning in Quillabamba staffed by an "obstetriz" (obstetric paramedic). Forty-five volunteer promoters provide advice and referrals for general medicine, family planning and mother and child care - of particular importance because of the high level of maternal malnutrition.

Staffing of the central clinic and community posts includes three part-time doctors trained in surgical long-term family planning procedures and two nurses. Five promoters are attached to the central clinic and three or four to each of the community posts.

The central clinic provides basic medical, pediatric, IUD insertions and vasectomy. No Minilaps are performed because of lack of equipment.

A range of short-term family planning services are available in both central clinic and posts where IUD insertion services also are available. Services are also offered in temporary locations in public markets. The Evaluation Team visited the central clinic, two market locations in Cuzco at Huanchac and Kasccaparo and a post at Chincheros.

During the first three months of 1993 the posts provided a total of 868 CYP's of family planning services, 643 (74%) long-term and 225 (26%) short-term. The central clinic provided 477 CYP's, 375 (79%) long-term and 102 (21%) short-term. With a total of 1345 CYP's of services provided, 1018 (76%) were for long-term services and 327 (24%) for short-term services. These figures are in accordance with trend towards increasing usage of long-term methods. In 1990, 35% were for these methods, 47% in 1991, 62% in 1992, with an estimated overall 76% for 1993.

It is important to note that the attention of the Evaluation Team was directed to the need to maintain availability of short-term methods since these, in this particular population, not infrequently acted as primary "stepping-stones" to use of long-term methods. In cases where a couple has four or more children, tubal ligation is frequently acceptable without short-term introduction.

The most frequently requested short-term methods were for condoms 194 CYP's (59%), foam 67, (21%), contraceptive pills and vaginal tablets 33 (10%) each method.

Significant cultural characteristics affecting the use of family planning includes the clandestine use of IUDs by women whose husbands disapprove, the concept that payment for service provides better quality products than those identical provided without charge by the MOH and that IUDs can precipitate uterine cancer as well as provoking marital infidelity.

#### 13.5.6 PLANFAMI

This agency, originally part of the parent organization PLANIFAM in Cuzco, became independent in 1989 and offered services in Puno beginning the

following year where a clinic and community program provides health care including family planning.

The central clinic provides a range of services including general medical and maternal and child care, limited pediatric services, Papanicolaou (with an excessively slow turn-around) and family planning. Community services are provided on a rotating basis in homes of promoters. In addition an itinerant clinic in Bella Vista offers care one day each week. A mobile clinic also provides family planning and general services.

Contacts have also been established with institutional authorities and community leaders for informational purposes regarding the program and its objectives.

The organization is staffed by a part-time physician, two obstetric paramedics, an auxiliary nurse and five administrative and service personnel. Twenty-nine promoters have been trained during 1992-3.

Community information, education and promotional activities take place periodically and are arranged to coincide with social gatherings and market days. Radio messages and presentations to social service groups including Mothers' Clubs also take place on an irregular basis.

Since the program operates in a province in which the 725,000 population numbers many Quechua and Amayra speakers, efforts have been made to provide appropriate information and counselling. An important issue with this target population appears the need for clients to preserve personal anonymity for which reason women prefer to attend services not in proximity to their homes.

It is noteworthy that the number of services (CYP's) provided has increased progressively since 1990. In that year 852 CYP's were provided, 1190 in 1991, 1930 in 1992 and an estimated 2600 in 1993. Since the program offers no surgical interventions, installation of IUD's represents the totality of available long-term methods available. IUD installation represented 89% (1990), 91% (1991), 90% (1992) and an estimated 89% (1993). Short-term methods represented minor selection by clients, contraceptive pills and use of condoms being 31% each of choice.

No member of the Evaluation Team visited the Puno program as this was not included in the original scope of work. However an interview by a team member with the director Sr. Juan de la Riva took place in Lima on 1st May.

### **13.5.7 PROFAMILIA**

One of the most well-established and experienced NGO's working in family planning and comprehensive health services, the program began operation in the marginal areas of Lima some 25 years ago. PROFAMILIA received its formal charter as a NGO in 1984. The organization now offers a range of services that include family planning, general medicine, OB/GYN, pediatrics, maternal and child care including immunizations, Papanicolaou, First Aid, nutrition and sex education for the communities served. Dental services are provided sporadically in some clinics.

Due to the entrepreneurial characteristics of the institution, and particularly that of the Director, assistance has been received from the European pharmaceutical industry and U.S. agencies supportive of family planning activities.

The agency provides assistance to peri-urban communities (pueblos jovenes) now in progress toward consolidation located in the southern section of Lima and, in addition, to businesses and colleges where programs are directed to adolescents. In addition, there is a center in Huancayo supported by the PVFP program. Six clinics in Cono Sur and two itinerant posts in the rural areas are supported by PATHFINDER.

The centers include those in fixed locations and those that are "itinerant" - meaning that services are provided by travelling teams comprising a doctor and nurse-supervisor on a weekly rotating basis assisted by local volunteer promoters.

The itinerant clinics are held in private homes of promoters, community clinics and other locations temporarily loaned for the purpose. A representative of the Evaluation Team visited a permanent clinic in rented property at San Juan Miraflores and an itinerant clinic in a community center at Villa El Salvador.

Within the PVFP program, four clinics at fixed locations have been constructed by the agency and include extensive capacity for up to 250 persons for community education to which much emphasis is given through an extensive IEC program utilizing virtually all forms of communication and instruction.

It is noteworthy that PROFAMILIA received a first-place award given by the "HISPANO MUNDO PARA EL PERU" in 1992 for excellence in the quality of community instruction and communication (INPPARES was ranked tenth - no other family planning/NGO was included).

The staff, comprising 3 part-time physicians (including the Medical Director), 7 auxiliary nurse-supervisors, an obstetric paramedic and 56 volunteer promoters in the Lima area, provide services at one fixed and 16 itinerant clinics.

The number of services provided by the Huancayo clinic has decreased markedly since 1990 (4219 CYP's), 1991 (3774), 1992 (2710), with an estimated increase in 1993 (3400).

However there are increases in the use of long-term (IUD) methods, 2527 (60% of total CYP's) in 1990, 2883 (76%) in 1991, 1383 (51%) in 1992 and an estimated 3400 (71%) in 1993.

In Lima at present no sterilization methods have been available due to lack of appropriate facilities - referrals are made to INPPARES and the MOH. However surgical facilities are now in an advanced stage of preparation at San Juan Miraflores so that sterilization procedures will be available there shortly.

The Medical Director is insistent that sterilization (Minilap and vasectomy) are not legal methods of birth control and that these are only undertaken if there are satisfactory medical indications. These indications are interpreted to include couples with 4 children, short inter-birth intervals, history of medical or obstetrical problems and possibility of genetic disease or malformation.

While counselling interviews present all family planning methods, the uncertainties of the natural methods are stated. In addition, the short-term methods are visualized as intermediate "stepping-stones" toward the long-term methods.

As result of PROFAMILIA's attitude towards sterilization and need to refer clients to other institutions, together with their posture toward natural and short-term methods, it is hardly surprising that there results emphasis on the IUD given the philosophy and circumstances under which they operate.

The range of family planning services provided by PROFAMILIA/ Lima has necessarily been limited for the reason stated. During the first three months of 1993, a total of 1837 CYP's of services were provided of which 1710 (86%) were for IUD insertion. 567 (33%) CYP's of IUD insertions took place at clinic level and 1143 (67%) at fixed and itinerant posts.

The number of CYP's has been diminishing progressively since 1990, although stability appears to have been reached in (estimated) 1993. In 1990, 11,082 CYP's of family planning services were provided, 8,145 in 1991, 6,600 in 1992 and (estimated) 7,500 in 1993.

**Short-term methods most frequently requested were contraceptive pills 71 CYP's (56%), condoms 31 (24%), other methods 25 (20%) - injectables and NORPLANT not available.**

**Of all family planning activities 5,813 (52%) were for long-term services (IUD's) in 1990; 5,340 (66%) in 1991; 3,747 (57%) in 1992; and, 3,516 (91%) during the first six months of 1993. When the Sterilization Clinic at San Juan Miraflores becomes operational, the 1993 figures for long-methods including sterilizations should be maintained or exceeded.**

## **SECTION 14 TRAINING**

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### **14. TRAINING ACTIVITIES**

The varying degrees of competence by which the NGOs conduct their administrative, managerial, supervisory and service activities must, in large measure, be attributed to the training activities conducted through the agency of PRISMA. Encouragement of entrepreneurial capacity and sensitization to the need to give urgent attention to financial self-sufficiency is also attributable to PRISMA initiatives.

The needs for instruction of NGO staff are identified at three levels:

- At the institutional level where observations, impressions and reports of field supervisors detect deficiencies in knowledge, attitudes and/or practices of staff operating clinics and posts.
- At the level of the PRISMA Committee on Education at which shared experiences of NGO members identify commonalities of needs, particularly among members of their of administrative and managerial staff.
- At the level of PRISMA where their technical experts make recommendations to the committee members for the conduct of educational activities directed toward higher level administration and technical professional staff active in the NGO individual programs.

Each NGO has an institutional Committee on Education where the reports and comments of administrative, managerial and supervisory staff are reviewed and training needs identified. In a number of cases, training of staff (particularly that of promoters) can be satisfied by mobilization of instructors and resources already in existence within the NGO itself. These courses may or may not require technical assistance of PRISMA.

#### **14.1 PRISMA - Project Level Training**

The need, content and conduct of the majority of instructional programs are identified at the PRISMA committee level at which representatives of the Lima-based NGO's are expected to attend weekly. Representatives of NGO's in Cuzco, Trujillo and Puno attend on a bimonthly basis because of time and travel cost involved.

In conversation with the PRISMA Coordinator for Family Planning who has the responsibility, among other duties, for the planning and organization of educational activities, and by inspection by an Evaluation Team member of the minutes of the PRISMA Committee on Education, it becomes clear that attendance at the weekly

meetings of the committee by NGO members is not wholly regular and that different individuals representing their particular agency are designated to attend. This practice reduces the effectiveness of the committee to identify needs consistently, diminishes continuity and impedes decision-making. A notable exception is that of PROFAMILIA, an NGO whose contributions have been consistent with attendance by the Coordinator of Training or her professional deputy.

Table 1 summarizes, in matrix form, educational activities conducted by PRISMA since January 1991 and includes activities planned through September 1993. The information in this table has necessarily been compressed with omission of certain details. The table has been designed to give a general overview of types of courses given and planned, and numbers of persons attending.

The data indicate that from January 1991, to December 1993, PRISMA has (or will have) conducted 33 courses of topics differing from "Counselling for family planning Promoters" to "Administration, Management and Autofinancing" to technical courses for health professionals including practical instruction in contraceptive sterilization techniques conducted in collaboration with university hospitals.

The instructional courses conducted by and/or with the technical assistance of PRISMA have, for the purposes of this discussion, been categorized into seven functional groups: (1) family planning training, counselling and methodologies, (2) Supervisory Techniques (3) Administration & Management (3) Management Information System (5) Sales and Marketing (6) Education of Technical Staff of NGO's, and (7) IEC.

Thirty-nine percent of the instructional courses have been in Group 1, Family Planning, fifteen percent in each of Groups 3 and 6 (Administration and Education), nine percent in IEC and six percent in each of the remaining two groups. (MIS & Sales and Marketing). This balance appears appropriate given the extent of the needs and the limited resources available.

Very roughly calculated - and not taking into account on-going educational activities such as instruction of NGO representatives of the PRISMA committees - some 1500 participants have received instruction. The preponderance of training has been focussed on family planning promoters.

The teaching methodologies employed are necessarily those most appropriate to the course objectives and content. In certain cases the cooperation of external agencies has been solicited. The methodologies include the "taller" or workshop in which participants take part in small group discussions according to their particular interest and formulate strategies and recommendations in summation review; the practical experience in which, for example, doctors observe and practice techniques of sterilization - programs conducted in conjunction with university teaching hospitals;

INSTRUCTIONAL COURSES FOR NGO'S CONDUCTED  
BY AND WITH TECHNICAL ASSISTANCE OF PRISMA

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NGO PARTICIPANTS	TOPIC	DATE	Type of Training		NGOs	TOPIC	DATE	Type of Training						
			1	2				3	4	5	6	7		
All	Counselling	Sept '81	83		INPARRES	Admin Clinics	Mar '82	29						
All	IUD insertions	April '82	21		All	Creativity	June '82	28						
All	FP Community Trainers	Aug '82	47		APROSAMI	Instit. Analysis	Feb '83	16						
CENPROF	FP Promoters	Oct '82	42		All	Admin Clinics	June '83	100						
PLANIFAM-Cusco	FP Promoters	Jan '83	33		All	Admin & Autofinance	July '83	40						
All	FP Counselling	Apr '83	44		All	Use of Software	Jan '81		35					
INPARRES	NORPLANT	Feb '83	8		4 PVO's	Computing	May '83		40					
4 PVO's	Natural Methods	Mar '83	27		All	Service Sales	Dec '82			22				
PLANIFAM-Puno	FP Promoters	Mar '83	24		All	Service Sales	July '83			90				
All	Surg Ster Technics	Mar '83	34		All	LT Methods	Sept '81					23		
All	Conselling Trainers	Apr '83	63		All	FP Perspectives-Peru	Jan '82					33		
All	Counselling Promoters	May '83	300		All	Design Training	Jan '82					20		
All	Surgical Technics	Aug '83	25		4 PVO's	Scientific Review	Aug '83					100		
All	Supervision	May '82		47	Ctee Training	Visual Aids	Tues '83					5		
PRO-FAMILIA	Supervision	Nov '82		14	All	IEC in FP. Part 1	Sept '82							21
4 PVO's	Supervision & Training	Feb '83		14	All	IEC in FP. Part 1	Sept '82							18
					4 PRO's + PRISMA	Gender	Sept '83							20
Total participants by Group				731	75			213	75	112	181	59		
Total participants Trained				1446										
Total number courses by group				13	3			5	2	2	5	3		
Total number courses				33										
Group as % total courses				39	9			15	6	6	15	9		

GROUP KEYS

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1. FP Training, counselling and methods
2. Supervisory Methodology
3. Administration, Management & Autofinancing
4. Management Information System
5. Sales & Marketing
6. Education of Technical Staff
7. Information, Education & Communication

-SPD-

**"exposicion" or didactic programs in which an instructor provides information to the attenders and the "seminario", representing a mixture of workshop and didactic education.**

**Several instructional courses particularly those directed to clinic and post field staff are conducted at the NGO agency level, being repeated over a two to three-day period at each individual institution.**

**According to PRISMA informants, evaluation of courses is conducted by pre- and post-test questionnaires and, where appropriate, by observations by PRISMA staff of proficiency at the field level.**

**It should be noted that while education of staff can improve professional competence, the ability to put this knowledge to work depends also upon the environment, equipment, supplies, cooperation by clients and attitudes and correct usage of technical skills of the individual professional. This degree of proficiency can only be judged by direct enquiry and observation in order to ascertain that procedures are performed in accordance with agreed protocols and accepted standards.**

**A general observation, based on statements made by several representatives of each NGO visited, was the need for increased training activities at all levels, from promoters and post supervisors to program directors and their governing boards or "Associations". Increased intensity of numbers and scope of educational programs is essential in order to improve performance, modernize levels of technical expertise, maintain high levels of enthusiasm and altruism and to diminish the negative impact of staff turn-over, particularly at the promoter level.**

**Of particular importance for the preservation of a high level of competence, proficiency and enthusiasm among the health professional staff (as well as others) is the need for the infusion into all instructional programs the concept of continuing education and to dispel any notion that competence was guaranteed at the moment that the diploma had been awarded. The principle of "life-time learning" requires a degree of dedication and introspection not always prominent in physicians and other high-level staff.**

**The principle can be inculcated by demonstration and by the ready availability of up-to-date informational materials including libraries containing contemporary books and journals, bibliographies and access to informational data-bases.**

**It is recognized that these services are costly and cannot be accorded high priority in circumstances in which the very survival of a NGO is threatened financially.**

**Circulation of family planning informational newsletters, bulletins, brochures and pamphlets provided at no cost to the NGO's already takes place. However it is**

suggested that use of these materials is encouraged, that affiliation of individual NGO's with health-related institutions, publishers (and, for example the Medical Library Association) in the US and other countries is explored with the objective of donations (for which transportation costs by the recipient NGO would be payable). It is suggested in addition that access at minimal cost to internationally available bibliographic data bases is explored. For example, the National Library of Medicine operates the MEDLARS/MEDLINE system which will provide references and a brief summary of international journal articles.

It appears that little use is made of videotapes in training programs because of lack of equipment by NGO's. This powerful communications media is ideally suited as a training aid to supplement technical medical training (e.g. use of AOV and NORPLANT service protocols) directed to doctors and other health professionals, interview and counselling techniques illustrating good and bad methodologies, communications in family planning and others.

#### 14.2 Individual NGO Level of Training

It is important to recognize that several NGO's conduct an array of training programs organized by their own technical staffs and without technical assistance inputs from PRISMA.

The extent of these largely independent activities is variable. INPPARES has an active and very extensive program directed toward the basic training of new family planning promoters, refresher courses for continuing family planning promoters, courses for new and continuing supervisors. During FY 1993 twelve courses are proposed for new promoters, six for continuing promoters, five for zonal supervisors six courses for health professionals in program development, three courses for instructors in family planning educational techniques, and four workshops for doctors in family planning long-term methods.

The Evaluation Team has reviewed detailed plans including general and specific objectives, content and structure of educational modules, audiovisual requirements and discussed evaluation techniques.

While the independent program for training of INPPARES is by far the most extensive, it is important to note that in discussion of training activities of other NGO's a clear distinction is often lacking regarding what activities should properly be considered as "Training" and how these should be distinguished from "Information, Education and Communication".

Without exception each NGO conducts activities under both rubrics, but the distinctions become blurred when training of family planning promoters is discussed -

sometimes as part of "Training" programs within the "Training Division", other times as part of "IEC" programs within that division.

In discussions regarding the differences between these two sets of activities, PROFAMILIA, for example is clear: "Training" ("Capacitacion") is concerned with the agency's professional staff, including administrative and health personnel. The training of family planning promoters is also included.

IEC is regarded as being concerned only with information transfer to the target community populations and, in addition, with the safeguarding and improvement of the institutional image.

PLANIFAM - Cuzco, for example, does not indicate a separate division for training in their organizational structure. Coordination and IEC are within a single operational unit responsible to the Director of Program Coordination. Training activities are conducted within the IEC range of activities.

With support from PRISMA a course for 35 family planning promoters took place in January 1993. While details have not been finalized further training activities are planned for September 1993 (15 Supervisors) and October (A course for 35 secondary school and college students in Human Sexual Relations including family planning short-term methods). Also in October an instructional course for three doctors who work part-time in the agency's clinics will be conducted in surgical sterilization procedures.

The unique character of ATLF internalizes its training needs and diminishes its requirements for assistance from PRISMA in the conduct of its operational family planning activities. The agency has taken advantage of the PRISMA project to benefit in administration and management. However the heavy emphasis on a highly personal teaching modality has caused the agency to develop its own norms, teaching materials and interview outlines.

"Training" as envisaged by ATLF is not clearly distinguished from "IEC" which, acting in conjunction, focus upon the strengthening of family bonds through responsible parenthood.

A group of seven educators, several of whom have trained abroad (Georgetown University and in Los Angeles) are responsible for the training of instructors who, in turn, teach couples who have selected natural family planning methods.

Along traditional lines CENPROF has conducted courses for their administrative staff to sensitize them to family planning objectives and methodologies. Basic courses for promoters are given, refresher courses for promoters and supervisors and, in April

1993, an enterprising program concerned with the problems of sexual education was provided to a group of 25 fathers and their sons.

APROSAMI does not identify a division of training, per se, in the administrative structure. However a Community Education Unit provides training for family planning promoters, obstetric paramedics (students from the University of San Marcos), students of the social sciences (from the University La Cantuta) and to college students and their teachers.

A Committee on Training develops an institutional training plan annually. In 1993 this plan, in addition to the activities mentioned, include instruction in sales and marketing, development of audio-visual aids in addition to four courses for clinic nurses and doctors in family planning-related activities. Pre- and post-tests are routinely conducted as evaluation instruments.

## **SECTION 15**

### **INFORMATION, EDUCATION, COMMUNICATION**

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#### **15. INFORMATION, EDUCATION AND COMMUNICATION**

Information, Education and Communication (IEC) is conducted at PRISMA and at the NGO level, as an activity separate from that of "Training", and makes an important contribution to three aspects of the programs. These include:

- ◆ development of an institutional image;
- ◆ sensitization of the clientele to the needs, character and advantages of family planning and the services through which it is available; and,
- ◆ dissemination of functional information regarding locations, times and costs of services available.

Each NGO has a locally-constituted committee comprised of the IEC division head and his or her assistant, training, administrative and technical staff including supervisors and physicians. This committee assesses IEC needs based on information provided by supervisors' reports reflecting field activities, by the physicians responsible for medical care including short term, long term and surgical services and by the Project Director reflecting policy.

From the deliberations of this committee, decisions are made regarding the appropriateness, feasibility and timeliness of proposed IEC ventures and their role within the yearly-approved work plan.

#### **15.1 Findings**

##### **15.1.1 PRISMA**

At the PRISMA level, a Committee on IEC is constituted by a representative of each NGO, and two representatives from the PRISMA IEC unit.

It is noteworthy that the NGO members - with exception of the NGO programs in Trujillo, Cuzco and Puno, who attend bi-monthly - are not represented with regularity by the same individuals. As a consequence there may be lack of continuity; needs and objectives not clearly and consistently articulated; and, a lack of decision-making authority.

IEC proposals are submitted by individual PVO's for consideration by the committee and, if approved with or without modification, funded through PRISMA.

An IEC project may be conducted by the individual NGO with or without PRISMA assistance; it may originate within the PRISMA IEC Committee when common problems are identified or from initiatives of PRISMA based on reports and observations of their field supervisors, review of NGO plans, upon IEC/PRISMA identification of needs or upon combinations of all of these sources.

According to the IEC/PRISMA coordinator, the principal problems encountered by the NGO's are (a) lack of adequately trained personnel in charge of IEC at the agency level, and (b) lack of coordination within IEC methodologies and failure to focus adequately on program goals and objectives.

#### 15.1.2 ATLF

Despite lack of a specific budget for IEC activities, this NGO has developed a range of informational materials including stickers, bulletins, flyers, brochures and slide presentations.

Among the materials produced, the Evaluation Team examined a "Guide to Family Planning" which included summaries of the "modern methods". Not surprisingly the need for medical controls in certain of these methods are mentioned and the advantages of natural family planning methods, emphasized.

The position of the Catholic Church and moral issues involved are discussed in a statement entitled "Responsible Parenthood and Family Planning". Another document discusses the legal issues emphasizing that the legislation underlines the integrity of the family, and the sanctity of matrimony and maternity as well as responsible parenthood.

Because of the broad socio-cultural foundation of this NGO in addition to family planning instruction, topics include, for example, the avoidance of accidents in the home, substance abuse, dress style, recreation and mental hygiene.

Large group meetings are arranged in target communities from which potentially interested couples are selected for individualized instruction and follow-up. Success in ATLF, where success appears to depend almost exclusively upon repeated home visits to participating couples, there are strictly defined interview guidelines to avoid incorrect or inconsistent information transfer. These precautions seem logical given the length of the ATLF instructional process (11 months) and the large number of small group presentations on which the success of the natural family planning methods depend.

Due to financial constraints, the use of TV and radio spots is restricted. ATLF does participate in family planning "Fairs" in market places and other public locations in conjunction with other NGOs in the PVFP.

### 15.1.3           **APROSAMI**

As has been previously mentioned, this NGO does not distinguish administratively between activities of "Training" (of professional health staff), and "IEC" (community information).

The agency has a long history of educational activities dating from 1979 when since that time, some 8000 presentations reached 210,000 persons; and 179 courses trained nearly 9000 participants.

The IEC unit emphasizes community education in family planning, sex education and sexually transmissible diseases through a structured program of public presentations, courses, campaigns, workshops and instruction focussed on a variety of socio-economic levels. Methodologies include informational pamphlets, flyers, brochures, radio and TV spots and the press. The agency has produced a manual on Human Sexuality.

An activity that appears to make APROSAMI unique is an orientation towards research. They have conducted an investigation into comparison of effectiveness of IUDs; evaluation of sterilization methods; profile of sterilization acceptors; use of the contraceptive pill among lactating mothers; and, in 1992, an investigation of quality of care. To the extent possible these activities should be encouraged and experiences shared.

A TV presentation by the Executive Director of APROSAMI was viewed on local Lima television. A five-minute interview/discussion reviewed the dangers of abortion as a method of birth control and the advantages of short-term anticonceptive methods. The message was directed towards adolescents and young adults.

### 15.1.4           **CENPROF**

In this agency, a Division of Information has responsibility for training of family planning promoters as well as publicity and community information. The IEC program contains four components: Logistics (production of videos, library, professional training); Autofinancing (Sales of educational materials, production of slides); Clinic and Out-Patient Services (instructional courses for staff, monthly meetings, guidelines for patient care); and, Community Activities.

The latter comprise the main thrust of CENPROF's IEC programs conducted through publicity in the mass media, public relations, interpersonal communication and training. Activities include workshops for organized groups, agreements with other NGOs, sex education and family planning seminars for couples, basic and refresher courses for family planning promoters, workshops for supervisors, publicity campaigns and publication of an informational bulletin.

There is a well-prepared plan of programs for twelve different activities, several of which are repeated monthly (e.g. workshops for supervisors and informational campaigns).

The program is active within budgetary constraints. A list of needed audio-visual equipment at the cost of some \$8000 has been prepared for purchase when funds become available.

#### **15.1.5 INPARRES**

The Instituto Peruano de Paternidad Responsable (INPARRES), because of its extensive activities and multiple financing sources, not surprisingly has the most extensive program in IEC.

Programs are organized according to a series of strategies, of which "Communication Population & Development of Human Resources" conducts eleven different projects of which six may be said to reside within the traditional IEC concept. These are:

- Information & Education in family planning and Human Sexuality
- Communication to Strengthen the Institutional Image
- Assistance to the Peruvian Government on Population Matters
- Family planning and the Prevention of HIV and AIDS
- Library of Audiovisual Materials in family planning and human sexuality.
- Training in family planning and Human Sexuality

Additionally, within the "Strategy for Service Modules in family planning" activities include:

- Family planning in Cooperation with Local Governments

- Community Actions in family planning
- Prevention of High-Risk Pregnancies
- Information for Adolescents and Young Adults
- Family planning Information in Businesses and Factories

Collectively all of the above projects could be said to contribute to two purposes of IEC: dissemination of information to selected target populations; and, strengthening the institutional image.

In early 1993 a new program for IEC directed towards community education was developed, the purposes of which are to reinforce knowledge regarding use of Long term methods, improve methods for community information transfer, extend outreach of family planning services and fortify the institutional image.

A series of strategies are developed to accomplish these purposes. These, in summary, include community sensitization through use of radio "spots", pamphlets on long term methods and small-group education, advertising materials, calendars, posters, flyers, and use of mass media presentations.

It is also proposed to attract new clients through improved services, including referrals, counselling, development of audiovisual teaching aids and publication of a family planning Newsletter.

To attempt to isolate from this plethora of activities the components derived from a particular funding source is difficult if not impossible. However, analysis of the budget submitted to PRISMA by INPARRES might indicate the kind and magnitude of inputs without attempting to specify exactly how they are utilized in output generation.

#### 15.1.6 PROFAMILIA

This agency, which won an award for excellence in 1991-92, has an IEC unit headed by a trained communication specialist. Working with a local IEC committee, annual plans are prepared and approved - subsequently presented at the PRISMA Coordinating Committee level.

The unit produces signs by which service posts are identified and the range of services and costs are advertised. Also produced are flyers, pamphlets, flags, radio "spots" and announcements by loudspeaker in places of public assembly. Slogans to identify the agency and its role are utilized in press announcements

and interviews. Announcements at community "fairs" are organized for Mothers' Day, Independence Day and other public holidays.

Communication and education directed to the population of reproductive age focuses upon family planning, human sexuality, relationships between fathers and sons and early social stimulation. Special attention is given to the education of adolescents in the 14 to 18 age group. Workshops focus on human sexuality and reproduction and are provided without charge to Educational Institutions in peri-urban areas where economic resources are limited.

Information is also provided to businesses and factories, directed toward employees of reproductive age and describing the advantages and methods of family planning. A counselling service is also provided in conjunction with the agency's Community Service Unit.

Finally, education and counselling, in cooperation with the municipalities in the district, is provided to married and pre-marital couples.

A developed program of evaluation of the above activities takes place through surveys conducted by private companies and by PROFAMILIA. Client attendance records are analyzed to determine the impact of these activities. It was found in a survey conducted in 1992 that a 6% increase in public knowledge of the NGO and its goals and objectives had been accomplished.

#### **15.1.7 PLANIFAM - Cuzco**

Training of health professional excluding family planning promoters is not viewed as an activity administratively separate from IEC within this NGO. In addition to a basic course for 35 promoters held in January 1993, courses for 15 supervisors, 50 adolescents (college and secondary levels), in sexual education and short term methods) and a practical instructional program for three doctors in surgical sterilization techniques are in the planning stage but have not yet been submitted to the PRISMA IEC committee for review.

In Cuzco the Evaluation Team witnessed use of loudspeakers, distribution of flyers, hats and condoms in two market place locations where itinerant clinics were in operation. Appointments for surgical interventions also could be made during a "jornada" or campaign conducted in collaboration with the local authorities.

This agency serves a region (INKA) notable for its size, variety of terrain, poverty, ill-health, illiteracy and indigenous population. It is an excellent example of the heterogeneity that has been referred to in this report.

For this reason, use of IEC materials (flyers, brochures etc) prepared and distributed by PRISMA are of limited use and have caused this NGO to focus on the development of communications materials more appropriate to the population they serve.

Experience dictates that while the PRISMA educational materials are appropriate for persons who are literate, including presentations to the Club de Madres, Vaso de Leche, secondary school and college students, they are of little value to the Quechua-speaking illiterate population that comprises the majority of the inhabitants in this zone.

During the Evaluation Team's visit to the Community Post at Chincheros, near Cuzco a film was shown to several indigenous women under poor conditions of projection and viewing. The film provided an overview of anticonceptive methods and a sound-track in English with Spanish sub-titles.

IEC promotional activities have therefore focussed on the production of materials that can be easily comprehended and utilized effectively in presentations in Quechua. In addition the cultural characteristics of the population are determinants of acceptable family planning methodologies. Natural family planning methods, for example, are unacceptable since men do not respect their wife's periods and the Billings method is too sophisticated and confusing. The IUD is believed to promote promiscuity and cause cancer.

These are among the factors that must be considered in the production of IEC materials that will be acceptable and useful in attracting acceptors.

On the other hand it was stated that following a survey, 86% of indigenous women interviewed indicated that they did not want more children, the average mother of whom gave birth to 7.2 children during her fertile life. As a result many would accept a long term method without graduating through short term alternatives.

Activities during 1993 include 40 presentations through municipal authorities, community organizations, public and private institutions, 22 talks in response to requests from social groups and businesses, attendance at two "family planning Fairs", a presentation on "World Population Day", distribution of informational materials on family planning, education of health personnel (Promoters and supervisors), articles in press and radio "spots", and production of a video presentation intended to strengthen PLANIFAM's image and to advertise the range and character of services provided.

## **15.2 Conclusions and Recommendations**

It is readily apparent that both PRISMA and the NGOs have spent considerable time and effort in IEC efforts. However, there is room for improvement. Anecdotal experiences together with discussions with IEC PRISMA and NGO coordinators suggest that there is need for a more structured approach to the management of IEC programs, and that plans must take into account the heterogeneity of the target populations and the philosophical differences of the agencies' goals and operational styles.

- 15.2.1 The Team endorses the inclusion of TV including VCR equipment to be provided to the NGO's in the equipment list prepared by PRISMA in March 1993. A recommendation is included that makes available basic equipment, (videocamera, editor, lights, etc) and supplies available to the IEC unit of PRISMA, to develop an operational communications development facility that is responsive to the newly identified needs and existing deficits.
- 15.2.2 During the conduct by PRISMA of TV productions for teaching and IEC purposes, NGOs should receive training in production methodologies.
- 15.2.3 That staff selected for participation in the IEC Committee be selected according to the following criteria:
- Qualifications
  - Personal and Professional Interest
  - Availability to attend all meetings
  - Sufficiently senior to get the tasks completed in their organizations
- 15.2.4 That the cultural heterogeneity of the INKA Region be explicitly recognized and that centrally developed materials and activities clearly recognize the unique needs of this zone.

## **SECTION 16 EQUIPMENT**

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### **16. BASIC FAMILY PLANNING EQUIPMENT AND INSTRUMENTS**

A review of equipment and instruments was conducted in each of the NGOs visited. The criteria for the review included the availability and condition of basic equipment and instruments needed to perform the functions of the level of the facility in which they were found.

Generally speaking, and with the exception of ATLF, instruments especially, were found to be old, of mediocre quality, in poor condition (rusted) and barely functional. In addition, some equipment including cardiac defibrillators that are basic to acceptable surgical procedures are not available. Through the ACPF/PRISMA program, sets of instruments for vasectomy have been provided. These sets appear to be in good condition and are generally adequately maintained.

In several central clinics and posts, the attention of the Evaluation Team was drawn to the need for sterilizing equipment. In one instance, for example, consultations, Pap Smears and IUD insertions, were being performed in a single room in a public market. Sterilization of instruments was being conducted over a kerosene stove on the floor of the room. While this was the most dramatic incidence of need, similar conditions and situations were observed in other units. Instrument packages and portable sterilization equipment should be made available for easy and ready transport to rotating sites. In addition, more effort must be made by the NGOs who work in such environments (markets, private houses, community centers, etc.) to ensure that such facilities meet basic conditions of hygiene, water and electricity.

The need for the provision of instrumentation and equipment that is reliable and adequate for the services provided and planned has been recognized by PRISMA. A study was conducted in March, 1993 and 41 items of instrumentation and equipment identified and assigned priority in three groups (Table 2). These included lamps, electric sterilizers, surgical instruments, vasectomy sets, microscopes, pediatric scales, sets for insertion and removal of IUD's, hospital beds, Minilap sets, suturing and other items.

In addition TV and ancillary equipment was included in order to make training video materials available locally. Such equipment would enable PRISMA to maintain a library of tapes for loan to NGOs in conjunction with training of administrative staff and groups of adolescents, adult males, community leaders and others.

The list provided by PRISMA was reviewed by each NGO following their investigation.

Discussions with NGO Directors by the Evaluation Team indicated that the items included in the PRISMA survey were indeed essential but that some minor adjustments were desirable in order to ensure an improved balance of instrumentation used in surgical procedures and to take into account the needs of clinics and posts newly inaugurated since March 1993.

In addition the Evaluation Team noted the lack of privacy for clients in some itinerant clinics particularly those taking place in single rooms where access was difficult to control. The provision of simple portable screens would contribute significantly to patient tranquility and to preservation of the intimacy of the doctor-client relationship particularly during the conduct of physical examinations, and the insertion and extraction of IUDs.

Medical directors did not indicate shortages of FP commodities with the exception of injectables, NORPLANT and in some clinics, lack of Minilap sets (addressed in the PRISMA survey).

#### 16.1 Recommendations

16.1.1 In general, it is strongly recommended that USAID and PRISMA take special note of basic equipment and instrument needs in the development of the budget extension. Please note that we are not advocating state-of-the-art technology, but fundamental, quality instruments that will meet basic standards

16.1.2 That the equipment and instrument inventory be reviewed with each NGO once again to ensure that all items and quantities are covered according to needs.

**CUADRO DE REQUERIMIENTOS EQUIPOS, INSTRUMENTAL Y MOBILIARIO MEDICO Y OTROS EQUIPOS POR INSTITUCION**

(Prepared by PRISMA for USAID, March, 1993)

<b>INSTRUMENTAL MEDICO:</b>	<b>PROFAMILIA/LIMA</b>	<b>PROFAMILIA/HUANCA</b>	<b>PLANFAMILIA/PUNO</b>	<b>APROFAMILIA/LIMA</b>	<b>INPPARES/LIMA</b>	<b>CENPROF/TRUJILLO</b>	<b>PLANFAMILIA/CUSCO</b>	<b>ATLFA/LIMA</b>	<b>PRISMA</b>	<b>TOTAL</b>	<b>PRIORIDAD</b>
LAMPARA CUELLO	16	6	8	20	30	10	5	4	6	102	1
ESTETOSCOPIO SIMPLE	12	4	4	6	10	8	4	4	8	50	1
ESPECULOS GRANDES	20	10	10	20	30	20	10	5	20	145	1
ESPECULOS MEDIANOS	40	30	40	30	50	60	30	20	60	430	1
PINZAS DE BIOPSIA	4	2	2	4	4	4	2	2	4	26	1
ESTERILIZ ELECTRICO	4	3	3	5	15	10	5	5	7	54	1
TAMBOPIES MEDIANO	20	5	3	20	40	10	5	3	6	113	1
TUERAS	10	5	5	6	20	10	5		10	71	1
TENSIOMETROS	5	4	4	5	10	9	4	4	8	50	1
EQUIPO INSERC. DIU	20	10	10	20	20	15	5		10	110	1
BANCOS GIRATORIOS	20	10	10	20	30	20	10	5	20	145	1
EQUIPO RETIRO. DIU	10	5	5	10	10	10	4		10	64	1
ELECTROC AUTERIO	4	2	2	4	6	4	3	2	4	31	1
ESCALERAS PELDANOS	20	10	10	20	30	20	10	5	20	145	1
FRONTO-LUZ	4	3	4	6	6	8	4	3	4	40	1
BALANZAS/TALLIMETRO	20	10	10	20	30	20	10	5	20	145	2
PERONERAS MEDIANAS	4	3	3	6	30	5	4	3	5	64	2
ESPECULOS CHICOS	12	6	12	12	35	15	6	4	20	122	2
ESTETOSCOPIO PINARO	4	3	3	4	7	5	4	4	6	40	2

INSTRUMENTAL MEDICO	PROFAMILIA/LIMA	PROFAMILIA/IRUANCA YO	PLANFAMI/PUNO	APROFAMILIA/LIMA	INPAARE/LIMA	CENPROF/TRUJILLO	PLANFAMI/CUSCO	ATLE/LIMA	PRISMA	TOTAL	PRORIDAD
ESTETOSCOPIO PEDIATRICO	4	3	3	4	4	5	3	3	4	53	2
CAMILLA GINECOLOGICA	4	4	2	6	30	4	4	4	4	64	2
MICROSCOPIO (5 OBJET)	1	1	1	1	1	1	1	1	1	0	2
BALANZAS PEDIATRICAS	20	10	10	20	30	20	10	5	20	145	2
EQUIPO MINILAP			4	6	6	6	4		6	32	2
PINZAS DE LIMPIEZA	10	6	5	6	30	10	5	3			
PINZAS DE CUELLO	10	5	5	8	30	10	5				
EQUIPO VASECTOMIA	4	2	2	6	6	8	2		0	34	2
MESA DE CURACIONES	20	10	10	20	30	20	10	5	20	145	2
PORTASUEROS	4	2	2	4	4	4	2	3	3	29	2
HISTEROMETROS	10	5	5	8	20	10	6		10	71	2
BOMBILLAS PEQUENAS	4	3	5	4	4	4	3	3	3	31	3
CUBETAS GRANDES	10	5	5	10	30	10	8	5	20	100	3
ASPIRADORES	4	2	2	4	4	4	2	3	3	25	3
CUBETAS CHICAS	10	5	5	10	30	10	6	3	20	100	3
ANILLOS RING				2,000		2,000			2,000	4,000	3
BOMBONERAS					70					70	3
COLPOSCOPIO	1	1	1	1	1	1	1		1	8	3
ECOGRAFO	1	1	1	1	1	1	1		1	8	3
CAMAS DE HOSPITALIZACION			3	3	8	6	4			28	3
CATOUT GROMICO (x)				1,200	1,200	1,200	800		1,200	5,400	3

<u>INSTRUMENTAL MEDICO:</u>	PROFA- MILIA/ LIMA	PROFA- MILIA/ HUANCA YO	PLANFA- MI/ PUNO	APRO- FAMI/ LIMA	INPPA- RES/ LIMA	CEN- PROF/ TRU- JILLO	PLAN- FAM/ CUSCO	ATLF/ LIMA	PREMA	TOTAL	PRIO- RIDAD
EQUIPO DE CIRUGIA MENOR	3	2	2	4	4	4	3	2	4	20	3

<u>EQUIPOS PARA PARTOS:</u>	PROFA- MILIA/ LIMA	PROFA- MILIA/ HUANCA YO	PLANFA- MI/ PUNO	APRO- FAMI/ LIMA	INPPA- RES/ LIMA	CEN- PROF/ TRU- JILLO	PLAN- FAM/ CUSCO	ATLF/ LIMA	PREMA	TOTAL	PRIO- RIDAD
AMNIO- TOMO	1	1	1	1	1	1	1	1	3	11	3
TUERAS	1	1	1	1	1	1	1	1	3	11	3
PINZAS KOCHER	1	1	1	1	1	1	1	1	3	11	3

<u>EQUIPOS DE SUTURA:</u>	PROFA- MILIA/ LIMA	PROFA- MILIA/ HUANCA YO	PLANFA- MI/ PUNO	APRO- FAMI/ LIMA	INPPA- RES/ LIMA	CEN- PROF/ TRU- JILLO	PLAN- FAM/ CUSCO	ATLF/ LIMA	PREMA	TOTAL	PRIO- RIDAD
PINZA PORTA AGUJA	20	10	10	20	30	20	10	5	20	148	3
TUERAS	20	10	10	20	30	20	10	5	20	148	3
PINZA DE DIRECCION	20	10	10	20	30	20	10	5	20	145	3
AGUJA SUTURÁ PAQUITA	20	10	10	20	30	20	10	5	20	145	3
CUBETA GRANDE CON TAPA	20	10	10	20	30	20	10	5	20	145	3

<u>EQUIPO AUDIO VISUAL/ SONOR:</u>	PROFA- MILIA/ LIMA	PROFA- MILIA/ HUANCA YO	PLANFA- MI/ PUNO	APRO- FAMI/ LIMA	INPPA- RES/ LIMA	CEN- PROF/ TRU- JILLO	PLAN- FAM/ CUSCO	ATLF/ LIMA	PREMA	TOTAL	PRIO- RIDAD
EQUIPO ALTAVOZ	1	1	1	1	1	1	1	1	1	8	1
EQUIPOS DE VIDEO	1	1	1	4	4	4	3	1	1	20	2
T.V. A COLORES	1	1	1	4	4	4	3	1	1	20	2

<u>EQUIPOS DE COMPUTO:</u>	PROFA- MILIA/ LIMA	PROFA- MILIA/ HUANCA YO	PLANFA- MI/ PUNO	APRO- FAMI/ LIMA	INPPA- RES/ LIMA	CEN- PROF/ TRU- JILLO	PLAN- FAM/ CUSCO	ATLF/ LIMA	PREMA	TOTAL	PRIO- RIDAD
COMPUTA- DORA									1	1	

**SECTION 17**  
**ANALYSIS OF PROJECT IMPLEMENTATION**

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**17. ANALYSIS OF THE PRISMA PVFP PROJECT IMPLEMENTATION PROCESS**

**17.1 Involvement of and Cooperation with NGOs**

This analysis is intended to triangulate findings and observations of the Evaluation Team with formally collected empirical data from staff of the NGOs. It is divided into two principal sections: quantitative and qualitative.

**17.2 Quantitative Analysis**

This section deals with the perception by the NGOs of the overall manner in which the PVFP has been implemented. Each NGO was given a self-administered ordinal scale opinion instrument and asked to rate the implementation process on a scale of 1 (Very much Disagree) to 6 (Very much Agree). Twelve individual items were included (See Appendix III-B). This instrument was given to all Senior NGO Staff. Thirty completed replies were returned and are included in the analysis. The only identifier on the instrument was the name of the NGO. The frequency of replies by agency is as follows:

NGO	No.
APROSAMI	2
ATLF	5
CENPROF	6
INPPARES	5
PLANIFAM	5
PROFAMILIA	7

**17.2.1 Dimensions Measured**

Direct items included the degree (ordinal scale 1-lowest, 6-highest) to which the PVFP was perceived to meet the following criteria: 1) Communication of purpose of PVFP (clear and with sufficient detail); 2) Relevance to the NGO (practical, realistic, needed, and addressed/respected the uniqueness of each

NGO); and 3) Participation (participation in implementation; agency control over implementation and client "comfort" with goals and implementation).

### 17.2.2 Analysis Procedures

Descriptive Statistics and histograms were performed on all variables for all agencies. Item analysis was conducted through Pearson's and Spearman's correlation analysis programs. Scale reduction was accomplished through Factor Analysis and three items were dropped from the scale (items relating to timing, staff time required and internal knowledge of issues "surprise findings").

### 17.2.3 Scale Construction

Two scales were derived from the data reduction techniques. One was based on individual factor scores, and the other was a summative scale which simply added the individual scores for each respondent (n=30) on each item (n=9) remaining in the analysis.

The remaining variables were subjected to parametric (Student's t-Test) and non-parametric (Chi-square) analyses.

### 17.2.4 Findings

The means for all items ranged between 3 and 4, or "average" in terms of the implementation process. The summed scale (minimum possible 9, maximum 54) produced a mean of 30.5 (range 14-44), with a standard deviation of 8.9, indicating a fairly "flat distribution", with the median at 33. Factor score analysis produced approximately the same results.

Nevertheless, analysis of histograms - splitting at about the mean - shows a slightly higher (not strong) distribution of favorable opinion about implementation.

There is a significant difference between the Lima and non-Lima NGOs. t-Test revealed that the Lima NGOs (mean 27.5) had a significantly lower opinion of implementation than the non-Lima NGOs (mean 35.6) (t-value 2.83; sig. <.008). This finding was confirmed by means of a chi-square test splitting at the mean,  $\chi^2$  Chi-square = 9.85, sig. <.001.

When ATLF was held out of the analysis due to the nature of its mission (natural family planning), the results were similar (Lima NGO mean 29.2), (non-Lima mean 35.6), t-value 1.9, sig. <.06. Chi-square 6.1, sig <.01.

### 17.2.5 Conclusion

While the general opinion of all respondents was that the PVFP has been implemented in a satisfactory manner, there is significant difference between those NGOs which operate in Lima and those in Cuzco and Trujillo. This substantiates anecdotal findings that some NGOs feel that PRISMA is always "looking over our shoulder" and "always checking on us", etc. This seems to be the case particularly in Lima. Further, Lima NGOs have had more involvement with other project elements. This may produce a more "negative" effect, especially if they are not involved in design.

In general, however, and especially given the largely uphill road with which PRISMA has been tasked, the data indicate that PRISMA has done a competent job of implementing the PVFP Project.

### 17.3 Qualitative Triangulation

In addition to the Process Scale analyzed above, two other instruments were administered to NGO staff. These were self-administered open-ended questions relating to the goals of the PVFP. Two separate instruments were used (See Appendices III-A and III-C). One was targeted exclusively at the Senior Management level; the other for base level staff participating in activities sponsored by the PVFP.

#### 17.3.1 Senior Staff Protocol

Senior staff were given a protocol asking them to describe or explain their opinions regarding the performance of their NGO with respect to the goals of the PVFP. The dimensions tapped were: 1) the achievements of your NGO with respect to the goals of the PVFP; the difficulties your NGO faced with the goals of the PVFP; the PVFP components which were/are most applicable to your NGO; the PVFP components which were/are least applicable; which components were not completely implemented in your NGO; and, opinions on what constitutes financial self-sufficiency and how to achieve it.

The detailed textual findings are contained in Appendix IV. Nevertheless, **these are well worth the reading in their entirety, as they reflect NGO Senior Management opinions in their own words.** The major findings of these opinions (consolidated by general categories) are topically summarized here:

**17.3.1.1 Achievements due to PVFP:**

- Improved FP services both in terms of quality and quantity of long-term methods as well as staff training (14 responses)
- Improved organizational and administrative capacity (10 responses)
- Improved institutional image and public awareness of FP both within the private and especially the public sector (9 responses).

**17.3.1.2 Difficulties in implementing PVFP goals:**

There was much more diversity in responses to this item than in the item on "achievements". Using gross categories the findings are:

- Amount and restrictions on project financing (9 responses)
- Reporting frequency should be quarterly not monthly (3 responses)
- Economic environment not conducive to income generation activities; and population served too poor to absorb increased prices (various nested responses)
- Administrative aspects: delays in receiving funds; delays in receiving methods; delays in T.A.; other NGOs exercise undue influence on PRISMA; short duration of PVFP (interrupts planning process)
- Reduction in CBD program salaries
- Social environmental responses: uneducated population; machismo; terrorist activities; etc.

**17.3.1.3 Most Applicable Components for NGOs:**

The items identified in this section break into three main clusters:

- IEC and Training (9)

- Emphasis on long-term, clinical methods
- Management and institutional capacity, including MIS, "operations research", addition of MCH and laboratory services

#### 17.3.1.4 Least Applicable Components:

This question seemed to capture NGO perceptions of PVFP implementation weaknesses, rather than the applicability of the components themselves to each NGO. (Comment: this could be interpreted to mean that the basic elements of the PVFP were not adequately "bulleted" in presentation, or, that at the outset, NGOs were paying more attention to simply being funded than to the issues PVFP was designed to address.)

- Issues of Self-Sufficiency because: much talk, no action; lack of a capitalization budget; pricing study not followed up; mass communication not relevant; too rigid financial oversight; computer (service statistics) system not complete; vasectomies and Norplant not relevant to one NGO; etc.

#### 17.3.1.5 Components not implemented:

This item elicited a list of issues that may be unique to each NGO as only two items (cost system and logistics system) had more than one response.

- Management systems; inter-agency collaboration; modern medical equipment; birthing centers; IEC for vasectomy; IEC directed at males; self-sufficiency project; injectables; computer systems inadequate; lack of strategic planning; pricing component.
- (Comment: it should be noted that three elements of TA - pricing, cost study and strategic planning, as well as systems for self-sufficiency appear in this section. This triangulates well with other findings obtained during the evaluation.)

#### 17.3.1.6 Definition(s) of Financial Self-Sufficiency:

It is noteworthy that most definitions offered were very similar. Three responses specifically used the word "dependency" on donors.

- Establish structural/institutional conditions which permit independence from donors (2)
- Generate income from other sources to cover costs and 1) cross-subsidize other activities; and 2) permit re-investment in the NGO.

17.3.1.7 Percentage of FY 92 and FY 93 Budget from Non-Donor Sources:

AGENCY	FY 92%	FY 93%
APROSAMI	18-28	25-30
ATLF	40	50
CENPROF	19-22	21-50
INPPARES	35	42
PLANIFAM	18-22	23-35
PROFAMILIA	34-43	34-43

It must be remembered that these are opinion questions and no reference was made to financial records. Further, the questionnaire was distributed to all Senior Staff, not all of whom may have had access to financial information, hence the variability in responses in some agencies.

17.3.1.8 Impediments to Financial Self-Sufficiency:

- Donor budgets don't permit medium- and long-term investment in profitable activities (3)
- Rental of sites (capital loss due to high rents)
- Target population cannot afford to pay real costs of services (5)
- Sole focus on FP and Health Sector activities (2)
- Lack of equipment budget siphons earnings away from investment (2)
- Service delivery costs too high; competition from Public Sector (free) in same zones

- Poor general economic conditions (3)
- Lack of TA in management; market study.

#### 17.3.1.9 Actions or Suggested Plans for Financial Self-Sustainability

While there is considerable diversity in the responses elicited, the common thread is to generate revenues from within the Health Sector. Only one minor activity (generate fees from photocopy and mimeograph services) taps any external domain.

- Increase/improve clinical laboratory services
- Sell services and IEC to the private sector (i.e. large companies)
- Use surgical sterilization facilities for other minor surgeries; increase kinds of non-family planning services available
- Establish a mobile X-ray unit
- Establish pharmacies
- Expand facilities into higher income areas which can pay higher fees
- Establish fixed posts which can evolve to full clinics
- Various cost reduction techniques (e.g. M.D.s paid on a fee-for-service basis); increase working hours; unspecified cost reduction
- Cost-sharing with municipal governments
- Mobile integrated services
- Increase fees (discreetly)
- Diversification (unspecified).

#### 17.3.2 Base level Staff Results

Unfortunately this instrument did not provide useful results. Its design assumed that the specific goals of the PVFP had been communicated

thoroughly throughout the organizations. The replies received indicated that base-level staff did not discriminate between PVFP goals and overall goals of the agency.

This finding has at least two interpretations: 1) That regardless of source of funding, the NGOs, as institutions, incorporated funds into their service delivery system in a fairly homogeneous form so that project-by-project financing factors do not have a noticeable effect at the base level; 2) That project-specific goals are not communicated vertically throughout the organization at a level of detail that encourages pro-active participation by base level staff.

#### **17.4 Recommendations for the extension period**

- Engage the NGOs early-on in the design of the extension.
- Encourage and persuade NGOs to set their own Year-One extension measurable targets.
- Assist NGOs with internal communication of the purposes and goals of the first year extension.
- Do "needs assessments" with NGOs at on-set of all Technical Assistance activities: market studies, cost analyses, strategic planning, and include representatives of each NGO on Technical Assistance panel or group.
- Establish a new full-time position of "Income Generation Coordinator" in the PRISMA structure whose primary responsibility would be the on-going assistance to NGOs on all issues relating to income generation.

**THE PROFIT PROJECT**

**EVALUATION OF  
USAID PERU PROJECT NUMBER 527-0335**

**PRIVATE VOLUNTARY FAMILY PLANNING SERVICE EXPANSION PROJECT**

**APPENDICES**

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## **APPENDIX I**

### **Scope of Work**

#### **I. BACKGROUND**

The Private Voluntary Family Planning Service Expansion Project (PVFP), No. 527-0335, was initiated on October 1, 1989 through a Cooperative Agreement with Asociacion Benefica PRISMA as the implementing agency. This project was the follow-on project to the Private Sector Family Planning Project (SPF) implemented by the Pathfinder Fund, which was terminated two years early (programmed dates Oct.'89 - Sept.'91) due to high overhead costs and administrative problems.

The PVFP project was designed to assist six service delivery PVOs to improve their capacity to offer family planning services. The objectives of the project are to:

- A. Strengthen the capacity of the PVOs to deliver family planning services (institution building).**
- B. Improve the availability of long-lasting contraceptive methods.**
- C. Maintain support for temporary supply methods and natural family, and**
- D. Enhance rural family planning coverage through PVO-public sector collaboration.**

AB PRISMA (Proyectos on Informatica, Salud, Medicina y Agricultura) was selected competitively as the implementing agency due to their proven administrative and programmatic ability to handle a portion of the logistically challenging USAID/Peru food program. However, due to their relative inexperience in the area of family planning, the mission decided to test PRISMA by signing a one year Cooperative Agreement and evaluating their performance for the first 8 months activities before awarding them the entire four year project.

The evaluation carried out in May 1990 showed a satisfactory performance by PRISMA. An amendment was prepared for the remaining three years. Two important new activities were added to PRISMA's project responsibilities:

- A. In agreement with the Ministry of Health (MOH) and the participating PVOs, PRISMA was asked to consolidate and distribute all USAID/Peru-donated contraceptive supplies.**
- B. In order to evaluate progress in family planning services in Peru in general and PVO services in particular, the 1991 Demographic and Health Survey (DHS) was included in PRISMA's cooperative agreement.**

As implementers of the PVFP project, PRISMA, has gained the confidence and cooperation of the participating PVOS. To date they have made progress on each of the following objectives:

**A. Institution Building component--**

**1. Planning**

- a. Development of annual project work plans and budgets.
- b. Development of institutional strategic planning capability through the provision of technical assistance to each PVO and organizing workshops on the subject (i.e., "Current Situation and Perspectives for Family Planning in Peru" and "Creative Approaches to Family Planning").
- c. Design, implementation and supervision of an individualized evaluation system.
- d. Analysis of the role of PVOs and their potential as family planning service providers.

**2. Computerized System**

- a. Implementation of a project accounting system.
- b. Design and implementation of an information system (PF Control) which includes accounts, service statistics and logistics modules. Manuals were designed and training offered to PVO staff in the use of the PF Control modules.
- c. Hard and software was provided for adequate handling of computerized project activities.

**3. Administration and Management**

- a. Training and supervision was provided on all financial and administrative aspects of the project. Manuals were prepared to institutionalize procedures.
- b. Coordinating meetings were held with management/administrative, financial and systems personnel to share experience and seek solutions to problems encountered.

**B. Improve availability of long lasting contraceptive methods**

**1. Coordination and funding of IEC and training activities of PVOS:**

- a. Seminar on long-lasting method for doctors, program coordinators and trainers (23 persons attended).
- b. Workshop to establish protocol for IUD insertion (attended by 21 doctors and coordinators).
- c. Workshop for family planning promoters on long-lasting methods attended by 47 promoters.
- d. Workshop for promoters on quality of care and counseling for long-lasting methods (91 participants).

**2. Reduce subsidies to CBD programs and assist in transition to clinical services for expansion of long-lasting methods service delivery.**

**3. Provided TA to help PVOs review their production (i.e., method mix vis-a-vis clinical services delivery capability). New targets have been established with emphasis on long-lasting methods and are being closely monitored to determine need for additional TA to meet goals.**

**C. Maintain support for temporary supply methods and Natural Family Planning:**

**1. Consolidation of all USAID/Peru-donated contraceptive supplies which involves the receipt, warehousing, distribution, tracking and assistance in programming for public and private sectors.**

**2. Conduct two national contraceptive inventories (1990 and 1991). As a result of these inventories, it was possible to rationalize shipments and distribution more efficiently, avoiding costly overstocks and waste and substantially improving Peru's ability to estimate contraceptive needs.**

**D. Expansion to rural areas**

**1. Programs have been initiated by PVOs in public sector facilities with modest success.**

**2. Two PVOs (PLANIFAM/Cuzco and PLANFAMI/Puna) have itinerant medical teams which rotate to rural areas offering IE&C and family planning services. PLANIFAM/Cuzco has been most successful in organizing Family Planning Fairs and PLANFAMI/Puno coordinates visits into the countryside with other humanitarian/community service agencies such as food distribution activities.**

## **II. PURPOSES OF THE EVALUATION**

- A. To assess the progress toward achievement of project objectives and identify and analyze the reasons for any shortfalls.**
- B. Apply the lessons learned from the past three years of work with PVOs and make recommendations for changes and/or corrective actions in the PVO service delivery approach within the Mission portfolio.**
- C. Recommend strategies which will improve the impact of the project. The Mission sees the need particularly for an extension of the project to define and implement programs which will make PVO family planning programs self-sustaining.**

To this end the Evaluation Team should analyze the following:

- A. The extent (or not) to which PRISMA has achieved the goals established in the original design and reasons for same.**
- B. What should PRISMA do in the one year extension being planned to help the PVOs improve their productivity, be better positioned in the family planning market, and move towards self-sufficiency. (The 1991 Demographic and Health Survey estimated that PVOs provide only about 7.4 percent of the family planning services in Peru.)**
- C. What role should the PVOs play in service delivery in the future:**
  - 1. What target Population should they serve?**
  - 2. What services should they offer?**
  - 3. How much should they charge?**
  - 4. Where should they locate?**
    - a. Appropriateness of current locations.**
    - b. Validity of public/private sector collaboration utilizing same public sector facilities.**
  - 5. Are differentiated prices possible based on:**
    - a. Family planning vs. non-family planning services**
    - b. Ability to pay**
    - c. Geographic locations, etc.**
  - 6. Review of PVO efforts to reduce costs and increase earnings.**

7. Review percentage of costs PVOs are recovering.
8. Review feasibility of PVO self-sufficiency in Peru's current economic climate and that projected for the short and long term.
9. What specific action/assistance will enhance the possibilities for self-sufficiency?

**D. Public/private sector collaboration:**

1. How can the public sector tap the private sector resources (e.g., share facilities with PVOs for clinical method provision).
2. How can the private sector increase its presence and services in the rural sector to complement/facilitate the work of the public sector.

**E. Recommendations for the one year extension - The team will work with the Mission Health, Population and Nutrition (HPN) and Program Development Project (PDP) offices to provide the necessary technical information for a Project Paper amendment.**

**III. EVALUATION TEAM LEVEL OF EFFORT (LOE) AND COMPOSITION**

**A. LOE - The team should consist of three members who will remain for a minimum of three to four weeks in-country.**

**B. Composition:**

1. Marketing specialist
2. Economist with experience in family planning and cost accounting.
3. Family planning program specialist with wide experience.

**IV. METHODOLOGY**

**A. Agenda - appointments, interviews and field trips will be arranged in conjunction with team members to facilitate their information gathering and assistance will be provided enabling them to meet their reporting requirements:**

1. All pertinent documentation will be sent to the Central Agency fielding team members to facilitate their familiarization with the subject situation prior to their arrival in-country. (See attached list of documents to be made available to the team.)

2. Mid-way through the TDY, the team will provide a verbal presentation of their findings to HPN and the PRISMA staff.
3. A preliminary report will be presented five working days before completion of their TDY to allow for review and discussion by and with the HPN and PRISMA staff.
4. A meeting will be held with Director, Deputy Director, Mission Program Officer and Financial Analyst to discuss the final report which will have included comments and observations made on the preliminary report.

#### **V. REPORTING REQUIREMENTS**

The final report will contain the technical basis for the PP Amendment for a one year extension to the project. It will include modifications and justifications for variations from the original design and activities and goals recommended by the team and agreed upon with the Mission and PRISMA staff.

The final draft report will be presented to the Mission before the team leader leaves the country.



U.S. Agency for  
International  
Development

**UNCLASSIFIED**  
**FAX MESSAGE COVER SHEET**

TO: Mr. Craig Carlson, R&D/POP/FPSC      DATE: March 8, 1993  
CITY/COUNTRY: Washington, D.C.      FAX No.: (703) 875-4413  
FROM: Gloria Nichtawitz, POP/HPN  
OFFICE CHIEF APPROVAL: <sup>GN</sup> Heather W. Goldman, HPN  
SUBJECT: SOW for PVFP Evaluation Team  
REF: a) Carlson/Nichtawitz FAX 2.11.93  
      b) Nichtawitz/Carlson Telcon 2.26.93

No. of Pages: (2)

Craig:

As indicated to you in our Telcon, the issues on which we need assistance about the role of the PVOs (pag. 4, item, 1-4 of SOW) were not intended as global policies but rather, to help formulate marketing/self-sufficiency strategies for PVOs. The project should assist the PVOs to achieve greater income generation and self-sufficiency. Following is a reformulation of the questions which we hope will clarify the type of help needed:

1. What services are needed? Are PVOs supplying them? (Issue of profitability of more vertical family planning services vs. integration with MCH services and who PVOs are currently reaching.)
2. What target populations are the PVOs best equipped to serve?
3. What target populations would be able to pay more for PVO services?
4. Where should the PVOs locate that would enhance their income generation prospects?

Larrabure y Unanue 110, Lima 1  
Phone: 333200, Fax: 337034

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Information will be available for the review and analysis of the team that will be of value in addressing these questions.

On the questions of public/private sector collaboration. We agree that this is a "more tangential" element of the SOW. But since it was an objective of the project which was expected to improve rural coverage (pgs. 4, 44 & 53 of PP) we hoped to gain new ideas on how this could be accomplished. It may not be the best strategy to improve self-sufficiency but greater use of public facilities in the afternoon, for example, can improve coverage.

I talked with Karen on Monday as planned. She is interested and would be a valuable asset to the team. She had two concerns:

- Other commitments - A Workshop April 19-24 here in Peru, and May 10, travel planned to Brazil.
- Payment - As a full-time employee of the Futures Group, her salary plus fees must be paid.

Perhaps if she cannot join the team full-time, she could work as a consultant to them during the first few days and certainly during the latter half of the exercise.

She can be contacted at (51-14) 41-9819.

Hopefully you will soon have the name of the third team member who should be a service delivery specialist. We cannot proceed with his or her country clearance until we have the name. We all agree that Don Nicholson and Tim Farrell look good.

Sincerely,



AGENCY FOR INTERNATIONAL DEVELOPMENT  
WASHINGTON, D C 20523

PANAFAX

TO: Gloria Nichtawitz  
ORGANIZATION: USAID/Peru  
FAX # : 9-011-51-14-337034  
TELEPHONE: 9-011-51-14-333200

FROM: Craig Carlson & Tom Morris  
OFFICE: R&D/POP/FPSD  
TELEPHONE: 703-875-4661  
DATE: February 11, 1993

NUMBER OF PAGES (INCLUDING COVER SHEET) 3

<input type="checkbox"/>	As Requested	<input checked="" type="checkbox"/>	For Your Information
<input type="checkbox"/>	For Clearance	<input checked="" type="checkbox"/>	For Comment
<input checked="" type="checkbox"/>	Per Conversation	<input type="checkbox"/>	Per Memorandum

Message:

Gloria:

Thanks for providing the SOW for the proposed PVFP evaluation. Tom and I have discussed it and have also shared it with key PROFIT Project staff. It looks like a very interesting undertaking and we and PROFIT staff are looking forward to being involved.

There are several elements of the SOW we would like to clarify with the mission.

1. The SOW strikes us as very ambitious. We would like to suggest some additional specificity with several parts of it in order to help direct the team:

1.a. On page 4, item C, points 1-4 strike us as are largely policy issues that are the responsibility of Peruvian leaders. It seems inappropriate to task the team with taking positions on these questions. The evaluation team can help facilitate decisions by providing information. Perhaps these information needs are what you are interested in. Please clarify this for us.

1.b. We suggest deleting item D.1. on page four of the fax. Tasking the team with investigating how the public sector can tap the private sector resources would require it to review/evaluate a considerably greater pool of issues, players, etc. It also

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seems one of the more tangential elements of this SOW that could be deleted to allow the team to focus on the most crucial issues of PVOs.

1.c. The four objectives noted for the PVFP (items A-D on page 1 of fax) are all qualitative. Are there any quantitative objectives that A.I.D. has for this project that we could share with the team?

2. LOE: We agreed to a maximum of one week preparation in the U.S. and two weeks in Peru. Its possible we could stretch the in-country time by several additional days. PROFIT staff have other country and travel commitments that prevent them from being available for any more than this length of time. The three to four weeks in-country noted in your fax will not be possible.

3. Does the mission have an operational definition of "self-sustaining" that they would like the team to use for this exercise?

4. Given the approximate two week duration that the team will have in country, we advise against holding a "mid-way" debriefing and presentation. Such an activity would take precious time away from the team's interviewing and site visit schedule. Any comments they might offer at the mid-way point would also be extremely preliminary and subject to reversal. We would welcome the chance to have the usual end-of-visit verbal debriefing with Mission HPN and PRISMA staff. And we can work out a schedule for submission of draft and final reports from the team that will be satisfactory to all .

5. Team Composition:

5.a. We want to verify that Karen Foreit will be available for the entire duration of time that the team is in Peru and is planning to participate fully in report development that takes place in country, and with review and comment on draft copies of the team's report.

5.b. As discussed in our phone conversation, Don Nicholson will participate with the team for only part of the time, most likely the period near the end of the team's two-week in-country visit.

5.c. Recruitment for the additional team member (to join Tim Farrell, Karen Foreit, and Don Nicholson) is proceeding. Names of people being considered include: Karen Lassner, John Bratt, and Andres Nobl.

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5.d. Depending on the time that Karen can offer, it may be necessary to recruit an additional team member to work with the full-time team members (Tim Farrell and the consultant being recruited). This may also be necessary because of the limited time the team has in-country.

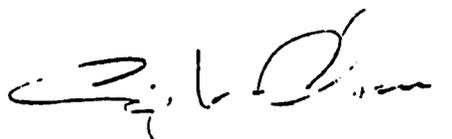
6. Re: Documentation being sent to R&D/POP. We would like as much quantitative data as is available. Of particular importance is the 1990 Evaluation Report, the Project Paper on the PRISMA Project, information on PRISMA and the six PVOs involved including how long have they existed, involvement with the PL 480 program, what they do, service statistics, where they are located, staffing, organization, services provided, budgets, and etc.

Please call or fax if you have questions with any of this. We look forward to your reply.

Best regards,



Tom Morris



Craig Carlson

**PROFIT PROJECT  
INTER-OFFICE MEMORANDUM**

**TO:** Craig Carlson, R&D/POP

**DATE:** February 11, 1993

**FROM:** Tim Farrell *Tim*

**REF:** Eval

**RE:** Peru Scope of Work; our meeting 10 Feb 1993

1. As we discussed, the SOW is very ambitious and needs to be made more specific. Section C, page 4, goes somewhat beyond an evaluation's traditional scope. Items 1-5 are largely policy/management issues. The evaluation can provide information for policy-decision makers, but I question whether it is appropriate for evaluations to answer the questions: "What...How much...Where...", etc. I think we can provide the information for them to answer these questions, but not answer the questions as such.

2. We discussed deleting D-1.

3. We agreed to 2-3 weeks in-country with a week preparation here in the US.

4. Can they provide us with quantitative objectives. Page 1's objectives are stated in qualitative terms. X

5. Do they have any baseline data? I have requested the Peru DHS report, but don't know when it will arrive. Do you have it for us to borrow? But, I'm also interested in any other baselines they (or the PVOs) might have. Also since they are apparently computerized, what summary service statistics can they provide?

6. On AB PRISMA itself, could we obtain more information (as well as on the PVOs)? Specifically,

a. How long has it existed? ✓

b. How long have they been involved with the PL480 program? ✓ " ..

c. Size of staff; facility locations; management and organizational structure ✓

d. Do they still have PL480 responsibilities besides contraceptive responsibilities?

e. What exactly was the role of DHS 1991 survey with respect to PRISMA? Did they sample in the PVO sites? and can those sites be identified from the data base?

f. What documentation is available for A, B, C, D on pages 2 and 3. Can we obtain it in advance.

Basically we would like to have as much quantitative documentation as possible. Time will not permit any serious survey, so our methods will be largely limited to key informant interviews and document review. Both methods are time-consuming both in implementation and analysis/synthesis, so any relevant information that we can obtain in advance is welcome. Similarly, the time needed for data analysis and interpretation will take longer than quantitative analyses and that desired in the SOW. We suggest that the final report be done in the US, submitted to the mission in draft form, and revised within a six-week time frame after we return.

In view of the reduced time in-country, it may be appropriate to add an additional member to the team. As mentioned, Don Nicholson will be available only at the beginning and/or end of the field work. Before making a formal request for another person, we would like to know the role that Karen Foreit will play and the amount of time she will have available for this project. In addition, based on the fax regarding security to Tom Morris, we need to know if the team (or a sub-group) will be permitted to Cuzco and Puno.

We are reviewing potential candidates as team members. At present these include Don and myself from PROFIT, Karen Lassner, John Bratt (FHI) and Andrés Nobl in Lima (I am faxing him for CV and time availability).

I return from Jamaica on 18 February. We should meet sometime (18 or 19) to try to nail down some specifics.

Thanks.

cc: Don Nicholson, Robert Bonardi, Peru File

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## **APPENDIX II**

### **Agenda for PVFP Evaluation (527-0335) April 18 - May 7, 1993**

#### **SUNDAY, April 18**

Arrive in country via American Airlines, Flight 917 at 15:36. Pick-up and transport to Pardo Hotel.

#### **MONDAY, April 19**

- 09:00 Security briefing USAID
- 09:30 - 12:30 Briefing with HPN Staff  
Dr. Heather W. Goldman, Chief  
Dr. Edgar Necochea, Deputy Chief  
Ms. Gloria Nichtawitz, Project Coordinator
- 12:30 - 13:30 Lunch
- 14:00 - 17:00 Proyecto en Informatica, Salud, Medicina y Agricultura (PRISMA) -  
Overview  
Ms. Josephine Gilman, Executive Director  
Mr. Jose Flores, Administrator  
Mr. Carlos Gutierrez, Administrator PVFP Project  
Ms. Gloria Nichtawitz, Project Coordinator

#### **TUESDAY, April 20**

##### **Technical Assistance Consultants:**

- 09:00 - 10:00 Francisco Verdera, Cost Study
- 10:00 - 11:00 Dina Li, Market Study
- 12:00 - 13:00 Roberto Tirado, Strategic Planning
- 13:00 - 14:00 Lunch - transportation to airport
- 15:45 Travel to Trujillo via Americana, Flight 820  
Arrival to Trujillo

18:00 Centro Nor Peruano de Capacitacion y Promocion Familiar (CENPROF)  
Dr. Felix Guillen, Executive Director  
Ms. Rosa Arteaga, Administrator  
Ms. Lelis Moran, Program Coordinator  
Mr. Carlos Gutierrez  
Ms. Gloria Nichtawitz

**WEDNESDAY, April 21**

am CENPROF

17:00 Return to Lima via Americana, Flight 821

17:50 Arrive Lima

**THURSDAY, April 22**

09:00 - 11:00 Seguimiento Analisis y Evaluacion para el Desarrollo (SASE) - PVO  
Marketing Plans

Dr. Baltazar Caravedo, Executive Director  
Mr. Armando Piliado, Economist  
Mr. Pablo Estenssoro, Economist  
Mr. Carlos Gutierrez  
Ms. Gloria Nichtawitz

13:00 - 17:00 Instituto Peruano de Paternidad Responsable (INPPARES)  
Dr. Miguel Ramos, Executive Director  
Dr. Eliseo Baroon, Program Director  
Sr. Dante Luza, Administrator  
Dr. Guillermo Guardia, Director Lima Family Planning Program

**FRIDAY, April 23**

04:15 Pick-up from Hotel to airport

06:15 Travel to Cusco, via Americana, flight 723

07:20 Arrive in Cusco, rest for 1-2 hours  
Lunch

13:00 - 18:00 Visit PLANIFAM  
Ms. Haydee Obando, Executive Director  
Mr. Ramon Paz, Program Director

**SATURDAY, April 24**

**Continue PLANIFAM Review, Urban Posts, Chincheros**

**SUNDAY, April 25**

**Continue PLANIFAM Review**

**MONDAY, April 26**

**09:45**                    **Return to Lima via Americana, flight 724**  
**10:50**                    **Arrive to Lima airport**

**13:00 - 13:30**           **Visit to the Ministry of Health**  
                                 **Dr. Andres Mongrut, Director of Social Programs**

**13:30 - 14:30**           **Lunch**

**14:30 - 17:00**           **PROFAMILIA**  
                                 **Mr. Alfredo Brazzoduro, Executive Director**  
                                 **Mr. Walter Gutierrez, Deputy Director**  
                                 **Dr. Jose Bendezu, Medical Director**  
                                 **Ms. Ernestina Sanchez, Program Coordinator**

**TUESDAY, April 27**

**am**                        **Mid-Term Briefing**  
                                 **APROPO**

**13:00 - 14:00**           **Visit to Peruvian Institute of Social Security (IPSS)**  
                                 **Ing. Angel Perez Rodas, Executive Director**  
                                 **Ing. Carlos Bustamante, Central Manager of Institutional Systems**  
                                 **Econ. Jorge Florian, Acting Manager for Planning and**  
                                 **International Cooperation**  
                                 **Dr. Enrique del Barco, Coordinator of Maternal Child Programs**  
                                 **Dr. Ramiro Farfan, Director of Decentralized Ambulatory Care**  
                                 **Program (PAAD)**  
                                 **Dr. Hector Pereda, Director of Specialized Health Programs**

14:00 - 17:00      **Asociacion de Profesionales para la Promocion de la Salud Materno -  
Infantil (APROSAMI)**  
Dr. Cesar Guzman, Executive Director  
Dr. Augusto Martinez, Medical Director  
Ms. Tania Ruiz  
Ms. Miriam Quintana

**WEDNESDAY, April 28**

09:00 - 12:00      **Follow up NGO Meetings**

13:00 - 17:00      **Asociacion de Trabajo Laico Familiar (ATLF)**  
Dr. Guillermo Tagliabue  
Dr. Vicente Villavicencio  
Srta. Sandra Homa

**THURSDAY, April 26**      **Follow-up NGO meetings**

**FRIDAY, April 30**

09:00 - 11:00      **Dialogue with HPN and PRISMA Staff re: Preliminary Findings**

pm      **Follow-up NGO Meetings**

**SATURDAY, May 1**      **Report Preparation, Follow-up NGO meetings**

**SUNDAY, May 2**      **Report Preparation**

**MONDAY, May 3**      **Follow-up NGO Meetings**

**TUESDAY, May 4**      **Follow-up NGO Meetings**

**WEDNESDAY, May 5**

**09:00**      **Presentation to Preliminary Draft to USAID and PRISMA**

**11:00 - 18:00**      **Follow-up NGO Meetings**

**THURSDAY, May 6**

**am**      **Report Preparation**

**15:00**      **Meeting with HPN and PRISMA with comments on Draft Report**

**FRIDAY, May 7**

**10:00**      **Meeting with USAID/Peru Deputy Director, HPN Staff, PRISMA Staff and Evaluation Team**

**13:00**      **Follow-up NGO Meetings, Report Preparation**

**SATURDAY, May 8**

**am**      **Follow-up NGO Meetings**

**pm**      **Departure**

**EL PARDO HOTEL:**

**Address:**      **Jiron Independencia 141, Miraflores**  
**Telephone:**      **47.0558 or 47.0283**  
**Fax:**      **44.2171**

## **APPENDIX III**

### **Data Protocols and Instruments**

#### **THE PROFIT PROJECT**

#### **EVALUATION OF**

#### **USAID PERU PROJECT NUMBER 527-0335**

#### **PRIVATE VOLUNTARY FAMILY PLANNING SERVICE EXPANSION PROJECT**

Five formal interview and observation instruments and protocols were employed during the PVFP evaluation. These are:

- A. "Management Questionnaire" -- Self-assessment tool for Directors and Senior Managers of the accomplishments and shortfalls of the PVFP; definitions of financial sustainability.
- B. "Implementation Process Questionnaire" -- Directors and Senior Managers assessment of the process by which the PVFP was implemented; evaluation of PRISMA implementation process.
- C. "Staff Questionnaire" -- Operational staff and supervisors; understanding of PVFP and organizational goals.
- D. "Intake Observations" -- Observation protocol for intake of new and continuing family planning clients.
- E. "Exit Interview" -- Interview schedule for clients on leaving service delivery point.

Protocols A-C were self-administered.

Protocol D is an observation protocol conducted by a professional Peruvian Sociologist contracted for this evaluation. She has extensive experience in Family Planning activities and has served as a supervisor to the DHS (1991), the Population Council. She is currently employed by the National Statistical Institute.

Interview Schedule E (Exit Interviews) was not administered systematically due to time constraints. It was, however, used to collect anecdotal data which appear throughout the evaluation report.

**THE PROFIT PROJECT**  
**EVALUATION OF**  
**USAID PERU PROJECT NUMBER 527-0335**  
**PRIVATE VOLUNTARY FAMILY PLANNING SERVICE EXPANSION PROJECT**  
**PROTOCOLO DE LOGROS DEL PROYECTO PVFP**  
**(Management Questionnaire: Process and Self-sufficiency)**

NOMBRE DEL ONG: \_\_\_\_\_ FECHA: \_\_\_\_\_

El propósito de este protocolo es obtener su opinión personal e individual sobre los logros y fallas de su propia agencia del proyecto PVFP.

Cada agencia posee una experiencia única en cuanto a la implementación de cualquier programa y sobre el ritmo de incorporación de sus metas.

Para conocer y entender sus experiencias en la implementación de los objetivos del PVFP pedimos su colaboración en el siguiente ejercicio.

1. En su opinion cuales son los logros mas exitosos que su agencia ha conseguido con el PVFP (enumere en orden de importancia)

a. \_\_\_\_\_  
\_\_\_\_\_ ; Por qué? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. \_\_\_\_\_  
\_\_\_\_\_ ; Por qué? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. \_\_\_\_\_  
\_\_\_\_\_ ; Por qué? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

d. \_\_\_\_\_  
\_\_\_\_\_ ; Por qué? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. En su opinion cuales son las dificultades mas serias que su agencia a tenido en PVFP  
(enumere en orden de importancia)

1. \_\_\_\_\_  
\_\_\_\_\_ ; Por qué \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_  
\_\_\_\_\_ ; Por qué \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_  
\_\_\_\_\_ ; Por qué \_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_  
\_\_\_\_\_ ; Por qué \_\_\_\_\_

\_\_\_\_\_

3. En su opinión, qué componentes de PVFP aplican mas al programa de su agencia?

a. \_\_\_\_\_  
\_\_\_\_\_; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. \_\_\_\_\_  
\_\_\_\_\_; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. \_\_\_\_\_  
\_\_\_\_\_; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

d. \_\_\_\_\_  
\_\_\_\_\_; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. ¿En su opinión, cuáles componentes del PVFP aplican menos al programa de su agencia?

a. \_\_\_\_\_  
\_\_\_\_\_; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. \_\_\_\_\_  
\_\_\_\_\_; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. \_\_\_\_\_  
\_\_\_\_\_; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

d. \_\_\_\_\_  
\_\_\_\_\_; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. ¿Qué componentes del PVFP no han sido totalmente implementados en el programa de su agencia?

a. \_\_\_\_\_  
\_\_\_\_\_; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. \_\_\_\_\_  
\_\_\_\_\_; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. \_\_\_\_\_  
\_\_\_\_\_; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

d. \_\_\_\_\_  
\_\_\_\_\_; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. ¿Cual es su propia definición sobre el concepto "Autosuficiencia Financiera?"  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. ¿Qué proporción de los ingresos anuales de la agencia viene de fuentes "no-donantes":

- Gestión '92: \_\_\_\_\_%
- Gestión '93 (proyectado): \_\_\_\_\_%

8. En su opinión, Cúales son los impedimentos mas graves para lograr la Autosuficiencia Financiera?

a. \_\_\_\_\_  
\_\_\_\_\_; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. \_\_\_\_\_  
\_\_\_\_\_; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. \_\_\_\_\_  
\_\_\_\_\_; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

d. \_\_\_\_\_  
\_\_\_\_\_; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. ¿Qué acciones o proyectos esta utilizando la agencia en este momento, que le facilitará el logro de la Autosuficiencia?

a. \_\_\_\_\_  
\_\_\_\_\_; Por qué \_\_\_\_\_  
\_\_\_\_\_

b. \_\_\_\_\_  
\_\_\_\_\_ ; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. \_\_\_\_\_  
\_\_\_\_\_ ; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

d. \_\_\_\_\_  
\_\_\_\_\_ ; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. ¿Qué clase de asesoría técnica cree usted que necesita la agencia para lograr la Autosuficiencia Financiera?

a. \_\_\_\_\_  
\_\_\_\_\_ ; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. \_\_\_\_\_  
\_\_\_\_\_ ; Por qué \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c.

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\_\_\_\_\_ ; Por qué \_\_\_\_\_

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d.

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\_\_\_\_\_ ; Por qué \_\_\_\_\_

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**THE PROFIT PROJECT**  
**EVALUATION OF**  
**USAID PERU PROJECT NUMBER 527-0335**  
**PRIVATE VOLUNTARY FAMILY PLANNING SERVICE EXPANSION PROJECT**  
**PROTOCOLO DEL PROCESO PVFP**  
**(Implementation Process Questionnaire: Management and Supervision)**

NGO: \_\_\_\_\_

El Propósito del documento PROTOCOLO es establecer un entendimiento acerca del proceso del proyecto PVFP.

Las dimensiones representan algunos factores, cuya importancia radica en el proceso de asesoría técnica. Dichos factores nos permiten entender el estilo y ritmo de los cambios introducidos y como coinciden con la ONG en cuestión.

Para los items que a continuación señalamos, le pedimos que usted marque su opinión en relación a la palabra (o frase) que detallamos. El punto de referencia es todo el Proyecto PVFP desde el inicio hasta la fecha.

**1. Los asesores explicaron las razones y los propósitos de los cambios o sugerencias:**

a) Con claridad:

<u>No de acuerdo</u>				<u>Muy de acuerdo</u>	
1	2	3	4	5	6

b) Con detalle suficiente:

1	2	3	4	5	6
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c) Con el tiempo necesario para su implementación:

1	2	3	4	5	6
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d) En el tiempo (época del año/programa) apropiado:

1                      2                      3                      4                      5                      6

**2. Los cambios/sugerencias fueron:**

a. Prácticas

No de acuerdo

Muy de acuerdo

1                      2                      3                      4                      5                      6

b. Realistas

1                      2                      3                      4                      5                      6

c. Reflejaron las necesidades de nuestro programa

1                      2                      3                      4                      5                      6

**3. Los métodos de implementación:**

a. Tomaron en cuenta las características únicas de nuestro programa

1                      2                      3                      4                      5                      6

b. Nuestra agencia mantuvo control del proceso de implementación

1                      2                      3                      4                      5                      6

**4. Nuestra agencia tuvo amplia oportunidad para participar en las decisiones sobre la implementación del Proyecto.**

1                      2                      3                      4                      5                      6

**5. Hoy en día nuestro personal se siente cómodo con los cambios que el Proyecto PVFP ha traído:**

1                      2                      3                      4                      5                      6

**6. No hubo nada sorprendente en relación a los hallazgos de la asesoría, solamente nos confirmaron lo sospechado:**

1

2

3

4

5

6

**THE PROFIT PROJECT**  
**EVALUATION OF**  
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**PRIVATE VOLUNTARY FAMILY PLANNING SERVICE EXPANSION PROJECT**  
**PROTOCOLO PARA PERSONAL OPERATIVO**  
**(Implementation Questionnaire: Base Level Staff)**

El propósito de este Protocolo es el de obtener información sobre los programas de Planificación Familiar de la agencia, desde el punto de vista del personal operativo. Como es de su conocimiento, la agencia esta participando en un proyecto patrocinado por A.I.D., cuyo propósito radica en el fortalecimiento de los componentes, tanto programáticos como los de administración y sistemas. Las preguntas que siguen piden su propia opinión en cuanto a la implementación del Programa.

1. En sus propias palabras, por favor anote las metas del Proyecto.

a. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

d. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

e. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. De las metas anteriormente señaladas; cuáles han sido logradas?

a. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**c.**

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**d.**

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**e.**

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**3. ¿Cuáles no han sido logradas?**

**a.**

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b. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

d. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

e. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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4. **¿Cuál ha sido su rol en el proyecto?**

a. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**b.**

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**c.**

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**d.**

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**THE PROFIT PROJECT**  
**EVALUATION OF**  
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**PRIVATE VOLUNTARY FAMILY PLANNING SERVICE EXPANSION PROJECT**  
**PROTOCOLO DE OBSERVACIONES DEL INGRESO DE CLIENTES DE PF**  
**(Intake Observation Protocol)**

El papel de la observadora es, en una forma discreta, observar y escuchar el comportamiento de las personas quienes atienden las clientes de PF en las oficinas de recepcion. Este incluye el proceso de registracion, entrevista inicial, y la invitacion a la consulta.

La escala de valores (puntaje) es de 1 (muy bajo, negativo) al 5 (muy bien, muy positivo).

**1. Recepcion**

- a. Cordialidad
- b. Cortesia
- c. Respeto
- d. Tranquilidad
- e. Amable

Observaciones: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. Entrevista Inicial**

- a. Con paciencia
- b. Vocabulario usado (evito terminos cientificos)

- c. Hizo sondeos apropiados
- d. Informacion completo y correcto

Observaciones: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. Consejos de PF**

- a. Hizo una explicacion de todos los metodos disponible
- b. Explico alternativas
- c. Dio informacion en cuanto contraindicaciones y posibles efectos secundarios
- d. Le dio tiempo a pensar
- e. Solicito preguntas

Observaciones: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**THE PROFIT PROJECT**  
**EVALUATION OF**  
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**PRIVATE VOLUNTARY FAMILY PLANNING SERVICE EXPANSION PROJECT**  
**PROTOCOLO DE ENTREVISTA DE SALIDA**  
**(Exit Interview Questionnaire)**

NOMBRE DE ONG: \_\_\_\_\_

FECHA: \_\_\_\_\_

NOMBRE ENCUESTADOR: \_\_\_\_\_

PUNTO DE SERVICIO:

CLINICA CENTRAL - SERVICIO DE PF SOLAMENTE

CLINICA CENTRAL - SERVICIO DE PF Y SALUD MATERNO-INFANTIL

POSTA PERMANENTE DE PF

POSTA ROTATIVA DE PF

OTRO (ESPECIFIQUE): \_\_\_\_\_

**Instrucciones:**

Cuando un cliente de PF ha terminado su consulta con el personal de el punto de entrega de servicios (PES), preguntale si estaria dispuesta a responder a unas cuantas preguntas acerca del servicio que ha recibido. Es es esencial que Ud. obtenga su consentimiento antes de empezar la entrevista. Por lo tanto, debera empezar con una Introduccion como lo siguiente.

"Buenas dias/tardes. Me llamo \_\_\_\_\_. Estamos interesados en conocer su opinion acerca del servicio que ha recibido aqui en la clinica/posta. Me gustaria hacerle unas cuanta preguntas acerca de la consulta que acaba de tener con el personal de la clinica y le estaria muy agradecida si Ud. podria dedicar un poco de su tiempo para hablar conmigo.

No voy a anotar su nombre y todo lo que me diga sera estrictamente confidencial. Su participacion es voluntaria y no esta obligada a responder a ninguna pregunta que Ud. no quiera. Me da su permiso para continuar?

Seccion I. Contenido de la consulta.

1. Cual es la razon principal para su consulta acerca de PF hoy?

- a. PF - Primera visita
- b. PF - Reaprovisionamiento de metodo
- c. PF - Control de metodo
- d. PF - Problemas con el metodo
- e. PF - Cambio de metodo
- f. PF - abandono de metodo
- g. PF - Consejeria
- h. PF - Obtencion de metodo
- i. PF - Otra razon: \_\_\_\_\_

2. Tuvo alguna otra razon para su visita de hoy?

- 0. No, ninguna.
- 1. Enfermedad de ella
- 2. Enfermedad del nino
- 3. Enfermedad - otra persona
- 4. Servicio de salud para ninos (imunizaciones, etc)
- 5. Sub-fertilidad
- 6. Otro: \_\_\_\_\_

7. No responde

3. Donde escucho por primera vez acerca de la PF?

0. Esposo/a
1. Pariente
2. Amiga/vecina
3. Partera
4. Promotor/a
5. Medios de Comunicacion masiva
6. No sabe/recuerda/responde

4. Que metodo de PF acepto usar o esta usando actualmente?

0. Ninguno
1. Pildora (no especificada)
2. Progesterona
3. Pildora combinada
4. Condon
5. DIU
6. Inyectable (clase) \_\_\_\_\_
7. Norplant
8. Espermicida
9. PFN (Planifiacion Familiar Natural)
10. Otro \_\_\_\_\_

5. Antes de venir a la consulta, deseaba usar algun otro metodo de PF?

0. No

1. Si - Cual? \_\_\_\_\_

9. No responde/no sabe

6. Para el metodo que acepto usar o esta usando actualmente, el personal de la clinica/posta: (lea cada una de las preguntas y marque la respuesta correcta y marque lo que corresponda)

Pregunta	No	Si	Poco	No Sa be
Le explicon claramente como funciona el metodo?				
Le indicaron como usar el metodo?				
Le hablaron los posibles efectos secundarios?				
Le dijeron que hacer si tuviera los efectos secundarios?				
Le dijeron donde conseguir el metodo?				
Le dijeron si Ud tenia alguna duda o pregunta en cuanto al metodo?				

7. Por favor, Ud podria explicarme como se usa el metodo que acepto o esta usando actualmente?

1. Dio una explicacion completa y correta

2. Dio una explicacion parcial pero correcta

3. Dio una explicacion incorrecta

4. No respondio

8. Durante la consulta el personal de la clinica/posta le hablo sobre otros metodos de PF?

0. No

1. Si

9. No responde

9. Esta dando de mamar actualmente?

0. No

1. Si

9. No responde

**Seccion II. Satisfaccion del Cliente**

10. Durante esta consulta piensa Ud. que ha recibido los servicios de PF que desaba ?

0. No (pase a 19a)

1. Si

2. Parcialmente (pase a 19a)

9. No responde

10a. Por que piensa Ud. que no la han atendido bien?

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**11. Durante esta consulta, el personal de la clínica fue amable?**

**0. No**

**1. Si**

**2. Parcialmente**

**9. No responde**

**12. Durante la consulta, le fue fácil entender al personal que la atendió?**

**0. No**

**1. Si**

**2. Parcialmente**

**9. No responde**

**13. Recomendaría Ud. este servicio de PF a familiares y amigos o le recomendaría servicios de otro lugar?**

**1. Venir aquí (pase a la pregunta 14)**

**2. Ir a otro lugar (pase al #13a)**

**9. No opina**

**13a. Por que?**

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**14. Cuanto tiempo espero desde que llego a esta clinica/posta para ser atendida?**

- 1. Sin esperar**
- 2. Hasta media hora**
- 3. Media hora hasta 1 hora**
- 4. De 1 a 2 horas**
- 5. De 2 a 3 horas**
- 6. Mas de 3 horas**
- 9. No responde**

**15. Piensa que el tiempo de espera fue razonable o muy largo?**

- 1. Razonable**
- 2. Largo**
- 9. No responde/opina**

**16. Por que medio de transporte vino Ud?**

- 1. A pie**
- 2. Carro privado**
- 3. Bicicleta**
- 4. Bus**
- 5. Taxi**
- 9. No responde**

**17. Vino aqui de su casa o de su trabajo?**

- 1. Casa**
- 2. Trabajo**
- 3. Otro lugar**
- 9. No responde**

**17a. Cuanto tiempo le tomo para llegar aqui?**

Indicar el numero en minutos \_\_\_\_\_

**18. Donde vive Ud?**

Nombre de vecindad \_\_\_\_\_

- 1. Mismo zona/distrito de la clinica/posta**
- 2. Fuera de la zona/distrito**
- 3. No responde**

**19. Es esta clinica de PF es la mas cercana a su casa?**

- 0. No (pase a 20)**
- 1. Si**
- 9. No responde**

**20. Por que vino a esta clinica/posta en de ir a la mas cercana?**

- 1. Transporte conveniente**
- 2. Mejores servicios**
- 3. Extension de servicios mas amplios (incluye otros servicios de salud)**

**4. Tuvo otras razones de estar en esta zona (ej. trabajo, compras, etc)**

**5. Anomia**

**6. No responde**

**Comentarios**

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**21. Esta Ud. satisfecho con los servicios de esta clinica/posta de PF?**

**0. Muy insatisfecha**

**1. Insatisfecha**

**2. Satisfecha**

**3. Muy satisfecha**

**4. No responde/opina**

**22. Le dijeron cuando debera retornar a la clinica?**

**0. No (pase a la #24)**

**1. Si (pase a la #23)**

**23. Le dieron alguna informacion por escrito? (Nota: Pida verlo)**

**0. No**

**1. Si (averiguado)**

24. Tiene Ud. alguna sugerencia para mejorar los servicios de PF en esta clinica o posta?

0. No

1. Si

Anota: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Seccion III. Indicadores Socio-economicos**

25. Que edad tiene?

\_\_\_\_\_

0 - No responde

26. Estado civil

1. Soltera (nunca casada)

2. Casada

3. Union libre / Conviviente

4. Separada/divorcada (viva sin companero)

5. Viuda

9. No responde

27. Cuantos hijos vivos tiene?

Total \_\_\_\_\_

27a. Cuantos son hombres/ Cuantas son mujeres?

Mujeres: \_\_\_\_\_

Hombres: \_\_\_\_\_

28. Quisiera tener mas hijos?

0. No (pase a la #29)

1. Si (Cuantos mas) \_\_\_\_\_ (pase a la #28a)

9. No responde

28a. Cuando quisiera tener su proximo hijo?

1. Menos de 12 meses

2. 12 a 24 meses

3. 25 a 36 meses

4. 37 o mas meses

9. No responde/no sabe/no opina

29. Sabe Ud. leer y/o escribir

1. No

2. Si

30. Cual es el ultimo nivel escolar que aprobo?

0. Ningun nivel

1. Primaria incompleta

2. Primaria completa

3. Secundaria incompleta
  4. Secundaria completa
  5. Universidad incompleta
  6. Universidad completa
  9. No responde
31. Puede leer y entender una carta o periodico facilmente, con dificultad, o nada en absoluto?
0. Nada
  1. Con dificultad
  2. Facilmente
  9. No Responde/contesta
32. Cual es su principal actividad economica?
1. Ama de casa
  2. Empleada de hogar
  3. Trabajadora fabrica
  4. Propio negocio (pequena escala)
  5. Oficinista
  6. Profesional
  7. Otro \_\_\_\_\_
  9. No responde

**33. A que escuela asiste su hijos/hijas?**

**1. Publica**

**2. Privada**

**3. No asiste por edad joven**

**4. No asiste (edad escolar)**

**8. No se aplica (hijo vive con otras personas y los padres no costean la educacion)**

**9. No responde**

## **APPENDIX IV**

### **Summary of Management Questionnaire Results**

#### **I. LOGROS EN PVFP PROFAMILIA**

- . **Confianza de la población en la institución por la calidad de los servicios que ofrece.**
- . **Confianza de los organismos públicos y privados en proyectos con la institución por la presentación de una óptica realista acerca de la conveniencia de instalar en el centro de trabajo, programas de planificación familiar.**
- . **Prestigio y confianza institucional a nivel nacional a través del reconocimiento de las autoridades a la labor de profamilia, con la firma de convenios y solicitud de apoyo en P.F., atención primaria de salud y educación.**
- . **Innovación en el área administrativa a través de un nuevo sistema que realizó cambios satisfactorios que redundó en beneficio de cada unidad y persona de la institución.**
- . **Mecanización integral del sistema estadístico a través de control y manejo de la base de datos.**
- . **Mejorar en la generación de ingresos (para 91 se logró por ingresos propios 14% y en el 92 el 34%)**
- . **Incremento de la producción de APPS del 92 a la fecha**
- . **Optimización del uso de métodos de larga duración (AQV Y DIU)**
- . **Estilo de dirección participativa (horizontal dentro de la institución permitiendo verificar y ordenar los lineamientos para repercutirlos en el accionar de la institución.**
- . **Reuniones constantes con el personal realizando la comunicación abierta y explícita que le permita tomar decisiones acertadas.**

#### **II. DIFICULTADES EN PVFP**

- . **La disminución de los aportes financieros de las entidades donantes debido a la recesión.**

- . Retraso de 15 a 22 días en la entrega de fondos por parte de PRISMA y limitaciones con el manejo de las adquisiciones que no están presupuestadas a pesar de que van en beneficio de las actividades del proyecto.
- . Imposibilidad de remuneraciones adecuadas para el personal
- . Constantes amenazas a la integridad física por parte del terrorismo que limita la promoción de servicios.
- . Los reportes financieros no deben ser mensuales sino trimestrales, ya que su elaboración impide atender actividades que también son prioritarias.
- . Limitaciones en Asesoría Técnica pues para obtener una debe ser necesidad de todas las ONGS sin considerar la particularidad de cada una de ellas.
- . La corta periodicidad de los proyectos que cuentan con apoyo financiero.
- . Carencia de apoyo en equipos (medicinas, camionetas y otros suministros ) ejemplo: guantes quirúrgicos, equipos médicos modernos).

### III. COMPONENTES QUE MAS SE APLICAN EN PVFP

- . Mejoramiento de la disponibilidad de métodos de larga duración (cambio de actividades de DCA a servicios médico comunitario)
- . Fortalecimiento de la capacidad de la institución en Ser. de P.F. (aumento de los servicios con permanente capacitación del personal)
- . El sistema de información se ha adecuado a las necesidades de la institución.
- . Incorporación de sistemas computarizados como FP control para una información real y precisa del desarrollo operativo.
- . Las capacitaciones con apoyo de PRISMA dirigido al personal administrativo y operativo de la institución, mejorando la capacidad de las personas en beneficio del desarrollo de sus actividades.
- . Apoyo de PRISMA en actividades de IEC para fortificar servicios de imagen institucional, comprobándose la mejora en promoción, y difusión, lográndose la aceptación de la población a la que sirve.

#### **IV. COMPONENTES QUE MENOS SE APLICAN EN PVFP**

- . Proyecto de autosostenimiento institucional, hasta la fecha se han venido realizando conversatorios que no se han concretado.

#### **V. COMPONENTES QUE NO HAN SIDO PLENAMENTE IMPLEMENTADOS EN PVFP**

- . El sistema gerencial de las APF'S para una buena toma de decisiones
- . La implementación de un sistema de costos que permita fijar precios y medir la rentabilidad.
- . Implementación de un buen sistema logístico ya que no existe un control adecuado de los almacenes intermedios y sus usuarios, lo que hace que la información llegue incompleta y con diferencias.
- . Implementación de equipos medicos modernos y de oficina en las clínicas de AQV.
- . Implementación de una clínica de partos, necesaria para obtener una mayor cantidad de usuarias en AQV.
- . Preparación de una campaña de motivación para la utilización de la vasectomia que permita captar nuevos pacientes.

#### **VI. AUTOSUFICIENCIA FINANCIERA**

- . Creación de condiciones que permitan a través de sus estructuras operativas, generar recursos propios que les permita seguir dando servicios de alta calidad a la población sin depender de las entidades donantes.

#### **VII. PORCENTAJE DE INGRESOS DE FUENTES NO DONANTES**

- . GESTION 92 aproximadamente desde el 34% al 43 %
- . GESTION 93 aproximadamente desde el 34% al 43 %

## **VIII. IMPEDIMENTOS PARA AUTOSUFICIENCIA FINANCIERA**

- . Falta de inversión en proyectos que generen rentabilidad por los bajos costos de los servicios que se prestan a la comunidad.
- . Falta de locales propios ( el costo del rubro de alquileres es elevado y el pago se efectúa en dólares)
- . Contar con apoyo solo para proyectos de PF impidiendo mayor desarrollo institucional y la atención en servicios integrales de salud familiar.
- . Falta de donaciones en equipos médicos modernos y medios de transporte, ocasionado porque la economía peruana se encuentra en recesión y no hay respuestas favorables a los pedidos de fondos éstos rubros .
- . La poca capacidad adquisitiva de los pobladores de las zonas marginales donde se brindan los servicios.

## **IX. ACCIONES/PROYECTOS QUE FACILITAN LA AUTOSUFICIENCIA FINANCIERA**

- . Han logrado la implementación de un laboratorio central de análisis clínico que permite generar recursos, satisfaciendo la demanda interna. Actualmente se vende el servicio a terceros.
- . Implementación del sistema de "ASOCIACION" en los 4 módulos de salud realizado a través de convenios con los médicos en base a un porcentaje de participación por consulta médica, logrando así mejorar los ingresos.
- . Ampliación de los horarios de atención que se dan actualmente en 3 turnos (mañana, tarde y noche) incluyendo los domingos.
- . Se ofertan charlas educativas de PF. y Salud Familiar a empresas públicas y privadas percibiendo retribución por los servicios.
- . Se brinda servicios de fotocopias y mimeógrafo
- . La implementación de una clínica urbana en el distrito de Surquillo, estratégicamente ubicada para la captación de pacientes manteniendo costos más elevados de consulta y atención.
- . Implementación de la clínica de AQV con la finalidad de extender sus servicios a otro tipo de intervenciones quirúrgicas.

- . **Se están realizando esfuerzos para obtener recursos para la compra de una clínica rodante con rayos X a fin de ofrecer atención médica en los centros laborales, en donde su personal pierde mucho tiempo en tener que ausentarse del trabajo para someterse a un examen médico.**
- . **Lograr implementar con equipos adicionales y modernos al laboratorio de análisis clínicos ya que actualmente tienen demanda en servicios de análisis clínicos (PAP, despistaje de cancer, afecciones ginecológicas y urinarias, etc.)**
- . **Implementación futura de una farmacia en el cono sur en apoyo a los servicios médicos y a la población con venta de medicamentos a menos costo que en las farmacias comerciales que generen un ingreso rentable.**

#### **X. ASESORIA TECNICA PARA LA AUTOSUFICIENCIA FINANCIERA**

- . **Visitas a ONG'S de países vecinos, que actualmente están logrando la autosuficiencia financiera (ejemplo: Profamilia de Colombia, Cemoplaf de Ecuador).**
- . **Capacitar a Directores o encargados del manejo financiero en cursos regulares de administración financiera de clínicas e instituciones que garanticen su aprendizaje, contando así con profesionales altamente calificados en autosuficiencia financiera.**
- . **Introducir cursos de mercadotecnia y estudios de prefactibilidad de proyectos con la finalidad de ir cambiando la mentalidad del personal. Implementación de un programa de costos basados en un estudio de costos standares y personal para su ejecución (es necesario contar con los costos a fin de medir la rentabilidad, fijación de precios para una buena toma de decisiones**

## **LOGROS DE APROSAMI**

### **I. LOGROS EN PVFP**

- . **Fortalecimiento administrativo ya que actualmente cuentan con información oportuna y veraz.**
- . **Fortalecimiento contable actualizando permanentemente el estado de los ingresos y egresos.**
- . **Concientización del personal para lograr un autosuficiencia Financiera.**
- . **Capacitación en planeamiento estratégico a nivel de comité técnico.**
- . **Implementación de Software de estadística de servicios sistematizando el reporte de actividades**
- . **Reconocimiento público y privado de la calidad el servicio que ofrecen.**
- . **Consolidación financiera de la institución ya que cuentan con patrimonio que respalda a la organización.**

### **II. DIFICULTADES PARA LOGRAR OBJETIVOS EN PVFP**

- . **Apoyo económico insuficiente debido al recorte de las donaciones**
- . **Dependencia económica de las entidades donantes que recorta la capacidad de acción y dirección.**
- . **Influencia de otras ONG'S que alteran la programación de actividades, afectando el logro de los objetivos propios de la institución.**
- . **Falta de subsidio para las intervenciones de AQV (la población que se atiende no puede cubrir sus costos)**
- . **Desactivación del programa DCA, dejándose de trabajar con promotoras indentificadas con la institución**

### **III. COMPONENTES DE PVFP QUE MAS SE APLICAN**

- . **Reforzamiento administrativo con la consecuente mejora en las actividades gerenciales del programa y de sus unidades operativas.**

#### **IV. COMPONENTES DE PVFP QUE MENOS SE APLICAN**

- . **Desarrollo institucional ya que requiere de apoyo a mediano plazo con programas de adquisición de activos y nuevas inversiones.**

#### **V. COMPONENTES DE PVFP QUE NO HAN SIDO IMPLEMENTADOS**

- . **Desarrollo de nuevos proyectos para cubrir la falta de recursos económicos**

#### **VI. AUTOSUFICIENCIA FINANCIERA**

- . **Lograr un nivel de ingresos adecuado que permita el desarrollo de actividades regulares, manteniendo un nivel de rentabilidad que permita un crecimiento sostenido.**
- ojo: Solicitan cambio de nombre por "RECUPERACION DE COSTOS", ya que la autosuficiencia es una utopía.**

#### **VII. INGRESOS ANUALES DE FUENTES NO DONANTES**

- . **GESTION 92 entre 18% a 28 %**
- . **GESTION 93 entre 25% a 30 %**

#### **VIII. IMPEDIMENTOS PARA AUTOSUFICIENCIA FINANCIERA**

- . **Falta de capital de inversión por los bajos costos de los servicios que se dan a la población.**
- . **Tipo de población que se atiende en la ONG, que carece de nivel educativo y pertenece a una clase social de escasos recursos económicos y de salud.**
- . **Las limitaciones de ayuda internacional que no permite desarrollar proyectos de inversión con financiamiento a mediano y largo plazo.**
- . **Contar con personal no capacitado para asumir el cambio.**

## **IX. ACCIONES PARA LOGRAR EL CAMBIO**

- . **Búsqueda de zonas de trabajo con una población adecuada que permita captar mayor cantidad de pacientes.**
- . **Política de incentivos económicos que permita mayor producción de los servicios y elevar el nivel de ingresos económicos**
- . **Mejorar la capacidad instalada de la clínica central generando mayores ingresos propios.**
- . **Instalación de postas fijas que a mediano plazo se conviertan en clínicas.**

## **X. ASESORIA TECNICA PARA LOGRAR AUTOSUFICIENCIA FINANCIERA**

- . **Asesoramiento en proyectos de desarrollo e inversión para permitir a la institución mayor soporte económico y financiero.**
- . **Capacitación al personal intermedio en el estudio de mercado y ventas.**

## **LOGROS DE CENPROF**

### **I. LOGROS EN PVFP**

- . **Aceptación de la población de los métodos de larga duración y/o permanentes facilitándose al usuario la adquisición de sus medicamentos (anestésicos) para su atención en cirugía a bajo costo**
- . **Identificación de la población con la institución**
- . **Incremento del uso de DIU'S en las postas comunitarias por los bajos costos de inserción**
- . **Mayor captación de usuarios de MAC'S en ferias locales de zonas rurales ofertando bajos precios por el servicio.**
- . **Diversificación en los servicios de consultorios externos, funciona como anzuelo para la captación de nuevos usuarios de PF dejando un margen de ganancia.**
- . **La implementación de servicios de clínica para internamiento e intervenciones quirúrgicas (AQV)**
- . **Identificación del personal con la institución**
- . **Lograr que las gestantes acudan al control de embarazo por ser probables usuarias de MAC'S de larga duración**

### **II. DIFICULTADES PARA LOGRAR OBJETIVOS EN PVFP**

- . **La actual crisis económica que atravieza el país, con la consecuente pérdida de poder adquisitivo de la población**
- . **El bajo nivel educativo de la población y su desconocimiento del uso de MAC'S y su accesibilidad.**
- . **La ideosincracia del pueblo y la idea de machismo que tiene el hombre peruano.**
- . **Escasos recursos económicos de la población a la que se brinda servicios y la actual recesión que afronta el país.**
- . **Falta de incentivos económicos al personal de la ONG , así como su capacitación profesional que no es permanente.**

- . No se cuentan con capitales que permitan inversiones que generen rentabilidad.
- . Falta de equipos como videos , mimeógrafo, laparoscopio con los que se puede obtener mayores recursos por menos servicios
- . Falta de ayuda oportuna para el logro de las metas
- . Falta de comunicación entre agencia o instituciones que permita conocer los cambios en el manejo contable del programa.
- . Falta de información del sistema tributario ya que no existe un consenso de las ONG'S a nivel nacional.
- . Las dificultades y restricciones económicas para lograr mayor difusión y educar a la población en Planificación Familiar.
- . El retraso con el que se reciben los métodos anticonceptivos.

### **III. COMPONENTES QUE SE APLICAN AL PROGRAMA DE PVFP**

- . Los métodos de larga duración y/o permanentes por ser más seguros y contar con personal médico calificado.
- . Mantener los servicios de la clínica ya que es un lugar de afluencia de pacientes.
- . Se proyectan a poblaciones urbano marginales jóvenes
- . Investigación aplicada que permite conocer problemas y resolverlos mejorando la calidad del servicio
- . Utilización de metodos físicos: espumas, jaleas, píldoras y condones por tener bajos costos y de fácil uso.
- . La difusión del uso de PF.
- . La utilización de programas educativos de salud reproductiva y PF. mejorando el criterio de la población sobre los MAC
- . Utilización frecuente de los servicios de consejería y orientación manteniendo informado al usuario.

- . La colaboración de promotores voluntarios que son los que convencen a las personas en edad fértil para que utilicen MAC. Esta acción es monitoreada por los supervisores de campo.
- . Mantener chequeadas las estadísticas del servicio

#### **IV. COMPONENTES QUE MENOS SE APLICAN EN PVFP**

- . La vasectomía
- . El Norplant por la poca difusión del método
- . Utilización de los medios de comunicación masiva por representar un costo muy elevado para la institución.

#### **V. COMPONENTES QUE NO HAN SIDO IMPLEMENTADOS**

- . Uso de hormonas inyectables
- . Los métodos naturales
- . Programas de orientación dirigidos exclusivamente al hombre, tratando de lograr la elección por pareja.
- . Material audiovisual variado para las charlas a la comunidad
- . Programas de información computarizado que permita facilitar el procesamiento de los datos.

#### **VI. AUTOSUFICIENCIA FINANCIERA**

- . Utilización de recursos generados por la institución para solventar gastos sin depender de donaciones .
- . Utilización de programas que permita generar recursos propios y mantener el servicio a la comunidad.

## **VII. PROPORCION DE INGRESOS ANUALES DE FUENTES NO DONANTES**

- . **GESTION 92** entre 19 % y 27 %
- . **GESTION 93** entre 21 % y 50 %

## **VIII. IMPEDIMENTOS PARA LOGRAR AUTOSUFICIENCIA FINANCIERA**

- . **La recesión económica y la pérdida de poder adquisitivo.** Actualmente los usuarios no tienen para cubrir sus necesidades y mucho menos asistir a un centro de salud.
- . **Altos costos institucionales por los servicios que se brindan a la comunidad**
- . **La dedicación exclusiva a programas de Pf dificultando la diversificación en el trabajo y producir nuevas fuentes de ingreso.**
- . **El alto índice de desempleo que existe en el país.**

## **IX. ACCIONES PARA LA AUTOSUFICIENCIA FINANCIERA**

- . **Se han realizado estudios para disminuir los costos, es decir los componentes de costos a variables aumentando la productividad**
- . **A través de la clínica se brinda servicios integrales de salud en zonas populosas (urbano-marginales, mercados, instituciones privadas y públicas, etc.)**
- . **Ampliación de los servicios externos de consultorio (ginecología-obstetricia, odontología, urología, medicina general, pediatría, etc.)**
- . **Ampliación de servicios intermedios como farmacia, laboratorio a fin de captar recursos.**
- . **Proyección a empresas privadas para atenciones de consultorio de salud y planificación familiar.**
- . **Creación de postas periféricas a costos bajos que generan ingresos y donde el médico gana por paciente atendido.**
- . **Elaboración de programas educativos que generan ingresos al ser ofertados.**

## **X. ASESORIA TECNICA PARA LOGRAR AUTOSUFICIENCIA FINANCIERA**

- . **Capacitación técnica para lograr autosuficiencia financiera**
- . **Capacitación a responsables de cada área en planeamiento y estrategia empresarial**
- . **En estudio de mercado, factibilidad y costos**
- . **Para implementación de servicios en la clínica**
- . **Para mejorar el IEC**
- . **Asesoramiento para el adecuado uso de los recursos disponibles**
- . **Asesoramiento financiero.**

## **LOGROS PLANIFAM**

### **I. LOGROS EN PVFP**

- . **Coordinaciones Inter-institucionales de actividades de PF en la Región Inca, logrando la unificación de criterios, zonificación de ambitos de trabajo logrando participación en diversas actividades, evitando la duplicidad de funciones.**
- . **Capacitación del personal operativo e PF. garantizando una prestación de servicios de alta calidad**
- . **Agilización de un Sistema computarizado logrando la obtención de datos contables, así como estadísticos y logísticos para una buena toma de decisiones gerenciales oportuna, inmediata**
- . **Prevalencia de métodos de larga duración y/o definitivos garantizando la entrega de servicios seguros y definitivos a bajos costos**
- . **Apertura de la posta de Quillabamba para incrementar recursos propios.**

### **II. DIFICULTADES PARA EL LOGRO DE OBJETIVOS EN PVFP**

- . **Presupuestos insuficientes, que se utilizan mayormente en el pago de remuneraciones al personal (80%).**
- . **Equipamiento limitado y deteriorado que limita la calidad del servicio que brindan**
- . **Limitada captación de recursos propios ocasionada por la recesión que actualmente afronta el país.**
- . **Falta de local propio que impide hacer ampliaciones y mejoras para diversificar los servicios, así como gastos elevados de pago de alquiler.**

### **III. COMPONENTES DE PVFP QUE MAS SE APLICAN**

- . **Planificación Familiar por ser la razón del servicio**
- . **Salud Materno-Infantil, porque permite atraer usuarias de PF.**

- . **Laboratorio Clínico, que actualmente provee de recursos propios a la institución siendo un complemento de los servicios de salud materno infantil y de Planificación familiar.**
- . **Comercialización de medicamentos que se ofertan a costos bajos y las facilidades que se brinda al cliente.**
- . **Aplicación de métodos de larga duración son seguros y dan APP'S**
- . **Brindar caalidad humana en la atención a las familias más pobres**

#### **IV. COMPONENTES QUE MENOS SE APLICAN APVFP**

- . **Ausencia de un sistema mecanizado que sea útil para un seguimiento de usuarios.**
- . **Asesoría para política de precios y éstos sean más competitivos en el mercado.**
- . **Estudio de mercado para un mejor conocimiento de los servicios que la población necesita evaluando costos y rentabilidad**
- . **Mejorar sistema de FPCONTRO y de costos por que determinan la evaluación del rubro existencias y determinación de costos que sean herramientas útiles en la toma de decisiones a nivel gerencial.**

#### **V. COMPONENTES QUE NO HAN SIDO IMPLEMENTADOS**

- . **Proyecto de Planificación Familiar corto por que no permite un manejo directo de logística con contabilidad en cuanto a información de costos**
- . **Diseños de planes estratégicos**
- . **Políticas de inversión que coadyuva lograr metas y autosostenimiento**
- . **Análisis de costos de cada uno de los servicios para determinar cuales son los que generan mayores ingresos**
- . **Política de precios acorde con la realidad**

## **VI. AUTOSUFICIENCIA FINANCIERA**

- . **Es el logro de la institución para llegar a ser empresa generando sus ingresos para poder cubrir los gastos, compitiendo en el mercado que le permita obtener utilidades para su propia reinversión.**

## **VII. PROPORCION DE INGRESOS ANUALES DE FUENTES NO DONANTES**

- . **GESTION 92 entre 18% a 22%**
- . **GESTION 93 entre 23% a 35%**

## **VIII. IMPEDIMENTOS PARA LA AUTOSUFICIENCIA FINANCIERA**

- . **Recorte presupuestal de fondos provenientes de donaciones impidiendo realizar inversiones que generen rentabilidad**
- . **Falta de estudios sobre proyectos de factibilidad y/o inversión ya que los intentos de asesoría han sido superficiales.**
- . **Falta de orientación y asesoría para lograr la autosuficiencia financiera. La institución no cuenta con capacidad económica para contratar consultores en la materia y la institución donante ya no prevee este tipo de gasto.**
- . **Limitaciones al no ofrecer servicios de salud con equipamiento adecuado.**
- . **Falta de inversión en equipos como un ecógrafo, implementación de una sala quirúrgica.**

## **IX. ACCIONES PARA LOGRAR AUTOSUFICIENCIA FINANCIERA**

- . **Implementación de un laboratorio clínico**
- . **Establecimiento de la venta de medicamentos**
- . **Personal operativo con el sistema de destajo que permite reducir costos**
- . **Jornadas de salud con un sistema itinerante de servicios básicos de salud permitiendo la promoción de los servicios.**
- . **Fortalecimiento del área de IEC buscando la promoción dentro de la comunidad.**

## **X. ASESORIA TECNICA PARA LA AUTOSUFICIENCIA FINANCIERA**

- . En finanzas e inversiones que permitan conocer proyectos de inversion factibles y realizables en la localidad**
- . Para la determinación de costos para cada uno de los servicios, conocer el margen de pérdida o ganancia para la toma de decisiones**
- . Políticas de inversión en servicios que generen mayores ingresos**
- . Intercambio de experiencias con profesionales de la salud y administración para el fortalecimiento de conocimientos técnicos y profesionales.**
- . Capacitación al personal de salud y administración para mantenerse permanentemente actualizados y mejorar los servicios y políticas de admistración.**

## **LOGROS INPPARES**

### **I. LOGROS EN PVFP**

- . **Apoyo a programas comunitarios urbano-marginales de Lima (clínicas), zonas de baja prevalencia de usos de MAC.**
- . **Apoyo económico para desarrollar las clínicas comunitarias, fortaleciendo la estrategia de INPPARES de mejorar el servicio de métodos de larga duración (DIU, Norplant, vasectomía)**
- . **Reforzamiento de áreas de información, educación y capacitación , tendiendo al mejoramiento de la calidad de los servicios a través de las coordinaciones con los comités institucionales.**
- . **Apoyo en la entrega de suministros de anticonceptivos y equipo médico, permitiendo el desarrollo de los programas y el equipo e instrumental médico para mejorar la calidad de la entrega de servicios.**
- . **Capacitación al personal para la entrega de servicios.**

### **II. DIFICULTADES PARA LOGROS EN PVFP**

- . **Falta de entrega oportuna de los anticonceptivos, dificultando la distribución a los diversos programas.**
- . **Falta de apoyo al sistema de ACPF en la base -Promotoras- porque del trabajo en la comunidad va a derivar los potenciales usuarios de métodos de larga duración.**
- . **La aplicación de métodos de caja en cuanto a los gastos no concuerdan con los principios contables generalmente aceptados.**
- . **La implementación de informes con detalles especiales obliga a duplicar el procesamiento de las operaciones en su sistema de computo.**

### **III. COMPONENTES DE PVFP QUE MAS SE APLICAN**

- . **Apoyo al programa de servicios clínicos de Lima (clínicas comunitarias y postas)**

- . **Apoyo al programa de IEC y capacitación porque mejora la calidad de la entrega del servicio**
- . **Coordinación con los comités de IEC y Capacitación**
- . **Apoyo al reforzamiento institucional mejorando la capacidad**

#### **IV. COMPONENTES QUE MENOS SE APLICAN**

- . **Rigidez en los controles económicos financieros (para el apoyo que da PRISMA las exigencias son rígidas y absorbente).**
- . **Sistema de inversiones prácticas, auditorías mensuales de documento por documento.**

#### **V. COMPONENTES NO IMPLEMENTADOS AL PROGRAMA DE PVFP**

- . **Falta de coordinación con otras instituciones privadas y públicas convenientes para aunar esfuerzos y sopesar acciones.**
- . **Sistema de costos por proyectos necesario para determinar costo beneficio.**
- . **Sistemas mecanizado para la información por de INPPARES más compleja de otras ONG que están efectuando programas especiales**
- . **El estudio de costos ya que no se tiene presupuesto para un empleado a tiempo completo que se ocupe de mantener información actualizada.**

#### **VI. AUTOSUFICIENCIA FINANCIERA**

- . **Poner en práctica planes concretos para aumentar progresivamente el nivel de recuperación de costos, incentivar las actividades que tengan posibilidades de generar recursos para apoyar otras que son necesarias pero no productivas.**

#### **VII. PROPORCION DE INGRESOS ANUALES DE FUENTES NO DONANTES**

- . **GESTION 92 35%**
- . **GESTION 93 42%**

## **VIII. IMPEDIMENTOS PARA EL LOGRO DE LA AUTOSUFICIENCIA FINANCIERA**

- . **Situación económica del país con una gran depresión e índices altos de inflación (la población cada vez se hace más pobre)**
- . **Población urbano marginal cada vez más empobrecida (falta de poder adquisitivo)**
- . **Ampliación de los programas del sector público que trabaja en zonas urbano marginales con distribución gratuita de MAC'S**

## **IX. ACCIONES PARA LOGRAR AUTOSUFICIENCIA**

- . **Aumento discreto de tarifas de atención**
- . **Diversificación de los servicios para mayor captación de clientes y de ingresos.**
- . **Compartir costos de algunos proyectos con las municipalidades disminuyendo los gastos de INPPARES y de los donantes**
- . **Estimular proyectos de generación de recursos**

## **X. TECNICAS DE ASESORAMIENTO PARA LOGRAR AUTOSOSTENIMIENTO**

- . **Curso de sistematización de costos, facilita determinar costos por proyectos y mejorar los sistemas que tienen.**
- . **Estudio de mercado para facilitar la programación de PF**
- . **Desarrollo de recursos diferentes a los de PF.**
- . **Reforzamiento administrativo gerencial.**

## **LOGROS ATLF**

### **I. LOGROS EN PVFP**

- . **Mantener el lugar y el espacio que le corresponde a la planificación natural.**
- . **Haber mejorado la calidad del servicio de PFN**
- . **Respeto institucional, seriedad, profesionalismo, mística de sus técnicos, los servicios educativos, aval de la iglesia y espacio logrado**
- . **Reconocimiento valido del trabajo que realizan .**
- . **Reconocimiento de Prevalencia de Métodos Naturales por el INEI.**

### **II. DIFICULTADES PARA LOGROS EN PVFP**

- . **Falta de conocimiento de los moradores de PFN**
- . **Disminución del presupuesto**
- . **Falta de una política que conduzca a la autogestión**
- . **Ningún apoyo en partidas presupuetales de bienes y servicios**

### **III. COMPONENTES QUE MAS SE APLICAN PVFP**

- . **Contabilidad computarizada**
- . **Información, Educación y comunicación**

### **IV. COMPONENTES QUE SE APLICAN MENOS EN PVFP**

- . **Estadístico, no se ha encontrado un programa que se identifique con los objetivos y metas del programa**
- . **Análisis de producción de actividades**
- . **Logístico (no se cuenta con apoyo para bienes y servicios)**

- . **Búsqueda de elementos que apoyen la autogestión, el único interés está centrado en el cumplimiento de metas, sin proyectarse al futuro sobre la estabilidad de la ONG ATLF.**

#### **V. COMPONENTES NO IMPLEMENTADOS EN PVFP**

- . **Apoyo logístico para el centro medico ATLF, el único interés está centrado en la captación de usuarias.**

#### **VI. AUTOSUFICIENCIA FINANCIERA**

- . **Capacidad institucional para generar recursos propios de una manera disciplinada, eficiente y sostenida en el tiempo, que permita gradualmente cumplir metas y objetivos y proyectarnos en el tiempo espacio con mejores planes de desarrollo.**

#### **VII. PROPORCION DE INGRESOS DE FUENTES NO DONANTES**

- . **GESTION 92 40%**
- . **GESTION 93 50%**

#### **VIII. IMPEDIMENTOS PARA LOGRAR AUTOSUFICIENCIA FINANCIERA**

- . **Falta de asesoría para un buen manejo administrativo**
- . **Falta de recursos para invertir en equipos y propaganda**
- . **Falta de un estudio de mercado entre ONG'S, ya que otras también brindan éstos servicios creando una competencia estéril.**

#### **IX. ACCIONES PARA LOGRAR AUTOSUFICIENCIA**

- . **Centro médico ATLF con diversidad de servicios ofertados a costos accesibles de acuerdo a la zona de trabajo.**
- . **Ofrecimiento de los servicios a empresas privadas para cubrir problemas de salud de sus clientes y/o trabajadores.**
- . **Se ofertan servicios de educación y capacitación a las empresas**

**X . ASESORIA TECNICA NECESARIA PARA LA AUTOSUFICIENCIA FINANCIERA**

- . **Técnico administrativa para el manejo computarizado del centro médico ATLF**
- . **Marketing para vender imagen del centro médico a la comunidad y organizaciones públicas y privadas.**
- . **Crear sistemas de préstamos financieros para facilitar la compra de equipos y/o ampliación de infraestructura.**
- . **Crear un banco de ideas entre las ONG'S para mejorar la calidad de los servicios**

## **APPENDIX V**

### **Summary of Intake Observation Protocols**

#### **PLANIFAM (CUZCO)**

##### **OBSERVACIONES DE INGRESO**

La clínica presta servicios en el local de una vivienda de 2 pisos acondicionada para recepcionar y atender a los pacientes.

El ambiente destinado a la recepción de los clientes está unido a la sala de espera y dividido por una tabiquería de madera de la consejería lo que permite apreciar que no existe una adecuada privacidad en cuanto a la atención que se brinda al paciente.

En cuanto a las entrevistas iniciales con los clientes de la clínica ésta se realiza de manera adecuada dándole confianza y seguridad.

No se pudo observar propiamente una consejería, pero en la recepción la srta. encargada de la atención trata de dar información sobre los métodos de P.F., aunque en la mayoría de los casos tiene que interrumpir la conversación por la llegada de nuevos clientes que tiene que atender.

Las dos observaciones de ingreso se refirieron a una cliente continuadora del método (DIU) y a una joven pareja que de alguna forma recibió información sobre los métodos anticonceptivos, exceptuando la explicación de la ligadura de trompas y la vasectomía, tal vez por la edad de la pareja. Asimismo se advirtió que en los ambientes de recepción, espera, consejería y consultorio existen afiches, rotafolios y folletos de Planificación Familiar que en la mayoría de los casos no son usados para la información y lograr así un mayor entendimiento por parte del cliente.

#### **JORNADA DEL MERCADO DE WANCHAQ**

Esta actividad estuvo dirigida a las personas que trabajan en el mercado Wanchaq, y a los vecinos del lugar. La intención de captar nuevos clientes de P.F. y de Servicios integrales de salud que la Clínica Central de PLANIFAM está brindando actualmente es muy positiva, pero se ve afectada en sus metas y logros porque el ambiente donde se recepcionó y atendió a los pacientes no contaba con una adecuada infraestructura y era muy notorio la falta de instrumental médico requerido para consultas de ginecología, pediatría, medicina general, así como la ausencia de un equipo de esterilización de instrumental médico y muebles que permitan dar comodidad tanto al paciente como al médico proveedor del servicio.

Asimismo no se contaba con el servicio higiénico indispensable (sin agua, sin desagüe y luz). Hay que resaltar el hecho de que el nivel educativo de éste sector de la población es muy bajo y que sus condiciones de vida son de extrema pobreza, ya que en algunos casos no se pudo efectuar el examen de pap debido a la falta de medios económicos ( S/. 3.00 era el costo).

El médico que atendió durante esta jornada dió muestras de una gran identificación con las pacientes que atendía, ya que hacía grandes esfuerzos para ser entendido en las indicaciones que daba y en algunos casos conversó en Quechua con las pacientes.

El hecho de tener más de 20 personas en espera de ser atendidos en un tiempo relativamente corto no ayudó en nada a la interacción médico paciente ya que la consulta no podía durar más de 10' (minutos) por persona. Asimismo se apreció el hecho de que constantemente se ocasionaba desorden en la espera de los pacientes para ser atendidos a pesar de los esfuerzos que realizaban las personas encargadas de la recepción y cobro de los costos del servicio.

Al final de cada consulta se entregaba al paciente una invitación a visitar la clínica central, con un detalle breve de los servicios que brindan y con la dirección del local.

Un pedido general del público usuario de éstos servicios fué de que éstas jornadas se realicen con más frecuencia (cada dos o tres meses) y que se dé la publicidad necesaria para enterar a la población de localidades vecinas.

#### POSTA FIJA DE TTIO

Local igualmente pequeño, que brinda comodidad e higiene a los pacientes de ésta localidad. La recepción y la sala de espera están juntos y se encuentra dividido del consultorio por una tabiquería de madera. Les está haciendo falta un equipo de esterilización de materiales médicos, equipo de oficina (sillas, escritorios, mesas, etc.) así como las instalaciones de servicios de agua y desagüe.

Desde un primer momento se pudo notar que el personal que da servicios en éste local es muy conocido y respetado por los pobladores de ésta localidad.

Se observaron dos consultas, una de ellas demandó una atención aproximadamente de 30' por ser un caso especial (presencia de miomas en el útero) y encontrarse la paciente en un estado muy nervioso. La obstetriz que la atendió fué muy paciente y minuciosa, tratando de prestarle ayuda social y económica al ofrecerle servicios a muy bajos costos por encontrarse actualmente el esposo de la paciente sin empleo.

El segundo caso trató de una paciente que cambió de método, usaba inyectables y para mayor seguridad decidió usar el DIU, que le fué colocado luego de una explicación más o menos amplia sobre como funciona el método y de sus posibles efectos secundarios, también se le

dió una explicación de la importancia que tiene para la salud de la mujer el examen de Pap, pues permite realizar un despistaje de cáncer al cuello del útero.

#### **POSTA FIJA DE CHINCHERO**

Local ubicado a 45' de la ciudad del Cuzco, es muy confortable, limpio ofreciendo comodidad y privacidad al paciente .

Se observó que tienen en buen estado un proyector de película que lo utilizan para documentar a sus pacientes sobre todos los métodos de planificación familiar que existen. El trato que reciben los pacientes se puede calificar de bueno, empezando porque los encargados de la posta hablan Quechua y conocen en su mayoría a los pobladores de ésta localidad. El profesional médico atendió a una usuaria de DIU que después de un año venía al control del método por sospechas de embarazo.

El profesional aprovechó ésta circunstancia para recalcar a la paciente la importancia de un control debido en las fechas señaladas y lo indispensable que es el examen Pap. También le hablo sobre la probabilidad de la esterilización femenina y masculina.

Entrevistada la paciente manifestó que las mujeres de Chincheros tenían mucho temor de usar MAC porque la iglesia después les negaba todo tipo de ayuda económica (alimentos, ropa y medicinas) y que algunos conocidos de ella sentían vergüenza con el Dr. que era del lugar.

#### **CENPROF-TRUJILLO**

##### **POSTA FIJA DE WINCHAZAO**

Posta que da servicios médicos y de P.F. al AA.HH. del mismo nombre y que funciona en un local de la comunidad carente de servicios higiénicos . Es un ambiente relativamente pequeño pues la recepción y espera están divididos del consultorio por una tabiquería de madera. La cantidad de pacientes que atienden llega entre los 12 a 14 pacientes diariamente. Lógicamente no se brindan las condiciones necesarias que permitan optimizar la calidad del servicio. Los costos de atención se encuentran al alcance de la población.

La atención del médico proveedor es buena y las pacientes manifiestan que desean que los servicios se amplíen, pues actualmente sólo dan atención dos días a la semana, que se intensifiquen las campañas de motivación a la población.

## CLINICA CENTRAL

Funciona en un edificio de cuatro pisos con ambientes adecuados para las consultas, pero espacios pequeños para la consejería. Se nos manifestó que hacía tres días que se había terminado de acondicionar el pequeño ambiente que se encuentra en el primer piso para dar consejería a los clientes de P.F. y de medicina general. También se pudo observar que el personal tiene un alto grado de identificación con la labor que realizan esmerándose en dar información y consejería. Tienen folletos, afiches rotafolios educativos de P.F. que usan muy poco para mejor instruir a las usuarias. La persona que tiene a su cargo la consejería también tiene funciones relacionadas al equipamiento de las postas rotativas y por ello su labor se ve recargada.

En general el trato que se da a las personas es de mucho respeto, cordialidad, amabilidad tratando de captar adecuadamente al usuario de PF. En general la consejería demora entre 15 a 20' aproximadamente dándose énfasis en los métodos de larga duración como DIU en algún caso Norplant, AQV femenina y masculina.

## INPPARES

El local de la clínica central es adecuado y en el primer piso cuentan con cuatro consultorios de atención integral de salud y P.F. Su horario de atención es de 8 am. a 8 pm. concentrándose la mayor cantidad de pacientes entre las 4 y 7 pm. La recepción del cliente es ya rutinaria y al parecer no se brinda consejería previa antes de entrar a consulta, a pesar de que tienen personal especialmente capacitado para ésta tarea.

Se nota cortesía y amabilidad con el cliente que en la sala de espera cuenta con un televisor que lo entretiene mientras espera.

En el consultorio No. 3 no se pudo observar la atención por negativa del médico quien argumentó que respetaba mucho la privacidad del cliente.

Luego de algunas coordinaciones con el Jefe del servicio, se logró observar la consulta del servicio No. 2 , en donde se percibió que igualmente ésta se desarrolla de manera rutinaria y cansada, ya que el médico lee la historia clínica de la paciente, pregunta porque viene a consulta, chequea a la paciente y extiende una receta si fuera necesario. Entre 5'a 10' dura la consulta. También se observó que entre las 2 a 3 pm. no se atendió a ningún paciente.

La encargada de la consejería, dejó entrever que en la actualidad había malestar y descontento entre el personal de la clínica, por cambios habidos en el horario de atención al público y otras disposiciones que los afectaba en sus relaciones personales e institucionales, y que por otro lado el servicio se brinda hasta las 8pm pero que ella solo trabajaba hasta las 5pm.

El nuevo Jefe del Servicio manifestó que recientemente habían realizado una pequeña encuesta de opinión al público en la que se preguntaba acerca de los horarios y costos de atención, así como sobre la calidad del servicio en salud y PF. con la finalidad de un futuro próximo mejorar la atención.

De las entrevistas realizadas, se tomo nota de un paciente que la semana anterior había sido operado de vasectomía, quien manifestaba tener la seguridad de que la operación había sido un éxito y que se encontraba satisfecho, pero que tenía dudas sobre sus reacciones futuras (actividad sexual, relaciones familiares, etc.) ya que había notado que desde la operación se alteraba con mucha facilidad y sus actitudes estaban afectando las relaciones familiares y que a todo esto sólo tenía un hijo.

Otro de los usuarios manifestó que las consejerías deben ser obligatorias para las parejas, ya que la mujer siempre tiene la responsabilidad de la conservación de la familia.

## PROFAMILIA

Cuenta con dos clínicas centrales de atención en salud integral y PF. Sus servicios están dirigidos a dar atención a los distritos ubicados al sur de Lima Metropolitana . Las visitas se realizaron a los módulos que funcionan en los distritos de Chorrillos (AA.HH. Santa Isable de Villa) y San Juan de Miraflores (AA.HH J.C. Mareategui). En ambos casos se observó que la atención es esmerada y que el personal médico y auxiliar cuentan con el respeto de la población ya que desde hace aproximadamente 18 años vienen brindando servicios en éstos lugares. El horario de atención es en 3 turnos a fin de poder cubrir la demanda de éstos servicios( pediatría, ginecología, odontología, etc.)

La estructura de ambos locales es de material pre-fabricado y cuenta con ambientes que dan privacidad a la consulta.

En Santa Isabel de Villa la recepción y la sala de espera se encuentran en un mismo ambiente que es pequeño.

Se ha notado también la falta de servicios higiénicos dentro de los consultorios, que permitan dar al profesional y usuario mayores condiciones de higiene.

De la entrevista realizada en éste local se puede decir que la paciente manifestó que a pesar de que ella goza de atención en el Instituto Peruano de Seguridad Social, ella prefiere la atención de éste módulo por la enorme confianza que le tiene a todo el personal y a la calidad del servicio que recibe.

En el AA.HH. J.C. Mareategui se apreció que el ambiente de espera se encuentra descubierto, que los servicios higiénicos no tienen agua, pero que los consultorios brindan comodidad y privacidad al cliente. A todo esto hay que agregar que igualmente las personas entrevistadas

manifestaron la gran confianza que tienen con el personal encargado de éste módulo, los atienden con mucha paciencia, escuchan sus problemas y tratan de darles soluciones.

En la visita que se realizó a la clínica de Surquillo no se encontraron pacientes, y la persona encargada manifestó que recién desde el 3 de marzo se encuentran brindando servicios en éste local, que aproximadamente al mes tienen 32 pacientes y que de éstos solo 2 o 3 son de PF. Para solucionar ir captando pacientes se encuentran elaborando toda una estrategia de comunicación y difusión a colegios, centros laborales, mercados, etc.

## **APROSAMI**

La clínica funciona en un local de 4 pisos y brinda servicios de salud familiar y P.F., cuenta con consultorios de ginecología, obstetricia, pediatría, psicología, intervenciones quirúrgicas, sala de operaciones. Los pasadizos del local son estrechos, por ello no brinda comodidad al paciente ya que éstos se han convertido en los ambientes de espera. La cantidad de pacientes en ginecología/PF. es de aproximadamente 20 pacientes por cada turno y por ello la consulta no puede durar más de 10', el profesional médico tiene que ser muy preciso en sus indicaciones/sondeos con la paciente. La consejería se realiza en la mayoría de los casos en los pasadizos, creando en ciertos momentos confusión y desorden ya que tienen una gran demanda de servicios.

Lo que es muy loable es el grado de identificación del personal con las labores y responsabilidades que tienen dentro de la institución. En todo momento se aprecia la cortesía y amabilidad con que los clientes son tratados.

En todos los ambientes y pisos del local se pudieron apreciar afiches, folletos y propaganda sobre los MAC.

La Srta. Mirna Quintana, coordinadora del programa educativo, manifestó que hasta octubre/92 habían contando con 283 promotoras y que por cambios habidos en las directivas para captar pacientes para métodos de larga duración y/o permanentes, después de una evaluación se han quedado 21 orientadoras distribuidas en los distritos que se encuentran bordeando el mar (Callao, San Martín de Porres, Ventanilla, Puente Piedra, Ancón y los Olivos). En la actualidad APROSAMI cuenta con la clínica central, 4 postas fijas: Angamos=Ventanilla; Arrenal=Puente Piedra; Daniel Alcides Carrión=Olivos y Esteras en Ancón), que permanentemente son evaluadas a fin de ir introduciendo cambios que permitan mejorar el nivel de capacitación de su personal y la calidad del servicio que ofertan. También cuentan con 12 postas itinerantes que dan servicios 1 vez a la semana en el horario de 2 a 6 de la tarde en los AA.HH. de los distritos arriba mencionados. Para las postas itinerantes no cuentan con el material médico necesario para ampliar la cobertura del servicio. Asimismo prestan atención en postas intermedias que atienden 2 veces a la semana en el horario de 2 a 6 pm.

La Srta. Quintana enfatizó el hecho de que a partir de los cambios realizados para interesar a la población en el uso de MAC de larga duración el uso del DIU se ha incrementado en un 40% y la pildora y preservativos a bajado en un 5% aproximadamente. También recalcó que en un primer momento no contaron con la aceptación debida, pero que a partir de Diciembre /92 se comenzó a notar la recuperación de usuarias nuevas y continuadoras para los métodos de larga duración y/o permanentes. En la actualidad vienen realizando dos operaciones de vasectomía por mes, que esperan superar largamente ésta cifra.

Estan elaborando todo un programa de capacitación sobre PF. en los comités vecinales, charlas a la comunidad así como el desarrollo de programas juveniles destinados a orientar a jóvenes líderes en la comunicación para que hagan efecto multiplicador en sus familias y comunidad, también los orientarán en la formación de micro-empresas a fin de ir generando empleo.

Asimismo remarcó que el personal de la clínica necesita incentivos económicos y psicológicos que les permita mantener el ritmo de trabajo e identificación con la labor que desempeñan dentro de la institución.

Considero la posibilidad de recibir ayuda económica que les permita preparar banderolas y propagandas diversas para mantener constantemente informada a la población sobre los beneficios que brinda una adecuada política de salud familiar y de uso de MAC para la PF.

#### ATLF

En las visitas que se realizaron a ésta Asociación Laico Familiar no se tuvo la oportunidad de observar consultas y atención al público por la falta de pacientes, ya que la población no siente interés por el uso de los métodos naturales de PF.

En el Callao Parroquia Matriz, se encontró que recientemente se habían cambiado de local, por ser de más bajo costo, ofrecer mejores condiciones e instalaciones.

La encargada de la consejería Sra. Maritza Luján manifesto que era muy difícil captar usuarias en la zona debido a que en la mayoría de los casos se les tenía que hacer un seguimiento en sus domicilios y que el lugar está poblado por personas que viven al margen de la Ley.

Los costos de consulta son bajos:

Consulta S/. 2.00; PAP 2.50; Cauterización 5.00 y Pregnosticon 4.50

Actualmente desarrollan charlas en los encuentros de novios, se efectúan visitas domiciliarias, se dan charlas educativas en colegios a los padres de familia y profesores. Asimismo cuentan con un buen material de información pero lo usan muy poco por la falta de pacientes.

La Sra. Luján se mostró muy amable, cortés mostrando inmediatamente las instalaciones del local.

## APPENDIX VI

### Persons Interviewed

In addition to interviews with family planning promoters and local supervisors at itinerant and fixed posts and clinics the following persons were interviewed individually or in small group meetings.

APROPO	ALIAGA, Elizabeth
APROPO	DELUQUE, Carola
APROPO	LOPEZ, Carmen
APROPO	VERA, Rosario
APROSAMI	BAFFIJO, Dra. Juana, i/c Itinerant Clinic
APROSAMI	GUZMAN, Dr. Cesar, Executive Director
APROSAMI	MARTINEZ, Dr. Augusto, Medical Director
APROSAMI	OTERO, Santiago
APROSAMI	QUINTANA, Miriam, Coordinator IEC
APROSAMI	RUIZ, Tania, Administrator
ATLF	CASTELLANOS, Eduardo
ATLF	TAGLIABUE, Dr. Guillermo, Executive Director
ATLF	VILLAVICENCIO, Dr. Vicente, Deputy Director
CENPROF	ARTEAGA, Rosa, Administrator
CENPROF	CABALLERO, Isabel
CENPROF	COBOS, Paul
CENPROF	ESPINOSA, Janeth, Instructor in IEC
CENPROF	GUILLEN, Dr. Felix, Executive Director
CENPROF	MORAN, Lelis, Program Coordinator
CENPROF	RAMIREZ, Raquel
INFOSERVE	CARPIO, Ronaldo
INPARRES	BARRON, Dr. Eliseo, Program Director
INPARRES	CAMPOS, Dr. Manuel
INPARRES	CLAVIO, Frank, Coordinator IEC
INPARRES	GUARDIA, Dr. Guillermo, Director, FP Program, Lima Clinic
INPARRES	IDELFONSO, Victor, Local Supervisor, Post 23, Distrito Santa Ana
INPARRES	JUAREZ, Richard
INPARRES	LACA, Enrique
INPARRES	LUZA, Dante
INPARRES	MELGAR, Nancy, Post Assistant
INPARRES	MOSTAJO, Eduardo
INPARRES	NIZAMA, Lic Estrella, Chief, Training Division
INPARRES	PORRASENCO, Julia, Zonal Supervisor
INPARRES	RAMOS, Dr Miguel, Executive Director
INPARRES	VILLEGAS, Cesar
IPSS	FARFAN, Dr. Ramiro, Director PAAD Program

IPSS	RODAS, Ing Angel, Executive Director
MOH	MONGRUT, Dr. Andres, Director, Directorate of Social Programs
PLANIFAM	ALVAREZ, Grimanesa, Nurse-Coordinator, IEC
PLANIFAM	ARAMIBAR, Dr. Manuel, i/c Afternoon Clinics
PLANIFAM	CARLOT, Bertha
PLANIFAM	CASAFRANCA, Luz Miriam, Assistant Coordinator, IEC
PLANIFAM	ESTRADA, Dr. Jose Antonio, i/c Itinerant Clinic
PLANIFAM	GONZALEZ, Ivan
PLANIFAM	LUNA, Miryam
PLANIFAM	OBANDO, Haydee, Executive Director
PLANIFAM	PAZ, Ramon, Director of Programs
PLANIFAM	SILVA, Luis
PLANIFAM	SOTO, Juana Mansilla, Obstetric Paramedic
PLANIFAM	WILLIS, Dr. Abel, i/c Morning Clinics
PRISMA	CARDOSO, Flor Rubio, Coordinator Family Planning
PRISMA	FERNANDEZ, Dr. Diego, Coordinator Training
PRISMA	GILMAN, Josephine, Executive Director
PRISMA	GUTIERREZ, Carlos, Administrator, PVFP Project
PRISMA	GUTIERREZ A., Carlos, Coordinator IEC
PRISMA	LEON, Carlos, Coordinator Programing
PRISMA	RAMIREZ, Flavio
PRISMA	ROSSI, Gabby
PROFAMILIA	BENDEZU, Dr. J. Raul, Program Director
PROFAMILIA	BRAZZODURO, Alfredo, Executive Director
PROFAMILIA	GUTIERREZ, Walter, Deputy Director
PROFAMILIA	PARRA, Miriam, Coordinator - Training
PROFAMILIA	SANCHEZ, Ernestina, Program Coordinator
PROFAMILIA	SOTO, Edith, Coordinator IEC
PROFAMILIA	VIDELA, Rigoberto
USAID	BORNECK, Maria Angelica, Specialist in Population Programs
USAID	BOYD, Donald W. Jr. Sub Director
USAID	BRICCNO, Arturo
USAID	FIEDLER, Jack, Health Economist Consultant
USAID	GOLDMAN, Dr. Heather, Chief, Office of Population & Health
USAID	NECOCHEA, Dr. Deputy Chief, Office of Populationa & Health
USAID	NICHTAWITZ, Gloria, Project Coordinator
ESTENSSORO,	Paulo, Investment Opportunities Consultant
LI,	Dina, Market Study Consultant
TIRADO,	Roberto, Strategic Planning Consultant
VERDERA,	Francisco, Cost Study Consultant.

## APPENDIX VII

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