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EVALUATION REPORT: FPMD TECHNICAL  
ASSISTANCE TO THE ASOCIACIÓN PRO-  
BIENESTAR DE LA FAMILIA (APROFAM),  
GUATEMALA

AUGUST 1995

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**FAMILY PLANNING MANAGEMENT DEVELOPMENT**

Project No.: 936-3055  
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## ACRONYMS

APROFAM	<i>Asociación Pro-Bienestar de la Familia</i> Association for the Well-being of Families
CA	Cooperating Agency
CBD	Community-based Distribution
FP	Family Planning
FPMD	Family Planning Management Development
GOG	Government of Guatemala
IEC	Information, Education, and Communication
IGSS	<i>Instituto Guatemalteco de Seguro Social</i> Guatemalan Social Security Institute
IPPF	International Planned Parenthood Federation
MSH	Management Sciences for Health
MOH	<i>Ministerio de Salud Pública</i> Ministry of Public Health
SOMARC	Social Marketing for Change
USAID	United States Agency for International Development

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## I. EXECUTIVE SUMMARY

In Guatemala, 23% of married women between the ages of 15-45 (23%) report using a family planning method, and even fewer (18%) use modern family planning methods. (DHS, 1987). Among rural or indigenous women, contraceptive prevalence rates are even lower (14% and 6% respectively). These are among the lowest contraceptive prevalence rates in Latin America. According to an analysis of the 1987 Demographic and Health Surveys, only 43% of the demand for family planning services is satisfied. In other words, there is a potentially significant latent demand for family planning services among Guatemalan women. Socio-cultural factors such as religion, ethnicity, and machismo tend to discourage the use of family planning methods. Distance and difficulty in access to family planning service providers are also barriers to these services.

The *Asociación Pro-Bienestar de la Familia* (APROFAM), the IPPF affiliate, faces two major challenges. On the one hand, APROFAM would like to continue the expansion of its services to rural and indigenous populations with USAID's support. On the other hand, as financial support shifts towards rural areas, APROFAM's urban clinics must become financially sustainable. FPMD was approached to assist APROFAM in the creation of financially viable urban clinics.

FPMD began its assistance to the *Asociación Pro-Bienestar de la Familia* (APROFAM) in September 1994 and is still in the initial phase of implementation. During this first phase, FPMD has been providing APROFAM with technical assistance to help APROFAM identify and implement strategies for developing financially sustainable urban clinics. To date, FPMD has undertaken the following: an **in-depth needs assessment** of APROFAM in order to develop a better understanding of the organization's current situation and needs; **technical assistance** in clinic management focused on improving service quality, uniformity of services, and clinic efficiency as well as cost and financial sustainability; and a **market study** of current and potential markets conducted by local market research firm, Generis Latina.

In general, APROFAM and USAID have expressed satisfaction with FPMD's technical assistance and APROFAM hopes to continue to receive support from FPMD, particularly in the areas of sustainability, decentralization of its operations, and management training. Communication between FPMD consultants, APROFAM, and USAID has been open and positive. APROFAM expressed an interest in extending the duration of technical assistance visits so that consultants were accessible for longer periods of time. Another issue of concern was the length of time required to handle administrative matters such as purchase orders.

The question of how to provide attractive and acceptable health services to the Mayan population should be a more salient feature in FPMD technical assistance. Although FPMD's technical assistance has focused on APROFAM's clinics located in urban areas, some of these clinics attract women from nearby Mayan communities. Women from these communities may speak both Spanish and a Mayan dialect, but it is not clear that other cultural differences do not influence in decisions regarding health services. To date, no service providers have been very successful at reaching the Mayan population with family planning methods. Since APROFAM has had some experience providing services in Mayan areas and will be continuing its efforts to reach rural and indigenous populations, it might be important to document client preferences in the urban clinics where APROFAM has been relatively

successful at reaching Mayans. Both APROFAM and other public and private health organizations can also benefit from APROFAM's experiences.

APROFAM receives technical assistance from numerous cooperating agencies (CAs) including SOMARC, the Population Council, and IPPF, and others. FPMD consultants have coordinated activities with IPPF representatives, but have not had much formal contact with other CA representatives. Given some of the unanswered questions regarding the service preferences of the Mayan population, FPMD consultants should consider closer coordination with the Population Council representative in Guatemala City. As part of INOPAL II, the Population Council has conducted operations research on service utilization patterns among the Mayan population. It might be useful to consider these findings in light of FPMD effort to help APROFAM to develop financial sustainable urban clinics.

## **II. INTRODUCTION**

FPMD began its assistance to the *Asociación Pro-Bienestar de la Familia* (APROFAM) in September 1994, and is still in the initial phase of implementation. During this first phase, FPMD has been providing APROFAM with technical assistance to help APROFAM to identify and implement strategies for developing financially sustainable urban clinics. Given the brief period of time that FPMD has been working with APROFAM, it is premature to expect to be able to measure major changes in outcome or impact as a result of project activities. Consequently, this evaluation focuses on an analysis of the content of FPMD technical assistance and the process by which it has been provided than on its impact.

## **III. BACKGROUND**

### **A. Family Planning in Guatemala**

In Guatemala, 23% of married women between the ages of 15-45 report using a family planning method, and even fewer (18%) use modern family planning methods. (DHS 1987). Among rural or indigenous women, contraceptive prevalence rates are even lower (14% and 6% respectively) (DHS 1987). These are among the lowest contraceptive prevalence rates in Latin America.

Several social and cultural factors contribute to the low rates of contraceptive utilization. The social norms associated with machismo discourage women from taking responsibility for making decisions about sex or family planning. Generally, Guatemalan women feel that they should or must defer to their partner's wishes when deciding whether or not to use contraceptives. Strong religious beliefs associated with Catholic, Evangelical and traditional Mayan beliefs discourage the use of family planning methods.

The limited access and availability of family planning services further impede widespread utilization of contraceptive methods. A majority of Guatemalans, mostly Mayans, live in isolated or dispersed rural areas, and for many rural residents access to health services is complicated by distance and lack of transportation. Aspects of Mayan culture may further

reinforce barriers to adaption of family planning methods. Approximately one half of the Mayan women interviewed in the recent DHS spoke one of 23 Mayan dialects and virtually no Spanish. Almost 70% of Mayan women have had no formal education and 80% are illiterate. As a result, social marketing, health education campaigns, and products and services must be tailored to meet the needs of different linguistic groups. Finally, until 1985, the Government of Guatemala (GOG) did not recognize population growth as a concern, and the Ministry of Health discouraged family planning. Population issues and family planning policies were not included in national development plans. At an operational level, family planning methods were not available on a widespread scale through the MOH until the mid 1980s.<sup>1</sup>

Since no other organizations offered family planning services, APROFAM became the de facto national family planning service provider. In 1987, APROFAM was the primary source of family planning for women who used family planning methods (24.8%). Other institutions mentioned as sources of family planning include: the Ministry of Health hospitals, clinics, and posts (22.9%); the Guatemalan Social Security Institute (IGSS) (0.5%); community promoters (10.9%); private providers (16.7%); and pharmacies (24.3) (DHS 1987).

Despite the relatively low contraceptive prevalence rate, 47% of women in reproductive age (with partners) say that they do not want another child and 27% want to wait two years or more before their next pregnancy. According to an analysis of the 1987 Demographic and Health Surveys, only 43% of the demand for family planning services is satisfied.<sup>2</sup> In other words, there is a potentially significant latent demand for family planning services among Guatemalan women. The challenge for APROFAM and other health care providers is to develop effective and appropriate mechanisms for family planning services.

Table 1  
Summary of Key Indicators

	Total Fertility Rate (TFR)	Contraceptive Prevalence		Infant Mortality (deaths per 1000 live births)
		Total	Modern	
Guatemala	5.4	23%	19%	48/1000
Central America	3.5	61%	51%	37/1000
Latin America	3.1	60%	51%	44/1000

Population Reference Bureau. 1995.

<sup>1</sup>In 1985, the Congress adopted a new constitution which recognized the legal right of citizens to determine the number and spacing of their children.

<sup>2</sup>Albert M. Marckwardt and Luis H. Ochoa, *Population and Health Data for Latin America* (Columbia MD: Demographic and Health Surveys (DHS) Macro International, March 1993), p. 51. The estimate of total demand is based on a calculation of unmet demand, method failure and current use.

## **B. Asociación Pro-Bienestar de la Familia (APROFAM)**

APROFAM, the Guatemalan affiliate of the International Planned Parenthood Federation (IPPF), is the largest and the oldest organization offering comprehensive family planning services in Guatemala. APROFAM currently operates eight clinics in the capital city, 13 regional clinics as well as nine special clinics. These clinics provide a range of services in family planning, obstetric and gynecological surgery, pre and post-natal care, well-baby care, pap smears, oral rehydration, parasite control, and education. (See Annex 5 for map of clinic locations.) APROFAM also has a large community-based distribution (CBD) program operating in 21 departments staffed by an estimated 4,000 trained community volunteers. Volunteers distribute temporary family planning methods, oral rehydration salts (ORS), and antiparasitic medications to consumers.

In addition to its medical and community distribution services, APROFAM has undertaken a range of activities. APROFAM has national programs in adolescent, family life and self-esteem education curriculum development and a youth center in Guatemala City. On a policy level, APROFAM uses the mass media to make the public aware of population issues, sponsors academic and operations research on population and family planning issues, and organizes public and private forums for discussion of these issues. For example, APROFAM has commissioned well-known local researchers as part of APROFAM's population series and their findings are presented at policy level meetings.

APROFAM has traditionally been highly dependent on international donors—particularly USAID—for financial support. In 1995, 65% or US \$ 3.64 million of its funds come from the present USAID project due to expire in 1996. Recently, USAID made several strategic decisions regarding future funding that have had important implications for APROFAM: 1) USAID has decided to broaden its activities in health to include more Child Survival and HIV/AIDS programs in order to address other serious health problems in Guatemala; 2) USAID has also begun to fund the Family Planning Unit of the Ministry of Health and other health organizations; and 3) USAID has identified the rural and indigenous populations as the target population for programs in family planning given the relatively low contraceptive prevalence rates. In short, there will be less money available for family planning programs, and the resources available will be divided among several organizations. Faced with the prospect of a significant reduction in financial support, APROFAM realized that its urban clinics must become financially sustainable in order to continue providing services.

#### IV. FPMD's SCOPE OF WORK

In order to facilitate APROFAM's transition to financial self-sufficiency, MSH/FPMD was contacted and the following scope of work was defined:

##### A. Phase One

1. Complete an *in-depth needs assessment* of APROFAM in order to develop a better understanding of the organization's current situation and needs.
2. Provide *technical assistance* in clinic management focused on improving service quality, uniformity of services, and clinic efficiency as well as cost and financial sustainability.
3. Conduct a *market study* of current and potential markets. (Conducted by local market research firm, Generis Latina, ongoing)

Based on the findings from Phase I, FPMD will work with APROFAM to identify strategic options for achieving the sustainability of urban clinics. Once APROFAM decides on a course of action, FPMD will embark on Phase II of its technical assistance. During this phase, FPMD will assist APROFAM in developing an operational plan that incorporates the major technical, marketing and financial components necessary to make their urban services sustainable. FPMD will also provide training in clinic management and develop information and monitoring systems.

##### B. Activities to Date

Since FPMD activities were initiated in August 1994, FPMD has provided the following technical assistance.

##### 1. Management Needs Assessment

From August 28 - September 10, 1994, three FPMD consultants conducted an in-depth management needs assessment of APROFAM. The objective of this assessment was to identify the components of a development plan that would lead to the financial sustainability of the APROFAM's urban services. Since USAID was planning to continue to fund APROFAM's work in indigenous and rural areas and since APROFAM had an established network of well staffed and equipped urban clinics, it seemed logical to focus FPMD's assistance on APROFAM's operations in urban areas.

The FPMD team was well suited to the task since two of the three consultants had extensive experience in Guatemala and in the areas of financial and clinic management. The third was a Latin American with first hand experience in the

development and operation of a financially independent health care organization. The consultants interviewed central and regional APROFAM staff and USAID representatives.

The consultants identified several strengths and weaknesses. Among its strengths, APROFAM benefits from: 1) a bright, well educated and technically competent staff in administration and medical services in the capital and regional clinics; 2) good infrastructure including well-equipped clinics. APROFAM is planning to construct five new clinics in Coban, Zacapa, Quetzaltenango, Escuintla, and Puerto Barrios; 3) good information systems capable of providing the basic information necessary for operating financially sensitive clinics as well as experience in operations research and data collection, although this data is somewhat underutilized for decision-making; and 4) a growing level of sophistication and appreciation for the nature of organizational change necessary to become self-sustaining.

As an organization, APROFAM's ability to change may be influenced by its weaknesses. First, some observers suggest that the formal and rigid hierarchical management structure at APROFAM sometimes reduces flexibility and responsiveness to new problems and opportunities, especially at remote field sites since decisions tend to be deferred to the central office. Another issue of concern for some is that the staff of APROFAM at both central and regional levels includes more males and *Ladinos*<sup>3</sup> than females and Mayans. To the extent that clients may have a preference for service providers whom they perceive as being similar to themselves and that service providers who understand their clients can provide more appropriate services, the composition of staff becomes a relevant issue in service delivery. In addition, because of significant dependence on donors, APROFAM's programs and activities have lacked a strong market focus. The organization has concentrated on delivering services and products rather than satisfying clients' needs. As one consultant put it, "APROFAM has overextended beyond its mission. Now they are doing everything under the sun—youth education, leadership, operations research on injectable contraceptive methods project in their CBD program . . . All this pulls staff in too many directions and poor delegation leaves some key people buried." Finally, at the medical level, staff is not well supervised, particularly in the area of medical services. This has contributed to inefficient staffing patterns and excess staff capacity. There are no procedures, protocols nor technical training for staff to ensure quality standards nor are their performance evaluations or appraisals in place to identify and promote quality staff or eliminate excess personnel.

## 2. Technical Assistance in Clinic Efficiency and Cost Management

Since the management needs assessment, FPMD consultants have provided ongoing technical assistance (TA) to APROFAM in the areas of clinic management and costs. (January, March, and July 1995). During the first TA visit, the consultant worked

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<sup>3</sup>*Ladinos* refers to persons of indigenous and European ancestry. The more common Latin American term is *Mestizos*.

with APROFAM representatives to develop an operational plan for TA, a spreadsheet to indicate levels of self-financing among clinics, and identification of local firms that could undertake market research.

Two consultants made a second trip in March. The objective of this trip was to support the development and implementation of systems for identifying unit costs and profit margins for basic units of services, existing and planned, offered at APROFAM's urban clinics. During this visit, the consultants worked with APROFAM staff to develop a costing methodology which was then used to analyze data.

According to FPMD findings, APROFAM now generates 28% of its own income, (up from only 10% in 1992. This is generated by the sale of the following goods and services: clinical and laboratory services including birthing services (22%); sale of medicines (22%); contraceptive sales (17%); consultations (12%) and laboratory services. (11%) While there is considerable variation in income generation between the various urban clinics and services, in the aggregate they are presently able to cover 61% of operating costs (excluding administration and IEC expenses) or more than 50% of the budget when adjusted for overhead expenses. The range of revenues generated varies considerably from a low of 25% in Chimaltenango to 86% in Quetzaltenango.

During this visit in March, an FPMD consultant and APROFAM staff field tested a clinic management protocol in the Escuintla clinic to help staff to analyze the quality, efficiency, and productivity of individual clinics. The methodology is as follows: clinic managers received a copy of the clinic floor plan. Managers use this copy to map out a patient's movements through the clinic, noting where they go, with whom they speak, about what and how long they spend at each station. They also observed interactions between staff members. This methodology was refined and applied in APROFAM clinics in Chimaltenango, Quetzaltenango, Huehuetenango, Zacapa, and Coban during the third FPMD visit in May. The application of this protocol helped managers to realize the lack of systems and procedures for supervision and quality control within and across clinics.

The most recent follow-up visit was made in July 1995. At that time, an FPMD consultant provided continuing support to APROFAM in the area of clinic development and oversight of market research activities.

### 3. Market Research Activities

FPMD has contracted a local marketing firm, Generis Latina, to conduct a market study to collect information of current and potential markets for APROFAM's services and assess price elasticity of demand for different services in areas where APROFAM operates. Generis Latina proposed to conduct 1700 interviews with women between the ages of 15-44 years in six urban and peri-urban areas. (Quetzaltenango, Huehuetenango, Chimaltenango, Cobán, Escuintla, and Zacapa.) The target population was defined as a principally urban population. Rural residents and monolingual Mayan speakers were eliminated from the sample. An interview guide was developed

focusing on women's attitudes toward service providers, level of satisfaction with their current health care provider, knowledge of and interests in APROFAM services, personal information, and interviewer observations.

As of August 1995, the results of the market study were being analyzed, but findings were not yet available. Once the market studies are complete, FPMD and APROFAM will use this information to develop several different options for developing financially self-sustainable clinics.

## **V. FUTURE ISSUES**

During the course of the evaluation, several issues were raised which should be considered for future FPMD work with APROFAM.

### **A. Duration of Technical Assistance**

In general, APROFAM and USAID have expressed satisfaction with FPMD's technical assistance and APROFAM hopes to continue to receive support from FPMD, particularly in the areas of sustainability, decentralization of its operations, and management training. Communication between FPMD consultants, APROFAM, and USAID has been open and positive. In fact, FPMD has been credited with improving communication between USAID/Guatemala and APROFAM. APROFAM expressed an interest in extending the duration of technical assistance visits so that consultants were accessible for longer periods of time. Since FPMD was supporting new project activities in Guatemala with core funds, there were limited resources which resulted in shorter technical assistance visits.

Another issue of concern was the length of time required to handle administrative matters such as purchase orders. On at least one occasion, work was delayed due to administrative delays at MSH.

### **B. Definition of Target Population for Urban Clinics**

The Mayan population constitutes approximately half the total population and a significant portion of the potential market for family planning services. However, the Mayan population has also been one of the hardest markets to reach. One of the major external challenges facing APROFAM is how to design services to attract this clientele. A related question for service providers is whether or not there is a significant variation between Spanish-speaking Mayans and Ladinos in terms of their behaviors and preferences for health services. For example, do Mayans prefer to receive health services from other Mayans? Do Mayans have different perceptions about family planning services than Ladinos? How do language and cultural differences influence Mayans' decision to seek health services and their selection of health care providers?

The question of how to provide attractive and acceptable health services to the Mayan population should be a more salient feature in FPMD technical assistance. Although FPMD's technical assistance has focused on APROFAM's clinics located in urban areas, these clinics

attract women from nearby communities that are more rural (e.g., Quetzaltenango and Zúñil). Women from these communities may speak both Spanish and a Mayan dialect, but it is not clear that other cultural differences do not influence in decisions regarding health services. In fact, other researchers have argued that other aspects of Mayan culture influence service utilization (Ward n.d). Second, to date, no service providers have been very successful at reaching the Mayan population with family planning methods. Only 6% of Mayan women reported using family planning methods compared to 34% among Ladinas. Service providers need to identify barriers to service utilization and figure out ways in which they can enhance the attractiveness of their services. Since APROFAM has had some experience providing services in Mayan areas and will be continuing its efforts to reach rural and indigenous populations, it might be important to document client preferences in the urban clinics where APROFAM has been relatively successful at reaching Mayans. Both APROFAM and other public and private health organizations can also benefit from APROFAM's experiences

### **C. Coordination with other Coordinating Agencies**

APROFAM receives technical assistance from numerous cooperating agencies (CAs) including SOMARC, the Population Council, and IPPF, and others. FPMD consultants have coordinated activities with IPPF representatives, but have not had much formal contact with other CA representatives. Given some of the unanswered questions regarding the service preferences of the Mayan population, FPMD consultants should consider closer coordination with the Population Council representative in Guatemala City. As part of INOPAL II, the Population Council has conducted operations research on service utilization patterns among the Mayan population. It might be useful to consider these findings in light of FPMD effort to help APROFAM to develop financial sustainable urban clinics.

ANNEX 1

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ANNEX 2  
METHODOLOGY

This is a qualitative evaluation conducted in the FPMD office in Newton, Massachusetts in July 1995. The evaluation was conducted in three phases. First, a literature search was conducted using three different sources: FPMD project documents, unpublished APROFAM documents, and results of a POPLINE/MEDLINE data base search on APROFAM. After review of these documents, a short qualitative open-ended questionnaire was developed. Key consultants, FPMD and APROFAM staff were interviewed using this questionnaire. Additional information from APROFAM was requested in writing.

## ANNEX 3

### LIST OF PERSONS INTERVIEWED

**MSH/FPMD**

**Edgar Necochea  
Patricia Mott  
Michael Hall**

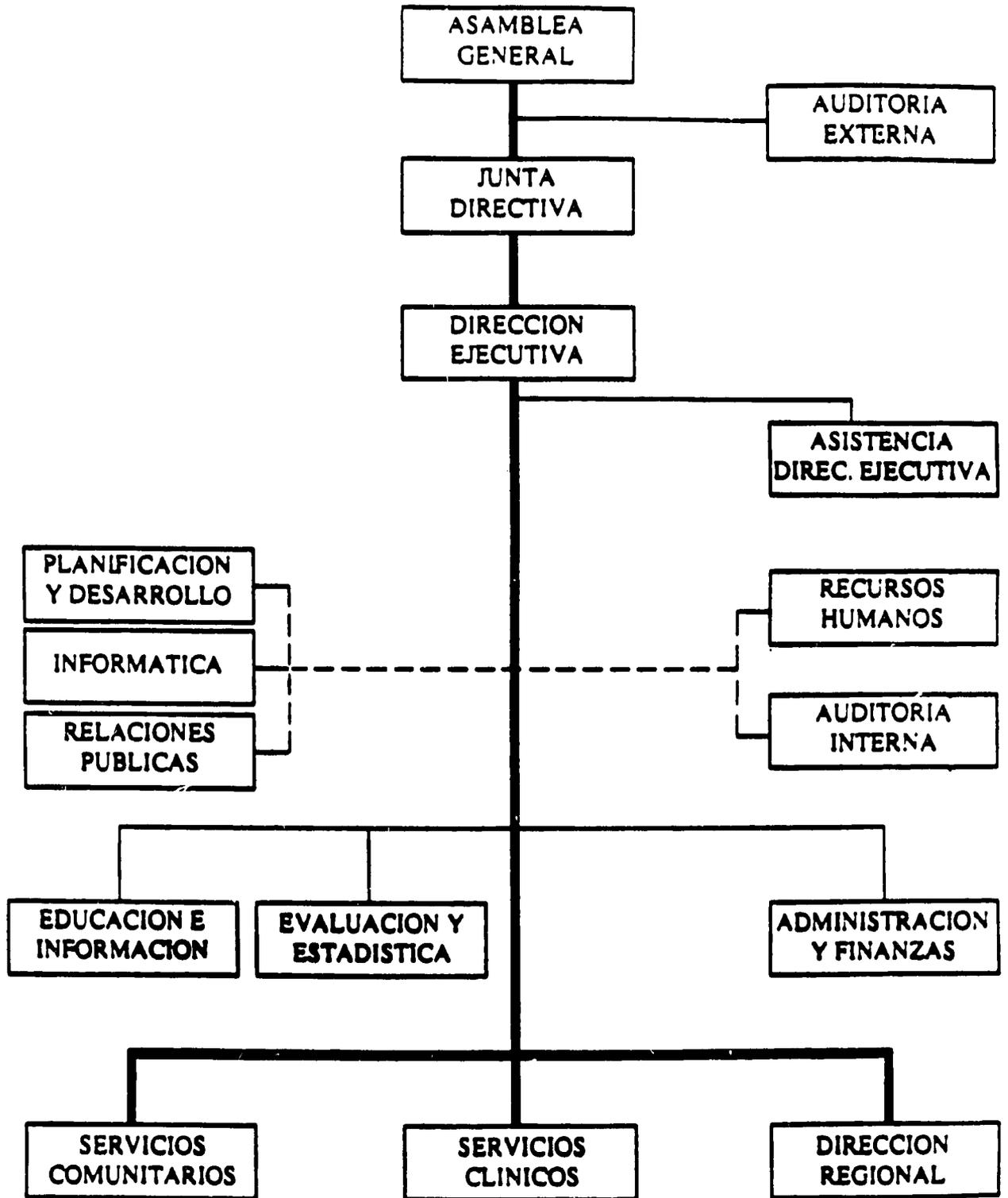
**APROFAM**

**Roberto Santiso**

ANNEX 4

ORGANIZATIONAL CHART OF APROFAM

**ORGANIGRAMA DE APROFAM**



ANNEX 5

MAP OF APROFAM CLINIC LOCATIONS

*[Handwritten signature]*

# CLINICAS MEDICAS APROFAM

## DEPARTAMENTALES

- ▼ Coatepeque
- ▼ Cobán
- ▼ Chimaltenango

- ▼ Escuintla

- ▼ Huehuetenango
- ▼ Jalapa
- ▼ Jutiapa

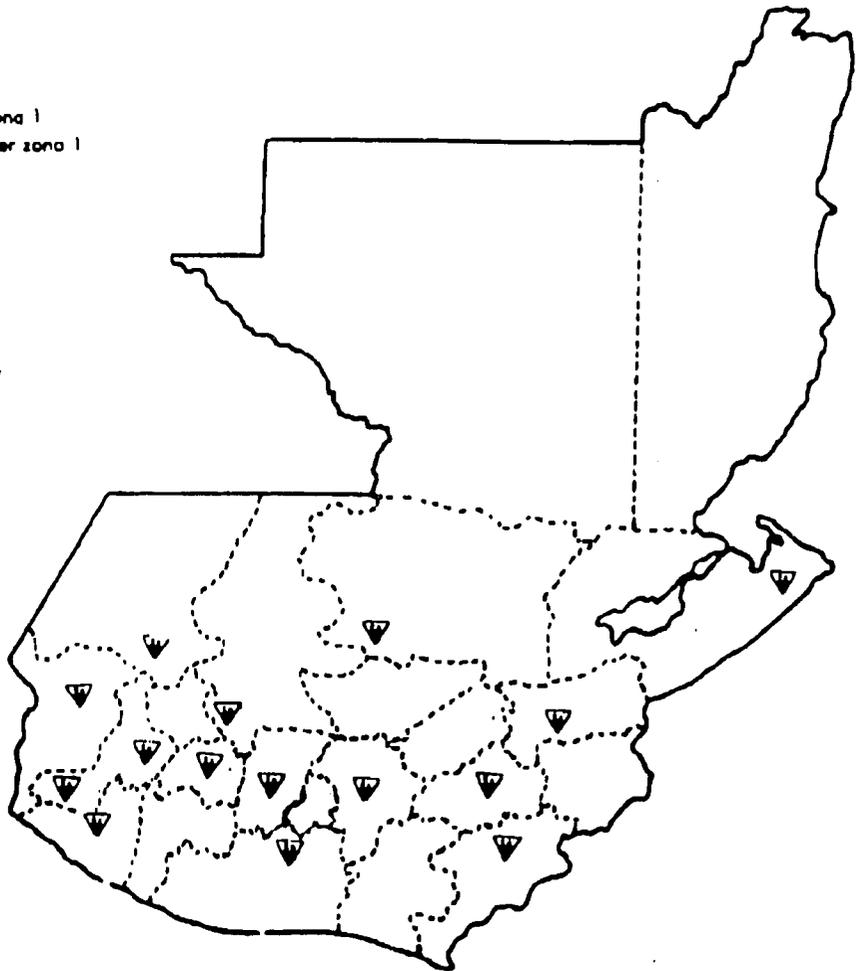
- ▼ Puerto Barrios

- ▼ Quetzaltenango
- ▼ Quiché
- ▼ Retalhuleu
- ▼ Solalá

- ▼ Zacapa

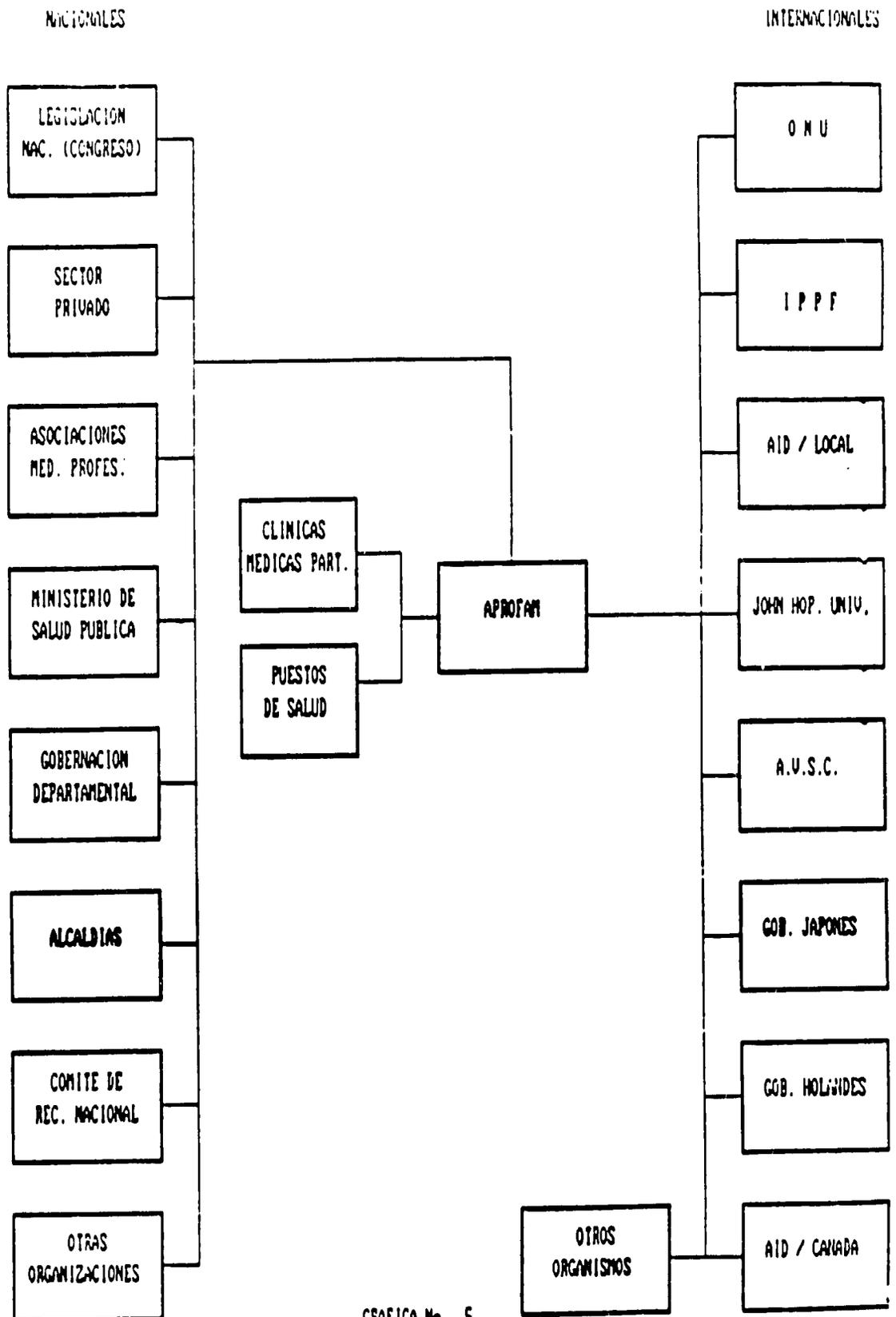
## EN LA CAPITAL

- Clinica central zona 1
- Clinica de la mujer zona 1
- CEPAR zona 1
- Clinica zona 5
- Clinica zona 6
- Clinica zona 7
- Clinica zona 11
- Clinica zona 18
- Clinica zona 19
- Clinica Nimajuyú zona 21
- Mixco



# APROFAM

## RELACIONES ORGANIZACIONALES EXTERNAS



GRAFICA No. 5

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