

H. EVALUATION ABSTRACT

Background

Family planning is an integral part of the maternal child health model developed by the Decentralized Health Services Project. The strategy is to reach the least accessible users, both in geographic and cultural terms, to encourage them to begin using contraception earlier in their reproductive lives to postpone the first pregnancy and to space subsequent pregnancies. The project targets poorly educated, rural women of low socioeconomic status, and also women between the ages of 15 and 24. The latter group has one of the highest age-specific fertility rates in Latin America.

In February, 1991, USAID signed a Cooperative Agreement with Profamilia, an IPPF affiliate, to implement the Mission Family Planning and Regionalization Project. The project stresses post-partum care and routine family planning visits. The project includes a nation-wide media campaign and the expansion of Profamilia's network of clinics and community distribution posts.

The evaluation was based on: a review of project documentation; site visits; and interviews with persons involved in the design, monitoring, implementation, and evaluation of the project.

Findings and Conclusions

- USAID/N's stated goals for the project have changed over the past six years and have become broader, vaguer, fewer and less measurable than the underlying (unstated) indicator of goal achievement, the Total Fertility Rate (TFR) has remained constant. In the absence of population-based surveys on TFR, both Profamilia and USAID/N have the proxy indicator "couple years of protection" (CYP) as their main performance indicator.
- The use of CYP has had a significant negative effect on program direction and operation. This emphasis has led Profamilia to focus on sterilization and sales of pills and injectables and detracted from such other important elements as method choice and quality of care.
- Profamilia lacks a coherent strategy. Its staff is dedicated and hard-working but their efforts have not been guided by a clear strategic direction. This lack of strategy has led to selection of clinics that do not adequately serve the rural target population, and a CBD program that is labor-intensive, costly and achieves limited results.
- The client services provided by Profamilia in its clinics are of good quality but limited primarily to surgical contraception. Other family planning services are not delivered with the same emphasis and quality. Counseling throughout the program is inadequate except for the preparation of clients for surgery. Clients are not provided the information they need to make informed choices about family planning.
- The lack of a clear guiding strategy at Profamilia also limits the effectiveness of the Information, Education and Communication (IEC) program. Profamilia has received extensive technical assistance and training in promotion, counseling, and the development of support materials for IEC. Much of this assistance has been utilized poorly because of unclear strategies and ineffective management.
- Serious deficiencies in the financial management of Profamilia are hindering progress toward sustainability. The current financial system does not provide adequate tools or information for managing the substantial funds provided by Profamilia's donors. The budgeting system is perfunctory and highly centralized. Costs are not controlled by management. As a result, Profamilia is not on the road to financial sustainability. In fact, the program is becoming more costly and less efficient.
- The evaluation team assessed Profamilia's organization and management to determine its capabilities to produce the project's expected results and contribute to its sustainability. Management had achieved results as measured by CYP and expansion of the program. It had not, however, created the management systems, procedures and norms that are needed to orient the staff and resources to produce the intended project results.
- USAID/N has been aware of these problems, but has not been able to solve them in spite of increasing oversight and intervention. The ability of USAID/N and Profamilia to work together as true development partners has deteriorated, especially in the past year. USAID/N complains that Profamilia willfully ignores the terms of the Cooperative Agreement and the recommendations of technical assistance aimed at strengthening the organization. Profamilia complains that increased oversight and frequent interventions by USAID has eroded its autonomy.

COSTS

I. Evaluation Costs

1. Evaluation Team Affiliation	Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (U.S. \$)	Source of Funds
Name Gary D. Bergthold Sandra A. Wilcox María Gutiérrez-Valencia Silvia Bomfim Hyppolito Jack Reynolds	DO No. 800 CCP - 3024-Q- 00-3012-00	\$111,210.70	Project
2. Mission/Office Professional Staff Person-Days (estimate): N/A	3. Borrower/Grantee Professional Staff Person-Days (Estimate): N/A		

SUMMARY

J. Summary of Evaluation Findings, Conclusions, and Recommendations (Try not to exceed three (3) pages)

Address the following items:

- Purpose of Evaluation and methodology used
- Purpose of activity(ies) evaluated
- Findings and conclusions (relate to questions)
- Principal Recommendations
- Lessons Learned

Mission or Office:

USAID/Nicaragua

Date This Summary Prepared:

July 7, 1997

Title and Date of Full Evaluation Report:

Mid-Term Evaluation of the Family Planning Expansion and Regionalization Project - 03/97

Profamilia, an IPPF affiliate, was a small organization with two clinics in Managua when the project began in 1991. Under the \$13 million Cooperative Agreement with USAID, it has expanded its network of regional centers to ten full-service clinics and two outreach programs in the Atlantic Coast. Its CBD outreach and referral program was begun in 1992 and has expanded to over 1,000 volunteers throughout the country. Over the life of project, the Mission and Profamilia have made a series of changes in the project design to reflect experience, including modifying the goal, purpose, funding level, completion date and types. The goal of the project is to increase knowledge, acceptance and early use of modern family planning methods.

USAID's Cooperative Agreement with Profamilia runs until 1998. The purpose of this mid-term evaluation is to assess project performance and to make recommendations in five areas: 1) performance indicators and achievements, 2) clinical services and quality of care, 3) community-based distribution and IEC, 4) financial management and sustainability, and 5) organizational management and sustainability.

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

The following are the most significant of the conclusions and the recommendations. See the full evaluation for the remainder.

- No accurate measure of project achievement is being used, except when national surveys are conducted - which is every five years or so.

Recommendation: Revise the indicators used to measure Profamilia's performance. Profamilia should develop a service statistics system to capture data on such essential information as characteristics of clients, continuity of use, complications and side effects, current users.

- The CYP is a week proxy indicator and subject to misinterpretation. It also distorts the direction of the project resulting in "goal displacement."

Recommendation: Profamilia and USAID/N should de-emphasize the importance of the CYP indicator. Instead, they should both increase emphasis on the indicators that will come out of the 1997-1998 survey. Develop a system for collecting new acceptor and current user data.

- Access appears to have increased due to expansion and regionalization. Target group access has not increased as much. Continuity of access is a major gap.

Recommendations: Profamilia should reorient all key project activities, including site selection, training, IEC, CBD and clinical services to focus on increasing access for the target group(s).

- There is no clear strategy to guide Profamilia's CBD program. CBD program is costly, urban-oriented, labor intensive, passive and neither efficient nor effective. Expensive training and technical assistance is largely wasted because it has no strategic focus.

Recommendation: Profamilia should determine how CBD fits into its overall mission strategy and define the proper role of CBD. Eliminate or severely reduce funding for CBD activities and stop all training and technical assistance in CBD and IEC.

- The effectiveness of the institutional image campaign has not been formally evaluated but findings suggest that it has not increased demand for services.

Recommendation: Profamilia and JHU/PCS should clarify the objectives of the institutional image campaign and evaluate whether these have been achieved.

- Cost recovery was highest at the beginning of the project (around 25%), but has been lower and relatively stagnant for the last four years. The problem has been that expenditures in the regional centers have been increasing faster than revenues.

Recommendation: Reduce the number of regional centers to those that are producing acceptable results and that have a reasonable chance of becoming self-sustaining within the next three to five years.

- Clinic-based services are growing more costly while achieving less. Incentives push providers to do as many sterilizations as possible while downplaying counseling, provision of other methods and informed choice.

Recommendation: Change the objectives and incentives in the clinic-based program to offer all available temporary methods, improve quality of services, counseling, informed choice, follow-up and so forth.

- Inadequate financial management is unable to control costs. Organization and management system is neither adequate to achieve or sustain expected results not to support changes needed in the organization.

Recommendation: Negotiate changes in Profamilia's management systems (finance, administration, personnel, planning, evaluation, etc.) to enable the organization to become organizationally self-sufficient within the next three to five years.

- Serious deficiencies in the financial management of Profamilia are hindering progress toward sustainability.

Recommendation: Profamilia should set a long-term sustainability objective that is reasonable and also an interim funding strategy that will ensure Profamilia's continued existence. Provide assistance and incentives to Profamilia to search for alternative funding sources.

In the face of these problem, USAID/N would be justified in curtailing, or even terminating funding of the project. The evaluation team understands that this option may have to be taken, but we believe that it should be a last resort.

USAID/N should renegotiate and amend the Cooperative Agreement with Profamilia to restructure the project. Profamilia should limit the activities it agrees to undertake to those that it does best and which have the greatest potential for becoming self-sustaining. These are the provision of clinical and temporary family planning services to women in urban areas who can afford to pay for them. Responsibility for women in rural areas should be left to the Ministry of Health (MINSa) and PVOs that are already working with these target groups. USAID/N should consider transferring funds that Profamilia will not need to MINSa and the PVOs.

ATTACHMENTS

K. Attachments (List attachments submitted with this Evaluation Summary; always attach a copy of the full report.)

The full evaluation report is attached: ***Mid-Term Evaluation of the Family Planning Expansion and Regionalization Project***

COMMENTS

L. Comments by Mission and Borrower/Grantee on Full Report

The Mission appreciates the tremendous effort of the evaluation team in this process. Through their work, they reconfirmed many of the concerns that the Mission held, and exposed other issues requiring treatment. As a result of this effort, PROFAMILIA is undergoing a full scale overhaul relative to management, strategy, objectives, internal operations, financial management, training and outreach. The Mission suspended disbursements for six months until the preliminary overhaul steps are taken. Additional funding will be tightly conditioned and managed until all reform features are in place.

The institutional trauma Profamilia has faced and the aggressive, yet professional manner in which they are pursuing the reforms should strengthen this PVO over the long term. The Mission views this organization, if it continues to reform and then perform, as a key change agent in reproductive health for Nicaragua.

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ANNEX 1

CONCLUSION	RECOMMENDATION	MISSION ACTION DECISION
<p>No accurate measure of project achievement is being used, except when national surveys are conducted - which is every five years or so.</p>	<p>Revise the indicators used to measure Profamilia's performance. Profamilia should develop a service statistics system to capture data on such essential information as characteristics of clients, continuity of use, complications and side effects, current users.</p>	<p>The Maternal and Child Health Results Team (MCH/RT) will work with Profamilia to develop appropriate indicators with technical assistance from Johns Hopkins and IPPF. (September 3rd.)</p>
<p>The CYP is a weak proxy indicator and subject to misinterpretation. It also distorts the direction of the project resulting in "goal displacement."</p>	<p>Profamilia and USAID/N should de-emphasize the importance of the CYP indicator. Instead, they should both increase emphasis on the indicators that will come out of the 1997-1998 survey. Develop a system for collecting new acceptor and current user data.</p>	<p>The Maternal and Child Health Results Team (MCH/RT) will work with Profamilia to develop appropriate indicators with technical assistance from Johns Hopkins and IPPF. (September 3rd.)</p>
<p>Access appears to have increased due to expansion and regionalization. Target group access has not increased as much. Continuity of access is a major gap.</p>	<p>Profamilia should reorient all key project activities, including site selection, training, IEC, CBD and clinical services to focus on increasing access for the target group(s).</p>	<p>Profamilia with TA will reorient activities and submit as part of Action Plan. (September 30th)</p>
<p>There is no clear strategy to guide Profamilia's CBD program. CBD program is costly, urban-oriented, labor intensive, passive and neither efficient nor effective. Expensive training and technical assistance is largely wasted because it has no strategic focus.</p>	<p>Profamilia should determine how CBD fits into its overall mission strategy and define the proper role of CBD. Eliminate or severely reduce funding for CBD activities and stop all training and technical assistance in CBD and IEC.</p>	<p>New strategy will be developed and implemented by October 30. Responsibles: Profamilia, MCH/RT and IPPF</p>
<p>The effectiveness of the institutional image campaign has not been formally evaluated but findings suggest that it has not increased demand for services.</p>	<p>Profamilia and JHU/PCS should clarify the objectives of the institutional image campaign and evaluate whether these have been achieved.</p>	<p>No action will be taken. Low on priority scale vis-a-vis other recommendations.</p>

<p>Cost recovery was highest at the beginning of the project (around 25%), but has been lower and relatively stagnant for the last four years. The problem has been that expenditures in the regional centers have been increasing faster than revenues.</p>	<p>Reduce the number of regional centers to those that are producing acceptable results and that have a reasonable chance of becoming self-sustaining within the next three to five years.</p>	<p>Profamilia and Price Waterhouse consultants will restructure and implement new financial/administrative system to enable Profamilia to analyze data and make decisions. The new system should be up and running by mid October.</p>
<p>Clinic-based services are growing more costly while achieving less. Incentives push providers to do as many sterilizations as possible while downplaying counseling, provision of other methods and informed choice.</p>	<p>Change the objectives and incentives in the clinic-based program to offer all available temporary methods, improve quality of services, counseling, informed choice, follow-up and so forth.</p>	<p>Profamilia with TA will reorient activities and submit as part of Action Plan. (September 30th)</p>
<p>Inadequate financial management is unable to control costs. Organization and management system is neither adequate to achieve or sustain expected results not to support changes needed in the organization.</p>	<p>Negotiate changes in Profamilia's management systems (finance, administration, personnel, planning, evaluation, etc.) to enable the organization to become organizationally self-sufficient within the next three to five years.</p>	<p>Profamilia and Price Waterhouse consultants will restructure and implement new financial/administrative system to enable Profamilia to analyze data and make decisions. The new system should be up and running by mid October.</p>
<p>Serious deficiencies in the financial management of Profamilia are hindering progress toward sustainability.</p>	<p>Profamilia should set a long-term sustainability objective that is reasonable and also an interim funding strategy that will ensure Profamilia's continued existence. Provide assistance and incentives to Profamilia to search for alternative funding sources.</p>	<p>New strategy will be developed and implemented by October 30. Responsibles: Profamilia, MCH/RT and IPPF</p>

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Mid-term Evaluation of the
Family Planning Expansion and Regionalization Project
A Report to Profamilia and USAID/Nicaragua

by

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March 1997

H

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When an evaluation team sweeps into town the busy lives and work of many people are disrupted. We wish to thank the Executive Director and staff of Profamilia for the many hours of time they gave for interviews and for the full access to documents and information they provided. We especially appreciate Profamilia's generous loan of a vehicle for our use and the skill and courtesy of our driver, Larry Chacon Duvan.

The team also appreciates the time and support of the USAID/N mission which provided a mountain of reports and attended numerous briefings in support of our effort to conduct a transparent evaluation that held no surprises.

Thanks also to Ms. Aracely Arce who served as secretary to our team. Her ability to solve problems and grace under pressure eased our work considerably.

Finally, we thank the people of Nicaragua whose unfailing humor in difficult times provided many light moments for the team. For many of us, this trip to Nicaragua was not just a job but a nostalgic visit to a country and old friends we love.

This report was prepared by the evaluation team and does not necessarily reflect the views of Profamilia, USAID/N or PopTech.

Gary Bergthold
Jack Reynolds
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February 22, 1997

ABBREVIATIONS AND ACRONYMS

AID	Agency for International Development
APP	Año Protección Pareja
CBD	Community-Based Distribution
CDC	Centers for Disease Control
CODEMU	Colaboración al Desarrollo de la Mujer
CPR	Contraceptive Prevalence Rate
CYP	Couple Years of Protection
DCA	Distribución Comunitaria de Anticonceptivos
DHS	Demographic and Health Survey
DHS	Development of Health Services (project)
EMIPLAFA	Maternal Child Health and Education (PROFAMILIA)
FHS	Family Health Survey
IEC	Information, Education and Communication
INCAE	Instituto Centroamericano de la Administración de Empresas
IXCHEN	Centro de Mujeres IXCHEN
IPPF	International Planned Parenthood Federation
IUD	Intra-Uterine Device
JHU	Johns Hopkins University
MEF	Mujeres en Edad Fértil
MINSA	Ministry of Health of Nicaragua
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
OB/GYN	Obstetrics and Gynecology
PCS	Population Communications Services
PROFAMILIA	Asociación Pro-Bienestar de la Familia Nicaraguense
RAPID IV	Resources for the Awareness of Population Impacts on Development
R4	Results Report and Resource Request
TD	Sexually Transmitted Disease
TFR	Total Fertility Rate
TGF	Tasa Global de Fecundidad
TOT	Training - of - Trainers
UNFPA	United Nations Population Fund
USAID/N	United States Agency for International Development/Nicaragua
VS	Voluntary Sterilization
WRC	World Relief Corporation



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SUMMARY

At the request of USAID/Nicaragua, a five person team spent three weeks in February, 1997, conducting an evaluation of the Family Planning and Regionalization Project of Profamilia. Profamilia, an IPPF affiliate was a small organization with two clinics in Managua when the project began in 1991. Under a Cooperative Agreement with USAID it received \$13 million in funding to expand its network of regional centers to ten full-service clinics and two outreach programs on the Atlantic coast. Its CBD outreach and referral program was begun in 1992 and has expanded to over 1,000 volunteers throughout the country. The goal of the project is to increase knowledge, acceptance and early use of modern family planning methods.

USAID's Cooperative Agreement with Profamilia runs until 1998. The purpose of this mid-term evaluation is to assess project performance and to make recommendations in five areas:

1. Performance indicators and achievements
2. Clinical services and quality of care
3. Community-based distribution and IEC
4. Financial management and sustainability
5. Organizational management and sustainability

The evaluation found that USAID/N's stated goals for the project have changed over the past six years and have become broader, vaguer, fewer and less measurable but the underlying (unstated) indicator of goal achievement, the Total Fertility Rate (TFR) has remained constant. In the absence of population-based surveys on TFR, both Profamilia and USAID/N have the proxy indicator "couple years of protection" (CYP) as their main performance indicator.

The use of CYP has had a significantly negative effect on program direction and operation. The emphasis on CYP has led Profamilia to focus on sterilization and sales of pills and injectables and detracted from such other important elements as method choice and quality of care.

Another major finding of the evaluation is that Profamilia lacks a coherent strategy. The staff of Profamilia is dedicated and hard-working but their efforts have not been guided by a clear strategic direction. This lack of strategy has led to selection of clinics that do not adequately serve the rural target population and a CBD program that is labor-intensive, costly and achieves limited results.

The client services provided by Profamilia in its clinics are of good quality but limited primarily to surgical contraception. Other family planning services are not delivered with the same emphasis and quality. Counseling throughout the program is inadequate except for preparation of clients for surgery. Clients are not provided the information they need to make free and informed choices about family planning.

The lack of a clear guiding strategy at Profamilia also limits the effectiveness of the IEC program. Profamilia has received extensive technical assistance and training in promotion, counseling and the development of support materials for IEC. Much of this assistance has been utilized poorly because of unclear strategies and ineffective management.

Serious deficiencies in the financial management of Profamilia are hindering progress toward sustainability. The current financial system does not provide adequate tools or information for managing the substantial funds provided by Profamilia's donors. The budgeting system is perfunctory and highly centralized. Costs are not controlled by management. As a result of all this, Profamilia is not on the road to financial sustainability. In fact, the program is becoming more costly and less efficient.

Finally, the evaluation team assessed Profamilia's organization and management to determine its capability to produce the project's expected results and contribute to its sustainability. Again, we found that management had achieved results as measured by CYP and expansion of the program. It had not, however, created the management systems, procedures and norms that are needed to orient the staff and resources to produce the intended project results.

The USAID/N mission has been aware of these problems for some time. Apparently, the mission has not been able to solve these problems in spite of increasing oversight and intervention. The ability of USAID/N and Profamilia to work together as true development partners has deteriorated, especially in the past year. USAID/N complains that Profamilia willfully ignores the terms of the Cooperative Agreement and the recommendations of technical assistance aimed at strengthening the organization. Profamilia complains that increased oversight and frequent interventions by USAID has eroded its autonomy.

The evaluation team made a number of recommendations that we believe will enable Profamilia to redefine its mission and strategy and more effectively achieve its intended results. These recommendations are listed in the following pages.

CHAPTER 1: INTRODUCTION

BACKGROUND

Population, Family Planning, and Fertility Rates in Nicaragua

The Current Situation

Nicaragua's population is estimated at 4.3 million. Fertility is declining somewhat and contraceptive use is steadily increasing. Whereas UN estimates placed the average number of children per woman of fertile age at 5.5 during the late 1980s, the 1993 Family Health Survey estimated the fertility rate at 4.6 children, still the fourth highest rate in Latin America. While fertility is declining among older women, it is increasing among adolescents. Nicaragua now has the highest adolescent fertility rate in Latin America. Paradoxically, the same survey estimated knowledge of contraception at 97 percent and estimated the contraceptive prevalence rate (CPR) at 49 percent, equal to the average CPR for the Central American region. In other words, almost 50 percent of married women in Nicaragua between the ages of 15 and 49 are using a method of contraception.

Still, the population of Nicaragua continues to grow by approximately 2.7 percent per year -- a relatively high rate for Central America. If nearly 50 percent of women in union use contraception, why then should fertility rates and population growth rates remain so high? First, due to high fertility rates in the past, there are a significant number of women entering their reproductive years. Although their fertility is lower, their absolute numbers make for a high population growth rate. Second, although knowledge of contraception is almost universal, less than 50 percent of women of fertile age use modern methods. Last, the choice of family planning method in Nicaragua is female sterilization. Data from the Family Health Survey of 1992 reveal that most women seek surgical contraception only after they have exceeded their ideal family size of 3 children. Poor women who have little formal education and those who live in rural areas are least likely to use contraception and, hence, have the highest fertility rates.

The Mission Strategy

The USAID/Nicaragua family planning strategy is reflected in Result 3.3 under the Strategic Objective: Better Educated, Healthier, Smaller Families.

Result 3.3: Increased Use of Reproductive Health Services and Practices

In order to achieve this program outcome, the Mission is pursuing a combined public/private sector family planning program. Family planning services form an integral part of the Decentralized Health Services (DHS) Project's maternal child health model. The model stresses the importance of post-partum care and routine family planning visits. The Mission will continue to supply the Ministry of Health with such temporary contraceptive methods as pills, condoms, IUDs and Depo-Provera.

The Mission is implementing a Family Planning Expansion and Regionalization Project through Profamilia, the local IPPF affiliate. The project includes a nationwide media campaign and the expansion of Profamilia's network of clinics and community distribution posts. This project targets

poorly educated, rural women of low socioeconomic status. The Family Health Survey has shown that poor, rural and less-educated women are the least likely to use contraception. Another target group is women between the ages of 15 and 24, who have one of the highest age-specific fertility rates in Latin America. The strategy is to reach the least accessible users, both in geographic and cultural terms, to encourage them to begin using contraception earlier in their reproductive lives to both postpone the first pregnancy and space subsequent pregnancies.

Profamilia's Goals and Activities

Over the life of project, the Mission and Profamilia have made a series of changes in the project design to reflect experience, including modifying the goal, purpose, funding level, completion date and types of activities. The current project goal is to increase knowledge, acceptance and early use of modern family planning methods. The project purpose is to increase client access to a range of contraceptive methods, especially in rural and marginal urban areas.

By the end of the project in 1998, Profamilia should:

- a) provide 150,000 couple years of protection annually;
- b) develop cost recovery mechanisms to generate 34 percent of its operating costs;
- c) design and implement an effective information, education, and communication (IEC) campaign aimed at non-users of contraceptives living in rural and marginal urban areas;
- d) adopt a plan for achieving gender diversity in the work force, augment its senior management staff and train them in their respective areas of responsibility; and
- e) engage other NGOs in providing national coverage of private sector family planning services.

The Cooperative Agreement includes expanding the network of regional centers to eleven full-service clinics and two outreach programs on the Atlantic Coast. The number of CBD workers was to be expanded to over 1,000.

Profamilia now operates ten full-service family planning clinics, two in Managua and one each in Masaya, Rivas, Chinandega, Matagalpa, Jinotega, Boaco, Juigalpa, Ocotal and an outreach program in the North Atlantic Coast. The second clinic in Managua is scheduled to be closed. Two more clinics are scheduled to open in Leon and San Carlos in 1997, as is an outreach program in Bluefields.

More than 1,070 CBD workers are now providing outreach and contraceptive methods and referrals, though 43 percent of these community distribution posts are located in commercial pharmacies or stores. Profamilia now provides an annual average of 133,000 CYPs and provides contraceptives to other NGOs which provide an additional 18,000 CYPs per year. Twenty per cent of the services, gynecological and family planning, are provided in Managua — and the remaining eighty per cent are provided by the regional centers and CBD posts.

EVALUATION SCOPE OF WORK

The scope of work prepared by USAID/N consists of five major questions, which are shown below. The detailed SOW can be found in the Appendix. It contains over 60 subquestions that indicate the major areas of interest to the Mission. These are summarized in parentheses below.

"USAID/Managua seeks the services of a contract team to conduct an evaluation of its \$13 million Family Planning Expansion and Regionalization Project. The Evaluation is intended to answer the following questions:

- 1) Relation to Mission Strategy Is the activity likely to contribute to achieving the Mission family planning and reproductive health strategy? (Emphasis: Appropriateness of indicators used and achievement of access.)
- 2) Achievement of Activity/Project Goal Is the project on schedule to achieve its goal: to increase knowledge, acceptance and early use of modern family planning methods? (Emphasis: Quality of clinical services.)
- 3) Achievement of Activity/Project Purpose Is the project on schedule to achieve its purpose: to increase access to a range of contraceptive methods, especially in rural and marginal urban areas? (Emphasis: CBD and IEC.)
- 4) Financial Sustainability Is Profamilia making adequate progress towards assuming an increasing share of its recurrent costs? (Emphasis: Financial management, pricing, cost-recovery, and financial sustainability.)
- 5) Organizational Sustainability Are the organization, staffing and management of Profamilia adequate to achieve the activity purpose and goal? (Emphasis: Management and administration.)"

The Evaluation Team met with USAID/N on the first and second days to clarify the SOW. USAID/N agreed that the Team would respond to the five major questions listed above, treat the subquestions as guidelines, and develop its own outline for responding to the SOW. That outline was incorporated into workplans for each member of the Team, which were reviewed and approved by USAID/N the following day.

METHODOLOGY

The Team spent three weeks in Nicaragua (except for one member who had to leave after two weeks). During this time the five members reviewed over 40 documents (see Bibliography), interviewed over 50 individuals (see List of Persons Interviewed and Contacted), and made site visits to five Regional Centers (also in the preceding list).

Statistical data on such key indicators as numbers of acceptors, continuation rates, complications, costs of services and characteristics of users often were not available. The fragmentary data that was found was verified through interviews and comparisons with similar data from other sources. Fortunately, a national survey is planned for later this year and it should yield specific data on many of the missing indicators.

Around the middle of the second week the team held a mid-term briefing with USAID, another with Profamilia, and a third with both groups. Only the preliminary findings were presented at these

meetings. The conclusions and recommendations were presented later at the final briefings, which were held just before the Team departed.

USAID/N specifically requested that the findings, conclusions and recommendations be presented in as concise a manner as possible, and that the report be equally concise. The Team has tried to comply with these requests and has attempted to limit each chapter to 7-10 pages. Where necessary, additional information has been included in the Appendix.

CHAPTER 2: PERFORMANCE INDICATORS AND PROJECT ACHIEVEMENT

EVALUATION QUESTIONS AND ISSUES

This chapter deals with the general question: "Is the (project) likely to contribute to achieving the Mission's family planning and reproductive health strategy?" The Mission is especially interested in the following:

1. Are the indicators appropriate?
2. Has the expansion of clinics and CBD posts increased access among the target population?

FINDINGS

Indicators

To answer the first question we need to examine the project's goal, purpose and expected outputs. Have they changed over time? What is the USAID/N strategy for the population/family planning sector? Has the choice of indicators had any significant effect on project operations?

Appendix A summarizes the goals and objectives of USAID/N, Profamilia and the project as they have evolved over the past six years. Indicators, target groups and major activities are also described. An examination of this data and interviews with USAID/N and Profamilia staff lead to the following findings.

1. **USAID/N's stated goals have become broader, vaguer, fewer and less measurable over time.** They have gone from clear statements of intent (to reduce population growth or fertility) to broader statements (to have "better educated, healthier and smaller families"). This has been a response to directives from AID/Washington to limit and consolidate program goals, objectives and indicators.
2. **The underlying (but unstated) objectives of USAID/N and Profamilia have not changed much at all in the past six years.** They are to reduce population growth by reducing fertility by increasing contraceptive use. Both organizations have remarkably similar goals and objectives.
3. **The formal indicator of goal achievement has also remained the same.** It is the Total Fertility Rate (TFR). Both USAID/N and Profamilia agree that this is the preferred indicator.
4. **Neither the TFR nor its best proxy, the contraceptive prevalence rate (CPR) can be measured on an annual basis.** This is because they require national, population-based surveys, which are expensive. Profamilia and USAID/N both recognize and accept this.
5. **Even lower-level proxy measures (numbers of new acceptors, current users, continuation rates) cannot be obtained on an annual basis in Nicaragua at this time.** USAID/N and Profamilia both understand this.
6. **The only proxy indicator for which data can be collected regularly at this time is the CYP (couple years of protection).** Both USAID/N and Profamilia have agreed to use this as their main performance indicator despite its limitations.

In summary, USAID/N and Profamilia agree on the broader goals and indicators for the project. The Team also agrees that these are appropriate.

The problem lies with the proxy indicator, CYPs.

Research going back at least 30-40 years has shown that the choice of indicators drives performance. If the indicator on which a project is judged is new acceptors, management and staff will strive to increase new acceptors. If the indicator is continuation rates, efforts will focus on increasing continuation.

The wrong indicator can also divert a program away from achieving desired goals. Has the choice of the CYP distorted the direction of Profamilia's work? The short answer is "yes."

7. The use of CYP has had a significant negative effect on program direction and operations.

We will first examine why that has happened. Our recommendations will suggest what can be done about it.

Profamilia's interpretation of the project's goals and objectives is stated in its latest annual report.

Strategic Objective: Improve mother and child health by increasing use of modern contraceptives to space births and reduce the TFR. Increase knowledge and early use of modern contraceptive methods, especially in rural and marginal urban areas. This will be evaluated through the increase in CYPs from 57,000 in 1993 to 155,000 in 1998.¹ Profamilia takes this last statement very seriously.

- 8. It is clear from interviews with Profamilia staff at all levels that they feel under tremendous pressure to produce CYPs.** This is true at the central office and the pressure goes to the regional centers, clinics, providers and even the CBD promoters. This leads to pressure in the clinics to perform as many sterilizations as possible, since each sterilization counts for 10 CYPs. A packet of pills counts for less than one-tenth of one CYP and an injection for only one-fourth of a CYP. The pressure at the CBD posts is to sell as many pills and injections as possible and to refer as many customers as possible to the clinics for sterilizations.
- 9. The emphasis on CYP achievement has led to "goal distortion."** While this focus on sterilizations and sales of pills and injectables clearly helps Profamilia meet its main project objective, it also detracts from such other important elements of the program as method choice and quality of care. It has been obvious to the Evaluation that this is a widespread phenomenon and is directly attributed to Profamilia's interpretation of its primary responsibility under the agreement.
- 10. USAID/N has unintentionally contributed to this goal displacement.** The transition to the new SO/PO format has led to some confusion within USAID/N as to what the guiding goals and objectives are for the Population/Family Planning program in Nicaragua. While the underlying objective is to reduce population growth and fertility, the operational indicators have been reduced to one, the CYP. This is considered an "interim" indicator by Pop/FP technical staff, but it is more than that to Agency (and perhaps Mission) management. At a PopTech Key Consultants meeting that two of the Team attended last December, AID/W explained that under the new system, Sectors and Missions are held accountable for achievement of the planned results stated in their Results Framework. Even though they said that this is only one of many factors taken into account in

¹ Profamilia. Informe Anual Octubre 1995 a Septiembre 1996. Proyecto 524-0312-A. Octubre 2, 1996, p. 2. Emphasis added.

making funding decisions, they also said that the purpose of the new R4 system is to determine which Missions have achieved the results they promised with the resources they were given. Those Missions that achieve or exceed their planned results, they said, will not face budget cuts. Since the only family planning indicator in the USAID/N framework now is the CYP, the Agency is unwittingly contributing to pressure on both the USAID/N staff and Profamilia to produce CYPs.

Achievement

The second evaluation question asks whether the new regional centers, clinics and CBD network have achieved what they were meant to do: increase access and contraceptive acceptance among young, poorly educated, low socioeconomic status women in rural areas? The answer seems to be yes, no and we can't tell.

Access has Increased in Some Ways

- 1. Access has increased, especially in departments and towns outside Managua.** As of December 31, 1996 there were 10 regional centers, and 1099 CBD posts that had been established. The majority of these are outside of Managua and have been set up under the project. These new sites are serving areas that had not been adequately served before. For example, in 1991 all of the 223 CBD posts that existed then were located in Managua. By 1993 the majority of the posts (233 of 427, or 55 percent) were located outside of Managua in five Departments. At the end of 1996 there were 871 posts (80 percent) outside of Managua.
- 2. These clinics and posts provided 133,133 CYPs in calendar year 1996.** That is over twice the amount that was produced in the baseline year of 1991 (51,711). The clinics provided most of the CYPs (113,176 or 82 percent). The CBD posts provided the rest (24,759 or 18 percent). The top five regions (after Managua) were Masaya (16,260), Juigalpa (15,950), Chinandega (13,340 CYPs), and Rivas (13,340). Jinotega had the lowest achievement at 2,950.² See Appendix B, Tables 1 and 4 for detailed tables. Plans call for four more centers/clinics to be set up this year, in Leon, San Carlos, Rio San Juan and the Atlantic coast at Puerto Cabezas.
- 3. Coverage has expanded greatly.** From a purely geographic point of view, the expansion is placing Profamilia clinics in most of the country's major departments, including those in the mountainous and Atlantic coastal areas (see map). Coverage, if measured by the number of towns that have Profamilia clinics or CBD posts, has expanded greatly. For example, Chinandega has at least one CBD post in 15 of the Department's 21 towns. That amounts to "coverage" of 71 percent of Chinandega. Of course, one CBD outlet in a town may not be adequate, but it still means that Profamilia contraceptives and services are closer to the target group than then were before.

Profamilia estimates population coverage, also. Of the approximately one million fertile age women in Nicaragua, Profamilia is "assigned" to cover 16 percent through its 10 Regional Centers. This

² There are slight differences in the CYP figures depending on the calculations. The table produced by the Evaluation Team is based on actual service units produced during the calendar year. The table produced by Profamilia is an estimate of annualized achievement. The performance of new clinics that were opened during the year has been adjusted to estimate the number of CYPs they would have achieved if they had been open for the entire year. See Ocotal as an example, where 244 sterilizations were actually performed in 1996. Profamilia calculated that if that clinic had been open all year it would have performed 732 sterilizations, which would translate into 7,320 CYPs. See Appendix B, Table 4.

amounts to 151,658 women. Coverage for 1996 was 137,933 CYPs (annualized). This is 91 percent of the assigned amount. See Appendix B, Table 2 for details.

Access is Still Limited in Other Ways

1. **Access is still limited for the target population.** On the other hand, the answer is also "No," for several reasons: the choice of locations, the urban nature of the clinics and many CBD posts, the closing of some CBD posts, the absence of significant outreach services from these posts, and the lack of follow-up of women on temporary methods. Most of these issues will be discussed in other sections of this report. A few that relate to the objective of increasing access will be discussed here.
2. **Site selection for Regional Centers and Clinics is not based on a strategic plan.** The Team has learned from a number of sources that there is no strategic planning behind the selection of sites for the centers and clinics. No analysis of unmet need, proportion of the target group in the area, potential demand, existence of other clinics (especially MINSA services), etc. has gone into site selection. Sites appear to be selected intuitively or subjectively, sometimes for reasons that have nothing to do with the project (such as the presence of a university, or the attractiveness of the area). Apparently, a new center was supposed to be set up in Esteli, a coffee and tobacco area of potential high demand. It was switched, apparently without a clear explanation of the reasons, to Jinotega, which is very close to an existing center in Matagalpa. Jinotega had the lowest targets and lowest performance of all the centers this past year and was the object of a special evaluation to determine why demand was so low.

The selection of San Carlos is also controversial. Apparently, this town, which is right on the edge of Lake Nicaragua and close to the Costa Rican border, is expected to serve mostly tourists and women from Costa Rica who seek sterilization (sterilization is illegal in Costa Rica). There is also some controversy about the Atlantic Coast clinic. It may be set up in Puerto Cabezas even though we have been told that the demand and need are greater in Bluefields.

3. **Site selection of CBD Posts is not based on the location of the target group.** In early 1996, Profamilia's Planning and Evaluation unit conducted a study of the persons in charge of CBD posts.³ The only data available to Profamilia about their posts at this time were their names and addresses. The survey showed that the largest proportion of posts were in the homes of housewives (27.6 percent) and health workers (26.3 percent). The latter included physicians (5.4 percent), pharmacists (4.2 percent) and midwives (1.9 percent). Other important groups were shop owners (7.5 percent) and teachers (5 percent).
4. **The majority of these CBD posts are in "urban" or semi-urban areas** (depending on the definitions of "urban" and "rural," see below). For example, of 105 posts in Chinandega, 76 percent are in "urban" areas: 28 percent in Chinandega, 28 percent in El Viejo and 20 percent in Leon. Or put another way, $\frac{3}{4}$ of Chinandega's CBD posts are in 3 of its 21 towns.

When asked about this, the Regional Director in Jinotega said that they consider all of the towns of Jinotega to be urban. Everything outside is rural. Over two-thirds (68 percent) of the 96 posts are in the urban area.

³ Dirección de Planificación, Evaluación e Investigación. Profamilia. Características de los Responsables de Puestos de Distribución Comunitaria de Anticonceptivos de Profamilia. (undated).

5. **Most CBD posts are operate passively.** Rather than take information and contraceptives to the communities, the CBD volunteers wait for community members to come to their places of business. That is, there is no outreach, which would normally be a *sine qua non* for extension of services to hard-to-reach areas. Many, if not most CBD volunteers, see their job as selling contraceptives, rather than providing IEC and appropriate referral advice or contraceptives to women in need. The CBD program appears to be a hybrid between a "real" community-based distribution program and a quasi-social marketing program. The former usually relies heavily on personal contact with potential acceptors in their communities. The latter relies more on advertising to bring customers to service providers.
6. **A significant proportion of CBD Volunteers do not seem well-suited for the job.** The survey also produced some startling data that raise serious questions about the CBD selection criteria and process. Fifteen percent of the CBD respondents were over 50 years old, 20 percent were highly educated (university or higher), 16 percent had more than 6 children and 8 percent of those were under 40 and were not using any family planning method! Among those with 4-5 children, 18 percent were under 40 and not using family planning. The study did not examine the reasons for this. It is possible that none of these people were in need of family planning, but not likely.
7. **A significant proportion of CBD posts close each year.** At the end of 1996 Profamilia summarized the status of its CBD posts and reported that 440 new posts were opened, 659 were continued and 218 closed during the year. A total of 1,099 posts were active. Although this is a significant gain over 1995 (877 posts), the attrition was quite high. One way to summarize this is in terms of net gain. Although 440 new posts were opened in 1996, 218 also closed. The net gain was only 50 percent of new openings. That is, Profamilia has two open two new posts to gain one that will remain open. The Team is not sure why so many posts closed (16 percent of the total). Competition from other outlets has been mentioned by one long-term CBD volunteer as one explanation.⁴ Whatever the reason, the net effect is costly, and it could mean that at least some clients are left without a source of contraceptive supplies. This could have serious personal and political consequences if these clients become pregnant as a result.

Data on Access is Too Limited

Finally, there isn't enough data to be able to tell whether access has increased or not. This is a reflection on the paucity of basic planning, operational and evaluative data. These are some of the gaps.

1. **Lack of key definitions of the target group.** The 1992-93 survey confirmed that the need for family planning is greatest among married women in rural areas, those with less education (< primary school), those in lower socio-economic groups, those under age 30, and those with 3 or more children. The team agrees that this is the right target population. Although USAID/N and Profamilia accepted this in principle, none of these key terms have been defined operationally for the

⁴ The Team has been told by some field staff that some sites are already overcrowded with contraceptive outlets. That is, supply has exceeded demand in some areas. One CBD volunteer who has been selling Profamilia contraceptives out of her coffee shop for over 10 years said that she used to have 500 customers. That has dwindled to 50. She believes the explanation is competition from other outlets in her area.

project. Without clear definitions it is impossible to even identify the target group(s), much less design services, outreach and IEC for them.⁵

- **Rural:** there is no standard definition of what this means. Many people say it means "anything outside of Managua," in which case, any center or post that is located in a city or town, such as Jinotega, would be "rural." As we know, all of the centers and clinics and many of the CBD posts are located in Department capitals. Others say it means anything outside Managua and the capitals of the Departments. Others use population density (people per square kilometer) or occupational criteria (for example,, agriculture, ranching) to define rural areas. Although the census and the 1992-93 survey both use "rural," we could not find definitions of the term in the reports.
 - **Young women:** this has been defined in various documents as women aged 15-24, women under 20, women 20-34, women under 30 or simply "young" women or even "adolescents."
 - **Poorly educated:** A large portion of the population is poorly educated. The 1992-93 survey estimated that almost half (46.9 percent) had no education at all or only some primary education. In rural areas the majority (73.8 percent) fall into this category. A large number of women are illiterate. It makes a big difference programatically how IEC is designed if the target group is illiterate.
 - **Poor/low socioeconomic status.** This is a similar problem. Most of the population is poor and in the low SES category, especially in rural areas. But there is no operational definition of what this means in the project. As far as we can tell, no SES classification is used to identify target groups.
2. **Lack of client records.** Records are not kept for clients who come to Profamilia clinics for temporary family planning methods. They are for those who come for sterilizations. The CBD distributors keep no client records at all. Not only does this mean that we have no idea who is being served (urban or rural women, poorly educated or not, etc.) but the clinics and distributors do not have a system for follow-up. This is an especially serious shortcoming for women on temporary methods, since there is no way for the distributor or the clinic to identify who needs which method at what time. This can easily lead to contraceptive failures and charges that the program is contributing to increases in unwanted fertility rather than decreases.

It also points out one of the major drawbacks of the CYP. There is no effective annual protection for a women if she does not use her contraceptive continually (and correctly) over the year. The CYP tempts managers to make a leap of unwarranted faith that 12-13 cycles of pills distributed provide such protection.⁶ But if they are distributed to 12-13 separate women who are not followed

⁵ During one of the mid-term briefings several of the participants agreed that this was "splitting hairs," since everyone knows who the target groups are and the definition used in the 1992-93 survey was generally accepted. The Team believes that this is not the case, and that project efforts have been misdirected toward achievement of CYPs, sterilizations and number of CBD posts precisely because there is no agreement or who the target groups are, much less how to reach them.

⁶ Ibid. See p. 2. "...PROFAMILIA tiene el compromiso de estar protegido a 155,000 parejas anualmente. Al 30 de septiembre de 1996, es esta protegiendo como promedio proyectando al año 128,064 parejas..." Emphasis added. The key word here is pareja (couple). Profamilia is saying that it is protecting 128,064 couples.

to make sure that each gets and uses the pills she will need for the rest of the year, then this could result in 12-13 pregnancies.

- 3. Lack of service statistics.** In addition, the lack of adequate information in and from the clinics on new acceptors, continuing users, dropouts, method switching, side-effects, complications, and other basic service data not only means that the providers are inadequately informed about their clients, but also that the project lacks basic information needed for planning, supervision and evaluation. For example, the project has no idea (and no way to determine) the number of individual women it has served. It cannot determine the average number of visits a woman makes each year. Most important, it cannot determine whether the women coming to the clinics and CBD posts are from the project's target group.

CONCLUSIONS

Indicators

- 1. No accurate measure of project achievement is being used, except when national surveys are conducted - which is every five years or so.**

Neither the TFR nor the CPR have been specified as performance indicators for the project. For practical and expedient reasons, the major (and now only) measure of project "results" is couple years of protection. USAID/N views the CYP as an interim measure, and not an end in itself. It really wants to see increases in contraceptive prevalence, continuity of use, and increased acceptance of family planning by younger women in rural areas. So does Profamilia. The problem is that this is impossible to measure on a regular basis. It requires a national-level survey, such as the one that was undertaken in late 1992-93 and the one that is planned for 1997-1998. In the meantime, USAID/N accepts CYPs as a proxy. Profamilia, on the other hand, sees the CYP as the only quantified objective in their agreement, and the one for which they are held accountable. They feel great pressure to produce enough CYPs each year to meet their project target.

- 2. The CYP is a weak proxy indicator and subject to misinterpretation. It also distorts the direction of the project resulting in "goal displacement."**

The CYP is not an indicator of program effects, much less impact. At best it is an estimate of the quantity of contraceptives distributed. It does not even measure accurately the quantity of contraceptives used. Although this indicator has been used for over 30 years and tomes have been written about it, the fact remains that it cannot be used to measure a program's results. However, the indicator itself seems intuitively logical and its name (couple-years of protection) gives the false impression that X number of couples are fully protected from unwanted pregnancies for the entire year. This statement has been made repeatedly by Profamilia, both in public meetings and in its various reports.

The indicator also distorts program direction, if taken too seriously, as it is in Profamilia. If the key indicator were new acceptors or active users, then Profamilia would be trying to perform well on those indicators. Since CYP is the key indicator, it emphasizes achievement of CYP goals. This has led to an overemphasis on sterilization (because it produces the most CYPs for the least effort) and sales of pills and injections (with minimal screening and no follow-up) outside of the clinics. Not only does this distort program direction, it lessens the attention given to informed choice, quality of

care, and continuity of use. This is not only a disservice to the clients, it is also a political disaster waiting to occur. All it will take is one death or serious complication for the press (including the international press) to start investigating, reporting and charging Profamilia and USAID/N with harming the very people they are trying to help. The team has already heard such statements being made on radio and television during its short stay in Nicaragua.

Achievement

- 1. CYP achievement is close to the target, and should exceed it this year.**

The project is doing well in terms of CYP achievement. The figures for calendar year 1996 show 133,133 CYPs achieved. The target for 1997, which have not yet been approved, is 155,000 CYPs, and there is every expectation that this target will be met.

- 2. However, in terms of accurate measurement of project achievement, CYP performance is meaningless. No hard data on actual achievement are collected to assess project performance.**

As noted above, the CYP is a weak measure of contraceptives distributed, not of contraceptive prevalence or fertility. And until the next survey is undertaken later this year, there will be no practical way to determine whether the program has had any effect on contraceptive use or any impact on fertility.

- 3. Access appears to have increased due to expansion and regionalization. Target group access has not increased as much. Continuity of access is a major gap.**

Although it is clear that the project has increased access to many areas that were not served by Profamilia before 1991, it is less clear that there has been a significant increase in access for the project's target group. This is because all of the clinics and the majority of the CBD posts are located in urban areas. Thus, access to rural women is still limited. Young people are reluctant to be seen going to the clinics, and this is probably the case with respect to the CBD posts, as well. Thus, access to young women also remains limited. The lack of records and follow-up means that continuity of care and continued access to contraceptives is also problematic. Outreach to the target groups is also limited, since the CBD volunteers are largely vendors, rather than communicators or promoters.

RECOMMENDATIONS

Indicators

- 1. Profamilia and USAID/N should de-emphasize the importance of the CYP indicator. Instead, they should both increase emphasis on the indicators that will come out of the 1997-1998 survey.**

Both Profamilia and USAID/N need to accept each other's perspectives (and bureaucratic reporting requirements) and find ways to reorient themselves toward their common goals, which are to: 1)

reduce population growth; by 2) reducing total fertility; by 3) increasing contraceptive prevalence, especially among younger, less-educated, rural women.

It seems that Profamilia is taking the CYP indicator too seriously and USAID/N is reinforcing that by not shifting its emphasis to the broader goals of the program and acting as a buffer to reduce the pressure on Profamilia to meet its (CYP) objectives.

Among the actions that both sides can take immediately are: 1) reduce the emphasis on the CYP as the key indicator; keep reminding everyone that population growth, total fertility, contraceptive prevalence and increased acceptance of family planning by key target groups are the real objectives; 2) keep reminding people that the next survey and census will be conducted soon and that performance will be judged then on those indicators and not the CYP; 3) encourage Profamilia to provide supplementary data (including qualitative data, newspaper articles, reports from consumer groups) whenever possible on the broader indicators.

2. Replace the CYP. Develop a system for collecting new acceptor and current user data.

Over the medium term, say the next 2-3 years, Profamilia, USAID/N and IPPF should combine forces to develop an adequate reporting system that will enable Profamilia and MINSA to do away with the CYP and replace it with a more relevant indicator, such as new acceptors and/or current users. Not only would such indicators provide a more accurate view of program accomplishments, but they would redirect Profamilia's efforts in the right direction.

USAID/N should provide technical assistance to Profamilia and MINSA to set up an interim system for collecting data on key performance indicators (such as new acceptor characteristics, current users, side-effects, and dropouts). For example, a limited number of sites could be selected around the country to represent Managua, urban areas outside of Managua, and rural areas. Volunteers in those sites could be trained to collect the needed data from all households in their catchment areas. This data could be reported and analyzed on a quarterly basis.

Achievement and Access

1. Profamilia should develop a service statistics system to capture data on such essential information as characteristics of clients, continuity of use, complications and side effects, current users.

This type of data is needed by the regional centers for follow-up and local planning. The data is also needed by the central office for evaluation and adjustments in the strategic and operational plans. There is a wealth of experience in this area that has been compiled over the last 30 years, and there are many models to choose from, including manual and computerized systems, and systems for use by less educated and illiterate volunteers. Thus, there is no excuse for the program not having a basic service statistics system at a minimum. USAID/N (and/or IPPF) should provide the technical assistance that Profamilia may need to design, test and implement such a system.

2. Profamilia should reorient all key project activities, including site selection, training, IEC, CBD and clinical services to focus on increasing access for the target group(s).

Although most of the service elements are in place, they need to be reoriented toward the achievement of the project's objectives, especially improving access to high quality family planning services among "young, poorly educated and less economically advantaged couples living in rural areas," if that is, indeed, the main target group.

This will require a complete reorientation of the organization, from the Board and Executive Director down to the CBD volunteers. The most obvious prerequisites for undertaking this reorientation are a strategic plan and leadership. Profamilia has neither at the moment and must restructure itself to set these elements in place.

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CHAPTER 3: CLINICAL SERVICES AND QUALITY OF CARE

EVALUATION QUESTIONS AND ISSUES

This chapter deals with the question: Is the project on schedule to achieve its goal, to increase knowledge, acceptance and early use of modern family planning methods? The emphasis in the SOW is on six project elements that affect the quality of clinical services.

1. Access to quality contraceptive services and follow-up
2. Counseling
3. Access to other reproductive health services
4. Clinical training
5. Supervision
6. Appropriate family planning service providers

FINDINGS

Access to Quality Contraceptive Services and Follow-up

Surgical Sterilization Services

- Profamilia's policy is that women who are more than 25 years old and have two children or more are acceptable for sterilization. Some women receive surgical contraception at a younger age, however, if they have completed their reproductive life. MINSA norms state that sterilization may be performed on clients over 30 years old if they have attained their desired family size or for any age client who has three or more children.
- MINSA has recently developed norms for surgical contraception but they do not include detailed guidelines for surgical procedures.
- Surgeons do not test clients for pregnancy before sterilization is conducted. Nurses ask clients about their last menses, breast feeding and previous contraceptive use to determine possibility of pregnancy.
- Clinic facilities visited by the evaluation team are clean and well-equipped.
- Quality of care of clinical methods was observed to be good. The evaluation team observed surgical procedures, interviewed clients in the recovery room, and interviewed four MINSA physicians. Data on such QOC indicators as complications and failure rates are not available
- Undocumented reports alleging excessive complications and poor management of complications, especially during training of physicians, could not be verified by the evaluation team. No verifiable data is available on complication rates.

- Complications from surgeries such as infections are sent to public hospitals to be treated. Minor cases are followed up in community visits.
- Profamilia's clinics keep good clinical records for sterilized patients, but they do not provide follow-up of users on a regular basis to determine complications, failure rate or "regret".
- Sometimes Clinic Directors encourage physicians to do "case studies" to determine client's method compliance and follow-up of special complaints and side-effects but the results of these studies are not analyzed systematically.
- Clinics are usually located far from the rural clients and are not appealing to young people as they are set up more for clinical than for general family planning purposes.
- Surgical contraception is sometimes provided by Profamilia in rural MINSA clinics where operating rooms are not available. In these "mobile clinics" the clinical team cleans and decontaminates the facility and uses sterile equipment carried with them.
- Integration between MINSA and Profamilia's services is taking place as follows: a) public hospitals are being used to perform Profamilia's sterilization procedures in areas where Profamilia does not have a clinic; b) the clients who are to be sterilized are referred to MINSA health centers to have their lab exams; c) MINSA CBD posts refer people to Profamilia's clinics to have sterilization done; and d) physicians from the public sector are being trained by Profamilia.

Temporary Methods in Clinics

- Relatively few temporary methods have been delivered through Profamilia's clinics and CBD posts. The 10 Regional Clinic Centers have offered the following CYP data for each contraceptive method. No data are available on new acceptors or individuals served.

Method	Units	CYP	Percent
Pill	256,786	17.119	12.9
Condom	293,309	1.955	1.5
Depo-Provera	31,512	7.878	5.9
IUD	687	2.405	1.8
Sterilization	10,329	103.290	77.7
Total	XXX	133.132	100.0

- The provision of IUDs is low in Profamilia clinics (626 insertions for all regional clinic centers in 1996). MINSA reports that from January to November, 1996, 21 percent of their clients chose IUD as their contraceptive.
- Depo-Provera has been introduced well in Profamilia clinics and appropriate counseling is being provided.
- The positive acceptance of Depo-Provera, in Profamilia's opinion, is because the method offers confidentiality and long term protection. Another factor is that the oral contraceptives preferred by many women (Neogynon) has been in short supply since March, 1996.
- Written protocols with guidelines for service providers are not available in all clinics but they can be found at the Central office. One Social worker interviewed by the team had written guidelines on contraceptive methods in her possession.

Reasons for the Emphasis on Sterilization

- Factors that lead to the heavy concentration on sterilization and low delivery of temporary methods include:
 - ◆ Profamilia sets monthly targets for surgical contraception (between 138 to 160/month/clinic center and 90 percent of bed occupation daily) as well as for temporary contraceptive methods delivered at the clinics. Targets are based on historical data. Those are progressive targets and do not take into account local conditions.
 - ◆ Physicians are paid an incentive for each sterilization procedure (45 cordobas) but not for IUD insertions and other temporary contraceptive methods.
 - ◆ Profamilia has an agreement with other NGOs, to refer sterilization clients to Profamilia but not for clients for the temporary contraceptive methods.
 - ◆ Transportation from rural communities to Profamilia clinics is sometimes provided by Profamilia or other NGO's but only for sterilization clients.
 - ◆ Prices charged for temporary contraceptive methods are high for poor people living in rural areas.
 - ◆ Confidentiality is not provided for clients of temporary methods in the clinics. Privacy is provided for external consultations only.

Counseling

- Counseling preparing clients for surgical contraception is done by the social workers and is of acceptable quality. Counseling for temporary methods delivered in the clinics is not adequate because it is usually done by the receptionist rather than a trained counselor and privacy is not provided.
- According to Profamilia's norms, counseling on temporary contraceptive methods is supposed to be given to sterilization candidates. This was not observed by the evaluation team. Most sterilization clients probably are not counseled on alternative contraceptive methods.
- Some regional directors and CBD supervisors conduct lectures and organize seminars in the community to talk about human reproduction and family planning subjects but promotion of family planning services is not a high priority.

Access to other reproductive health services

- Profamilia offers such preventive gynecological services on an outpatient basis as pre-natal care, gynecological examinations and cancer detection screening.
- Cancer detection screening relies mainly in taking of the pap smear. Other simple exams such as ascetoacid and schiller tests are not being provided. Biopsies are also not taken at Profamilia's clinics.
- No system has been set up to ensure that clients with positive pap smears receive proper treatment. No feedback is received from MINSA hospitals and other clinics where patients are referred.
- Suspected pre-cancer lesions (Cervical Intra-epithelium Neoplasias - CIN) detected through pap smear cytological exams are not being treated properly in Profamilia clinics. There is no electric or

crio cauterium device in the clinics with the exception of the Monseñor Lescano clinic, but it is not being used. One of the medical specialists said that trichloroacetic acid is being used to treat Human Papiloma Virus (HPV) lesions.

Clinical Training

- Profamilia has offered training courses to 259 physicians in minilap and 402 nurses and surgical technicians in surgical technology since 1991 under USAID/N funding. Those courses were attended by professionals from MINSA and from Profamilia as well, and they came from the following departments: Managua, Esteli, Leon, Chinandega, Masaya, Boaco, Nueva Segovia, Juigalpa, Jinotega, Ocotal, San Carlos, Matagalpa, Carazo, Rivas, RAAN, Granada, Madriz and Bluefields.
- There is no requirement at Profamilia that service providers (except surgeons who perform sterilization) attend training or are certified before delivering services.
- The evaluation team did not observe any physician training but a typical course outline shows that the training lasts three weeks and includes practical training and skill practice on surgical procedures. The training also includes administrative subjects, counseling, cleaning and sterilization of medical equipment, sexually transmitted diseases/AIDS, pelvic exam and collecting pap smear. Other subjects include oral and injectable hormonal contraceptives, post-partum and post-abortion contraception, IUD, sterilization techniques (tubal ligation and vasectomy) and post-surgery care. Refresher courses are also provided which last one week.
- The great majority of clinical training for physicians is provided in the Managua Clinic of Profamilia by the Supervisor of Medical Services.
- No official data is available but it is reported that bladder perforations and other complications have occurred during surgeries, chiefly during physicians' training. It is to be expected that complications will increase when surgical techniques are being taught but it is important to have valid data in order to determine the extent of the problem.
- MINSA has been training clinic personnel on IUD insertion on an in-service basis, under a UNFPA agreement. This training includes a post partum and post abortion IUD insertion.
- MINSA does not have any monitoring system to evaluate the effectiveness of Profamilia's training program. They stated they would like to assess Profamilia's training of MINSA physicians.
- MINSA officials interviewed by the assessment team from the Permanent Training and from the Integral Maternal Health Departments were pleased with the training program offered by Profamilia on sterilization procedures.
- Profamilia has evaluated clinical training courses for physicians through pre-and post-tests and follow-up questionnaires. A long-term (two to three- year) follow-up questionnaire was sent to 120 trainees. Fifty questionnaires (42 percent) were answered and the conclusions were:
 - ◆ Thirty percent (15) of the physicians who attended the courses were not performing surgery after the course. Most (13) said they had no facilities or institutional support to perform sterilization. Two respondents did not feel competent to perform the surgical procedure they had learned.
 - ◆ Of the 35 trainees who were performing surgeries, 18 (70 percent) reported they had no difficulties at all, except sometimes spending excessive time to access tubes. Seven

reported some complications such as: bleeding (2), skin haematoma (1), a subcutaneous emphysema (1). Three reported uncompleted tubal ligation due to excessive adhesions. Only one client had to be referred to a hospital (Bertha Calderon) for management of the complication.

- Profamilia's management reports that training MINSA physicians improves the relationship between the two organizations.
- USAID/N technical assistance has been provided on clinical guidelines (INTRAH), and management of services (see Appendix H). Profamilia has been slow to adopt and implement recommendations made by the consultants.

Supervision

- Profamilia provides supervision on a monthly basis in all of its regional clinics. This supervision is done by the medical director. Additional supervisor visits are made if there are problems or if the clinic has been opened recently.
- No protocols are used for supervision visits and reports are made and sent to the Executive Director only when problems must be solved at that level. These reports consist of the objectives of the visit, which of these objectives were accomplished, problems detected and recommendations to solve them.
- Physicians in regional clinics are instructed to call the Medical Director immediately if any complications occur during surgery. He supervises the management of complications by telephone.

Appropriate Family Planning Service Providers

- The administrative and supervisory personnel in the clinics are well-trained professionals. They are, however, often assigned to tasks for which they do not have the appropriate training. The staff who supervise CBD workers are not social workers as described in their job descriptions but are nurses and psychologists. Surgical nurses are usually not trained operating room nurses but auxiliary nurses.
- Auxiliary nurses and operating room nurses are inserting IUDs. They claim to be properly trained but we did not observe the quality of any insertions. Profamilia doctors reported that they did not approve of nurses inserting IUDs. MINSA officials state that nurses are providing IUD services effectively.
- Counseling and delivery of temporary methods is done almost exclusively by the clinic receptionist. The appropriate personnel for counseling are often busy with something else. The social worker must do visiting, supplying and counseling in the community; nurses are assisting surgeons and clinicians in providing clinical methods.

CONCLUSIONS

1. **The emphasis on surgical contraception (sterilization) as the predominant family planning service provided by Profamilia has impacted the quality of care in several ways:**
 - Clinical services and counseling for sterilization clients are high quality. This is not only due to good training, but also to the high volume of surgical procedures, which provides the surgeons with steady practice. That allows them to hone their skills and develop a high level of expertise.
 - Sterilization clients are not counseled properly on alternative methods available to them. They are not provided free and informed choice of methods.
 - Counseling for other temporary methods in the clinics is inadequate and lacks proper confidentiality and privacy.
 - Incentives provided to physicians to perform sterilizations have negatively affected the amount and quality of other family planning services and has led to the neglect of other important quality of care considerations such as client follow-up on compliance and complications.
2. **Profamilia has no process for measuring quality of care or regularly monitoring quality of clinical services.** Laboratory audits have not been conducted. Service providers receive no written information on quality of care they can use to improve the services they provide.
3. **No studies have been conducted to determine whether complication rates are within acceptable limits.** This is especially true for surgery conducted in "mobile units".
4. **Written protocols for clinical care of clients are not adequate and are not available in most clinics.** Neither Profamilia nor MINSA have complete guidelines for clinical family planning service.
5. **Profamilia has no system for follow-up of complications and referrals to other health facilities.**
6. **Supervision of the regional clinics by the medical director is adequate, but visits are not documented on a regular basis.** Supervision focuses on sterilization and not on other family planning services provided in the clinics.
7. **Training emphasizes surgical contraception and neglects IUD insertion and other temporary methods.**
8. **Profamilia provides considerably fewer IUD insertions than MINSA.** Possible reasons are that Profamilia physicians do not encourage IUD use, promotion of IUD is low, and counseling is inadequate.
9. **Profamilia is offering preventive such services as pre-natal care, gynecological consultations and cancer screening.** These services are high quality except for cancer screening for which inadequate treatment is available for women who have pre-cancerous conditions.

RECOMMENDATIONS

1. Profamilia should provide a full range of family planning services in its clinics including all available temporary methods.
 2. Profamilia should develop written protocols for all family planning methods. They should be made available to all service providers.
 3. Profamilia should expand training of clinical personnel to include practice in provision of all family planning methods.
 4. Profamilia should provide counseling that allows clients free and informed choice of family planning methods.
 5. Profamilia should provide privacy and confidentiality for all family planning clients.
 6. Profamilia should end special incentives to physicians to discourage the provision of sterilization over other methods.
 7. Profamilia should develop a system to monitor the quality of care for all services and provide routine feedback on quality of care. This information should be used in supervising and evaluating service providers.
- Profamilia should develop supervision protocols and written reports of supervision visits should be maintained.

CHAPTER 4: CLIENT ACCESS TO INFORMATION

EVALUATION QUESTIONS AND ISSUES

Achievement of Activity Purpose: To what extent has Profamilia increased client access to information about reproductive health and family planning and modern methods? This chapter will assess the effectiveness of the CBD network and educational outreach activities being conducted by Profamilia. The following areas will be addressed:

1. Profamilia's CBD network
2. Counseling and training for CBD volunteers
3. IEC materials
4. Profamilia's institutional image campaign
5. Utilization of technical assistance

FINDINGS

CBD Network

- According to project reports, the CBD program covers approximately 84-95 percent of the towns and rural areas in Nicaragua.
- The CBD program delivers between 80-90 percent of the temporary methods distributed by Profamilia. The only temporary method which has any significant distribution through the clinics is Depo-Provera.
- The number of CBD posts increased from 715 in the first quarter of 1995 to 954 in mid 1996. However, the CYP per CBD post declined by 26 percent. Thus, productivity per CBD distributor has declined. The annual report speculates, and field interviews also indicate, that the decline was due to the program's discontinuation of its most popular pill, Neogynon, as well as increased competition from other organizations that distribute temporary methods.
- Despite the extensive and growing network of posts, CBD activities only account for 19 percent of Profamilia's CYP, the bulk of which comes from the sale of pills.
- Approximately 40 percent of CBD posts are located in pharmacies and small shops. The rest are home-based. The advantage of the pharmacies and shops is that they are convenient to rural users. The disadvantages are that shopkeepers rarely attend CBD training and provide little or no counseling and follow-up on contraceptive users.
- Weaknesses identified in the CBD program are:
 - ◆ Most CBD volunteers do not actively promote the methods they distribute.
 - ◆ Until recently, the CBD volunteers only received a one-day family planning orientation with limited follow-up training. As a result, they did not thoroughly counsel people who wanted FP methods.

- ◆ The number of CBD posts has increased without a corresponding increase in numbers of supervisors to train and follow-up on CBD volunteers. CBD supervisors each cover 60-80 CBD volunteers.
 - ◆ Part of the supervisor's job is to provide community education and motivation in order to promote the use of CBD posts. Supervisors do not have time to do much of this due to the large numbers of volunteers they supervise and the amount of time they spend recruiting clients for sterilizations.
 - ◆ There are no CBD supervision guidelines which clearly define the CBD volunteer's duties or standards by which to judge how well they are performing their duties.
 - ◆ Although a CBD volunteer profile does exist for recruiting new distributors, many of the requirements are overlooked. Volunteers are recruited who do not meet basic qualifications, such as literacy. Staff who were interviewed questioned the appropriateness of training materials for illiterate volunteers.
- Costs and efficiency. A recent study showed that the CBD component was the most expensive in two of the eight regional centers and second most expensive in five more. The most expensive was Matagalpa at C\$ 267,603, which was 36 percent of the center's costs for the first nine months of 1996. Overall, CBD costs accounted for 31 percent of total costs in these eight centers. Administration accounted for 33 percent, sterilization 22 percent, and clinical services 14 percent. The largest CBD costs were for personnel (45 percent) and transportation (43 percent). The latter includes transportation costs of clients who referred by CBD volunteers to the clinics for sterilization.

Counseling and Training for CBD volunteers

- A CBD training program began in 1996 with the assistance of Johns Hopkins University/ Population Communications Services (JHU/PCS). Four courses are planned for 1998. The courses are designed as Training of Trainer (TOT) courses in which supervisors and the Profamilia training staff are first trained to teach the course curriculum (five-day course). Then supervisors, with the help of central and JHU staff, train the CBD volunteers in their respective regions (two days).
- An Interpersonal Communications/Counseling (IC/C) TOT and follow-up course for CBD volunteers was taught in 1996. The follow-up course was designed for low literacy audiences and was given to 70 percent (700) promoters. No evaluation of knowledge and skills was done at the end of the course. An evaluation of the effectiveness of this training is planned for the end of 1997.
- The CBD volunteers who were interviewed by the team expressed confidence about their ability to counsel clients regarding methods and their side-effects. Supervisors, however, expressed concern about how well the counseling methodology was understood by the CBD participants, given the short length of the course and limited practice sessions.
- Clinic staff (doctors and nurses) were also trained in the JHU counseling methodology but according to the INTRAH CBD needs assessment (6/96), there is concern regarding how much general counseling about all contraceptive methods clients receive given the pressure to refer clients for sterilizations. During field visits, the team was told at one clinic that unless the client insisted on being informed about temporary methods, they were usually only informed about sterilizations.
- At present a TOT in Contraceptive Technology is being conducted by JHU/PCS staff for CBD supervisors. Follow-on CBD training is planned for later this year.

- A third TOT for CBD supervisors entitled "Achieving Customer Satisfaction through Quality, Selling, and Promotional Techniques," and a fourth entitled "Quality Management and Supervision Skills," are planned for 1997- 1998. These will be given to supervisors and Profamilia training personnel. Supervisors who participated in pilot testing the third course with CBD personnel reported that the response of participants was very positive. They believe the course would be useful in teaching distributors to promote their services actively.
- PCS is also planning to support Profamilia's CBD network in a "Topic of the Month," on-the-job training activity which will be conducted by the supervisors. PCS is also exploring the possibility of using distance education through radio to train Profamilia's CBD volunteers, MINSA field workers and personnel from other institutions. The purpose is to provide on-going training to CBD volunteers who cannot always be available for training events.

IEC Materials

- CBD volunteers and supervisors, clinic personnel and training staff all reported that there is a need for educational and counseling materials.
- Presently, field staff have some method-specific pamphlets which have been reprinted from another organization. There is some question about the utility of these pamphlets because they are small, have a lot of text and few diagrams. PCS has been working with Profamilia's communications staff to develop method-specific flyers which will be printed on different colored paper (a separate color for each method). The drafts that were shown to the evaluators also have a lot of text and it was unclear whether they were adjusted for low reading levels.
- When questioned about the amount of text in the flyers, the communications consultant stated that if the CBD promoters had more training or other resource materials, they would not have felt it necessary to include so much information. Profamilia staff have requested a reference manual for promoters.
- A few of the clinics and posts have flipcharts on family planning themes. However these are outdated and in poor condition. Everyone interviewed stated that they need new flipcharts.
- PCS is currently providing assistance to Profamilia's communications staff in the development of the following materials: 1) thirteen method-specific pamphlets; 2) a pamphlet for adolescents (10-page comic book style); 3) interactive flipchart (for adolescents); 4) an institutional brochure targeting political leaders; 5) calendars for the CBD network; and 6) a flipchart for promoters. So far, 4 and 5 have been completed, 1 and 2 are still being developed and 3 and 6 are planned for later this year.
- During 1997, PCS plans to assist in the development of additional support materials for the promoters about temporary methods, associated risk factors and guidance for referrals.

Institutional Image Campaign

- PCS has provided technical assistance to Profamilia for the development of a mass media campaign utilizing radio and billboards with the objective of promoting and repositioning Profamilia's institutional image as a reproductive health services provider. The campaign began in September, 1996, and will continue through March, 1997. As part of the campaign a new logo and slogan were developed along with two institutional brochures and a calendar.

institutional image campaign that PCS was helping them develop as PCS's campaign, not Profamilia's. Recently, the situation has improved. Profamilia has hired a communications professional to run the Social Communications Department and this individual is an effective counterpart to PCS.

CONCLUSIONS

CBD Network

1. There is no clear strategy to guide Profamilia's CBD program.

Profamilia now distributes temporary methods through both home-based and shop-based distributors. With no data on the costs or effectiveness of either approach, Profamilia has been pursuing both. A clear strategy to determine the proper function and approach of CBD volunteers is needed to guide selection of posts and volunteers, develop appropriate supervision and training, and prepare IEC materials that are appropriate.

The CBD program is viewed by the Executive Director and the Social Communication Director as the key outreach and promotional activity conducted by Profamilia. Yet it only accounts of 19 percent of the institution's CYP. Furthermore, the CBD volunteers are only involved in the sale of temporary methods. Since sterilization is the priority method promoted by the institution and it is clinic based, it is not clear how CBD fits into this strategy. Profamilia needs to decide who it wants to serve with which methods and then determine how CBD fits into the strategy.

2. Profamilia's CBD program is costly, labor-intensive and not especially effective or efficient.

CBD accounts for 31 percent of operating costs, almost half-again as much as sterilization services. Yet it only produces 18 percent of the CYPs, compared to 82 percent for the clinics. CYP production also declined by 26 percent in 1996 compared to 1995. In addition, about half of the "CBD" posts are commercial sales outlets in towns and cities. Finally, the dropout rate of CBD volunteers is quite high (16 percent last year). This adds to the cost significantly, as each of those posts have to be replaced.

3. Profamilia is participating in a country-wide IEC strategy, that is being developed by the National IEC Subcommittee.,

This subcommittee, which is composed of more than 20 organizations working in family planning, has developed a strategy to reach specific target groups through multiple channels and activities. While Profamilia's communications staff has played a lead role in the development of this strategy, it has not applied the strategy to Profamilia.

4. Training has not been based upon a clear CBD strategy.

A significant amount of training is being provided to the CBD volunteers through the technical assistance of INTRAH and JHU/PCS. Although the training has not been formally evaluated in the field, it appears to have been very good quality and it has covered skill areas (counseling, contraceptive technology and promotion and sales techniques) that the CBD volunteers need in order to sell contraceptives. What is not clear is what Profamilia really wants the CBD volunteers

to do. Should they just sell methods from pharmacies and other commercial establishments? If this is the case then most of the training mentioned above is probably not appropriate. It would be more efficient to design a special training program for commercial personnel who have limited time to educate clients and provide them with large quantities of materials to distribute. On the other hand, if Profamilia sees the role of the CBD volunteer as one of active promotion of family planning in the community, then the training should be oriented toward that role.

5. Selection and supervision of CBD volunteers does not follow prescribed guidelines.

Profamilia has not developed appropriate selection criteria, job descriptions, performance objectives, and provided adequate supervision to CBD volunteers. Profamilia will have to apply the selection criteria strictly to ensure the recruitment of effective promoters. They will also have to provide them with adequate supervision. These promoters will need to be active in visiting community members and applying sales techniques that they are taught. They will need to conduct community education activities, learn how to take advantage of public events as promotion opportunities, set up booths at markets, festivals, and so forth to promote family planning.

6. Training of CBD volunteers has preceded the development of educational materials.

A large variety of pamphlets, flip charts and calendars are being developed to support CBD counseling and educational activities. Unfortunately, due to pressure from USAID/N to start training, CBD volunteers have been trained in counseling before these materials were completed. This reduces the effectiveness of training and makes re-training on the use of new material necessary.

Profamilia has conducted many IEC activities. However, there has not been any attempt on the part of the Profamilia's IEC department or institutional management to develop a strategic plan that defines IEC objectives, and what communications activities should be carried out. This lack of a guiding strategy is evident throughout the IEC area and will be further discussed in the following conclusions.

Institutional Image Campaign

1. The effectiveness of the institutional image campaign has not been formally evaluated but findings suggest that it has not increased demand for services

The campaign's reach was hampered by the national elections which dominated the media and caused an increase in media costs. As a result, the media channels and frequency of message transmission were insufficient, based on indirect evidence, and had little impact on the intended audience. Also, the objectives for the institutional image campaign were unclear. Was its purpose to promote services or create a positive institutional image? What target groups was it intended to reach? It is clear that this campaign and the communications department were not guided by a clear institutional strategy.

Utilization of Technical Assistance

1. **Start-up and use of IEC technical assistance has been slow but it appears to be on track at this time.**

There was high turnover in PCS and Profamilia staff. Also Profamilia did not understand how to work with technical assistance agencies and did not provide appropriate counterparts to PCS staff. They expected PCS to do the work for them. However, as the working relationship evolved, Profamilia hired a communicator and is now working in partnership with PCS. PCS is also assisting the communications department to think about a Profamilia communications strategy. This is being done through their assistance in the development of a strategy for the National IEC Campaign, which is helping members to identify key objectives, target groups, age groups, geographical areas and appropriate media strategies for reaching these.

RECOMMENDATIONS

1. **Profamilia should determine how CBD fits into its overall mission and strategy and define the proper role of CBD.**

This is probably the most important action that Profamilia can take to improve CBD and IEC. There is no point in continuing with the current approach to either until the objectives of CBD and IEC are clear. Although it is encouraging to see that training and materials development are improving in many ways, it is largely a futile exercise if there is no clear objective or strategy. Ideally, Profamilia should assess its experience with the various CBD units it has, assess their advantages and disadvantages (including costs, dropouts, and productivity) and develop one or more models to test before expanding the current system any further.

2. **Profamilia should decide whether selling of temporary contraceptive methods through a network of distribution points throughout the country is a priority activity.**

If it is they need to put much more emphasis on strengthening the promotion and educational aspects of that program. Profamilia may decide that it wants to divide the program between volunteers who work out of commercial posts and those who work out of their homes. In that case, selection and training and supervision will have to be developed consistent with these two different functions.

3. **Profamilia should improve supervision of CBD volunteers.**

The alternatives are to either hire more supervisors and provide more vehicles and/or have the existing supervisors devote more time to supervisory activities and less to sterilization recruitment. International standards recommend a ratio of 30 distributors per supervisor.

4. **Profamilia should train and motivate CBD volunteers to provide community education.**

Now supervisors to do the education but they do not have enough time. The supervisors should be training the CBD volunteers to take over more of this function. In order for the CBD volunteers to do effective community outreach, they should be provided with a reference manual that has information about all methods and other aspects of their work. This should be coordinated with supervision instruments.

5. **Profamilia should train CBD volunteers to counsel clients about natural family planning methods.**

Often for religious or cultural reasons, these methods are preferred in certain communities. Given the need to broaden Profamilia's method mix, they should be offered.

6. **Profamilia should verify that the counseling and promotion training being provided to CBD volunteers and supervisors is consistent with the function of the CBD volunteer.**

The training being provided by the JHU/PCS is designed for CBD volunteers who are going to promote use of temporary methods. This training also needs to be followed-up by field supervision and refresher training. A shorter training program designed for pharmacists and other people selling temporary methods in commercial establishments should be developed for that kind of distributor.

7. **Profamilia should supply CBD volunteers with adequate educational and promotional materials.**

In addition to the print materials currently being developed, they also need audiovisual equipment and materials to use in the regions. Movie and slide projectors would be useful and are easily transported. There may also be a need to supply generators for areas that do not have electricity.

8. **Profamilia should provide CBD volunteers with training about how to use the new print materials being developed for use with clients.**

Print materials to be used by CBD volunteers should be designed for audiences with low reading levels, since this is the primary target group. Materials are best received if they have appropriate graphics and little text.

Institutional Image Campaign

1. **Profamilia and JHU/PCS should clarify the objectives of the institutional image campaign and evaluate whether these have been achieved.**

According to the evaluation SOW, one of the purposes of the campaign was to attract more clients to Profamilia. Initial findings indicate that neither the message was appropriate nor was there sufficient media coverage to do this.

If there are funds for another campaign in the future, another approach should be taken. Alternative strategies might include: contracting directly with local radio stations, as has been done in Matagalpa and Jinotega; using additional low-budget media such as providing local buses with tapes that can be played on local routes; specific entertainment events targeting the desired audiences (young couples 15-24); dispensing of promotional items such as hats, T-shirts, key chains, pens, etc.

2. **Profamilia should continue its participation in the development of the National RH/FP campaign being developed by the IEC Subcommission.**

Profamilia's leadership role in this process is important for its status as a leading organization in family planning and to develop strategic planning skills for the staff of the communications department.

CHAPTER 5: FINANCIAL MANAGEMENT, COSTS AND SUSTAINABILITY

EVALUATION QUESTIONS AND ISSUES

The principal question from the Scope of Work was: Is Profamilia making adequate progress toward assuming an increasing share of its recurrent costs? Four main subtopics were identified:

1. Financial management: cost accounting systems, involvement of the regional centers, performance, and impact on the organization and the project;
2. Cost containment and cost recovery: cost analysis, level and sources of cost recovery, uses of revenues, pricing;
3. Financial sustainability: prospects, alternative mechanisms.

FINDINGS

Financial Management

1. **There are serious deficiencies in all aspects of the financial system.** Financial management has been poorly implemented over the life of the project. This has had a severe impact on project operations as costs have gotten out of control.
2. **An automated financial system that should have been set up years ago is still incomplete.** The financial system consists of portions of a Fund Accounting system. All of the modules have not yet been installed, including the Budget module. Those that have been set up are not integrated. In addition, the system is obsolete.
3. **The current system does not provide adequate tools or information for managing the substantial funds provided by the donors.** It does not provide adequate information for management decisionmaking or for forecasting income and expenditures. Expenditures are paid on an ad hoc basis, depending on funding available, rather than on a sound forecast of projected expenditures. The Finance department lacks knowledge of modern administration methods, and advanced automated accounting systems.
4. **The budgeting process is perfunctory and highly centralized.** Department and Regional directors have little input to the budget and no control over their portion of it. They do not have access to their own budgets, nor do they receive any feedback on the progress of their budgets. This does not contribute to cost containment. There is no organizational budget at Profamilia. Profamilia prepares an annual budget to be sent to IPPF. The format and requirements of IPPF, which segregates Profamilia's program by "Strategy," is not useful for USAID/N, which requires the budget to follow a specific line item category, and to provide information per activity. The budgeting function is done as a routine requirement of IPPF rather than as an exercise to determine the programmatic and financial needs of the organization.

5. **The accounting system is incapable of generating income and expenditure by cost center.** The system implemented with the assistance of IPPF and the Population Council does not provide information for decisionmaking. The system is incomplete and lacks a budget module. The automated Fund Accounting system implemented at Profamilia only segregates income and expenditure by donor without providing much detail regarding costs at the service level. The lack of a cost accounting system prevents the organization from obtaining valuable cost information which would assist in cost control, price setting and cost containment. A Chart of Accounts for a Cost Accounting System has been developed by Narciso Salas y Asociados, Public Accountants at the request of Profamilia. During this evaluation, Profamilia's Financial Analyst at IPPF came to Nicaragua to discuss the details of the Chart of Accounts and her recommendations to Profamilia's Finance Department. It is expected that Profamilia will soon receive technical assistance from IPPF in the implementation of its Cost Accounting System.
6. **The lack of a cost accounting system severely limits the analysis of income and expenditures at the service level.** In fact, no cost analysis is performed. No analysis of recurrent costs has ever been undertaken by. The Finance Department does not make use of modern methods of analysis such as cost and variance analyses. In the meantime, steady increases in recurrent costs are making the program unsustainable after the project ends.
7. **The financial reporting system is very limited, both in content and in distribution.** Department and Regional directors do not receive regular financial reports. The Cooperate Agreement with Profamilia requires that the finance function be decentralized. With approximately 18 months to PACD, decentralization would be very expensive to set up and operate. An alternative would be for Profamilia's Headquarters to provide the Regions and its own Departments monthly budgetary information and feedback.
8. **Control of costs is non-existent and severely restrained by the lack of adequate information.** The Regional Directors enter into contractual agreements with NGOs for provision of services at a reduced cost without consulting Finance. Finance finds this out when the agreements reach their office. In some cases the agreements require that Profamilia's clinic provide the services on credit. Profamilia had difficulty collecting its funds from at least one commercial enterprise, TELCOR. Credit is also extended to the pharmacies and other commercial enterprises Profamilia supplies with contraceptives. No credit system or collection system has been established by Profamilia.
9. **The separation of Administration and Finance is causing duplication of effort.** This practice does not contribute to cost control. The inventory control area is an example. Two separate inventories are being used. One department controls purchases of medical equipment, supplies and the vehicle fleet through it's own automated inventory module. The other department controls the contraceptive inventory through another automated inventory module. No budget or plan is prepared by the Regional Centers. Shipments of set quantities of supplies and purchases of stock are made on a quarterly basis rather than on a forecast of needs.
10. **Technical assistance has been inadequate to remedy these problems.** Efforts to install a cost accounting module have been underway for a number of years, but it is not clear when a fully-operational system will be up and running. Profamilia received technical assistance from IPPF and Population Council to set up a Fund Accounting System. Although the technical assistance was timely, it is unfortunate that the Accounting System was not what Profamilia needed at the time, which was a Cost Accounting System.

The automated Fund Accounting System module includes a Budget module that was to be implemented together with the accounting module. This was not possible due to significant variations between the accounting code structure of the module and Profamilia's budget. The automated Budget module has not yet been set up.

Both an Inventory Control and a Check Generator module were also installed at that time. According to the Finance Department's staff, there were plans to integrate all of these modules and install them on a network, but these plans did not materialize. The Finance staff searched their files to no avail for documentation pertaining to the establishment of this computerized system in order to chronologically trace the technical assistance provided by IPPF to Profamilia.

11. **Communication Between USAID/N's Finance and Profamilia is Limited.** Except for the Finance Director, Profamilia's Finance Department staff are not familiar with the Cooperative Agreement between USAID/N and Profamilia. Very limited communication exists between the Finance Departments at Profamilia and USAID/N. This has contributed to Profamilia's staff not being well-informed about USAID/N's regulations, the Cooperative Agreement and Standard Provisions.

An example of the this is that Profamilia did not depreciate assets, including the real estate donated by USAID/N, until this year, although it is clearly stated in Handbook 13 "Standard Provisions" paragraph 1 that "title to all property under this grant shall vest in the grantee."

Another example is that the 1991-1993 audit of Profamilia prepared in 1994 by Narciso Salas y Asociados, Public Accountants is still pending acceptance by USAID/N. Profamilia's Finance Department did not have information as to why USAID/N had declared the English version of the 1991-1993 not official.

The Terms of Reference for the 1993-1996 Audit being conducted by KPMG Peat Marwick require that the Auditors recalculate Profamilia's overhead rate retroactively to 1991. The adjustment of the overhead rate can represent a need for an adjustment of those rate upwards or downwards. If the rates have to be adjusted downwards, Profamilia's budget could be severely affected financially. No information was available at Profamilia's Finance Department as to the reasons why USAID/N has requested that overhead rates be recalculated retroactively to 1991.

Costs

1. **The costs of the project are relatively high and have been increasing year-by-year.** This appears to be due partly to the expansion of clinics and CBD posts. As the following table shows,

Table 1: Profamilia Operating Costs 1991-1996 (in thousands of Cordobas)

	1991	1992	1993	1994	1995	1996
Central (1)	1,463,123	2,607,964	3,683,509	5,584,895	6,548,319	7,599,161
Clinic/CBD (2)	869,294	1,758,768	2,884,516	4,626,279	7,132,807	10,055,993
Total	2,332,417	4,366,732	6,568,025	10,211,174	13,681,126	17,655,154
Percent increase		87.2%	50.4%	55.5%	34.0%	29.0%
Percent central	62.7%	59.7%	56.1%	54.7%	47.9%	43.0%
Percent clinic/CBD	37.3%	40.3%	43.9%	45.3%	52.1%	57.0%

(1) Central includes offices of Documentation, Administration, Training, IEC, Evaluation and Planning.

(2) Clinic/CBD includes all Regional Centers, Managua clinics, VS, CBD, EMIPLAA, CODEMU, Adolescents, Lab

expenses have increased significantly each year. Between 1993 and 1996 total costs rose about C\$3 million per year. Clinical and CBD service costs rose rapidly and surpassed central costs in 1995. The 1996 figures show that Clinic/CBD activities now account for 57 percent of total expenditures.

2. **Central costs are very high, especially Administration.** The following table summarizes the costs of four groups of activities: 1) the Regional Centers (except Managua); 2) Managua clinics and laboratory; 3) Managua outreach (CBD, adolescents, seminars); and 4) Central office support costs (training, IEC, administration, etc.). The data are summarized for 1991-1996 and the latest year, 1996. In general, the Central support costs have accounted for half of all expenses and the regional clinics for about one-third. Managua clinic and outreach services make up the rest, about 18 percent overall and 14 percent in 1996.

	1991-96	Percent	1996	Percent
Regional Centers	16,144,673	27.4	6,720,810	35.1
Managua Clinical	5,766,730	9.8	1,672,641	8.7
Managua Outreach	4,310,320	7.3	1,089,281	5.7
Central Support	32,669,375	55.5	9,677,865	50.5
Total	58,891,098	100.0	19,160,597	100.0

Within each category we see that five of the eight regional clinics spent around C\$1 million in 1996 (see Appendix B, Table 8 for details). In Managua the sterilization service was the most expensive activity. In the Central office the largest category of all was Administration, which accounts for one-third of all of Profamilia's costs, almost C\$6.2 million in 1996. A breakdown of the Administrative costs was not available, but another table indicates that one of the major cost items is the Regional Coordinator's office (C\$1.7 million in 1996, see Appendix B, Table 9).

3. **Operating costs per CYP have increased significantly.** The next table shows the average cost per CYP from 1991 through December 1996. These figures include all of Profamilia's operating costs (Regional Clinics, CBD, training, Managua outreach, administration, adolescent program, etc.). They do not include overhead, capital expenditures (land and buildings), in-kind contributions from CBD volunteers and others, or international technical assistance. If those items were added, the costs would probably be 50-100 percent higher. The cost per CYP rose sharply and steadily from 1991-1994, when it leveled off at about C\$132. Again, this reflects the expansion of services and the increased costs of administrative support.

Table 3: Couple Years Protection, 1991-1996 (in Cordobas)

	1991	1992	1993	1994	1995	1996
Total costs	2,332,417	4,366,732	6,568,025	10,211,174	13,681,126	17,655,154
Total CYPs	51,711	49,405	56,137	74,038	103,991	133,333
Cost/CYP (Cordobas)	45.10	88.38	117.00	137.92	131.56	132.41
Cost/CYP (US\$)	4.90	9.07	12.72	14.99	14.30	14.39

Operating costs only, excluding overhead, construction costs, technical assistance, volunteer labor, etc. Exchange rate = C\$ 9.2 = US\$ 1.

4. **Cost per CYP is much higher for CBD than clinical services.** The direct operating costs were calculated for the eight Regional Centers outside of Managua. These costs do not include Central support costs or center administrative and non-family clinical services. They are only the direct costs attributed to the clinic surgical contraceptive and CBD components (see Appendix B, Table 6 for details). CBD costs per CYP are significantly higher than Clinic costs (surgical contraception, not non-family planning clinic services) in all eight Centers. The highest CBD cost per CYP was in Ocotal, but that could be due to the clinic just opening in late 1996. Jinotega has the next highest CBD cost/CYP, which would appear to be due to low CYPs, rather than to high costs. Jinotega achieved only 801 CYPs in its CBD component. The average for all clinics was 1,680. Jinotega's costs overall and for CBD were the lowest of the group after Ocotal.

Table 4: CYPs per Regional Center, Sterilization and CBD Components, 1996

	Matagalpa	Jinotega	Juigalpa	Boaca	Chinandega	Rivas	Masaya	Ocotal	Average
Clinic	20.12	36.35	13.65	11.19	16.22	15.93	13.38	51.83	16.81
CBD	88.16	208.84	78.13	162.20	120.61	150.83	171.32	513.47	123.18
Total	24.49	60.56	16.11	23.82	19.02	19.78	17.81	66.79	22.50

Operating costs for Regional Centers only, excluding Central Office costs, overhead, construction costs, technical assistance, volunteer labor, etc. Exchange rate = C\$ 9.2 = US\$ 1.

Cost Recovery

1. **Profamilia's Regional Centers are losing more money each year.** The following table summarizes the revenues, expenditures and deficits incurred by the regional clinics (including Managua) in 1996 and for the total number of years each clinic has been open (See Appendix B, Table 11 for more details). Several points should be emphasized. All of the clinics are losing money. They have significant deficits every year. The expenses for all of the clinics have increased significantly almost every year. The revenues have increased slightly every year. The net deficits, therefore, have increased significantly almost every year. The proportion of costs recovered (revenues/expenses) has grown smaller every year. The deficit has grown over C\$1 million each of the last four years. The total accumulated deficit at the end of 1996 was almost C\$17 million.

Table 5: Revenues and Expenditures per Clinic, 1991-1996 (in Cordobas)

	1991	1992	1993	1994	1995	1996	Total
Revenues	179,667	319,280	450,315	684,665	998,170	1,564,952	4,197,049
Expenses	397,792	1,193,448	2,062,570	4,062,953	5,455,325	7,811,930	20,984,018
(Deficit)	-218,125	-874,168	-1,615,855	-3,378,287	-4,457,155	-6,235,977	-16,779,567

Finance Department, Profamilia. Please note that Managua expenditures are for sterilization only. These are operating costs only. They do not include costs of land, building, overhead, or Central office costs.

2. **The steadily increasing deficits indicate high operational costs in relation to revenues from provision of services.** In analyzing the above table, however, the initial investment in facilities, equipment and training must be taken into account. This diminishes the relative proportion of cost recovery in relation to operational costs. With the exception of Ocotal, Masaya and Jinotega, which are new clinics (one and two years old respectively), all clinics' deficits have steadily increased.
3. **The project is far from reaching its goal of 34 percent cost recovery by the end of 1998.** Cost recovery was highest at the beginning of the project (around 25 percent), but has been lower and

relatively stagnant for the last four years. The figure for 1993 was 16.7 percent. The figure for 1996 was also 16.7 percent. The following table present Profamilia's rates of recovery by donor source through sale of services.

Table 6: Percentage of Total Expenditures Recovered, 1991-1996 (in thousands of Cordobas)

	1991	1992	1993	1994	1995	1996
Profamilia total operating expenses	2,332.4	4,366.7	6,568.0	10,211.2	13,681.1	17,658.2
Percentage of USAID/N costs recovered	0	4.8%	7.3%	7.2%	8.8%	12.7%
Percentage of IPPF costs recovered	25.6%	22.3%	13.1%	9.3%	9.3%	8.2%
Percentage of USAID/N & IPPF costs recovered	25.7	22.30	13.1	9.3%	54.3%	51.5%
Percentage of all costs recovered (USAID/N, IPPF, Profamilia)	25.3%	24.4%	16.7%	13.6%	15.2%	16.7%

Source: Financial Statements, Finance Department, Profamilia.

4. **Expenditures in the regional centers have been increasing faster than revenues.** This appears to be due to several factors: 1) CBD expansion; 2) increased transportation costs (for CBD supervision and transport of clients to centers for sterilization); 3) increased sterilizations (lack of economies of scale, thus each sterilization represents a loss), and 4) increased "exonerations" for women who are unable to pay for sterilizations and contraceptives.
5. **Prices for contraceptives are not based on clearly established criteria (such as demand, competition, ability to pay, market segmentation, volume discounts).** Profamilia does not use cost analysis methods to set prices. Its pricing policy is not based on clearly established criteria. For instance, Profamilia does not take into account the ability of clients to pay.
6. **Profamilia sells contraceptives to pharmacies and other commercial establishments at the same prices it sells to it's CBD volunteers.** The Evaluation Department at Profamilia has estimated that 55 percent of sales of contraceptives in Profamilia's CBD program are made to these commercial establishments.
7. **Exonerations represent 15-20 percent of total revenues.** Under the present policy, exonerations represent between 15-20 percent of total revenues in some clinics. In addition, Profamilia has to pay a honoraria to the performing physician of C\$45, which represents 60 percent of the C\$75 fee.

Profamilia ends up recovering between 25 percent and 30 percent of the total fee of those partially exonerated surgeries. If we add to these the cost of performing the service, Profamilia does not recover any costs at all in these cases.

No data is kept at Profamilia's Headquarters on exonerations. The only data available comes by way of the weekly reports attached to the Bank Account deposits. This data however, presents only global information on the fees exonerated. No distinction is made between partial or total exonerations or exonerations from referral by agreements with other NGOs or MINSA.

Cost Containment

1. **Cost containment is not a priority for Profamilia.** The team found no evidence of any serious attempt to analyze costs or identify opportunities for cost containment.
2. Since cost accounting and cost analysis are not done, there is little information available to identify areas where costs could be lowered.

Financial Sustainability

1. **Financial sustainability has not been a priority, either, perhaps for good reasons.** No alternatives to price increases have been explored.⁷ Profamilia is almost completely dependent on two donors (USAID/N and IPPF) for its financial needs. It is unreasonable to expect this kind of organization to become financial independent in the foreseeable future, especially when the project objectives are to increase services to poor, hard-to-reach women.
2. **The costs of reaching the target group will increase and the revenues from them will decrease.** Women who are in rural areas, especially those in mountainous and Atlantic coast areas, are going to be very hard to reach. It will cost much more in terms of staff time, transportation, IEC materials, and so forth, to recruit one of these women than it will to recruit an additional client in Managua. Since the target group is also young, less educated, lower SES and poor, it is unlikely that they will be able or willing to pay for services and contraceptives. We can expect that the more Profamilia tries to reach such women, the more it will cost and the less revenue will be provided by them. This is not a viable sustainability strategy.
3. **As with many other aspects of the project, there is no clear sustainability objective.** As far as the team can tell, there is no qualified or quantified sustainability objective, such as, "by 2005 Profamilia will be self-sustaining." The 34 percent cost recovery objective may be perceived as being the same thing, but of course, it is not.
4. **Profamilia has very few options for increasing revenues other than raising prices.** Those that have been suggested are: adding RH/MCH and other health services, developing a social marketing

Table 7: Revenues Received by Profamilia, 1991-1996 (In Cordobas)

	1991	1992	1993	1994	1995	1996
USAID	0	83,492	238,015	441,321	810,899	1,509,112
IPPF	590,808	970,712	846,712	914,754	1,262,164	1,300,646
USAID Overhead	0	460,930	389,895	565,145	1,155,058	1,505,447
Other Income	7,501	3,477	13,106	30,587	10,457	146,530
Total	598,309	1,518,611	1,487,728	1,951,807	3,238,578	4,461,735

Source: Finance Department, Profamilia

⁷ Profamilia claims that it submitted a request to USAID/N to permit Profamilia to expand its array of services. According to Profamilia, USAID/N turned down this request. USAID staff explained that no formal request was submitted. Profamilia's Annual Workplan proposed this option. USAID/N asked for a proposal, including cost and revenue estimates. None was submitted by Profamilia.

program, and finding other donors. As far as diversification of funding is concerned, with the exception of C\$196,452 received from the Hewlett Foundation in 1993; and C\$215,789 in 1994 Profamilia has not been actively seeking financing from other donors to cover its recurrent costs. Profamilia has received revenues from the following sources from 1991 through 1996.

5. **Overhead from USAID/N represented 50.9 percent of Profamilia's total revenues in 1996.** For some reason, Profamilia treats overhead as income (see Appendix B, Table 10). The Team was unable to find out why, what is included in the overhead pool, and whether overhead costs are included in one or more expenditure lines. The overhead rate is subject to a retroactive audit and the amount of overhead could be increased or reduced. The combined overhead plus disbursements from USAID/N in 1996 represented 67.6 percent of Profamilia's total revenues.
6. **No long-term investments have been made by Profamilia.** With the exception of the land and buildings purchased for the regional clinics, Profamilia has no capital assets.

CONCLUSIONS

Financial Management

1. There are serious deficiencies in all aspects of the financial system.
2. An automated financial system that should have been set up years ago is still incomplete
3. The current system does not provide adequate tools or information for managing the substantial funds provided by the donors.
4. The budgeting process is perfunctory and highly centralized.
5. The accounting system is incapable of generating income and expenditure data by cost center.
6. The lack of a cost accounting system severely limits the analysis of income and expenditures at the service level.
7. The financial reporting system is very limited, both in content and in distribution.
8. The separation of Administration and Finance is causing duplication of effort.
9. The Finance Department lacks knowledge of modern administration methods and advanced automated accounting systems.
10. Technical assistance has been inadequate to remedy these problems.

Costs

1. The costs of the project are relatively high and have been increasing year-by-year, due partly to the expansion of clinics and CBD posts.
2. Central costs are very high. Administration accounts for one-third of all costs.

3. Operating costs per CYP have increased significantly.
4. The cost per CYP is much higher for CBD than for clinical services.

Cost Recovery

1. Profamilia is far from reaching it's project goal of 34 percent cost recovery by the end of the project.
2. Cost recovery was highest at the beginning of the project (around 25 percent), but has been lower and relatively stagnant for the last four years. The figure for 1996 was 16.7 percent.
3. The problem has been that expenditures in the regional centers have been increasing faster than revenues. This appears to be due to several factors: 1) CBD expansion; 2) increased transportation costs (for CBD supervision and transport of clients to centers for sterilization); 3) increased sterilizations (lack of economies of scale, thus each sterilization represents a loss), and 4) increased "exonerations" for women who are unable to pay for sterilizations and contraceptives.
4. Prices for contraceptives are not based on clearly established criteria (such as demand, competition, ability to pay, market segmentation, volume discounts).

Cost Containment

1. Cost containment is not a priority for Profamilia. It is, however, essential if financial sustainability is to be achieved.
2. Since cost accounting and cost analysis are not done, there is little information available to identify areas where costs could be lowered.

Financial Sustainability

1. This has not been a priority, either, perhaps for good reasons. Profamilia is almost completely dependent on two donors (USAID/N and IPPF) for its financial needs. It is unreasonable to expect this kind of organization to become financial independent in the foreseeable future, especially when the project objectives are to increase services to poor, hard-to-reach women.
2. The costs of reaching such women are likely to be higher and the prospects of their paying for family planning services and contraceptives are likely to be lower.
3. As with many other aspects of the project, there is no clear sustainability objective.
4. In lieu of raising prices Profamilia has very few options for increasing revenues. Those that have been suggested are: adding MCH and other health services, developing a social marketing program, and finding other donors.

RECOMMENDATIONS

Financial Management

1. Profamilia should entrust the Finance Department with full authority and responsibility for financial management of the organization. This should be performed in cooperation with the Regional and Department directors.
2. An automated, up-to-date cost accounting system should be installed as soon as possible.
3. Annual budgets should be prepared by the Regional and Department heads, negotiated and consolidated by the Finance Department and submitted to the Executive Director and Board for approval.
4. Variance analysis of income and expenditures should be done regularly with the causes investigated and corrected.
5. Cost analyses should be performed regularly at all levels of administration.
6. Financial reports should be prepared and distributed monthly.
7. Cost control measures should be installed and implemented by the Finance Department.
8. Duplication of effort between the Finance and Administrative departments should be eliminated.
9. Technical assistance that is needed by the Finance Department should be solicited and utilized.
10. Communication between Profamilia's and USAID/N's Finance Departments should be increased and improved.

Cost Containment

1. Even before the cost accounting system is established, all departments and regional centers should begin to examine their own costs and develop recommendations for reducing costs and improving efficiency.
2. The Finance Department, in collaboration with the Planning and Evaluation Department, should undertake a comprehensive examination of costs by year, department, account, program and activity.
3. Profamilia should not hesitate to request technical assistance in conducting this analysis and setting up standard procedures for ongoing cost analysis.
4. Profamilia should look carefully into the CBD program, honoraria for surgeons, transportation, administration, and regional center costs for possible cost reductions.
5. Partnerships with NGOs, MINSA and others to share costs should also be examined.

Cost Recovery

1. Profamilia and USAID/N should examine the project's cost-recovery objective in light of the project's programmatic objective to extend services to poor, hard-to-reach women. These objectives seem to be at cross-purposes.
2. If the priority is cost-recovery, then Profamilia should probably concentrate on providing services in densely-populated, middle-class neighborhoods to people who can afford to pay. If the priority is poor, rural women, then Profamilia and USAID/N need to reduce the expectations for cost-recovery.

Financial Sustainability

1. Profamilia should set a long-term sustainability objective that is reasonable and also an interim funding strategy that will ensure Profamilia's continued existence.
2. In addition to the option of increasing prices for contraceptives and services, Profamilia should carefully examine the options that have been proposed to date: expanding RH/MCH services, soliciting contributions from other donors, and establishing a social marketing program.

CHAPTER 6: ORGANIZATIONAL SUSTAINABILITY OF PROFAMILIA

EVALUATION QUESTIONS AND ISSUES

This chapter deals with whether the organization, staffing and management of Profamilia are adequate to achieve the project's expected results and contribute to its sustainability. The following issues are addressed:

1. Organization and management systems.
2. Performance of key organizational units.

FINDINGS

Organization and Management Systems

A sustainable organization has several identifiable features. It has a clearly stated mission that describes the organization's purpose, general objectives and core values. It also has a strategy that defines the way the organization will achieve its objectives and management systems that are aligned to support the organization's mission. The management systems of a sustainable organization include :

- An organization structure that permits the free flow of information from top to bottom and vice versa.
- Procedures and norms that define and establish work standards and routines.
- Planning that focuses all personnel and resources on achieving organizational objectives.
- Coordination that creates teamwork toward common goals and manages conflict.
- A personnel system that attracts skilled people, defines their responsibilities, manages salaries and benefits, and provides appropriate performance feedback.
- Supervision that maximizes each member's contribution to the purposes of the organization.
- Training that provides all employees the skills and knowledge they need to respond to changing organizational demands.
- Management information that promotes effective planning and decisionmaking.
- Resources, both financial and physical, that support the work of the organization.

We have examined the status of these systems at Profamilia.

Mission and Strategy

- The official statement of Profamilia's mission and strategy was adopted in 1988 and has not been updated to reflect changes in the Cooperative Agreement with USAID/N. (See Appendix G)

- Senior staff of Profamilia have received training in mission and strategy formulation but have not used their knowledge to update the mission and strategy of the organization.
- Interviews with Profamilia's staff demonstrate uncertainty and differing views of mission and strategy.

Organization and Structure

- An organization chart was developed in late 1995 which accurately describes the present organizational structure (see Appendix H for Profamilia's organization chart).
- Many routine activities (purchasing, vehicle repair) must pass through three of four departments. Routine actions take excessive time and expense.
- Decisionmaking is highly centralized in the office of the Executive Director.
- Profamilia and USAID/N agreed one year ago to add the position of Deputy Director to assist the Executive Director in managing the organization. This position was never filled because the two organizations could not agree on a suitable candidate for the job. However, a new candidate has been proposed and is currently under review by USAID/N.
- Profamilia's Board of Directors meets regularly and records decisions as specified in Profamilia's statutes. The Board reviews and approves budgets, contracts with donor agencies, and key personnel decisions. It does not, however, set performance objectives for the Executive Director, nor does it have a formal process to evaluate his performance.

Procedures and Norms

- A manual of operations was adopted in 1993 that contains job descriptions but does not establish work standards and routines.
- Written procedures and norms have been established for travel, purchasing, and vehicle assignment. Guidelines are not available for other managerial functions.
- The senior staff has not been organized to compile, review and update internal procedures and norms.⁸
- Profamilia's decisions and actions are often out of compliance with the terms of the Cooperative Agreement with USAID/N.

Planning

- Department and Regional Center heads at Profamilia do not prepare annual work plans that include:
 - ◆ Department objectives
 - ◆ Activities related to objectives

⁸ Project Paper, p. 19. The project paper states, "The senior staff will constitute a permanent technical advisory committee (TAC), chaired by the Executive Director. This TAC will periodically compile, review and update the internal norms and rules (Internal Methods and Procedures) that are also to be used within the organization to ensure consistency in the type and quality of operations and outputs."

- ◆ Resources needed to carry out activities
 - ◆ Follow-up and evaluation
 - ◆ Annual budget
- Some department and Regional Center heads plan short-term activities but these plans are not related directly to organizational strategies.
 - Department and Regional Center heads do no budgeting and work without budget information.
 - Department and Regional Center heads spend much of their time reacting to events rather than anticipating and working out solutions to problems.

Coordination

- Meetings involving department heads in planning and coordination are infrequent. The Regional Directors meet annually to plan their activities for the following year.
- Communications are mostly verbal - face to face and by telephone. Profamilia has only two incoming telephone lines and outgoing and incoming calls often take hours to connect.
- The senior staff of Profamilia does not view itself as a functioning team.
- Profamilia meets infrequently with MINSA and local NGOs to coordinate plans and activities.

Personnel

- Staff members, in headquarters and the regions, are hard-working and committed to the mission of Profamilia.
- Salaries and personnel classification policies were created in September 1996, by Price and Waterhouse but have not yet been implemented by Profamilia.
- Frequent staff turnover in key positions has reduced Profamilia's effectiveness.
- Candidates proposed by Profamilia for some key positions have not met the criteria established in the Cooperative Agreement.
- Staff morale is low in the central office and staff members complain that their abilities are not being utilized fully by the organization.

Supervision

- Staff of Profamilia do not have individual performance objectives.
- Supervision is informal; no supervision procedures or policies have been formulated.

Staff Training

- Training functions are spread among three different offices: the Department of Social Communication, The Training Coordination and Documentation Center, and the Department of CBD Training.
- IPPF and Profamilia have proposed training plans for 1997 but they have not been approved by USAID/N.

- Seven training and technical assistance programs have been carried out since 1992 aimed at strengthening Profamilia's organization and managerial capabilities. These programs have been in administration of clinics, strategic planning, information and financial systems, finance and budgeting, and organizational development (see Appendix I for detailed table).
- Reports by technical assistance consultants and trainers describe only partial or no implementation of recommendations and systems developed by technical assistance interventions. A lack of management skill and follow-up is usually stated as the reason.

Information, Research and Evaluation

- No management information system exists that is capable of providing accurate and timely data that is useful for managerial decision-making and developing reports for funding agencies.
- Computers within Profamilia are not networked and do not integrate finance, service and administrative functions.
- A number of relevant research and evaluation studies have been undertaken within Profamilia but the results are rarely used by management.
- A management information system (SAC) is being partially tested (3 of 7 modules) in 3 clinics but the system is not expected to be fully implemented for at least one year.

Performance of key organizational units

Administrative Support

- The Administrative Director of Profamilia is responsible for purchasing, coordination and maintenance of vehicles, inventory and maintenance of buildings. His main function is to execute orders made elsewhere in the organization and he is not effectively managing the resources under his responsibility.
- The purchasing policy of Profamilia is that purchases under \$1,000 are handled by the Administrative Director and purchases above that amount are managed by the Executive Director. The Administrator does not participate in planning purchases nor does he have a budget or receive information on spending.
- A system is in place for coordinating the movement of vehicles and controlling their use. The system for managing maintenance and repairs is complex and time-consuming, resulting in vehicles being out of service for long periods of time. The administrator has no records of the costs of maintenance of vehicles and, therefore, does not manage costs and performance of the vehicle fleet.
- Inventories are kept manually but a computerized system of inventory control is presently under development. The administrator maintains an inventory of physical assets but does not actively manage the effectiveness or efficiency of the use of physical assets of Profamilia.
- The maintenance and cleanliness of Profamilia's buildings is well-managed. The floors are mopped continuously.

Commodity Procurement

- Systems for managing commodity procurement are quite informal and there have been many instances of non-compliance with USAID/N guidelines.
- USAID/N has disallowed Profamilia vouchers for non-compliance with the Cooperative Agreement.
- Profamilia has not followed USAID/N open competition procedures for procurements in several instances.
- Profamilia has failed to request prior USAID/N approval for contracts and sub-grants as specified in the Cooperative Agreement.

Profamilia-USAID Relations

- The contractual relationship between USAID/N and Profamilia changed from a grant to a Cooperative Agreement in 1994. Under a Cooperative Agreement USAID has increased oversight of contracts, purchasing, hiring and management decisions. The implications of this change are not understood or accepted by Profamilia's Board of Directors and top management.
- The ability of Profamilia and USAID/N to work together as true development partners has deteriorated, especially in the past year. USAID/N complains that Profamilia willfully ignores the terms of the Cooperative Agreement and the recommendations of technical assistance aimed at strengthening the organization. Profamilia complains that increased oversight and frequent direct meetings called by USAID with Profamilia's Board of Directors and senior staff has eroded Profamilia's organizational autonomy.
- The team was told repeatedly that the USAID/N mission has been aware of the management problems for some time. There is nothing in these findings that we didn't already know. Apparently, the USAID/N mission has not been able to solve these problems.

CONCLUSIONS

- 1. The organization and management of Profamilia is neither adequate to achieve or sustain expected results nor to support changes needed in the organization.**

Organizations typically pass through three distinct stages in their life cycle. First is the entrepreneurial or "building" stage in which a charismatic and visionary leader builds the organization and expands it to meet the needs of its clients or customers. The second stage is the managerial or "nuts and bolts" stage in which the gains of the first stage are consolidated and sound management systems are installed to make the organization efficient and effective. Third is the bureaucratic stage which consolidates the gains of the previous stages by routinizing procedures throughout the organization.

The leadership of Profamilia has been highly successful at expanding the organization from a small staff of 40 in two urban clinics to a staff of 180 in 10 Regional Centers and 1,100 CBD posts. Profamilia has reached the second stage in its development and needs to restructure itself accordingly. It is time for a different form of leadership that can introduce modern management systems, empower staff and promote teamwork.

- 2. Profamilia's Board of Directors, staff and resources are not aligned toward a coherent and well-understood mission and strategy.**

Although Profamilia's staff is dedicated and hard-working, they are oriented more towards task accomplishments than realizing a clear organizational strategy. Part of the reason is the issue of goal displacement addressed in Chapter 2 of this report. Another reason is the lack of a stated mission and strategy that articulates clearly the direction the organization should take and the lack of dissemination of the strategy throughout the organization.

- 3. Profamilia's organizational structure does not provide adequate coordination between some departments nor does it provide adequate supervision of operational departments.**

The Executive Director now has seven directors reporting to him in addition to his responsibilities to manage Board and donor relationships and relations with outside organizations. This seriously overextends his ability to coordinate and control the organization. In addition, many routine decisions require the participation of several different departments. This is especially true of administration and finance which are involved in almost all purchasing and logistical decisions.

- 4. The lack of procedures and norms to establish work standards and guide routine decisions reduces Profamilia's effectiveness and efficiency.**

Written and updated procedures and norms are needed to reduce the number of decisions that are sent to the Executive Director, to standardize decisionmaking and to reduce the number of decisions and actions that are out of compliance with the Cooperative Agreement. Some procedures have been developed (for example, salaries and position classifications). Now they need to be implemented, and others should be developed.

- 5. The lack of long-term planning at Profamilia places managers in a reactive role and does not foster effective use of the organization's resources.**

Because they do no long-term planning, have no budgetary control and receive little financial or performance information, department heads at Profamilia are not performing as true managers but as technicians or clerks. Department heads must have the managerial tools and skills required to become managers if they are to play their proper role in guiding the organization to achievement of its mission.

- 6. Communication within the organization is inadequate and reduces coordination between individuals and departments.**

Communication problems are of two types, technical and interpersonal. The technical problem is that the organization relies almost entirely on the telephone for communications between its many locations. The two lines at the central office are overwhelmed with calls from clients, regional offices and the public.

A major obstacle to effective communication is the infrequency of staff meetings involving all department heads to coordinate and plan activities and to identify and solve problems. At present, staff meetings serve principally to pass information from the Executive Director.

7. Supervision of staff is inadequate, especially at the central office.

Several deficiencies combine to make supervision inadequate. Too many departments are supervised directly by the Executive Director. Staff do not have individual work plans or performance standards. There is no process for performance review and evaluation.

8. Information systems at Profamilia do not provide useful and timely information for management decisions.

There are several problems with Profamilia's information system. Appropriate indicators of performance are not being used (see Chapter 2). Procedures to guide routine collection of data on useful indicators have not been developed, the system is not integrated in a way that can inform managers of the performance of their units. In general, Profamilia's management shows little interest in or support for management information, research or evaluation.

RECOMMENDATIONS

1. Profamilia's Board of Directors should attend a workshop on strategic planning to set a new direction for the organization.

This workshop should be facilitated by an expert in strategic planning and should be for a minimum of three days. The workshop should include:

- A review of the present situation of Profamilia (including an analysis of this assessment).
- Analysis of the organization's environment (including especially USAID, IPPF and MINSA).
- Formulation of Profamilia's mission (including objectives and indicators of performance).
- Decisions about Profamilia's strategy (priorities and programs, for example priorities regarding surgical contraception, CBD, social marketing, training, etc.) and financial and organizational sustainability.

2. Profamilia's Board of Directors should put into place a leadership team that can carry out its mission and strategy and introduce the organizational systems that it needs to become sustainable and achieve its intended results.

3. Profamilia should re-organize its structure to better support its strategic objectives.

After clarifying its mission and strategy and putting into place its management team, the next step will be to restructure the organization. Since the proper organizational structure depends on the decisions about mission and strategy, we are not able at this time to recommend the proper structure.

We can, however, suggest two directions. Reduce the span of control of the Executive Director by establishing an operational manager and a manager of services (medical, CBD, etc.). Also,

functions such as training (now in three departments) and administration and finance (now separate departments) should be combined under unified leadership.

- 4. Profamilia's management should develop written procedures and norms that are aligned with the mission and strategy of the organization.**

These procedures and norms should include administrative areas (for example, purchasing, personnel, finance) service areas (family planning services, CBD), and information (research and evaluation).

- 5. Profamilia should introduce a process of annual planning in all departments.**

These plans should include departmental objectives, plans, budgets, and individual performance targets. Supervision and individual performance evaluations should be based upon these objectives and plans.

- 6. Profamilia should implement a plan for improving internal and external communications.**

The communication plan might include improved voice and electronic communication systems and improved meeting skills.

- 7. Profamilia should implement a plan for networking and integrating computer systems.**

Profamilia has a number of unlinked computers and computerized systems in finance, administration, research and evaluation. They should be integrated to provide timely, relevant and accurate information for management decision-making and reporting.

CHAPTER 7: NEW STRATEGIC DIRECTIONS

The purpose of this chapter is to summarize the main conclusions of this evaluation and to recommend a change in the project that we hope will enable USAID and Profamilia to achieve the results that they both want.

CONCLUSIONS

It should be clear from the findings of this evaluation that the project is in serious trouble. The report has identified a number of major problems:

- Overemphasis on CYP achievement, which has distorted program direction and operations to such a degree that the main objective - to increase use of contraceptives by poor, young women in rural areas - has been pushed aside.
- Clinic-based services that are growing more costly while achieving less. Incentives that push providers to do as many sterilizations as possible while downplaying counseling, provision of other methods and informed choice.
- A CBD program that is costly, urban-oriented, labor intensive, passive and neither efficient nor effective. Expensive training and technical assistance that is largely wasted because it has no strategic focus.
- Inadequate financial management that is unable to control costs.
- An organization and management system that is neither adequate to achieve nor sustain expected results.

In the face of these problems, USAID/N would be justified in curtailing, or even terminating funding of the project. The Team understands that this option may have to be taken, but we believe that it should be a last resort. USAID/N should first try to work with the Board of Directors to restructure the project so that those elements that Profamilia is willing and able to strengthen can be continued.

RECOMMENDATIONS

USAID/N should renegotiate and amend the Cooperative Agreement with Profamilia to restructure the project. Profamilia should limit the activities it agrees to undertake to those that it does best and which have the greatest potential for becoming self-sustaining. These are the provision of clinical and temporary family planning services to women in urban areas who can afford to pay for them. Responsibility for women in rural areas should be left to MINSA and PVOs that are already working with these target groups. USAID/N should consider transferring funds that Profamilia will not need to MINSA and the PVOs.

Specifically, we recommend the following actions:

- Revise the indicators used to measure Profamilia's performance.
- Eliminate or severely reduce funding for CBD activities and stop all training and technical assistance in CBD and IEC.

- Reduce the number of Regional Centers to those that are producing acceptable results and that have a reasonable chance of becoming self-sustaining within the next three to five years.
- Change the objectives and incentives in the clinic-based program to offer all methods, improve quality of services, counseling, informed choice, follow-up and so forth.
- Negotiate changes in Profamilia's management systems (finance, administration, personnel, planning, evaluation, etc.), to enable the organization to become organizationally self-sufficient within the next three to five years.
- Provide assistance and incentives to Profamilia to search for alternative funding sources.

APPENDIXES

A: GOALS, OBJECTIVES, INDICATORS AND TARGET GROUPS

B: TABLES

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- Table 2: Couple Years of Protection, Calendar Year 1996
- Table 3: Cobertura Geográfica a Diciembre 1996 (Geographic Coverage through December 1996)
- Table 4: APP por Departamento (Clinica y DCA) Diciembre 1996 (CYP by Department [Clinics and CBD] December 1996)
- Table 5: Resumen de Usuarías de Minilap de 1995 (Summary of Minilap Acceptors, 1995)
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- Table 7: Summary of Expenditures by Donor Source and Activity, 1991-1996
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C: SUMMARY OF SCOPE OF WORK

D: LIST OF PERSONS INTERVIEWED

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F: PROJECT EVALUATION SUMMARY

G: MISSION OF PROFAMILIA NICARAGUA

H: PROFAMILIA ORGANIZATION CHART

I: TRAINING AND TECHNICAL ASSISTANCE: IMPLEMENTATION AND IMPACT ON PROFAMILIA

APPENDIX A: GOALS, OBJECTIVES, INDICATORS AND TARGET GROUPS

Source	Project Goal	Indicator	Project Purpose	Indicator	Target Groups
Project Paper (4/91)	To harmonize Nicaragua's population growth rate with the country's socio-economic development	Population growth rate < 3.2 (DHS)	To expand and strengthen the delivery of Family Planning services in Nicaragua	CYP increased From 62,000 to 168,000 per year by 1995 (Profamilia)	Not stated. Assumed to be women aged 15-49.
Amendment 1 (9/94)	To increase knowledge, acceptance and early use of modern family planning methods.	Knowledge of contraception, CPR (DHS)	To increase access to a broader range of contraceptive methods, especially in rural and marginal urban areas.	CYP increased from 57,000 in 1993 to 155,000 in 1998 (Profamilia and other NGOs)	Not stated. Assumed to be women aged 15-49, especially in rural and marginal urban areas.
Source	Program Outcome	Indicator	Results	Indicator	Target Groups
Strategy for 2000 (4/95)	More people using family planning methods	CPR (DHS) 55% by 1998	2. Increased demand for FP services, esp. 15-24 age group. 2. Increased access to FP services	CYP increased From 62,000 to 168,000 per year by 1995 (Profamilia)	1) Poorly educated, rural women of low socio-economic status; 2) Women between the ages of 15 and 24.
R4 (3/96)	None	None	None	None	Young, poorly educated women, women in low socio-economic status and women who live in the mountainous and Atlantic coastal areas.
Profamilia Annual Report (10/96)	Improve mother and child health.	None specific. Implicit: birth spacing and TFR.	Increase use of modern contraceptives.	CYPs increased from 57,000 in 1993 to 155,000 in 1998.	(Assumed to be women 15-49), especially in rural and marginal urban areas.

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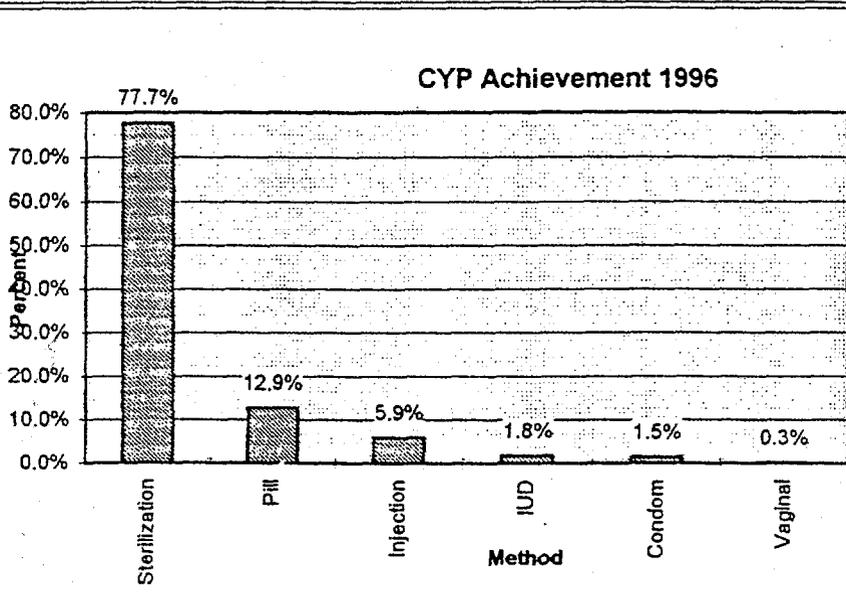
Appendix B: Tables

Table 1: Profamilia Project Targets and Achievements: 1991-1998										
		1991	1992	1993	1994	1995	1996	Total	Target 98	Percent
Clinics		2	3	6	7	8	10	10	11	90.9%
CBD Posts (New)		49	89	245	329	324	440	1,478		
CBD Posts (Closed)			32	98	105	98	218	551		
CBD Posts (Active)		223	280	427	651	877	1,099	1,099	800	137.4%
Percent closed			10.3%	18.7%	13.9%	10.1%	16.6%			
Units										
Medical Consultations		5,521	11,485	4,770	27,712	41,733	51,634	142,855		
Nurse Visits		1,542	3,317	2,539	15,313	21,975	43,878	88,564		
Total clinic visits		7063	14802	7309	43025	63708	95512	231,419		
Pap smears		2607	3569	4684	5588	8442	11107	35,997		
Units										
Vasectomies		82	100	119	194	233	224	952		
Tubectomies		2,527	2,995	3,791	5,351	7,229	10,115	32,008		
IUDs		217	248	338	439	609	687	2,538		
Pills		347,282	256,024	216,597	228,206	333,305	256,786	1,638,200		
Injections					391	10,791	31,512	42,694		
Condoms		149,303	27,970	103,964	206,449	281,662	293,309	1,062,657		
Vaginals		5,358	2,490	5,409	2,726	3,326	2,889	22,198		
Female condom							93	93		
CYPs										
	Factor									
Vasectomies	10	820	1,000	1,190	1,940	2,330	2,240	9,520		
Tubectomies	10	25,270	29,950	37,910	53,510	72,290	101,150	320,080		
IUDs	3.5	760	868	1,183	1,537	2,132	2,405	8,883		
Pills	15	23,152	17,068	14,440	15,214	22,220	17,119	109,213		
Injections	4	-	-	-	98	2,698	7,878	10,674		
Condoms	150	995	186	693	1,376	1,878	1,955	7,084		
Vaginals	7.5	714	332	721	363	443	385	2,960		
Female condom	100	-	-	-	-	-	1	1		
Total		51,711	49,405	56,137	74,038	103,991	133,133	468,415	155,000	85.9%
Units										
Seminar participants									3,360	0.0%
MDs/Nurses trained		69	80	88	78	58	58	431	400	107.8%
Social workers trained		64	55	72	59	30	101	381	250	152.4%
CBD volunteers trained		99	166	89	117	39	660	1,170	370	316.2%
Community leaders trained		255	267	358	467	656	793	2,796	1,250	223.7%
Profamilia staff trained		40	48	42	46	139	19	334	870	38.4%
Other NGOs trained								-	100	0.0%
CBD flip charts produced								-	400	0.0%
CBD pamphlets produced								-	50,000	0.0%
Cost recovery (all sources)		25.3%	24.4%	16.7%	13.6%	15.2%	16.7%		34.0%	17.3%

Sources: Profamilia Annual Report, Dept. Planning and Evaluation, Project Paper, Amendment 1

Table 2: Couple Years of Protection, Calendar Year 1996

CYPs	Units	Factor	CYPs	Percent
Sterilization	10,339	10.00	103,390	77.7%
Pill	256,786	15.00	17,119	12.9%
Injection	31,512	4.00	7,878	5.9%
IUD	687	3.50	2,405	1.8%
Condom	293,309	150.00	1,955	1.5%
Vaginal	2,889	7.50	385	0.3%
Total			133,132	100.0%



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TABEL 3: COBERTURA GEOGRAFICA A DICIEMBRE 1996

Centros Regionales	Áreas asignadas Depart. y Municip.	Población Asignada de Mujeres en edad fértil		Metas para finales de 1996		Cobertura al 30 de Diciembre de 1996			No. de Puestos operando al 30 Dic. 1996			No. de Puestos en la Base			
		MEF	Proporción de territorio asignada por Centro Regional	APP'S	Proporción con respecto al territorio asignado	APP'S	Proporción con respecto al territorio asignado	% de Cumplimiento de la Meta	No.	App's por puesto	MEF promedio por puestos	No.	Ide. en Mapa	Proporción con respecto al no. de puestos activos	
Managua	Depto de Managua Dept. de Carazo (Dinamba, San Marcos y Dolores), Depto de León (La Paz Centro, Nagarote)	314,617	31%	36,671	11%	29,488	9%	83%	228	30	1,380	100	●	44%	
Chinandega	Depto de Chinandega, Depto de León (León, Larreynaga, Teica, Achuapa, Sta. Rosa, Quezazuque, El Jicaral)	149,340	15%	15,524	10%	16,262	11%	106%	112	22	1,333	104	●	93%	
Matagalpa	Depto de Matagalpa (excepto Matiguas, Río Blanco, Muy Muy), Depto de Estelí (Estelí, La Trinidad, San Nicolás)	103,129	10%	16,919	16%	13,693	13%	81%	142	28	726	108	●	76%	
Juigalpa	Depto de Chontales, Depto Río San Juan, Depto de RAAS (Nueva Guinea, El Rama, Bluefields, Muelle de los Bueyes, La Cruz de Río Grande, Laguna de Perlas, Kukrahill, Prinzapolka, Corn Island)	101,716	10%	18,142	18%	20,691	20%	114%	151	28	674	121	●	80%	
Masaya	Depto de Masaya, Depto de Granada (Granada, Dinamo, Diria)	86,356	8%	17,559	20%	18,169	21%	103%	129	11	669	57	●	44%	
Ocotul	Depto de Nueva Segovia, Depto de Madriz, Depto Estelí (Condega, Pueblo Nuevo, San Juan de Limay)	70,981	7%	8,333	12%	7,962	6%	96%	51	11	1,392	34	●	67%	
Boaco	Depto de Boaco, Depto de Matagalpa (Matiguas, Río Blanco, Muy Muy), Depto RAAS (Panwas)	54,254	5%	12,035	22%	11,378	21%	95%	110	17	493	79	●	72%	
Rivas	Depto de Rivas, Depto de Carazo (Jinotepe, Sta. Teresa, El Rosario, La Paz de Carazo, La Conquista), Depto Granada (Nandaimé)	56,824	6%	13,688	24%	15,490	27%	113%	82	22	693	82	●	100%	
Jinotega	Depto de Jinotega	55,790	5%	5,093	9%	4,098	7%	80%	94	9	594	78	●	83%	
Fundación Wanki Lupia	Depto RAAN (Puerto Cabezas, Waspam, Rosita, Siuna, Bonanza)	36,208	4%	8,694	Leon 6%	704	← DCA restrado como perdidas								
TOTAL		1,029,216	100%	151,658	15%	137,933	13%	91%	1,099	23	937	763		68%	

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Table 4

		PROFAMILIA DE NICARAGUA																				CUADRO No. 4		
		APP POR DEPARTAMENTO(CLINICA Y DCA)																						
		DICIEMBRE 1996																						
Tipo de Método		MANAGUA		MATAGALPA		BOACO		JUGALPA		CHINANDEGA		RIVAS		MASAYA		JINOTEGA		OCOTAL		Pérdidas 1/		TOTALES		% App Por Método
	TOTAL	UNID	APP	UNID	APP	UNID	APP	UNID	APP	UNID	APP	UNID	APP	UNID	APP	UNID	APP	UNID	APP	UNID	APP	UNID	APP	
Pastillas	CLINICA	2,788	186	520	35	670	45	575	38	538	36	299	20	200	13	446	30	25	5		0	6,061	407	
	DCA	77,671	5,178	40,768	2,718	19,095	1,273	42,723	2,848	24,488	1,633	16,877	1,125	14,706	980	5,155	344	1,592	318	4,380	292	247,455	16,709	
	TOTAL	80,459	5,364	41,288	2,753	19,765	1,318	43,298	2,887	25,026	1,669	17,176	1,145	14,906	994	5,601	373	1,617	323	4,380	292	253,516	17,117	12%
Condono Masc	CLINICA	3,885	26	822	5	1,082	7	1,452	10	1,094	7	561	4	536	4	1,114	7	100	2		0	10,646	72	
	DCA	75,819	505	67,203	448	12,158	81	36,804	245	32,751	218	20,945	140	14,741	98	9,671	64	3,502	70	6,566	44	280,160	1,914	
	TOTAL	79,704	531	68,025	454	13,240	88	38,256	255	33,845	226	21,506	143	15,277	102	10,785	72	3,602	72	6,566	44	290,806	1,987	1%
Depopovera	CLINICA	1,852	463	706	177	948	237	1,031	263	676	169	1,555	389	961	240	609	152	60	45		0	8,418	2,133	
	DCA	4,576	1,144	2,758	690	2,119	530	4,452	1,113	2,377	594	2,163	541	1,177	294	1,519	380	217	163	1,324	331	22,682	5,779	
	TOTAL	6,428	1,607	3,464	866	3,067	767	5,503	1,376	3,053	763	3,718	930	2,138	535	2,128	532	277	208	1,324	331	31,100	7,914	6%
L de Cobre	CLINICA	190	665	78	273	70	245	57	200	64	224	68	238	66	231	44	154	3	32	1	4	641	2,265	
	DCA		0		0		0		0		0		0		0		0					0	0	0
	TOTAL	190	665	78	273	70	245	57	200	64	224	68	238	66	231	44	154	3	32	1	4	641	2,265	2%
Vaguales	CLINICA	60	8	47	6	22	3	21	3	18	2	1	0	7	1	10	1	5	2		0	191	27	
	DCA	468	62	616	82	133	18	162	22	286	38	253	34	354	47	102	14	13	5	253	34	2,644	356	
	TOTAL	528	70	663	88	155	21	183	24	304	41	256	34	361	48	112	15	18	7	253	34	2,835	383	0%
Condón Fem.	CLINICA	18	0	0	0	18	0	24	0	23	0	6	0	4	0	0	0	0	0		0	93	1	
	DCA		0		0		0		0		0		0		0	0	0	0			0	0	0	
	TOTAL	18	0	0	0	18	0	24	0	23	0	6	0	4	0	0	0	0	0		0	93	1	0%
Entenlizacion	CLINICA	2,125	21,250	926	9,260	894	8,940	1,595	15,950	1,334	13,340	1,300	13,000	1,626	16,260	295	2,950	244	7,320		0	10,339	108,270	
	DCA		0		0		0		0		0		0		0	0	0	0			0	0	0	
	TOTAL	2,125	21,250	926	9,260	894	8,940	1,595	15,950	1,334	13,340	1,300	13,000	1,626	16,260	295	2,950	244	7,320		0	10,339	108,270	78%
Totales APP	CLINICA	77%	22,398	71%	9,756	83%	9,477	80%	16,463	83%	13,779	88%	13,651	92%	16,749	80%	3,295	93%	7,406	0%	4	82%	113,176	82%
	DCA	23%	6,800	29%	3,938	17%	1,902	20%	4,228	15%	2,483	12%	1,840	8%	1,420	20%	801	7%	556	100%	701	18%	24,759	18%
	TOTAL	100%	29,488	100%	13,693	100%	11,378	100%	20,691	100%	16,262	100%	15,490	100%	18,169	100%	4,096	100%	7,962	100%	704	100%	137,934	100%
% APP por Departamento	CLINICA		20%		9%		8%		15%		12%		12%		15%		3%		7%		0%		100%	
	DCA		28%		16%		8%		17%		10%		7%		6%		3%		2%		3%		100%	
	TOTAL		21%		10%		8%		15%		12%		11%		13%		3%		6%		1%		100%	

1 Datos procedentes de Centros Clínicos

1 Las "Pérdidas" se incluyen en DCA y son las unidades que se han distribuido y no fueron canceladas por los pacientes

TABLE 5 : Resumen de Usuarias de Minilap de 1995

**PROFAMILIA DE NICARAGUA
EVALUACION E INVESTIGACION
Perfil de Usuarias de Minilap
Año 1995
Clínicas: Profamilia**

Hijos vivos	19 ó menos	20-24	25-29	30-34	35 -39	40-44	45 y más	Total	%
0					1			1	0%
1	2	7	15	14	7	1	4	50	1%
2	4	334	296	175	86	16	3	914	13%
3	4	570	627	352	133	21	3	1,710	24%
4		328	621	364	149	16	5	1,483	21%
5		122	453	387	148	29	5	1,144	16%
6 y más		32	409	631	601	155	17	1,845	26%
Total	10	1,393	2,421	1,923	1,125	238	37	7,147	100%
%	0%	19%	34%	27%	16%	3%	1%	100%	1/ 99%
Escolaridad:				Motivo de operación:					
Analfabetas	1206	18%	Paridad Satisfecha:		4,205	67%			
Alfabetas	402	6%	Problemas de Salud:		599	10%			
Primaria	3396	51%	Situación Económica:		1,244	20%			
Secundaria	1640	25%	Otros:		219	3%			
Total	6,644	100%	Total		6,267	100%			
Complicación:									
-Infectada	3	0.04%							
-Fallida	17	0.24%							
Total	20	2/ 0.28%							

Observación: La escolaridad y Motivo de operación total, no coincide con los rangos de edad total(Cirugías efectuadas) por que la información de las dos primeras fueron reportadas incompletas.

1/ Según informes estadísticos el No. de Minilap realizadas fue de 7,229; esta información corresponde al 99% de lo efectuado

2/ Las complicaciones solamente representan el 0.28% del total informado que fue de 7,147

**PROFAMILIA DE NICARAGUA
EVALUACION E INVESTIGACION**

EVALUACION E INVESTIGACION

Table 6: Project Operating Expenses, Regional Centers, 1996

Account	Matagalpa	Jinotega	Juigalpa	Boaco	Chinandega	Rivas	Masaya	Ocotal	Total	Percent
Clinic services	144,597	95,266	125,427	127,535	115,768	128,502	132,602	37,815	907,512	13.5%
Sterilization	196,266	119,782	224,786	106,049	223,512	217,394	224,152	127,919	1,439,860	21.4%
CBD	347,187	167,283	330,326	308,506	299,485	277,523	243,281	95,505	2,069,096	30.8%
Administration	335,383	248,066	333,333	271,063	309,321	306,366	323,537	177,270	2,304,341	34.3%
Total	1,023,433	630,397	1,013,872	813,153	948,086	929,787	923,572	438,509	6,720,809	100.0%
Largest account shaded										
Percent Distribution										
Clinic services	14.1%	15.1%	12.4%	15.7%	12.2%	13.8%	14.4%	8.6%	13.5%	
Sterilization	19.2%	19.0%	22.2%	13.0%	23.6%	23.4%	24.3%	29.2%	21.4%	
CBD	33.9%	26.5%	32.6%	37.9%	31.6%	29.8%	26.3%	21.8%	30.8%	
Administration	32.8%	39.4%	32.9%	33.3%	32.6%	33.0%	35.0%	40.4%	34.3%	
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Largest account shaded										
CYPs 1996										
Clinic	9,756	3,295	16,463	9,477	13,779	13,651	16,749	2,468	85,638	
CBD	3,938	801	4,228	1,902	2,483	1,840	1,420	186	16,798	
Total	13,694	4,096	20,691	11,379	16,262	15,491	18,169	2,654	102,436	
Cost/CYP (Cordobas)										
Clinic	20.12	36.35	13.65	11.19	16.22	15.93	13.38	51.83	16.81	\$ 1.83
CBD	88.16	208.84	78.13	162.20	120.61	150.83	171.32	513.47	123.18	\$ 13.39
Total	24.49	60.56	16.11	23.82	19.02	19.78	17.81	66.79	22.50	\$ 2.45

Table 7: Summary of Expenditures by Donor Source and Activity, 1991-1996						
	1991	1992	1993	1994	1995	1996
Total costs,						
Central IPPF	1,257,740	1,343,913	2,026,565	2,671,775	3,105,114	4,156,453
Central USAID	205,383	1,264,051	1,656,944	2,913,120	3,443,205	3,442,708
Clinic/CBD IPPF	867,019	977,940	1,292,173	1,382,461	1,364,187	1,571,787
Clinic/CBD AID	2,275	780,828	1,592,343	3,243,818	5,768,620	8,484,206
Summary						
Central	1,463,123	2,607,964	3,683,509	5,584,895	6,548,319	7,599,161
Clinic/CBD	869,294	1,758,768	2,884,516	4,626,279	7,132,807	10,055,993
Total	2,332,417	4,366,732	6,568,025	10,211,174	13,681,126	17,655,154
Percent distribution						
Central	62.7%	59.7%	56.1%	54.7%	47.9%	43.0%
Clinic/CBD	37.3%	40.3%	43.9%	45.3%	52.1%	57.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Percent Increase						
Central		78.2%	41.2%	51.6%	17.3%	16.0%
Clinic/CBD		102.3%	64.0%	60.4%	54.2%	41.0%
Total		87.2%	50.4%	55.5%	34.0%	29.0%
Central includes Documentation Center, Administration, Training Center, IEC center, Evaluation and Planning Center						
Clinic/CBD includes all Regional Centers, Managua clinics, VS, CBD, EMIPLAA, CODEMU, Adolescentes, Lab						

Table 8: Expenditures by Activity, 1991-96 and 1996				
	1991-96	Percent	1996	Percent
Regional Centers				
Matagalpa	3,350,444	6.1%	1,023,434	5.8%
Juigalpa	3,012,862	5.5%	1,013,872	5.7%
Boaco	2,049,102	3.7%	813,152	4.6%
Chinandega	2,501,209	4.6%	948,086	5.4%
Rivas	2,066,361	3.8%	929,787	5.3%
Masaya	2,022,662	3.7%	923,572	5.2%
Jinotega	703,524	1.3%	630,398	3.6%
Ocotal	438,509	0.8%	438,509	2.5%
Subtotal	16,144,673	29.5%	6,720,810	38.1%
Managua VS				
Managua VS	1,602,491	2.9%	699,054	4.0%
Mon Lezcano	2,256,581	4.1%	511,470	2.9%
Altamira	980,278	1.8%	202,733	1.1%
Laboratory	927,380	1.7%	259,384	1.5%
Subtotal	5,766,730	10.5%	1,672,641	9.5%
EM/PLAFA				
EM/PLAFA	974,017	1.8%	247,064	1.4%
CODEMU	936,718	1.7%	252,783	1.4%
CBD Managua	1,078,676	2.0%	288,284	1.6%
Adolescents	1,320,909	2.4%	301,150	1.7%
Subtotal	4,310,320	7.9%	1,089,281	6.2%
Central				
Document. Ctr	1,462,966	2.7%	135,826	0.8%
Training Ctr.	1,785,552	3.3%	437,432	2.5%
IEC Ctr.	4,192,212	7.6%	941,730	5.3%
Res/Eval Ctr	1,646,513	3.0%	472,758	2.7%
Administration	19,505,657	35.6%	6,184,672	35.0%
Overhead		0.0%		0.0%
Subtotal	28,592,900	52.2%	8,172,418	46.3%
Total	54,814,623	100.0%	17,655,150	100.0%
AID	32,797,498	59.8%	11,926,914	67.6%
IPPF	22,017,127	40.2%	5,728,240	32.4%
	54,814,625	100.0%	17,655,154	100.0%

Table 9

PROFAMILIA DE NICARAGUA
GASTOS DE OPERACION PROYECTO USAID-PROFAMILIA
31 DE DICIEMBRE DE 1996

NOMBRE DE LA CUENTA	PERSONAL	ADMINISTRATIVO	TRANSPORTE	MOBILIARIO Y EQUIPO	SERVICIOS	SUMINISTROS CLIN.	MATERIAL AUDIO V.	VARIOS	TOTAL
EMIPLAFA	167,987.16	4,885.51	59,865.59	787.71	-	-	-	6,100.05	239,226.02
CODEMU	143,420.52	3,689.12	99,121.79	2,785.94	-	-	-	2,838.68	251,856.05
CENTRO DE ENTRENAMIENTO	156,578.82	4,253.36	1,550.00	1,210.50	1,700.00	-	23,240.10	248,899.70	437,432.48
CENTRO DE DOCUMENTACION	81,245.99	3,435.87	-	-	-	-	59,631.10	11,378.00	135,888.96
INF. Y EDUCACION	174,380.37	13,543.53	41,121.98	6,958.90	632,578.68	-	18,431.81	54,739.32	941,730.55
PLANIFICACION Y EVALUAC.	440,769.44	21,929.14	542.00	792.00	-	-	-	8,725.46	472,758.04
DIR. COORD. REG.	96,034.28	47,237.39	87,023.80	1,570.50	10,933.81	-	-	1,490,327.41	1,733,127.19
DIR. SERV.MEDICOS	284,987.19	1,526.14	3,919.88	1,885.31	-	-	-	40.00	292,358.52
A.Q.V. MANAGUA	429,068.66	22,833.13	10,045.50	-	125,154.05	92,747.19	-	19,205.80	699,054.33
CENTRO REGIONAL MATAGALPA									
SERVICIOS CLINICOS	132,084.52	9,769.19	2,855.00	-	-	-	-	88.25	144,596.96
A.Q.V.	50,096.16	6,779.38	1,965.00	5,077.42	38,400.00	73,229.43	-	20,718.95	198,286.34
D.C.A.	134,505.21	1,913.22	170,889.93	-	-	-	97.09	39,781.88	347,187.33
DIR. ADMITIVA.	184,228.76	82,667.51	20,584.38	5,081.03	26,102.22	-	270.00	16,469.62	335,383.52
CENTRO REGIONAL JINOTEGA									
SERVICIOS CLINICOS	91,791.54	401.94	2,903.00	-	-	-	-	170.00	95,266.48
A.Q.V.	49,904.51	5,415.26	1,746.00	6,983.80	10,620.00	41,822.84	-	3,490.08	119,782.27
D.C.A.	69,597.86	1,485.34	66,852.88	-	-	-	-	29,347.17	167,283.25
DIR. ADMITIVA.	147,788.75	30,716.15	21,381.27	6,381.35	30,984.00	-	-	10,814.36	248,065.88
CENTRO REGIONAL JUIGALPA									
SERVICIOS CLINICOS	118,715.54	3,806.68	2,718.60	-	150.00	-	-	36.00	125,426.82
A.Q.V.	78,515.33	6,135.00	4,480.48	-	67,785.00	56,021.55	100.00	11,748.64	224,786.00
D.C.A.	144,722.71	1,705.50	161,311.98	-	-	-	-	22,586.13	330,326.32
DIR. ADMITIVA.	223,346.94	54,506.21	23,912.16	1,780.00	23,640.00	-	-	6,147.50	333,332.81
CENTRO REGIONAL BOACO									
SERVICIOS CLINICOS	121,448.25	2,775.69	2,838.00	-	-	-	325.00	148.00	127,534.94
A.Q.V.	6,055.36	3,959.90	241.00	-	39,830.00	44,716.76	-	11,249.08	106,049.10
D.C.A.	182,727.38	1,110.60	103,328.49	-	-	-	-	21,339.75	308,506.22
DIR. ADMITIVA.	169,498.84	61,002.70	23,750.11	1,368.87	6,356.80	-	-	9,085.93	271,063.25

Table 9

PROFAMILIA DE NICARAGUA
GASTOS DE OPERACION PROYECTO USAID-PROFAMILIA
31 DE DICIEMBRE DE 1996

NOMBRE DE LA CUENTA	PERSONAL	ADMINISTRATIVO	TRANSPORTE	MOBILIARIO Y EQUIPO	SERVICIOS	SUMINISTROS CLIN.	MATERIAL AUDIO V.	VARIOS	TOTAL
CENTRO REGIONAL CHINANDEGA									
SERVICIOS CLINICOS	111,912.42	3,181.89	636.00	-	-	-	-	38.25	115,768.38
A.Q.V.	81,877.53	1,819.54	54.00	-	59,785.60	88,195.95	-	11,779.13	223,511.75
D.C.A.	138,838.58	2,090.04	121,537.25	-	-	-	-	37,019.09	299,484.96
DIR. ADMITIVA.	203,882.62	56,982.78	14,892.44	9,702.64	10,702.00	-	-	13,158.14	309,320.62
CENTRO REGIONAL RIVAS									
SERVICIOS CLINICOS	107,689.54	20,640.48	61.00	-	-	-	-	111.00	128,502.02
A.Q.V.	74,886.84	2,040.50	10,430.00	-	51,535.00	59,438.87	-	19,062.95	217,394.16
D.C.A.	121,698.26	1,570.00	110,447.09	-	-	-	-	43,807.32	277,522.67
DIR. ADMITIVA.	182,171.33	62,651.34	15,275.29	8,428.20	22,906.00	-	-	14,936.23	306,368.39
CENTRO REGIONAL MASAYA									
SERVICIOS CLINICOS	121,714.88	9,581.43	198.00	-	-	23.00	-	1,084.34	132,601.65
A.Q.V.	58,235.06	2,952.08	1,944.00	-	84,165.08	66,114.75	-	12,741.12	224,152.09
D.C.A.	93,526.81	3,869.55	94,090.04	-	-	-	-	51,794.52	243,280.92
DIR. ADMITIVA.	194,652.35	74,907.15	23,845.71	6,901.88	6,070.00	-	7,150.94	10,009.28	323,537.31
CENTRO REGIONAL OCOTAL									
SERVICIOS CLINICOS	32,470.24	4,660.00	125.00	560.00	-	-	167.00	-	37,815.24
A.Q.V.	20,540.33	-	630.00	14,304.66	7,470.00	77,988.54	-	6,815.28	127,918.81
D.C.A.	30,089.00	15,018.50	48,669.33	-	-	-	-	1,747.70	95,504.53
DIR. ADMITIVA.	57,013.98	26,851.41	12,193.08	25,886.96	27,403.80	-	-	27,920.35	177,269.58
TOTALES C\$	5,488,659.86	686,099.95	1,369,577.03	108,425.47	1,284,270.02	600,098.88	109,413.04	2,297,495.44	11,924,042.69

Managua, 17 de Febrero de 1997.
 GOPAID96.XLS

Table 10

**ASOCIACION PRO-BIENESTAR DE LA FAMILIA NICARAGUENSE
PROFAMILIA**

**RESUMEN DE INGRESOS y EGRESOS
DONANTE: AID
1991 AL 1996**

No.	Descripción	1991	1992	1993	1994	1995	1996	TOTAL
I.- INGRESOS								
1.	Centro Regional Matagalpa	0.00	64,492.00	75,708.25	96,897.25	131,866.00	211,347.50	580,311.00
2.	Centro Regional Juigalpa	0.00	0.00	87,497.25	139,086.50	186,446.50	289,739.50	682,769.75
3.	Centro Regional Boaco	0.00	0.00	38,431.85	51,602.85	68,999.75	161,811.25	318,845.30
4.	Centro Regional Chinandega	0.00	0.00	25,893.50	111,703.50	127,121.50	188,271.75	452,990.25
5.	Centro Regional Rivas	0.00	0.00	0.00	42,031.00	118,567.80	151,274.20	311,873.00
6.	Centro Regional Masaya	0.00	0.00	0.00	0.00	90,608.25	146,626.99	237,235.24
7.	Centro Regional Jinotega	0.00	0.00	0.00	0.00	0.00	87,630.78	87,630.78
8.	Centro Regional Ocotol	0.00	0.00	0.00	0.00	0.00	16,501.50	16,501.50
9.	Venta de anticonceptivos / Managua	0.00	18,840.50	10,484.50	0.00	31,327.00	80,330.50	120,982.50
10.	Métodos inyectables	0.00	160.00	0.00	0.00	57,962.25	216,778.25	273,900.50
	TOTAL INGRESOS	0.00	83,492.50	238,015.15	441,320.90	810,899.05	1,509,112.20	3,082,839.80
II.- EGRESOS								
1.	Centro Regional Matagalpa	2,275.00	496,485.06	405,118.06	604,080.15	819,051.74	1,023,434.35	3,350,444.36
2.	Centro Regional Juigalpa	0.00	155,249.20	398,617.53	623,607.84	821,515.27	1,013,871.95	3,012,861.79
3.	Centro Regional Boaco	0.00	129,084.24	217,733.78	313,548.53	575,572.04	813,153.51	2,049,102.10
4.	Centro Regional Chinandega	0.00	0.00	265,625.40	565,892.82	721,604.85	948,085.89	2,501,208.86
5.	Centro Regional Rivas	0.00	0.00	0.00	414,938.50	721,635.46	929,787.24	2,066,361.20
6.	Centro Regional Masaya	0.00	0.00	0.00	497,656.14	601,433.98	923,571.97	2,022,662.09
7.	Centro Regional Jinotega	0.00	0.00	0.00	0.00	73,128.52	630,397.88	703,524.40
8.	Centro Regional Ocotol	0.00	0.00	0.00	0.00	0.00	438,508.87	438,508.87
9.	Anticoncepción Quirúrgica voluntaria/ Managua	0.00	0.00	305,247.40	0.00	598,189.19	699,054.33	1,602,490.92
10.	EMIPLAFA	0.00	0.00	0.00	92,155.22	188,920.89	239,226.02	520,302.13
11.	CODEMU	0.00	0.00	0.00	96,228.56	150,607.03	261,866.00	498,891.59
12.	Centro de documentación / Managua	0.00	0.00	0.00	35,709.56	79,483.91	135,826.37	251,019.84
13.	Centro de entrenamiento nacional	87,598.87	248,191.80	262,961.42	331,889.23	417,478.53	437,432.48	1,785,552.33
14.	INFORMACION y EDUCACION	19,389.40	234,753.10	557,367.44	1,376,752.83	1,062,218.86	941,730.55	4,192,212.08
15.	EVALUACION e INVESTIGACION	43,609.79	127,647.00	174,387.33	248,921.15	579,189.41	472,758.04	1,646,512.72
16.	ADMON. AID	54,785.79	653,455.28	662,229.09	956,557.41	1,801,797.04	2,028,218.56	6,158,043.17
	TOTAL EGRESOS	207,658.85	2,044,875.68	3,249,287.45	6,156,938.14	9,211,824.52	11,926,913.81	32,797,498.45
III RECUPERACION DE COSTOS:								
1	Ingresos:	0.00	83,492.50	238,015.15	441,320.90	810,899.05	1,509,112.20	3,082,839.80
2	Egresos:	207,658.85	2,044,875.68	3,249,287.45	6,156,938.14	9,211,824.52	11,926,913.81	32,797,498.45
	%	0.0000	0.0408	0.0733	0.0717	0.0880	0.1265	0.0940

ASOCIACION PRO-BIENESTAR DE LA FAMILIA NICARAGUENSE
PROFAMILIA

RESUMEN DE INGRESOS y EGRESOS
DONANTE: I.P.P.F.
1991 AL 1996

No.	Descripción	1991	1992	1993	1994	1995	1996	TOTAL
I.- INGRESOS								
1.	Clinica Monseñor Lazcano/Managua	90,285.25	115,766.50	101,949.75	103,304.50	104,215.00	124,813.00	640,334.00
2.	Clinica Altamira/ Managua	89,381.75	139,022.00	120,835.00	140,040.00	141,020.00	146,808.00	777,106.75
3.	Ingresos por Laboratorio	108,719.00	159,012.00	173,833.56	207,589.50	291,826.00	382,422.20	1,301,202.26
4.	Inserción de DIU / Clínicas de Managua	0.00	0.00	7,035.00	10,670.00	19,264.86	20,920.00	57,879.86
5.	Venta de anticonceptivos	304,422.00	545,418.80	443,258.75	447,465.25	680,948.25	637,000.67	3,058,511.52
6.	Métodos inyectables	0.00	0.00	0.00	5,885.00	24,900.00	8,882.00	39,267.00
7.	Servicios de entrenamiento	0.00	11,495.33	0.00	0.00	0.00	0.00	11,495.33
	SUB-TOTAL	590,808.00	970,712.43	846,712.06	914,754.25	1,262,164.11	1,300,645.87	5,885,796.72
7.	Overhead USAID	0.00	460,930.00	389,894.95	566,144.91	1,155,058.15	1,505,447.35	4,076,475.36
8.	Otros ingresos	7,501.81	3,477.50	13,105.98	30,587.51	10,457.25	146,530.52	211,680.57
	SUB-TOTAL	7,501.81	464,407.50	403,000.93	595,732.42	1,165,515.40	1,651,977.87	4,288,135.93
	TOTAL GENERAL	598,309.81	1,435,119.93	1,249,712.99	1,510,486.67	2,427,679.51	2,952,623.74	10,173,932.65
II.- EGRESOS								
1.	EMIPLAFA / Managua	98,303.96	105,937.44	149,014.06	83,881.31	8,740.23	7,837.94	453,714.94
2.	CODEMU / Managua	95,055.57	122,864.90	151,214.22	66,955.44	1,011.00	926.75	438,027.88
3.	D.C.A. / Managua	72,287.51	76,444.89	186,374.06	197,398.42	267,877.00	289,284.71	1,078,676.39
4.	ADOLESCENTES / Managua	143,927.00	161,819.66	207,968.59	251,081.70	254,962.08	301,149.88	1,320,908.89
5.	Clinica Monseñor Lazcano / Managua	281,580.97	273,672.46	361,889.90	395,882.32	442,086.13	511,469.71	2,256,581.49
6.	Clinica Altamira / Managua	113,936.98	138,947.69	118,340.92	221,430.81	184,889.36	202,733.32	980,277.97
7.	LABORATORIO	61,918.17	98,254.07	127,371.40	165,830.99	214,620.93	259,384.58	927,380.14
8.	Centro de documentación / Managua	1,162,624.03	0.00	11,081.93	38,239.80	0.00	0.00	1,211,945.76
9.	ADMINISTRACION	95,115.92	1,343,912.60	2,015,482.76	2,833,535.39	3,105,114.38	4,156,462.66	13,349,813.71
	TOTAL EGRESOS	2,124,759.11	2,321,853.41	3,318,737.84	4,054,236.18	4,469,301.08	5,728,239.55	22,017,127.17
III.- RECUPERACION DE COSTOS:								
1.	Ingresos propios	590,808.00	970,712.43	846,712.06	914,754.25	1,262,164.11	1,300,645.87	5,885,796.72
2.	Egresos	2,124,759.11	2,321,853.41	3,318,737.84	4,054,236.18	4,469,301.08	5,728,239.55	22,017,127.17
	%	0.2781	0.4181	0.2551	0.2256	0.2824	0.2271	0.2673
1.	Ingresos propios + overhead	598,309.81	1,435,119.93	1,249,712.99	1,510,486.67	2,427,679.51	2,952,623.74	10,173,932.65
2.	Egresos	2,124,759.11	2,321,853.41	3,318,737.84	4,054,236.18	4,469,301.08	5,728,239.55	22,017,127.17
	%	0.2816	0.6181	0.3766	0.3726	0.5432	0.5155	0.4621

Table 11: Revenues and Expenditures per Regional Clinic, 1991-1996, (in Cordobas)

Regional Center	1991	1992	1993	1994	1995	1996	Total	Post Recovery
Managua								
Revenues	179,667	254,788	222,785	243,344	276,562	331,951	1,509,097	
Expenses	395,517	412,620	775,476	617,313	1,225,164	1,413,256	4,839,346	31.2%
Surplus (Deficit)	-215,850	-157,832	-556,291	-373,968	-948,602	-1,081,304	-3,333,847	
Matagalpa								
Revenues	0	64,492	75,708	96,897	131,866	211,347	580,310	
Expenses	2,275	496,485	405,118	604,080	819,051	1,023,434	3,350,443	17.3%
Surplus (Deficit)	-2,275	-431,993	-329,410	-507,183	-687,185	-812,087	-2,770,133	
Juigalpa								
Revenues		0	87,497	139,087	186,446	269,739	682,769	
Expenses		155,249	398,617	623,607	821,515	1,013,872	3,012,860	22.7%
Surplus (Deficit)		-155,249	-311,120	-484,520	-635,069	-744,133	-2,330,091	
Boaco								
Revenues		0	38,432	51,603	66,999	161,611	318,645	
Expenses		129,094	217,734	313,549	575,572	813,154	2,049,103	15.6%
Surplus (Deficit)		-129,094	-179,302	-261,946	-508,573	-651,543	-1,730,458	
Chinandega								
Revenues			25,893	111,703	127,121	188,271	452,988	
Expenses			265,625	565,893	721,605	948,086	2,501,209	18.1%
Surplus (Deficit)			-239,732	-454,190	-594,484	-759,815	-2,048,221	
Masaya								
Revenues				0	90,608	146,627	237,235	
Expenses				923,572	497,656	601,434	2,022,662	11.7%
Surplus (Deficit)				-923,572	-407,048	-454,807	-1,785,427	
Rivas								
Revenues				42,031	118,568	151,274	311,873	
Expenses				414,939	721,635	929,787	2,066,361	15.1%
Surplus (Deficit)				-372,908	-603,067	-778,513	-1,754,488	
Jinotega								
Revenues					0	87,631	87,631	
Expenses					73,127	630,398	703,525	12.5%
Surplus (Deficit)					-73,127	-542,767	-615,894	
Ocotul								
Revenues						16,501	16,501	
Expenses						438,509	438,509	3.8%
Surplus (Deficit)						-411,008	-411,008	
Total								
Revenues	179,667	319,280	450,315	684,665	998,170	1,564,952	4,197,049	
Expenses	397,792	1,193,448	2,062,570	4,062,953	5,455,325	7,811,930	20,984,018	20.0%
Surplus (Deficit)	-218,125	-874,168	-1,615,855	-3,378,287	-4,457,155	-6,235,977	-16,779,567	

APPENDIX C STATEMENT OF WORK EVALUATION OF THE FAMILY PLANNING AND REGIONALIZATION PROJECT

Purpose

USAID/Managua seeks the services of a contract team to conduct an evaluation of its \$13 million Family Planning Expansion and Regionalization Project. The Evaluation is intended to answer the following questions:

- 1) Relation to Mission Strategy Is the activity likely to contribute to achieving the Mission's family planning and reproductive health strategy?
- 2) Achievement of Activity/Project Goal Is the project on schedule to achieve its goal: to increase knowledge, acceptance and early use of modern family planning methods?
- 3) Achievement of Activity/Project Purpose Is the project on schedule to achieve its purpose: to increase access to a range of contraceptive methods, especially in rural and marginal urban areas?
- 4) Financial Sustainability Is Profamilia making adequate progress towards assuming an increasing share of its recurrent costs?
- 5) Organizational Sustainability Are the organization, staffing and management of Profamilia adequate to achieve the activity purpose and goal?

Questions to be Answered by the Evaluation Team

- 1) Relation to Mission Strategy Is the activity likely to contribute to achieving the Mission family planning and reproductive health strategy?
 - a) Are the indicators [at the Result, Intermediate Result and project level in the Mission's strategic framework and the Project Paper/Cooperative Agreement] appropriate measures of program and project success? Have the indicators and targets distorted the range and quality of services provided or the population being served? How will the choice of indicators affect the achievement of higher level results?
 - b) Is the project reaching the target population? Will expansion of the clinic and CBD network increase access to family planning for the target population? Are current and planned clinics and CBD posts appropriately located?
- 2) Achievement of Activity Goal Is the project on schedule to achieve its stated goal: to increase knowledge, acceptance and early use of modern family planning methods?
 - a) What effect has Profamilia's rapid growth rate had on the quality of care, particularly the clinical services? Are the current quantitative targets appropriate?
 - b) What is the effect of monthly targets on the quality of care? Does the emphasis on surgical sterilization affect the quality of counseling provided, access of clients to other methods and other activities such as public awareness and patient education? Do public awareness/patient education programs reflect program emphases? What is the relationship

- between counseling and surgical sterilization? What is the relative access patients have to other methods?
- c) Is there a relationship between the structure of monetary and non-monetary incentives, counseling, method mix and quality of care? What is the effect, if any, of incentives on counseling, method mix and quality of care?
 - d) Profamilia trains public and private sector health workers in surgical sterilization. Does this training program affect clinic efficiency and quality of care? Should this training continue?
 - e) Are adequate written protocols for patient care in place? To what extent are they followed?
 - f) Do procedures exist for internal monitoring of quality of care and medical, nursing, and laboratory audits? Are they performed on a regular basis? Is statistical information related to quality of care collected, processed and fed back to care providers on a timely basis in order that they may monitor their performance?
 - g) Are adequate systems for patient follow up in place, especially for laboratory results or complications? Do standard procedures exist to refer complicated cases to local hospitals or other tertiary care facilities? Are they being followed consistently? Is there a system for detecting discontinuation and complication rates and undertaking follow up for these patients?
 - h) Are Profamilia's clinical norms and procedures consistent with Ministry of Health policies and norms for reproductive health and family planning?
 - i) Is the current system of medical supervision from the central to the regional level adequate to guarantee the quality of care?
 - j) How have the technical assistance, training and commodity inputs provided by USAID affected project implementation with regard to quality of care? Have the technical assistance contractors financed by AID both through local contracts and buy-ins to Global Bureau projects accomplished their objectives in a timely manner and transferred relevant technologies to local counterparts to ensure program sustainability? Has Profamilia designated counterparts to work with technical assistance contractors? How effective has Profamilia been in using the technical assistance and training provided?

3) Achievement of Activity Purpose To what extent has Profamilia increased client access to information about reproductive health and family planning and modern contraceptive methods?

- a) How effective are the outreach strategies employed by Profamilia in providing information to the target groups? How effective is client counseling in Profamilia's clinics? Do clinics and CBD workers have sufficient educational and counseling materials and equipment?
- b) How effective is Profamilia's use of mass media to promote awareness and use of services? Has Profamilia used USAID-financed technical assistance effectively in developing and implementing a national multi-media communication campaign? Has Profamilia provided technical counterparts to work with the contractor? Has Profamilia adopted technologies recommended by them?
- c) To what extent will the communication strategies increase demand for clinical services and hence the efficiency with which services are provided?

- d) Are the community-based distribution posts (CBDs) providing an adequate level of quality services? Is there any significant difference in the level and quality of services or the pricing between posts located in commercial pharmacies and stores and those that are not?
- e) Are the CBD workers receiving adequate training in norms and procedures for counseling, educational materials, contraceptives and supplies?
- f) Are the CBD workers supervised adequately?

4) Financial Sustainability Is Profamilia making adequate progress towards assuming an increasing share of its recurrent costs?

- a) What is the current level of Profamilia's cost recovery/financial sustainability? What percentage of costs does Profamilia recover through user fees, sale of contraceptives and services? How are these revenues spent? Are they channeled back into the project to cover recurrent costs as per the terms of the Cooperative Agreement?
- b) If needed, how could Profamilia increase its financial sustainability?
- c) Does Profamilia have a system for cost analysis and cost accounting sufficient to determine the cost of services and the efficiency with which they are provided by different clinics and to structure fees accordingly?
- d) Do Regional Centers have adequate access to budget information for purposes of management and cost recovery?
- e) Should the accounting and financial management functions remain as currently structured? Are there better alternatives?

5) Organizational Sustainability Is the organization, staffing and management of Profamilia adequate to achieve the expected results?

- a) Have training and organizational development programs been implemented as planned?
- b) How has management responded to the rapid geographic expansion of services? To what effect does management employ modern organization, information and delegation of authority systems -- and how have these systems performed?
- c) What have been the effects of AID and IPPF inputs of training and technical assistance in promoting the organizational development of Profamilia?
- d) What contribution to decision-making do Profamilia's research, evaluation and information systems make?
- e) Is Profamilia providing adequate logistical support to the project, both in terms of transportation for field work and medical supply logistics.
- f) Assess the performance of the financial management, commodity procurement and administrative support components of the project. Assess the performance and cost-effectiveness of property acquisition and clinic construction/refurbishment carried out by Profamilia. What impact do current financial and administrative management methods and styles have on organizational performance and project implementation?

Level of Effort

This evaluation will require the services of a team comprised of five members for a period of four weeks: one week of preparation time and report writing time in the U.S. and three weeks in Nicaragua. A six day work week is authorized. The International Planned Parenthood Federation may provide an observer to accompany the team during the evaluation.

Chief of Party/Expert in Management of Reproductive Health and Family Planning Programs: Position requires a Masters or Ph.D. in public health or related social science with at least ten years of experience designing, managing and evaluating reproductive health and family planning programs. Demonstrated analytical and writing skills required. Spanish at the 3+, 3+ level required. Familiarity with AID grant and cooperative agreement procedures desirable.

Family Planning Clinical/Quality of Care Expert: Requires medical degree with specialization in integrated reproductive health care and at least five years of clinical experience in reproductive health and family planning. Knowledge of state-of-the-art surgical and temporary contraceptive procedures required as well as familiarity with international standards of clinical care. Experience with medical and/nursing chart audit procedures or related methods of quality of care assessment required. Spanish at the 3+,3+ level strongly preferred.

Expert in Family Planning Organizational Analysis and Institutional Development: Advanced degree in business or public management with an emphasis in organizational analysis/organization development. At least five years of experience conducting organizational analysis and development for non-profit organizations. Spanish fluency at the 3+, 3+ level.

Cost Recovery/Financial Management Expert: Advanced degree in health economics or health care management with emphasis in financial management, cost analysis, cost recovery or pricing of services. Should have strong experience in the area of cost recovery for reproductive NGO health or family planning programs, some of which must be in a developing country and/or non-profit setting. Proven analytical and written communication skills required. Spanish fluency at the 3, 3+ level strongly preferred.

Family Planning/Reproductive Health Education and Outreach Specialist: Advanced degree in public health or related social science field with specialization in information, education, and communications (IEC). At least five years of experience working with IEC programs and NGOs, three of which must be in a developing country setting. Strong oral and written communication skills required. Spanish fluency at the 3+, 3+ level.

Deliverables

While in Nicaragua, the contractor shall provide two oral briefings:

a midterm statement of progress and preliminary findings, and;

a final presentation of findings, conclusions and recommendations.

The contractor shall present a written report in English summarizing the evaluation findings, conclusions and recommendations in prioritized fashion, not to exceed 50 pages, including:

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- a) a summary (not to exceed five pages) of the major findings, conclusions and prioritized recommendations (in Spanish and English);
- b) the body of the report (English only), with clearly stated and documented findings, conclusions and prioritized recommendations; and
- c) a draft Project Evaluation Summary (English only).

The contractor shall submit a draft of the report (minus the PES and appendices) at the time of the final debriefing. USAID will have five working days to respond with comments. Once USAID/Nicaragua's comments have been received, the contractor shall have seven working days to finalize the report. Eight days after receiving USAID's comments, the contractor shall have sent two complete copies of the report in English and two copies of the aforementioned sections in Spanish via air courier to the USAID/Mission in Nicaragua.

APPENDIX D: PERSONS INTERVIEWED/CONTACTED

Profamilia

Lic. Sergio Mártez Rivas, Director Ejecutivo
Lic. Noel Gómez Molina, Director Financiero
Sr. Noel Ruíz, Finance Director
Sr. Pedro Zelaya, Head Accountant
Sr. Jairo Narváez, Inventory Control
Sr. Franklin Callejas, Accountant Assistant
Sr. Leonardo Ruíz Roa, Director Administrativo
Ing. María Lourdes Avendaño, Systems Engineer
Ing. Marcelo Pereira, Systems Engineer
Dr. Sergio Sáenz M., Director de Operaciones
Ing. Carolina Zuniga R., Directora Planeación y Evaluación
Lic. María Marta Acevedo A., Directora Centro de Entrenamiento y Documentación
Lic. Veronica Matus Ruíz, Directora de Capacitación a DCA
Lic. María Auxiliadora Lacayo G., Directora de Comunicación Social
Lic. Sonia Gutierrez, Coordinadora de Recursos Humanos
Lic. María Eugenia Ramirez, Consultora de Comunicación

Field Trips

Matagalpa Regional Center, Dra. María Lily Chavarría, Directora
Jinotega Regional Center, Dr. Arnoldo Jose Bermúdez Diaz, Regional Director
Sr. Edgar Navarrete, Programa Salud, Mujer y Familia, Jinotega
Altamira Clinic, Managua, Dr.
Monseñor Lezcano Clinic, Managua, Dr. Jose Antonio Medrano, Regional Director
Masaya Regional Center, Dra. Darling Cuadra Prado, Regional Director,
Ing. Ana Tellez Robleto, Systems Analyst

USAID

Paul Greenough, Evaluation Officer
Karen Hilliard, Project Officer
Ilka Esquivel, Consultora en Salud Reproductiva
Mr. Mat Johnston, Deputy Controller, USAID/N
Mr. Sergio Watson, CPA, Financial Analyst, USAID/N
Ms. Sandra Espinosa, Financial Analyst, USAID
Ms. Mayra Benavente, Voucher Examiner, USAID
Mr. Michael S. Kenyon, Agreement Officer

IPPF

María Cristina Ramirez, Regional Supplies Coordinator
Mary France Semmelbeck

PRIME

Francesca F. Pereira, Program Manager for Latin America and the Caribbean

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KPMG Peat Marwick Auditors

Lic. Marcos Barrantes, Audit Manager

Lic. Indiana Bonilla, Supervisor, KPMG Peat Marwick

MINSA

Dra. María Elsa Martínez, Directora de Educación Permanente

Enfa. Lea Davila Mondego, Representante del Programa de FNUAP

Dra. Ximena Gutierrez, Programa de Asistencia Integral de la Mujer

Dr. Diony Fuentes, Programa de Asistencia Integral de la Mujer

Dra. Martha Montenegro Programa de Asistencia Integral de la Mujer

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Appendix E

1. USAID/Nicaragua. Semi-Annual Project Status Report. October 1, 1991-March 31, 1992 (5/90)
2. Project Paper: Family Planning Expansion and Regionalization Project (4/91)
3. USAID/Nicaragua. Semi-Annual Project Status Report. April 1, 1991-September 30, 1991.
4. Population Council. El Uso de Sistemas de Información Gerencial para Investigación de Operaciones Profamilia Nicaragua (11/93)
5. USAID/Nicaragua. Semi-Annual Project Status Report. October 1, 1992-March 31, 1993.
6. USAID/Nicaragua. Semi-Annual Project Status Report. October 1, 1993-March 31, 1994.
7. USAID/Nicaragua. Semi-Annual Project Status Report. April 1, 1994-September 30, 1994.
8. Family Planning Expansion and Regionalization Project. Amendment # 1 and #2. (7/94)
9. Family Planning Expansion and Regionalization Project. Amendment #1 and #2. (9/94)
10. USAID/Nicaragua. Semi-Annual Project Status Report. October 1, 1994-March 31, 1995
11. USAID/Nicaragua. Strategy for 2000 and Fiscal Year 1997 Action Plan. (4/95)
12. USAID/Nicaragua. Strategy for 2000. (8/95)
13. Population Council. Depo-Provera Introduction Workshop, Managua, Nicaragua, August 28 to September 1, 1995. (10/95)
14. Family Planning Expansion and Regionalization Project. Performance Report. (12/95)
15. USAID/Nicaragua. Results Report and Resource Request (R4). (12/95)
16. Family Planning Expansion and Regionalization Project. Performance Report. February 15-March 15, 1996. (3/96)
17. INTRAH Proposal. (3/96)
18. Family Planning Expansion and Regionalization Project. Performance Report. March 15-April 15, 1996.
19. Family Planning Expansion and Regionalization Project. Performance Report. May 15-June 15, 1996.
20. Informe Anual: Profamilia. October 1995-September 1996.
21. Johns Hopkins University/Population Communication Services. Scope of Work. (12/96)

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22. INTRAH. Operations Research proposal. (1/97)
23. Carolina Zuniga R. Dirección de Planificación, Evaluación e Investigación. Profamilia. Analisis Procedimientos Relacionados con Los DCA. Marzo 1996.
24. Dirección de Planificación, Evaluación e Investigación. Profamilia. Ejercicios para Planificación Estratégica y Operativa 1997.
25. Dirección de Planificación, Evaluación e Investigación. Profamilia. La Depo-Provera en Usuaris de Profamilia Nicaragua. Investigación. Septiembre 1996.
26. Dirección de Planificación, Evaluación e Investigación. Profamilia. Causas de la Baja Demanda del Centro Regional Jinotega. Investigación. Junio 1996.
27. Dirección de Planificación, Evaluación e Investigación. Profamilia. Características de los Responsables de Puestos de Distribución Comunitaria de Anticonceptivos de Profamilia. (undated)
28. Dirección de Planificación, Evaluación e Investigación. Profamilia. Perfil de Usuaris Minilap 1995. (Tables only, undated)
29. Satisfacción Actual de los Usuarios de la Clinica - Juigalpa. Investigación. Septiembre 1996.
30. Dirección de Planificación, Evaluación e Investigación. Profamilia. Satisfacción Actual de Usuarios de la Clinica - Altamira. Investigación. Septiembre 1996.
31. Dirección de Planificación, Evaluación e Investigación. Profamilia. Satisfacción Actual de las Usuaris de Consulta Externa - Clinica Chinandega. Investigación. Julio 1995
32. Dirección de Planificación, Evaluación e Investigación. Profamilia. Satisfacción Actual de las Usuaris de Consulta Externa - Clinica Matagalpa. Investigación. Septiembre 1995
33. Dirección de Planificación, Evaluación e Investigación. Profamilia. Satisfacción Actual de las Usuaris de Consulta Externa - Clinica Rivas. Investigación. Septiembre 1995
34. Dirección de Planificación, Evaluación e Investigación. Profamilia. Satisfacción Actual de las Usuaris de Consulta Externa - Clinica Juigalpa. Investigación. Julio 1995
35. Dirección de Planificación, Evaluación e Investigación. Profamilia. Satisfacción Actual de las Usuaris de Consulta Externa y Analisis de Flujo de Paciente - Clinica Monseñor Lezcano. Investigación. Julio 1995
36. Dirección de Planificación, Evaluación e Investigación. Profamilia. Analisis de Flujo de Paciente - Clinica Altamira. Investigación. Julio 1995
37. Dirección de Planificación, Evaluación e Investigación. Profamilia. Resumen de Investigaciones: Calidad de Servicios. Conclusiones, Recomendaciones, Resultados del Taller con Personal. (undated)
38. Profamilia y Centers for Disease Control. Encuesta sobre Salud Familiar Nicaragua 92-93. Managua, Nicaragua. Noviembre 1993.

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39. Profamilia. Plan de Trabajo y Presupuesto 1997. P.T.P. Noviembre 1996.
40. Ilka Esquivel. Proyecto de Expansión y Regionalización de Servicios de Planificación Familiar en Nicaragua/Profamilia. Evaluación del Desempeño 1995-1996. Enero 1997.
41. INTRAH. Proposed Nicaragua Operations Research Project: Structural and individual factors related to the effectiveness of CBD workers in Nicaragua. January 3, 1997.
42. Profamilia and Johns Hopkins University. Population Communication Services. "Estrategia de Fortalecimiento Institucional": Hacia un programa Nacional de Comunicación en Salud Reproductiva/Planificación Familiar. 1995-1998
43. Profamilia and Johns Hopkins University. Population Communication Services. "Logrando la Satisfacción del Cliente a través de la Calidad, la Venta, y Técnicas Promocionales: Un Curriculum de Capacitación para Promotores de Profamilia Nicaragua.
44. Profamilia. Informe de Encuestas de Grupos Focales para el Desarrollo de una Campaña de Imagen de Profamilia. Managua, Nicaragua.
45. INTRAH. Evaluación de Necesidades de Capacitación para Reforzar el Sistema de Distribución Comunitaria de Anticonceptivos de Profamilia. Managua, Nicaragua. 10-21 de Junio, 1996.

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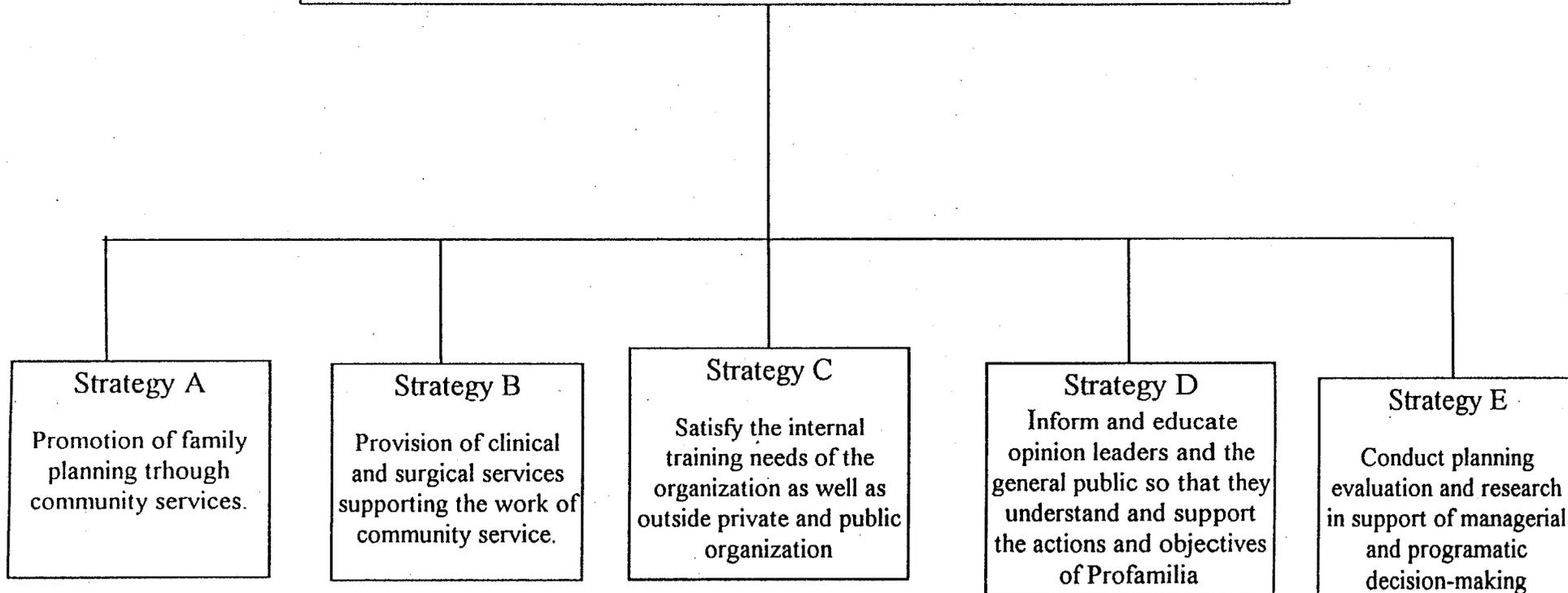
APPENDIX F: PROJECT EVALUATION SUMMARY

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Appendix G: Mission of Profamilia-Nicaragua

Profamilia is a non-profit, private organization whose mission is to promote reproductive health through family planning and sexual education as a human right of individuals and couples.

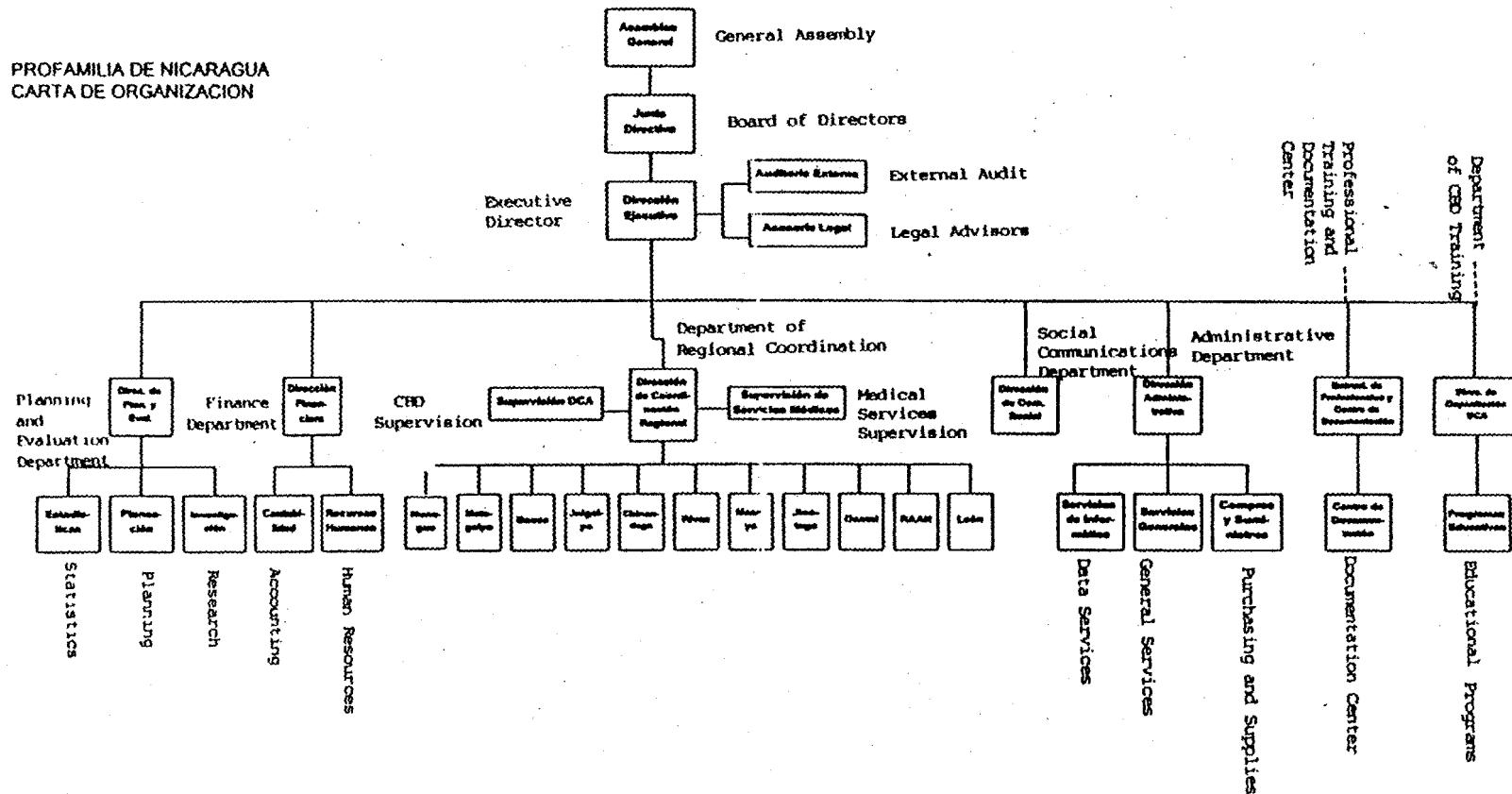
Offers services of information and education, clinics, community outreach, professional training and research, which permits the development of responsible parenthood oriented toward improving health and welfare of the individual, families and society.



02

PROFAMILIA DE NICARAGUA
CARTA DE ORGANIZACION

APPENDIX H



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**Appendix I: Training and Technical Assistance,
Implementation and Impact on Profamilia**

Training and TA Activity	Implementation	Impact on Profamilia
INCAE - Seminars on strategic planning for senior staff	Agreements on organizational mission and strategy	Results of seminars never adopted by Profamilia
Pop-Council TA to improve information and finance systems	Report written and submitted to Profamilia	Consultant follow-up reported no implementation of recommendations
APROFAM -Guatemala Technical assistance to strengthen clinic management	SAC system developed, Nicaraguan consultant followed up to help with implementation	Partial implementation (3 modules of 7 being tested)
TECAPRO (Costa Rica)develop software for finance and accounting	Developed system and trained staff	Partially implemented- (Limited ability to use the system to produce reports)
Juan Jaen, TA to develop budgeting system, USAID mission controller also provided extensive TA	Budgeting system designed and implementation plan developed	Work plan drafted by Profamilia but not implemented.
Price Waterhose to study and recommend salary and classification system	Report submitted September, 1996	No action taken by Profamilia to date
AED series of organization development seminars to strengthen teamwork, communications skill and strategic planning.	Partial attendance at workshops. Training suspended by AED due to low attendance	No action taken by Profamilia to date

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