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MID-TERM EVALUATION
OF THE
USAID/DR FAMILY PLANNING AND HEALTH PROJECT
(517-0259)

OCTOBER/NOVEMBER 1997

PREPARED BY
POPTECH
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FAMILY PLANNING AND HEALTH PROJECT
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EXECUTIVE SUMMARY

This **MID-TERM EVALUATION OF THE USAID/DR FAMILY PLANNING AND HEALTH PROJECT** No. 517-0259, a Project which from now on will be referred to as the "Project," was conducted from October 27 to December 31, 1997, by a team of consultants contracted by the Population Technical Assistance Project (POPTECH). This evaluation was funded by the Dominican Republic Mission of the United States Agency for International Development (USAID/DR). The *general objectives* of this evaluation are:

1. To assess the performance of the Project to date.
2. To provide recommendations to improve performance for the remaining three years of the Project.
3. To identify and prioritize areas of technical assistance for the remaining life of the Project.
4. To review the scope of Project activities in the context of USAID's new five-year strategy; and
5. To provide recommendations to USAID for the design of possible new activities to include reproductive health elements.

The methodology used by the Evaluation Team (ET) was based on a review of Project documents and on various reports and documents produced by the Dominican Government (GODR) and other entities. Also, some field work was done and due to time constraints for this evaluation, a limited number of personal interviews were conducted. The ET worked in *collaboration* with USAID/DR and *with entities* linked to the Project, which provided information. In conducting the evaluation, the Mission was aware of the extent of the task to be performed by the ET, given the duration and complexity of the Project and the number of participating institutions, which did not allow for contacts with international agencies and which limited exposure with GODR representatives. More time is required to conduct a detailed analysis of the Dominican situation during a period of USAID/DR strategy and project revision and of major political, legal, economic and social changes in the Dominican Republic (DR). Sharing the first preliminary draft report with entities involved in the Project was important, thereby providing the necessary feedback.

On June 11, 1993, the US Government signed a grant agreement with the GODR to implement a seven-year \$26.6 million Family Planning & Health Project. USAID contracted Development Associates, Inc. (DA) as the Institutional Contractor (IC) to manage a series of sub-grants with Non-Governmental Organizations (NGOs) working in Project areas and to provide Technical Assistance (TA) and financial support to ONAPLAN and the *Nuestra Señora de La Altagracia Maternity Hospital*.

The original Project objectives were to: 1- Expand the supply of Family Planning (FP) and Maternal-Child Health (MCH) services throughout lower income groups in the Dominican Republic (DR) by supporting the urban-oriented programs of PROFAMILIA and ADOPLAFAM and MUDE's rural-based program; 2- To implement a national level program

for HIV/AIDS/STD awareness and prevention through a cooperative agreement with AIDSCAP/FHI; and 3- Promote policy dialogue through institutional and technical support to the Oficina Nacional de Planificación (ONAPLAN), the Instituto Nacional de la Salud (INSALUD) and, to a lesser extent, the Ministry of Health (SESPAS).

Overall, the Project accomplished its objectives and reached proposed goals for service delivery, contraceptive distribution, IEC strategy design and respective material development, and also for the training of Project NGO personnel. The termination of funding for MCH services at the end of FY'96 and the placement of the HIV/AIDS/STD prevention component as a stand-alone activity called for an amendment to these objectives.

Some of the basic, highly optimistic assumptions made when the Project was designed were met only in part, and changes observed are affecting Project implementation and accomplishment. In general, the Project adequately contributed to the achievement of Mission Strategic Objective No 2 and to various Intermediate Results included in the new USAID/DR strategy for the next five years (1997-2002).

The Project and USAID/DR have promoted health policy dialogue by providing training, facilitating and fostering contacts and coordination between NGOs and government institutions, the exchange of information among NGOs and between these and the GODR, regarding both technical and administrative aspects and policy. Project impact on fulfillment of demographic and reproductive health goals is significant, though quantitative measure is not possible. Contraceptive use by women in union increased from 56% in 1991 to 64% in 1996, and today knowledge among both men and women of the existence of family planning methods is almost universal (99%). The Total Fertility Rate (births per woman) has decreased only from 3.3 in 1991 to 3.2 in 1996, that is, practically speaking, it stagnated during this five-year period, while for the same period the proportion of adolescents from 15-19 years of age who initiated procreation increased from 18% in 1991 to 23% in 1996. The reduction of fertility levels has been especially important in rural zones where fertility decreased from 4.4 to 4 children during the 1991-1996 period, while in urban zones the Total Fertility Rate (TFR) remained stable at 2.8 children.

The method mix combination of FP methods has evolved positively, especially with the increased use of all modern temporary methods, as inferred from the results of the comparison between ENDESA 91 and 96.

The following summarized findings and recommendations are mainly addressed to USAID. Project entities are analyzed in an attachment to this report, and pertinent recommendations are made:

A. General Recommendations for USAID Regarding the Project:

1. To continue the Project. We *conclude* that the fulfillment of Project goals and the significant role the Project plays in supplying reproductive health services make it essential for developing reproductive health in the country. However, major changes in health conditions have occurred in the DR, and the assumptions made during the Project design have only been met in part. We *recommend* that USAID continue the Project, making adjustments to keep pace with the changing environment in the DR, and revising and updating the assumptions, goals and indicators. It is important to note that while various changes and amendments have been made along with the implementing agencies, these have not been officially reflected in the Project. The revised and amended Project objectives, indicators and assumptions should appear in one single document. This is particularly important, as the ET had difficulty in visualizing the Project as a whole, due to the fact that it is so fragmented. Modification of the title of the Project should be considered, since it not only focuses on FP, but also encompasses more activities and undertakes actions mostly in the area of Reproductive Health.

2. To retain the institutional contractor. We *conclude* that the Institutional Contractor has fulfilled the most important functions of its contract; its experience is satisfactory and is accepted by the NGOs. It is assumed that if the Project continues under similar conditions, a contractor will be required. We *recommend* that USAID extend Development Associates' (DA) contract as the Institutional Contractor as long as USAID requires their services, to the extent that DA's structure and capacity for service delivery allows. We also recommend that USAID take into account the other Cooperating Agencies that worked on the Project

3. To reach new priority groups. Based on the findings of ENDESA 96 and on information provided by entities interviewed, we *conclude* that new RH programs and strategies are required, both in IEC and in service delivery for adolescents and post-partum women, which are new groups identified as priority for RH in the DR. We *recommend* that USAID develop new strategies and incorporate them into the Project to fund RH programs, both in IEC and in service delivery for adolescents and post-partum women.

4. To revise indicators and goals. We *conclude* that some indicators do not adequately measure the performance of the Project nor that of the agencies, and that some goals have either been met already, cannot be met, or do not constitute a stimulus or challenge for Project entities. Indicators for measuring the quality of services are not available. We *recommend* that USAID revise and establish more adequate indicators and goals for the Project, new potential indicators may be child-spacing and reduced fertility in women under 20 and over 35 years of age. Additional indicators for measuring the quality of service delivery are: levels of satisfaction with service delivery by users, levels of knowledge of the method utilized by user, identification of reasons for discontinuing methods by users, etc. This is only a suggestion. USAID, DA and the NGOs are those called upon to identify new indicators.

B. Recommendations for USAID Regarding the Dominican Government:

1. To consider the GODR for future actions in RH. We *conclude* that although the GODR has not established clear norms and budgets for the promotion of RH, it has shown interest in providing reproductive health services (RH), and has the physical infrastructure to facilitate the delivery of these services. We *recommend* that USAID consider the GODR for future RH actions and that USAID continue its efforts along with other agencies such as AVSC, which provides a clear example of action coordinated with the GODR, facilitating RH service delivery and the duplication of successful activities.

2. To provide technical assistance to the GODR. We *conclude* that the GODR is in need of TA in different areas, such as in the development of proposals for effective projects, among others, and that USAID can provide or finance this TA. We *recommend* that USAID provide TA to the GODR in the development of proposals for effective projects, as well as in other areas.

3. To provide the GODR with TA in the overall planning and logistics of methods supply.

4. To collaborate with the GODR and other agencies in coordination efforts. We *conclude* that USAID has undertaken successful coordination efforts along with the GODR and other donor agencies working in RH in the DR, and that this coordination continues to be necessary. We *recommend* that USAID continue its efforts to coordinate its actions with the GODR and other international agencies.

5. To urge the GODR to pay attention to RH in remote areas. We *conclude* that the GODR has available facilities and personnel. We *recommend* that USAID encourage and support the GODR so that, utilizing its facilities and personnel, and also with the contracting of NGOs, it will meet RH needs in remote areas.

C. Recommendations to USAID Regarding NGOs:

1. To make NGOs aware of the reduction in grant funds and to support efforts made by NGOs for leveraging new resources from the GODR and other donors.

2. To provide TA in creating and revising attainable and effective indicators. Training for NGOs should be provided through the IC. The implementing agencies should be well aware of the function and extent of the indicators, as they are the ones called upon to accomplish them. It should be noted that indicators are not static, that they can be changed to increase Project effectiveness in achieving Strategic Objective No. 2.

3. To consider the contracting of services. If the health sector reform evolves

toward the procurement of health services, it will be necessary to provide training in this area for both the GODR and NGOs, and to strengthen their administrative structures.

Given the number of entities involved in the Project, the role of each NGO and its contribution to the achievement of the objectives, the findings and recommendations are included as an attachment. Overall, Project activities have had a positive impact on RH in the DR, the most outstanding being the development of IEC strategies and materials for the promotion of RH and FP methods and the coordination activities carried out by the Interinstitutional Council and other Committees. Other activities that have impacted RH and Project management are the coordination and funding of the 1996 Demographic and Health Survey, and the training in the use of this information. Activities carried out in more densely populated areas and centers (e.g. free zones and marginal neighborhoods in principal cities) and the technical assistance provided are elements having a positive impact on the Project. The NGOs considered to be very positive the fact that consultants were selected in a democratic way and with a high degree of participation from the entities receiving TA.

It is likely that activities with lesser impact have been those implemented in remote, low-density, and low income areas, though these are clearly the areas in most need. Low impact activities are those involving competition with other Project entities.

The Project faces two conflicting policies: coverage of marginal areas vs self-sufficiency. This dilemma, which raises a problem for the NGOs, must be defined by USAID; while placing emphasis on including remote, lower income, in-need areas, where economically deficient programs are unlikely to be sustainable, the self-sufficiency of such programs must also be stressed.

I. OBJECTIVES, METHODOLOGY AND TARGET AUDIENCE OF THIS EVALUATION

A team of consultants contracted by the Population Technical Assistance Project (POPTECH) conducted the **MID-TERM EVALUATION FOR THE USAID/DR FAMILY PLANNING AND HEALTH PROJECT NO 517-0259**, which will be referred to as the "Project". This evaluation was funded by the United States Agency for International Development (USAID/DR).

The general objectives of this **MID-TERM EVALUATION FOR THE USAID/DR FAMILY PLANNING AND HEALTH PROJECT NO. 517-0259** are:

1. To assess the performance of the Project to date.
2. To provide recommendations for improving performance for the remaining three years of the Project.
3. To identify and prioritize areas of technical assistance for the remaining life of the Project
4. To review the scope of the activities under the Project in the context of USAID's new five-year strategy; and
5. To provide recommendations to USAID for the design of new activities to include reproductive health elements.

The Methodology used by the Evaluation Team (ET) was based on a review of Project documents and various reports and documents produced by the Dominican Government (GODR) and other entities. Also, some field work was done and a limited number of personal interviews were conducted, due to the time constraints for this evaluation. For field visits to entities and volunteers, clinics and service delivery locations, a semi-structured guide on aspects that should be observed was used. See lists of people contacted, publications consulted and the observation guide attached.

The ET discussed findings, and identified the strengths and weaknesses of Project actors; they then identified conclusions and developed relevant recommendations for the different areas and actors.

In conducting this evaluation, the Mission was aware of the extent of the task to be performed by the Evaluating Team (ET) and of the obstacles faced during a three-week period, which included holidays and the attempt of a nation-wide strike, and difficulties with the computer software. All of these placed constraints on collecting information, making practically impossible the exposure to other international agencies, and limited data collection with the GODR (ONAPLAN, CONAPOFA, SESPAS and other entities).

Despite the endless hours of work and even without the obstacles mentioned above, more time would have been needed to perform a thorough analysis of RH status in the DR and of a Project of such magnitude as the Family Planning and Health Project (517-0259),

particularly in a period of change in USAID/DR strategies and projects, and of significant political, legal, economic and social changes in the DR.

Fortunately for this evaluation, which is primarily for USAID/Dominican Republic, the implementing agencies and the institutional contractor, the ET enjoyed *the collaboration of USAID and all the entities involved in the Project*, which showed great interest in the process and devoted additional time to collecting and providing information and clarifications. A first preliminary evaluation report was shared with the entities involved, a very interesting exercise that contributed to creating a more positive attitude toward the evaluation, and that was even more useful for USAID/DR and for all the entities involved in the process. Sharing preliminary information allowed for adjustments in the report and for the clarification and revision of concepts, in a methodologically appropriate manner.

II. DESCRIPTION AND CONTEXT OF THE PROJECT

A. Background

The United States Agency for International Development (USAID) has been operating in the Dominican Republic for approximately 35 years. This agency provides assistance through bilateral agreements between the USG and the GODR, facilitating actions primarily through various NGOs in recent years.

On June 11, 1993, the USG signed a grant agreement with the GODR, through the Technical Secretariat to the Presidency, to implement a seven-year, \$26.6 million Family Planning and Health Project, consisting of three main components: Family Planning, AIDS/HIV/STD Prevention, and Health Policy Dialogue activities.

B. Project Goal and Objectives

The Goal of the Family Planning and Health Project is to contribute to the increased socio-economic participation of lower income groups in the Dominican Republic. **The purpose** of the Project is to accelerate the process of fertility decline, improve the health of women and young children, and enhance public health efforts to prevent the spread of Sexually- Transmitted Diseases (STDs) and AIDS.

The original project objectives were to:

1- Expand the supply of family planning and maternal-child health services throughout lower income groups in the Dominican Republic by supporting the urban oriented programs of PROFAMILIA and ADOPLAFAM and MUDE's rural-based program;

2- Undertake a national level program for HIV/AIDS/STD awareness and prevention through a cooperative agreement with AIDSCAP/FHI; and

3- Promote policy dialogue through institutional and technical support to the Oficina Nacional de Planificación (ONAPLAN), the Instituto Nacional de la Salud (INSALUD) and to a lesser extent, the Ministry of Health (SESPAS).

During FY96, USAID determined that, as part of an effort to narrow the scope of the health and population portfolio, funding for child survival activities would no longer be supported by the Mission. As a result, virtually no funding for child survival activities, including breast-feeding, oral rehydration therapy, immunization and acute respiratory infections, has been provided via the project since the end of FY96.

In August, 1997, USAID submitted a project amendment to the Dominican government which would remove the major support for the AIDS prevention component of the project and would place it as a stand-alone activity.

C. Project Target Population and Implementing Agencies.

The Project was initiated in 1993, primarily working with NGOs and with minimal participation from the government. At present, a close relationship is kept with the civil society through collaborating entities, while positive work relations are developed at different levels with the GODR

The methodology used by USAID for supporting RH programs has evolved according to the changing conditions of the country and to government support to such programs. The Family Planning and Health Project was preceded by projects with the GODR, later turning its focus to the NGOs which, through networks of volunteers, inform and distribute RH services and methods. Currently, adequate involvement is sought both by NGOs and the GODR, especially at this time of transition the country is undergoing. For service delivery and distribution of clinical RH methods, the Project relies on the NGOs' own clinics, associated clinics and physician's offices, while the Ministry of Health provides in its facilities over 40% of female surgical contraception services.

The Project target population consists of those groups from low or especially poor socioeconomic levels who are potential users of FP and RH methods. The locations where work is performed with the target population are defined in the description of each of the agencies' grants. Though there are still some problems with competition, duplication of efforts has been avoided to the extent possible through agreements at the Interinstitutional Council level and based on mapping system developed by DA for the Project, where areas of work for each NGO are identified.

D. Activities and Strategies.

The new USAID/DR five-year Strategic Plan for FY1997 to FY2002 sets new priorities as seen in Figure 1 below, Strategic Objective #2 - Increased Use of Effective Preventive Health Care Services, and is based on four Intermediate Results:

IR 2.1 Improved knowledge of and access to services which reduce the risk of STDs/HIV/AIDS.

IR 2.2. Improved Access to Family Planning and Other Reproductive Health Services.

IR 2.2.1 Increased outreach to special populations: youth, men and post-partum women

IR 2.2.2 Improved quality of care

IR 2.2.3 Improved prenatal and obstetrical care to reduce morbidity/mortality. (Partners/Counterparts GODR, NGOs, PAHO, UNICEF, UNFPA).

IR 2.3. Improved sustainability of the National Preventive Health System

IR 2.4 Increased support for rural community water and sanitation systems.

This new strategy is based primarily on the following assumptions:

- 1 The GODR will increase its investment in social sectors
2. The GODR will develop partnerships with NGOs to provide Technical Assistance and Services.
3. The health sector policy reform efforts produce a blueprint for the next steps toward a more rationalized sector.
4. The GODR and country leaders understand the potential socio-economic impact of the HIV/AIDS epidemic and include AIDS as an important theme in the health agenda.

Despite the fact that the new strategy emphasizes issues addressed in previous ones, the most important changes are likely to be in the focus on youth or adolescent populations and post-partum women, on improved prenatal and obstetrical care services, and on encouraging the GODR to develop partnerships with NGOs to provide TA and services.

As can be noted throughout the document, many of the concepts and recommendations made in this evaluation are based on this strategic change, using the contracting of services on the part of the GODR and highlighting the target populations addressed in the strategy as the basis for the revision and extension of the Project.

Unfortunately, the lack of clarity and of decisions at the time of the evaluation regarding both the possibility or the necessity of contracting services, as well as of GODR involvement prevent greater precision in the recommendations, since contemplating the alternatives today, we find that all possibilities are contingent upon future actions or decisions from USAID and/or the GODR.

USAID/Dominican Republic
Areas of Activity: FY 1997 - FY 2002

"In a collaborative style, USAID stimulates critical change to ensure equitable access by all Dominicans to basic social services and gainful employment within a free and just society"

FY 1997

Economic Development

S O 1 Strengthened Institutions which Contribute to Economic Opportunities for Poor Dominicans

- Microent credit
- Microent skills devel
- Basic education
- Policy Dialogue

Health/Population

S O 2 Increased Use of Effective Preventive Health Care Services

- HIV/AIDS prevention
- Reproductive health
- Sustainable preventive health system
- Community W/S

Democracy

S O 3 More Participatory, Representative, and Better Functioning Democracy Achieved

- Rule of law
- Civic education
- Civil society/electoral process

Energy/Environment

S O 4 Increased National Capacity to Produce Environmentally Sound Energy

- Env regulation
- Cty-based env protection
- Renewable energy

FY 2000

Health/Population

- HIV/AIDS prevention
- Reproductive health
- Sustainable preventive health system

Democracy

- Rule of law
- Civic education
- Civil society/electoral process

.....
Special Objective
: - Economic Policy Dialogue :
.....

FY 2002

Health/Population

- HIV/AIDS prevention
- Reproductive health
- Sustainable preventive health system

Democracy

- Rule of law
- Civic education
- Civil society/electoral process

Agency Objective: Stabilize World Population and Protect Human Health in a Sustainable Fashion

BEST AVAILABLE COPY

S O 2 Increased Use of Effective Preventive Health Care Services

IR 2 1 Improved Knowledge of and Access to Services which Reduce the Risk of STI/HIV/AIDS

IR 2 1 1 Expand public/private sector provision of STI/HIV/AIDS's information and services

IR 2 1 2 Increased high risk perception and health seeking behavior among vulnerable groups

IR 2 1 3 Policy environment conducive to increased resources for STI/HIV/AIDS and modifications of restrictive regulatory barriers

IR 2 1 4 Development of community based programs in support of people infected and affected by HIV/AIDS

IR 2 1 5 Improved availability and use of data to monitor STI/HIV/AIDS prevalence and trends

Partners/Counterparts GODR UNAIDS, PAHO, European Union, NGO

IR 2 2 Improved Access to Family Planning and Other Reproductive Health Services

IR 2.2 1 Increased outreach to special populations youth, men and post-partum women

IR 2 2 2 Improved quality of care (i.e. continuation rates, integrated services, technical capacity, etc)

IR 2 2 3 Improved prenatal and obstetric care to reduce morbidity/mortality

Partners/Counterparts GODR, NGOs PAHO, UNICEF, UNFPA

IR 2 3 Improved Sustainability of the National Preventive Health System

IR 2 3 1 Strengthen institutional capacity of public/private service providers

IR 2 3 2 Encourage GODR/NGO partnership

IR 2 3 3 Effective service delivery models marketed

IR 2 3 4 Increased private sector commitment and involvement in health service provision

Partners/Counterparts GODR, IDB, World Bank, NGOs

IR 2 4 Increased Support for Rural Community Water and Sanitation Systems

IR 2 4 1 Contracting mechanism established to enable NGOs to provide technical assistance and services

IR 2 4.2 Model documented, packaged and marketed by NGOs to GODR and donors

IR 2 4 3 Reforms adopted in water and sanitation sector to ensure coverage of rural and peri-urban population and to utilize cost effective approaches

Partners/Counterparts GODR, IDB European Union, NGOs

Critical Assumptions

- 1 GODR will increase investment in social sectors
- 2 Donors and multilateral agencies fulfill their commitments to provide additional resources that complement USAID/DR efforts
- 3 Purchasing power of middle and low economic groups is not diminished by economic conditions

E. Project Logframe Assumptions

1. Regarding the Goal:

No GODR opposition to voluntary family planning. Despite the fact that there is no opposition by the GODR, family planning is not openly recognized as a priority health area, and, given the influence of the Catholic Church, both past and present governments have provided only timid support for family planning activities, considering this area for attending to high obstetrical and reproductive risks. It should be noted that the GODR provides services to over one third of FP users, and that in diverse GODR analyses and publications, such as “Salud-Visión del Futuro”, the promotion of reproductive health is included.

Continued domestic stability In general, the period covered by the Project shows changes both at the national level, where presidential elections took place within a highly stressful political climate, and at the sector level, where the instability in the Ministry of Health (MOH) stands out, with 5 Ministers since 1993, a prolonged strike by doctors and nurses, a series of budgetary constraints and, primarily, the presence of a new government interested in accomplishing major developments in the health arena, but without the experience and political support to achieve them. As mentioned in the publication “Salud-Visión del Futuro,” for many years the country has been immersed in a process of discussion regarding health sector and social security reforms, and at this time a Health Sector Reform and a Proposal for Social Security System Reform are under consideration, which has not only been energy- and time-consuming for the sector, but has created major expectations and instability in institutions and individuals concerning the norms and policies that will govern the future, and has generated political pressure to obtain the maximum benefit from a changing situation. Pressure from the Catholic Church has been a factor, creating a movement toward restriction on RH aspects and services.

Continued economic development in the D.R. Even with the above-mentioned problems and with many others affecting economic development, since 1992 there has been a major increase in the real growth rate of 5.4 percent, on average, reaching 7.2 percent in 1996. This remarkable performance has been achieved in highly dynamic areas related to the foreign sector, such as tourism, free zones and telecommunications (USAID/Dominican Republic Results Review-Resource Request FY 1996/1999, April 21, 1997, Page 10).

Natural disasters do not affect the population program. During the period there were no natural disasters affecting the population program.

2. Regarding the Purpose:

NGO Management commitment to self-sufficiency. Despite the existence of this commitment and of the interest from NGOs regarding self-sufficiency, given the characteristics of the programs, the populations served, and their geographic scattering and location, along with the low economic capacity of groups being served and the financial and administrative structure of NGOs (except for PROFAMILIA which has established marketing as a self-sufficient activity, and the Evangelina Rodríguez and Rosa Cisneros Clinics, where a high level of sustainability has been achieved), the commitment and interest shown by NGO management have not led to a significant increase in self-sufficiency.

Other international donors continue to support FP activities in the D.R

Although there are new international donors who are supporting RH activities in the D R., such as the GTZ, a German organization, there is a general reduction in financial assistance on the part of institutions such as FNUAP, OPS, and UNICEF. Due to time constraints, the ET could not conduct a situational analysis or make projections regarding international assistance for RH

No significant deterioration in consumer purchasing power. Although there was an increase in the Per Capita Gross National Product of 5.3 per cent in 1996, this assumption was not met because the average increase over the last five years was only 2.4 per cent. Unemployment and underemployment rates are high (16/30%), though they indicate significant progress and have met the goals of Strategic Objective 1.2. Inflation, estimated at 16 per cent, continues to affect individual purchasing power. At the time of the evaluation, there was an announcement of a nation-wide strike, particularly motivated by the decrease in consumer purchasing power. It should be taken into consideration that the deterioration in purchasing power is accompanied by difficulty in replenishing supplies, which may affect the Project, not only by limiting the ability of users to pay for services and contraceptives, but also by affecting the distribution systems, making necessary a higher frequency in the provision of contraceptives to promoters or volunteers, as their limited economic capacity only allows for the purchase of very small quantities. In many cases, offering a higher amount of credit to promoters will result in the inability of the volunteers to pay, as the money they receive is mainly destined to meeting immediate and primary needs. Deterioration in purchasing power can be summarized in a comment made by one Project NGO in discussing the first draft of this evaluation. "The target populations (populations at the poverty line and in extreme poverty) of each of our institutions have experienced a deterioration in their purchasing power. There are studies from national institutions indicating that a significant percentage of households with adult

workers cannot meet their basic needs with the income earned as a family unit, thus leading to an increase over previous years in the relative proportion of households at the poverty line and in extreme poverty. Furthermore, it is this segment of the population which experiences the highest unemployment and underemployment rates.”

No detrimental opposition to FP from religious and political groups.

Opposition by the Catholic Church to family planning has been strong and continuous. At the time of this evaluation, a series of newspaper articles appeared, where the sterilization program was directly criticized, and there were frequent TV programs where FP was rejected when employing methods different from those accepted by the Catholic Church. As previously mentioned, though there is no evidence, it seems that projects for the Reform of the General Health Law had to undergo adjustments regarding reproductive health aspects in response to recommendations made by the Catholic Church. Project NGOs have commented that in many communities, site personnel have been harassed and intimidated by parish priests or lay groups, forcing them to abandon some of the work areas. This opposition by the Catholic Church has likely resulted in the Government’s assuming a low profile regarding FP.

3. Regarding Outputs:

Coordination and collaboration among the Project’s implementing agencies.

This has been widely achieved, especially through the Interinstitutional Council and the various Committees (Finance, IEC, Services and Evaluation). At the volunteer level, and with the aim of fulfilling service and expansion goals, there is some competition for referrals of female users. This, which could represent a healthy competition in commercial programs, may result in the duplication of efforts and services, thereby increasing Project costs.

Private clinics and physicians are willing to continue offering family planning services. Service statistics from the various institutions and from ENDESA 96 show in their findings significant collaboration among private clinics and physicians. Clinical methods are preferred in the D.R. The assumption is true.

Subsidized goods and services do not compete in price with the commercial sector. Institutions implementing the program normally charge for their products and services the prices established by the Interinstitutional Council, which are clearly lower than market prices, except in the case of contraband or theft. Affiliated doctors normally charge “social” prices, which are lower than those charged to their regular patients.

The Government is receptive to policy dialogue with the private sector. Up to

now the Government has been open to dialogue and has permitted broad involvement of the private sector in the proposed National Health System Reform. However, given the changes introduced in the Reform regarding reproductive health issues, it is difficult to determine the status of this assumption for the Project.

4. Summary of the status of the assumptions:

Assumptions have only been met in part. Although services are being provided and the GODR has made no opposition, there has been no support for developing RH and FP policies, and the possibility of restrictive norms exists for the future. Domestic stability has been limited. Economic development has been sectorized. Fortunately, natural disasters have not occurred. Despite commitment of NGOs to achieve self-sufficiency, only a few have achieved it and in specific programs. There is a reduction in international funding. There has been a deterioration in users' purchasing power. Private physicians and clinics continue to offer RH and FP services. Competition between the commercial and subsidized sectors has not been an obstacle to the Project. The GODR has been receptive to policy dialogue, but these dialogues have not been translated into positive actions. Today, the passive reactions or attitudes of the Dominican Government regarding reproductive health could invalidate the assumptions and could seriously affect the Project, especially in relation to the support of the GODR.

Some of the basic assumptions made during the design of the Project were highly optimistic, and changes observed affect Project implementation and accomplishments. In general, the Project adequately met the goals of Strategic Objective No. 2 of the Mission and some of the Intermediate Results cited in the new five-year USAID/DR Strategy; it is necessary, however, to revise result indicators set for the end of the Project by adding quality concepts and establishing more realistic programmatic goals. Some of the goals have already been surpassed and others are likely to be unattainable, or it may become difficult to establish a measurable causal relationship between the activities of the Project and its goals.

III. SCOPE AND IMPACT OF THE PROJECT FOR FISCAL PERIOD 1994-1997.

A. GENERAL ASPECTS

1. OVERALL IMPACT OF THE PROJECT

The Project expanded the supply of Family Planning (FP) and Maternal-Child Health (MCH) services throughout lower income groups in the Dominican Republic by supporting the urban oriented programs of PROFAMILIA and ADOPLAFAM and MUDE's rural-based program; accomplished most of the proposed goals, especially regarding service delivery, contraceptive distribution, IEC strategy design and materials development, and training for Project NGO (Non-Governmental Organization) personnel, all of which can be directly attributable to the Project. In Annex 1, "ANALYSIS OF THE PERFORMANCE OF PROJECT IMPLEMENTING AGENCIES", an analysis of goal fulfillment by entity is included.

As mentioned elsewhere in this report, during FY96 USAID determined that, as part of an effort to narrow the scope of the health and population portfolio, funding for child survival activities would no longer be supported by the Mission. As a result, virtually no funding for child survival activities, including breast-feeding, oral rehydration therapy, immunization and acute respiratory infections, has been provided via the project since the end of FY96. Therefore, these objectives were accomplished before the termination of the funding. Even so, most of the Implementing Agencies have continued their efforts in this area using counterpart funds.

While the Project should have undertaken, along with AIDSCAP's actions, a national level program for HIV/AIDS/STD awareness and prevention, significant changes in the funding and structuring of these activities have occurred, e.g. the removal of this component from the Project, which did not allow for full accomplishment of this objective under the Project.

The Project and USAID/DR have promoted health policy dialogue through institutional and technical support to the Oficina Nacional de Planificación (ONAPLAN), the Instituto Nacional de Salud (INSALUD) and to a lesser extent, to the Ministry of Health (MOH), and especially through the provision of training, and by facilitating and promoting contact and coordination between NGOs and governmental organizations. Numerous activities can be mentioned in this field, such as those carried out by the Interinstitutional Council (with the participation of GODR representatives), the contribution to the funding of ENDESA'96, training in the use of statistical information for planning, thereby facilitating the design of proposals for policies and legal matters, participation in the design and use of IEC materials, and strategies for the promotion of RH, among others.

Actions taken directly by the Project and through the Interinstitutional Council and its committees, such as IEC, Finance, Services and Evaluation, have served as an important

vehicle for the coordination and exchange of information among NGOs, and between these and the GODR

The Project and USAID have promoted health policy dialogue by providing training and by facilitating and promoting contact and coordination between NGOs and governmental organizations, by promoting the exchange of information among NGOs and between these and the GODR regarding both technical and administrative aspects and policy.

Project objectives, in spite of the changes that have been mentioned, have been achieved through four grantees which, by means of subgrant agreements, receive funding via the Institutional Contractor, Development Associates, Inc. (DA). Table 1 of Annex 1 shows total funding by institution, expenditures to date and the balance of funds available under the current subgrant agreement. The objectives of each subgrant are contained under the program description of the respective grant agreements. Each grant or subgrant has also been amended to show the annual benchmarks which will contribute to achieving the objectives during the life of the Project. Revisions are specifically intended to meet recommendations made by the Regional Inspector General (RIG), the requirements of USAID's reengineering process and its new strategic plan (1996).

In summary the Project has achieved the revised objectives and accomplished the expected results for service delivery, contraceptive distribution, IEC strategy design and materials production and training of Project NGO personnel, all of which are directly attributable to the Project. Termination in funding for Maternal-Child health services since the end of FY'96 and the structuring of the HIV/AIDS/STD prevention component as a stand-alone activity necessarily called for a modification of Project objectives.

2. DEMOGRAPHIC IMPACT

National level impact of the Project on RH in the Dominican Republic is significant regarding the prevalence of contraceptive use. The Project has specific goals, but it is not possible to determine either quantitatively or by percentage, the direct impact of the Project on these indicators. ENDESA'96 (1996 Demographic and Health Survey), shows a nearly universal knowledge (99%), among both men and women of the existence of FP methods and of an increased prevalence of contraceptive use, which increased from 56% for women in union in 1991 to 64% in 1996. However, the Total Fertility Rate (TFR) (births per woman) only decreased from 3.3 in 1991 to 3.2, that is, it virtually stagnated during the five-year period.

For the same period, the proportion of adolescents between 15 and 19 years of age who initiated procreation increased from 18% in 1991 to 23% in 1996, which demonstrates the necessity of concentrating efforts in this area. While the Project was an essential element and catalyst in achieving these reductions, the stagnation in the fertility rate and the increase in the percentage of adolescents who have initiated procreation are issues posing some concern.

Reduction in the level of fertility occurred mainly in rural zones, where it decreased from 4.4 to 4 children during the 1991-1996 period, while in urban zones the TFR remained at approximately 2.8 children.

The combination of FP methods has evolved positively, as evidenced by the increased use of all modern temporary methods, and by the reduced use of traditional ones, as can be noted in the following table

TABLE 1

**PREVALENCE OF CONTRACEPTIVE METHODS
AMONG WOMEN IN UNION, 1991 AND 1996**

METHOD	ENDESA 1991*	ENDESA 1996
STERILIZATION	39%	41%
PILL	10%	13%
IUD	2%	2%
OTHER MODERN METHODS	2%	3%
TRADITIONAL	5%	4%
NO CONTRACEPTIVE USE	44%	37%

*There is a rounding error in the ENDESA '91 Graph 4.2, Page 54, where the percentages total 102%.

Regarding Indicators, It Was Determined That:

a) Goals regarding Total Fertility and Infant Mortality Rates, and the percentage of high risk births have not been accomplished, and most likely will not be achieved by the year 2000 (See Annex 7)

b) Goals for intermediate result indicators, e.g. the percentage of women aged 15-19 using contraceptive methods and the percentage of children under 4 months who are exclusively breast-fed, have been achieved or are about to be achieved.

c) Most of the goals for process indicators have been achieved.

d) Indicators that are lagging behind are the total CYPs delivered along with temporary methods. The number of reproductive health consultations provided in the Project clinics is in the same situation. This may be explained by the change in the combination of contraceptive methods with VSC reduction.

e) The goal of replicating, in five hospitals, FP services for post-partum women has been achieved in only two at the present time. This five-hospital goal can be achieved by the year 2000 with assistance from other agencies such as AVSC.

f) The percentages of operational expenditure coverage achieved with NGO counterpart funds are very low. The Project design assumes a proportional counterpart increase and a reduction in grant funds. This indicator was extremely difficult to attain, except for PROFAMILIA.

While it is not possible to make a percentage quantification of Project impact on variations observed in demographic figures, it can be affirmed that the Project has contributed positively to accomplishments made in the RH field.

B. SCOPE OF THE PROJECT

1. PROJECT MANAGEMENT BY USAID.

According to the Grant Agreement, USAID's responsibilities regarding the Procurement Plan are very limited. The Project was designed to keep procurement to a minimum, the most significant being the contracting of an Institutional Contractor (IC), the acquisition of implementation and technical assistance, and the design of the scope of work for evaluation and audits envisioned by the Project.

USAID/DR has funded the Project and contracted the IC and other Contracting Agencies (CA) to manage the Project and to provide technical assistance and grants to the implementing agencies. USAID/DR has also obtained technical assistance for Project

implementation, developed the scope of work for evaluations and audits, procured contraceptive methods and managed the importation and distribution of contraceptives through DA, thereby offering a timely supply of contraceptive methods.

As part of the technical assistance provided by USAID through the contracting of firms, a key element has been the interest process development within the current reengineering phase. Furthermore, USAID/DR has provided understanding and a rapid response to the implementing agencies, the timely provision of funds and the processing of information through the IC. The technical assistance provided is widely accepted by the implementing agencies, maintaining excellent communication channels with the IC and NGOs, which results in the acceptance of suggestions and recommendations by the NGOs.

Within the period under evaluation, significant changes in policies, strategies and in the Project itself have taken place, which have been reflected in adjustments in the programs. Lack of accord regarding coordination and collaboration between DA and AIDSCAP has made work in HIV/AIDS/STDs difficult. Coordination and collaboration problems are not only the responsibility of DA. The HIV/AIDS/STD component is included in the Project, but its description is very vague. Coordination with AIDSCAP, the AIDS prevention agency operating at that time, was assumed, but conditions for that collaboration or cooperation were not specified. AIDSCAP offered two types of training assistance to DA: "Syndromic Approach for Clinicians and Non-Clinicians" and "Counseling for Non-Clinicians." Despite the training provided by AIDSCAP to the implementing agencies, they have not been satisfied or regard this assistance as incomplete. While DA provided IEC materials on HIV/AIDS and STDs to network volunteers, they understand that they should receive more training in this area.

Other Contracting Agencies (CAs) have provided satisfactory TA services according to USAID needs and to the availability and capacity of other CAs, such as Access to Voluntary and Safe Contraception (AVSC), John Snow, Inc. (JSI), and Family Health International (FHI). Also, Macro International, Deloitte and Touche, Population Council, ALEPH and CESDEM.

2. DEVELOPMENT ASSOCIATES, INC. AS INSTITUTIONAL CONTRACTOR

USAID selected Development Associates, Inc. (DA) as the Institutional Contractor. DA was founded in 1969 with headquarters in Arlington, VA. It has projects and contracts with the US Federal and State governments and with governments in other countries with NGOs, private firms and multilateral organizations.

The following were DA's responsibilities:

- 1) To coordinate the administrative and technical assistance for the various organizations and programmatic activities under the Family Planning and Health Project
- 2) To provide support mechanisms for technical assistance to include a Chief of Party (five years), a health communications/evaluation and monitoring specialist (three years), one year of assistance in financial planning and institutional development, two years of assistance in family planning and health care, and one year of assistance in strategic planning, research and special studies.
- 3) To manage Project grants for recipient institutions.
- 4) To coordinate and collaborate with AIDSCAP/FHI, the agency contracted for STD/HIV/AIDS prevention, in technical assistance-related activities beneficial to both agencies.
- 5) To report Project progress to USAID.
- 6) To establish an IEC system along with implementing agencies.
- 7) To establish an evaluation and monitoring system for optimizing the Project

As the Institutional Contractor, DA has provided adequate personnel and technical assistance in a timely manner. It has appropriately delivered and controlled the Project funds and financial management. It has supervised and provided adequate monitoring through reports and on-going personal contact. The timely flow of funds has been one of the characteristics highlighted by Project NGOs.

A significant IC effort in focussing on processes rather than on products is observed. For example, IEC activities included strategies and processes as well as materials design and production, taking into account that traditionally efforts have been focussed on materials design. This has resulted not only in the unification of messages and IEC materials but also in learning how to develop them.

In addition, DA has contributed to the increase in institutional capacity of Project NGOs, as reported by the NGOs themselves, through training and support in automated MIS, efforts for self-sustainability, and the improvement of financial systems.

The IC provided timely Technical Assistance in the areas required and conducted specific studies for supporting the resolution of problems which arose during the Project. It implemented Project self-evaluation activities and has undertaken efforts in collaboration with the Dominican Government for the design and implementation of population development plans and the creation of a socio-demographic data infrastructure aimed at analysis and local use. In general, excellent relationships with implementing agencies having good administrative staffs and highly competent technical personnel were observed and reported. Administrative and financial management have been excellent.

In analyzing the Grant Agreement for the Family Planning and Health Project in detail, some activities were not expressly stated in the contract, such as support to NGOs for the leveraging of funds from other donors and contractors, therefore, this does not comprise a specific part of the NGOs' duties. However, given DA's experience, some activities have been supported by the IC and should continue to be supported in order to obtain support from other donors or institutions for the purpose of attaining positive results in the generation of resources and grants.

As previously mentioned, lack of accord regarding coordination and collaboration between DA and AIDSCAP made it difficult to take actions in HIV/AIDS/STDs. Coordination and collaboration problems are not only DA's responsibility, but are also due to the ambiguity of the Project regarding AIDSCAP and its efforts toward STD/HIV/AIDS prevention. This demonstrates the need to improve coordination and planning prior to the implementation of activities in which ICs are involved.

REGARDING THE DOMINICAN GOVERNMENT.

Although not stated directly in writing, the GODR is interested in offering reproductive health (RH) services, including AIDS prevention (there is already a law regarding AIDS prevention). The GODR assumes that it is the national entity responsible for offering RH services, and in fact possesses the physical infrastructure and

adequate resources for offering these services, as stated in the results of ENDESA '96, which notes that of the total number of female contraceptive users, the public sector comprises 36.1%, as follows:

Oral contraceptives	18.3%
IUD	59.2%
Contraceptive injections	22.7%
Diaphragm, jelly and tablets	6.9%
Condoms	9.3%
Female surgical sterilization	41.1%
Male surgical sterilization	00.0%
Norplant implants	52.0%

USAID has made major efforts to coordinate activities and donations from international organizations; for example, they participated through the Project in the development of IEC strategies for the promotion of FP and RH methods, and in the financing of ENDESA '96, but it is the GODR that must identify its needs and priorities so that donors can respond with technical assistance and financing for government needs and programs.

In limited contacts with government entities, observations and comments have been made regarding the need for greater coordination and clarity in the activities of CONAPOFA-PROCETS-SESPAS, especially in the transition period that emerged with the change in functions among these government entities in the area of RH and in the structuring of the Health Sector. This provides an interesting field for the Project regarding TA and the coordination of activities with the GODR, as there is a need to define the roles of CONAPOFA and PROCETS and for the possible transfer of functions or activities to SESPAS, as well as the need to consider a transition period and the transfer of knowledge, areas in which the GODR requires TA. There is little coordination between government policies and actions and between the actions and policies of the NGOs regarding RH; in particular, there is a lack of integrated proposals for projects and activities that could be financed by international donors.

Although it has been documented, comments have been made regarding pressure from the Catholic Church to modify the legal norms under consideration, establishing serious restrictions on RH and FP.

In the DR there is no system of accreditation to guarantee adequate quality of care in RH services. The interest shown by the GODR in the area of RH services has been recognized by USAID and is reflected in its strategies, as USAID is again looking for an opening and is demonstrating interest in supporting government RH activities, without abandoning support to the NGOs, which implies an opening and a combining of efforts between the public and private sector. However, neither the GODR nor its specialized entities have developed specific documented proposals on RH activities or on projects that could be financed or assisted by USAID. This may be due to the limited experience of some new officials in the preparation of these projects or proposals, or perhaps they are waiting for donors to come forth and offer their support.

In spite of government interest in RH, resources assigned to this area are very limited, especially for the purchase of contraceptives and for the logistical support of their management areas in which the GODR has little experience. However, as stated previously, in spite of the lack of allocation of resources and of clear norms, interest from the public sector is reflected in services offered, as it accounts for 59.2% of female IUD users and 41.1% of female surgical sterilizations, thus indicating clear governmental commitment to reproductive health.

The political and governmental changes that are taking place in the DR provide interesting opportunities for the GODR, opportunities that should be taken advantage of *at the right moment* to strengthen its normative role in health care and to improve the availability of reproductive health services (RH) by means of a larger budget for this area, and to improve NGO coordination and support. One of the ways in which the GODR can show its interest in RH is by including in its budget line items for offering RH services, especially for the purchase of contraceptive and logistics.

Among the health services offered by the GODR are VSC, IUD insertion, and the distribution of oral contraceptives and condoms, but coverage could be much better in many areas. It seems that the GODR is the most logical entity for offering FP and RH to the areas of greatest need, those that possess few resources and are the most remote and least densely populated, taking advantage of the facilities and services provided by the Ministry. In some areas NGO services can be used for promotion, IEC, training and supplementary services, or even to contract RH services directly.

With the announced reduction in support from international donors, it is necessary for the GODR to become strengthened in the areas of design, budgeting, and planning of services, as well as in the purchase and distribution of contraceptives, and in other areas where the NGOs have the possibility of offering support and collaboration.

3. ANALYSIS OF THE PERFORMANCE OF PROJECT IMPLEMENTING AGENCIES

There are clear differences in the levels of “maturity” and in the characteristics of the NGOs associated with the Project, in their programs and their organization, which makes it difficult - and maybe debatable - to make generalizations. Although the findings regarding the scope and impact of each NGO activities are presented in an Attachment, the following generalizations are offered, simply to facilitate the understanding of a complex Project, accepting beforehand the imprecision that may occur from grouping such dissimilar entities:

- The NGOs have offered reproductive health services (family planning) and other health services to the needy target population that did not have access to either services or resources, although in some cases the NGOs tended to concentrate more on achieving quantitative goals rather than on achieving adequate levels of cost-effectiveness.
- The NGOs are respected in their communities and by their users or clients, and their work has had a positive impact on both the integration of methods and the delivery of services. Their programs emphasize free choice of method and a high quality of service, and in general have succeeded in the area of community outreach.
- The NGOs have made a considerable contribution to increasing the population’s access to FP services.
- The NGOs participated actively in the design of strategies and IEC materials for RH, and later in the production and distribution of standardized materials for IEC. They have also received training, although they are still in the learning phase regarding the adequate use of the automated MIS for designing service activities and for their monitoring and evaluation. It may become necessary to augment training to reach NGO mid-level management and operational level personnel, as the strengthening of the administrative, financial and programmatic systems continues to be a priority for some NGOs, and more efficient feedback and monitoring systems are required to facilitate the most suitable corrective actions.
- The Project design envisioned that the implementing agencies would achieve a high degree of self-sustainability. At the Project mid-term evaluation, a serious

concern arose as to whether or not the majority of the NGOs would be able to achieve self-sustainability, and whether or not they could guarantee the continuation of RH services. The level of coverage for operational expenses is low (except for PROFAMILIA). The NGOs must improve their ability to promote and to offer services in light of the imminent reduction in funds contemplated for the end of the Project.

- The Project provides the DR with successful models for offering FP services; one example is the post-partum care program, which is worthy of replicating.
- Some duplication of efforts and competition among entities have been observed at the field level. This could be considered positive among commercial entities, but in the case of RH implies a lesser degree of efficiency in the utilization of resources. This competition has continued in spite of the efforts of the Inter-Institutional Council, the other Committees, and INSALUD. Also, efforts have been made to coordinate activities through the use of tools, such as the cartographic system (mapping) already initiated by ONAPLAN and developed for FP by DA, and the updating of the inventory of existing FP services.
- It has been noted that some NGOs need to update or develop new strategies for their programs, especially when employing strategies that were useful at the beginning of FP programs, but whose conditions have changed. Sufficient activities and programs for new target populations are not being offered, such as for adolescents, clearly identified in ENDESA 96 as a priority population.
- The Project global indicators assumed a governmental action that is not included in the Project assumptions. The Project result and impact indicators should correspond to Project actions, not to third parties.
- The supervision carried out by the majority of the NGOs for the volunteer networks was costly and unnecessary, since volunteers are well trained and know what they have to do. Supervision must be done under different conditions, whenever necessary promptly and less routinely.
- There is an unsatisfied demand regarding the prevention of sexually transmitted diseases and AIDS. The network of Project volunteers is an excellent vehicle for providing ITC and should not be underestimated.

4. ACTIVITIES OF GREATER AND LESSER IMPACT.

In general, Project activities have had a positive impact on RH in the DR. Those of greatest impact have been:

- ▶ The population's increased access to FP services.
- ▶ Users' ability to choose freely the method to be utilized.
- ▶ The development of IEC strategies and materials to promote FP and RH methods.
- ▶ Coordination by the Inter-Institutional Council and other Committees (Finance, IEC Services and Evaluation).
- ▶ The coordination and financing of the 1996 Demographic Health Surveys and training in the use of this information.
- ▶ Activities in areas and centers of high population density, such as free zones and marginal neighborhoods in principal cities.
- ▶ The selection of consultants -according to the NGOs- in a democratic manner and with a high degree of participation from the entities receiving TA.

Perhaps activities of lesser impact have been those carried out in more remote, less densely populated areas, that possess fewer resources and enter into competition with other entities already offering services. Some of the services offered were not of the highest quality but this should change with the projected accreditation.

Since its inception, the Project has supported the upgrading of entities through training and the utilization of successful techniques, with the goal of achieving greater impact, lower costs and less effort in adapting programs to the changing situations in the country and in reproductive health. Some NGOs have made positive advances in this upgrading, with results that would be interesting to analyze and to share with the entities.

IV. POSSIBLE PROJECT ACTIVITIES FOR THE NEXT 3 YEARS.

Given the multiple changes and uncertainties in the area of RH in the DR, instead of designing Project activities for the next three years, the ET (Evaluation Team) considers it more prudent to identify areas in which Project activities can be developed, so that later, in accordance with the development of events over time and with changing conditions, USAID/DR can determine its course of action and can coordinate Project activities for the next three years with the GODR, NGOs and with other organizations. Today, for example it would be premature to recommend a detailed collaboration with the GODR, since its interest and ability to work in the area of RH and the legislation governing its actions is unknown.

A. REGARDING THE PROJECT

1. GRADUAL REDUCTION IN SUPPORT

In light of the reduction in support from international donors, and to avoid a traumatic situation it is necessary to establish a program of gradual decrease in support from USAID/DR and to increase generation of NGO resources in order to guarantee institutional and program survival at the end of the Project.

2. CONTRACTING OF SERVICES

In view of the changes that are taking place and that are anticipated in the DR, the ET (Evaluation Team), based on experiences in other countries, has emphasized the importance of training for NGOs in negotiating the sale and offer of services to State and private entities. Supposedly there will be a change in the contracting of services with the Health Sector Reform, which can be considered an option.

It is perfectly understandable that the contracting of services may raise fears, since this contemplates a total change in mentality from an entity that utilizes resources to an entity that sells the services it offers, and that this sale must cover its costs, requiring a good system of management information and accounting, studies of supply and demand, cost-benefit analysis, and in general, modern administrative techniques.

As experience in this area cannot be improvised, it is likely that there will be contracting of health services by the GODR or by private entities, the possibility of

allocating special funds as an experiment has been mentioned, without implying any risk for institutional stability, or that a part of the USAID support or grant funds be used in the form of **service contracts**, with all pertinent procedures and formalities that apply to this type of contract, in order to provide valid experience and institutional strengthening in this field. This decision should be based on various factors, such as convenience for USAID and for the implementing agencies and on the feasibility of introducing this change during the remaining time.

3. IMPROVED PROJECT INDICATORS AND GOALS.

During the design of the Project, TA for the creation of qualitative indicators was not planned. It is important that indicators to be designed not only focus on quantitative aspects, but also include qualitative aspects of the services and supplies to be offered or provided

The designing of goals and indicators is not a simple task that can be improvised. The defining of indicators and the setting of goals are technical processes involving not only TA (technical assistance), but also the participation of NGO personnel, similar to the method used by the Project in defining IEC strategies, where after a costly process, useful materials and strategies were obtained. Not only is a broad knowledge of institutions required, but also the technical assistance of demographers, so that indicators and goals can be designed based on concrete statistics.

Precisely because of these factors, the evaluating team does not deem it advisable to recommend or establish goals or indicators in a hasty or ill-thought out way. The following are just a few examples of new indicators:

- Birth-spacing
- Fertility reduction in women under 20 years and over 35 years of age.

Qualitative indicators such as. degree of satisfaction by users for services provided, level of knowledge of the method employed by user, identification of reasons for discontinuation of methods by users, etc. However, this must be decided by the main actors of the Project. It is they who are called upon to undertake this endeavor, assuming TA has been provided.

In terms of the fulfillment of goals, in the providing of service delivery, and in the distribution of FP methods, IEC and training activities, recipient NGOs have achieved or surpassed annual benchmarks.

4. PRIORITIZATION BETWEEN SELF-SUFFICIENCY AND COVERAGE OF MARGINAL AREAS.

At present, the Project is facing two conflicting policies: coverage of marginal areas and self-sufficiency. This presents a problem for the NGOs because in remote, low income, needy areas it is unlikely that these programs will be cost-effective, the sustainability of these institutions diminishes, and they become financially deficient.

It is important that USAID clarify these criteria to the NGOs and that it approach the GODR regarding RH service delivery in remote, lower income areas where the Ministry of Health has the facilities and personnel available to provide these services, or regarding the contracting of NGOs to provide them.

B. POSSIBLE ACTIVITIES WITH THE DOMINICAN GOVERNMENT:

1. RESPONSE TO NEEDS IDENTIFIED BY THE GOVERNMENT.

As discussed elsewhere in this report, the Project can most adequately respond to Government needs in the area of reproductive health by facilitating service delivery at its facilities and with its personnel, in coordination with NGOs and other agencies, providing TA in various fields, supporting the Government through donations of contraceptives, and coordinating these GODR services with other agencies and entities.

There are numerous opportunities for collaboration, but *it is mainly the GODR that has to identify these opportunities and submit clear proposals to AID and other donors*. In addition to the traditional target populations for FP and RH actions, there are new target populations, for example, adolescents. Policy changes pose new areas in the contracting of services and institutional strengthening. There are also ad-hoc activities which require funding, such as the support provided to ENDESA 96.

The comparative advantage of USAID is primarily in the areas of technical assistance, logistical support, and the donation of contraceptives to NGOs, and also in the support of demonstration programs for service delivery, in policy dialogue, and in coordination activities.

The ET is not clear regarding priority policy issues that should be dealt with,

such as mechanisms guaranteeing reasonably priced, high quality service delivery and RH supplies for communities, but this can be achieved with the cooperation of the GODR, though clear written policies are not available

The evaluating team had limited contact with agencies and GODR representatives (ONAPLAN, CONAPOFA, and SESPAS) which did not provide for clarification regarding State RH programs and their needs. For example, it was suggested that CONAPOFA, in order to work with international donors such as USAID, develop and propose specific programs with clear goals, activities and budgets, indicating in each case the needs intended to be met and the counterpart or support to be offered by the GODR in the execution of those activities. In the case of ONAPLAN, planning for 1998 was not yet available at the time of the visit (November 11/1997), nor was there a budget.

It is the GODR that must identify its needs and submit requests to international donors. TA in the identification of problems and the development of proposals could be useful for both the GODR and USAID/DR and for other international donors. In this way, more sound and documented proposals would be produced.

Based on the interest shown by the GODR in RH activities and the financial, regulatory and legal framework, the Project could:

- Collaborate in the coordination of activities to allow the GODR to meet, with its own personnel and facilities, the needs for RH services in the most economically depressed areas that are farthest from the cities, while Project NGOs serve the more populated zones with greater financial potential with funds from USAID. On the other hand, the GODR can contract NGOs to work in those zones where they may have already worked.
- Provide TA to the GODR, so that it can incorporate into its budget line items for RH service delivery, and especially for the procurement of contraceptives if these are not donated by international organizations.
- Provide TA to the GODR regarding the development of policies, strategies, norms and procedures, so that it can provide or contract effective, high quality services.
- Coordinate and finance, if necessary, TA for the GODR from PROFAMILIA in the acquisition of and logistical support for contraceptives.

- Coordinate and promote the contracting of RH services between the GODR and NGOs

2. SERVICES TO BE OFFERED BY NGOs TO THE GOVERNMENT

The NGOs can provide many services to the GODR, but perhaps the most noteworthy and obvious are the contracting of IEC and RH services, and technical assistance in areas such as procurement and training

C. ROLE OF THE INSTITUTIONAL CONTRACTOR.

The role of the institutional contractor must evolve to keep pace with new changes and needs in the Project and in the country. The scope of work of the Institutional Contractor should continue under the same terms and conditions as the current Project.

D. POSSIBLE ACTIVITIES WITH NGOS.

1. COORDINATION OF NGO ACTIVITIES.

During data collection by the ET, comments were heard regarding competition that existed in some instances among volunteers in recruiting new users. This competition, which shows an interesting desire both for personal and institutional improvement, would be very beneficial in a commercial entity, but only results in the inefficient use of Project resources, as the same actual or potential user is visited and served by various volunteers from different entities.

In order to avoid this duplication of efforts, the following solutions, among others, are put forward (These are only suggestions; USAID, DA and the NGOs are the ones who must define this)

- Clear definition and identification of geographic areas in agreements, for example, the specification of work areas to be covered.

- Agreements at the Committee and Interinstitutional Council level, allowing mid-level management participation in the decision-making process and encouraging volunteers to carry out these decisions.

2. TECHNICAL ASSISTANCE IN GENERAL AND FOR INSTITUTIONAL STRENGTHENING.

To continue providing TA in institutional strengthening to NGOs, especially in the use of techniques already learned, such as automated MIS, the use of statistics, cost accounting, and the use of IEC strategies and materials.

To develop a pilot program for the training of NGOs in the contracting and delivery of RH services, particularly between NGOs and the GODR. The program must undertake this training without decreasing the NGOs financial capacity, enabling them to improve it, and training them for subsequent contracting with the State.

To support entity accreditation and RH programs in order to guarantee better health care for the users that is more suitable to their needs. To provide TA to those NGOs or areas that require it to obtain accreditation and increased service delivery to the community, provided that this does not imply the risk of limiting RH services already available.

To support programs for generating resources and institutional survival for entities To provide more TA to those NGOs that require it for the generation of resources.

To support the creation of programs targeted to new priority groups of users and marketing programs To provide TA to those NGOs interested in programs aimed at youth and post-partum women and other services required by the community, provided they are financed or self-sufficient. Of particular interest is the design of marketing-oriented (social and community) programs in higher density areas with greater financial potential.

To provide training in the identification and revision of indicators. This training must not only be directed to quantitative, but also to qualitative indicators.

3. NGO CAPACITY FOR DELIVERING SERVICES UPON TERMINATION OF THE PROJECT AND IMPACT OF A REDUCTION IN FUNDS ON THE FINAL TWO YEARS OF THE PROJECT.

Each of the NGOs has a different level of institutional maturity and its own capacity for sustainability (institutional, programmatic and financial). Given the activities, policies and strategies of each NGO, different programs and strategies should be designed. PROFAMILIA is perhaps the only NGO with the ability to outlive a gradual, drastic reduction in financial assistance from USAID; however, even PROFAMILIA, which already faces a reduction in support from IPPF, would be seriously affected in its ability to guarantee the continuation of all of its programs without the support of USAID/DR and other donors.

More time and information are required to make a precise diagnosis of the financial sustainability of each NGO and its programs. With limited amounts of data collected and analyzed, it seems that, except for PROFAMILIA's marketing program and clinics, the other PROFAMILIA and NGO programs rely mainly on donations of financial and material resources to continue their activities and programs. These institutions primarily serve zones and programs which are financially deficient due to the type of services they provide, and to the characteristics and economic ability of the population being served. They are institutions that were not designed for commercial purposes or for generating their own resources. They are entities that deliver programs in marginal zones, where profit is not an option. This poses the need for USAID/DR to define its policies concerning sustainability or self-sufficiency regarding service delivery and contraceptive distribution in marginal, low income, rural areas far away from main centers.

A program for improving NGO sustainability (institutional, financial and programmatic) could envision the following:

a. To make a diagnosis of the actual and projected financial self-sufficiency and sustainability for each of the NGOs, their programs and areas.

b. To identify programs and areas with the highest degree of financial sustainability and self-sufficiency, and to focus institutional efforts in these areas, seeking special funding for areas of particular social interest. To define in each zone what their priorities are, their capacity for self-sufficiency or coverage of services and supplies.

c. To coordinate activities with the State in such a way that the Government may undertake RH activities in remote, needy, low income areas where the Ministry has adequate available resources and facilities or is able to contract services to NGOs.

d. To determine the possibility that changes already initiated in the Health Sector Reform result in the contracting (procurement) of services by public and private institutions. If the procurement of services becomes a reality, the administrative, financial and programmatic capacity of each NGO for contracting the delivery of services and strengthening those areas where it is required, should be determined.

e. To improve the use of resources and techniques (such as automated MIS, service statistics, cost accounting, etc.) being offered by DA.

If the decision has already been made to reduce the amount of assistance, a planned, gradual reduction in financial support, in accordance with each NGO, is recommended, allowing sufficient time for institutional adjustments in such a way as to guarantee the survival of the entity, provided that interest and the capacity for self-sufficiency or for leveraging new donated resources exist. This planned reduction should be agreed upon in writing, including specific short-term goals and permanent monitoring. This could result in a Project similar to the IPPF Transition Project, but should take into account the reality of the reductions and possible agreement regarding mechanisms for leveraging resources

E. POSSIBLE NEW AREAS/STRATEGIES OR PROGRAMS.

The ET had limited exposure to international agencies and GODR representatives (ONAPLAN, CONAPOFA and SESPAS); therefore, it is not advisable for the ET to present recommendations to USAID/DR regarding new work options, especially in the face of a possible reduction in assistance. Not as a recommendation, but as an identification of work areas, the following options can be taken into consideration:

- ▶ TA for policy and strategy development, if timing for policy formulation is considered appropriate, in the event that this poses the risk of placing restrictive regulations and policies on RH, it is preferable not to broach the subject.
- ▶ TA for the replication of successful experiences, such as the experience with the Hospital de Maternidad, IEC strategy and material development, among others.
- ▶ TA for the development of activities aimed at specific populations, such as adolescents and the Armed Forces, among others.

- ▶ To collaborate with both private and governmental agencies in the preparation of projects or proposals for leveraging resources from national and international donors, especially projects where USAID/DR has a vested interest.

V. CONCLUSIONS AND RECOMMENDATIONS:

1. Regarding the Overall Project:

1. To continue the Project. We *conclude* that the fulfillment of Project goals and the significant role the Project plays in supplying reproductive health services make it essential for developing reproductive health in the country. However, major changes in health conditions have occurred in the DR, and the assumptions made during the Project design have only been met in part. We *recommend* that USAID continue the Project, making adjustments to keep pace with the changing environment in the DR, and revising and updating the assumptions, goals and indicators. It is important to note that while various changes and amendments have been made along with the implementing agencies, these have not been officially reflected in the Project. The revised and amended Project objectives, indicators and assumptions should appear in one single document. This is particularly important, as the ET had difficulty in visualizing the Project as a whole, due to the fact that it is so fragmented. Modification of the title of the Project should be considered, since it not only focuses on FP, but also encompasses more activities and undertakes actions mostly in the area of Reproductive Health.

2. To retain the institutional contractor. We *conclude* that the Institutional Contractor has fulfilled the most important functions of its contract; its experience is satisfactory and is accepted by the NGOs. It is assumed that if the Project continues under similar conditions, a contractor will be required. We *recommend* that USAID extend Development Associates' (DA) contract as the Institutional Contractor as long as USAID required their services, to the extent that DA's structure and capacity for service delivery allows. We also recommend that USAID take into account the other Cooperating Agencies that worked in the Project.

3. To reach new priority groups. Based on the findings of ENDESA 96 and on information provided by entities interviewed, we *conclude* that new RH programs and strategies are required, both in IEC and in service delivery for adolescents and post-partum women, which are new groups identified as priority for RH in the DR. We *recommend* that USAID develop new strategies and incorporate them into the Project to fund RH programs, both in IEC and in service delivery for adolescents and post-partum women.

4. To revise indicators and goals. We *conclude* that some indicators do not adequately measure the performance of the Project nor that of the agencies, and that some goals have either been met already, cannot be met, or do not constitute a stimulus or challenge for Project entities. Indicators for measuring the quality of services are not available. We *recommend* that USAID revise and establish more adequate indicators and

goals for the Project, new potential indicators may be child-spacing and reduced fertility in women under 20 and over 35 years of age. Additional indicators for measuring the quality of service delivery are: levels of satisfaction with service delivery by users, levels of knowledge of the method utilized by user, identification of reasons for discontinuing methods by users, etc. This is only a suggestion. USAID, DA and the NGOs are those called upon to identify new indicators.

2. Regarding the Dominican Government:

1. To retain the GODR for future actions in RH. We *conclude* that although the GODR has not established clear norms and budgets for the promotion of RH, it has shown interest in providing reproductive health services (RH), and has the physical infrastructure to facilitate the delivery of these services. We *recommend* that USAID retain the GODR for future RH actions and that USAID continue its efforts along with other agencies such as AVSC, which provides a clear example of action coordinated with the GODR, facilitating RH service delivery and the duplication of successful activities.

2. To provide technical assistance to the GODR. We *conclude* that the GODR is in need of TA in different areas, such as in the development of proposals for effective projects among others, and that USAID can provide or finance this TA. We *recommend* that USAID provide TA to the GODR in the development of proposals for effective projects, as well as in other areas.

3. To provide the GODR with TA in the overall planning and logistics of supplying methods

4. To collaborate with the GODR and other agencies in coordination efforts. We *conclude* that USAID has undertaken successful coordination efforts along with the GODR and other donor agencies working in RH in the DR, and that this coordination continues to be necessary. We *recommend* that USAID continue its efforts to coordinate its actions with the GODR and other international agencies.

5. To urge the GODR to pay attention to RH in remote areas. We *conclude* that the GODR has available facilities and personnel. We *recommend* that USAID encourage and support the GODR so that, utilizing its facilities and personnel, and also with the contracting of NGOs, it will meet RH needs in remote areas.

3. Regarding the NGOs:

1. To make NGOs aware of the reduction in grant funds and to support efforts made by NGOs for leveraging new resources from the GODR and other donors.

2. To provide TA in creating and revising attainable and effective indicators. Training for NGOs should be provided through the IC. The implementing agencies should be well aware of the function and extent of the indicators, as they are the ones called upon to accomplish them. It should be noted that indicators are not static, that they can be changed to increase Project effectiveness in achieving Strategic Objective No. 2.

3. To consider the contracting of services. If the health sector reform evolves toward the procurement of health services, it will be necessary to provide training in this area for both the GODR and NGOs, and to strengthen their administrative structure.

4. **Recommendations for Activities After Year 2,000:**

Many of the activities recommended for 1998 - 2000 can continue after the year 2000. USAID should make its decisions based on the needs and effectiveness of such actions after the year 2000.

Regarding USAID's relationship with the Government of the Dominican Republic, we recommend retaining the possibility of providing TA to the GODR in the areas needed. At this point, the ET is reluctant to make additional suggestions, as this is unsteady ground, moreover, it should not be forgotten that presidential elections will take place in the country in the year 2000, and there may be a new government with different ideas. Yet USAID should collaborate with the GODR, primarily in the area of RH policies, and should also provide guidance to the GODR in the identification of FP service needs.

While it is certain that after the year 2000 USAID will not sponsor this FP Project, if the GODR has not been able to take the responsibility of providing these services by then (either with its own or with contracted resources), USAID can decide under which strategy it will continue supporting Family Planning: it could, for example, contract out FP services to NGOs which it has supported through TA and donations, within the framework of a new project, where the contracting of services through a bidding process could be made based on the level of satisfaction with the services of the NGOs working in RH.

It is important to raise USAID awareness of the importance of its mission for the country in sponsoring this type of FP project. No doubt there are other major needs USAID can cooperate with, but the task of expanding quality access to RH services will remain a priority for the country.

Recommendations made regarding new target populations can also be applied beyond the year 2000. If the extended Project begins to address adolescents, for instance, we do not consider that the work to be done in those two years will be sufficient. For this reason it is essential that FP actions continue.

Furthermore, USAID can conduct a bidding process for entering into agreements to provide ad-hoc services to populations that have not been addressed and are in need.

In addition, work done to improve the quality of health care should not be ignored, undertaking more efforts for reducing maternal mortality and improving hospital services.

Conducting demographic surveys such as ENDESA is important for the country and for measuring important pre and post-project aspects.

VI. LESSONS LEARNED

1. A very extensive Project covering numerous areas and entities over a long period of time is difficult to manage, and requires full periodic revisions for the integration and coordination of its actions. The Project being evaluated covered very dissimilar areas and involved entities with diverse levels of maturity in a period of major change in the DR, which resulted in numerous partial changes; however a full revision of the Project was not made, which would have facilitated its management and evaluation
2. Indicators and goals must be attainable and motivational, and in the event that significant amendments to the Project are made, or that the assumptions or conditions of the country change, they should be revised. Goals and indicators must be attributable to the Project, and if possible, qualitative aspects should be included
3. There is a dichotomy between the decision to work with economically disadvantaged populations and the sustainability efforts of implementing agencies. The achievement of sustainability in working with populations with such characteristics is significantly more difficult.
4. The amount of time and effort spent in learning scientific and democratic processes for the development of IEC materials should be taken into account to make the processes more efficient.
5. Technical assistance should be ongoing. New situations and changes will require continuous technical support.
6. Once experience is gained and maturity increased, the agencies and the Project should respond to this new stage, thus avoiding stagnation.
7. The Project has made interventions in a wide range of populations. This network should be used not only for FP, but also for other activities: STD/HIV/AIDS prevention, the conducting of censuses, surveys, etc.

A N N E X E S

ANNEX 1

ANALYSIS OF THE PERFORMANCE OF PROJECT IMPLEMENTING AGENCIES

ANALYSIS BY ENTITY

1 Asociación Pro-Bienestar de la Familia, Inc. (PROFAMILIA)

The Asociación Pro-Bienestar de la Familia, Inc (PROFAMILIA) was founded in March of 1996, that is, it has an institutional track record of 30 years. It has been receiving support from USAID on a bilateral basis since 1987 for funding Reproductive Health activities.

In 1993, PROFAMILIA signed a Grant Agreement with DA under the USAID Family Planning and Health Project for the implementation of an array of activities that included providing both clinical and community services, social marketing, youth programs, community health and medical training, among others.

Its objectives are

a To increase the prevalence of contraceptive use and to improve maternal-child health by providing family planning and maternal-child health services in rural and urban marginal communities. This would be achieved through the distribution and sale of temporary methods at subsidized prices in commercial sector locations, and by making referrals for clinical contraceptive methods, including the creation of medical training centers for performing vasectomies,

b To provide information and education to resident physicians in aspects related to family planning and maternal-child health, and in STD/HIV/AIDS prevention,

c To reduce the number of pregnancies and STD/HIV/AIDS infections in adolescents in selected areas of the country, by using the multiplier system for increasing the knowledge and distribution of barrier methods.

d To reinforce the knowledge and abilities of PROFAMILIA staff working in community and clinical programs, including community volunteers, paramedical and medical personnel, as well as to train private physicians in IUD insertion, Norplant insertion and removal, and in procedures for both male and female surgical sterilization, and,

e To increase financial sustainability of its activities by making the program more efficient charging for services according to ability to pay, and by developing other sources for subsidizing financially deficient activities (cross-subsidization)

PROFAMILIA's Target Population

The work area of this institution covers 26 provinces, where it deals with low income groups with unmet needs in urban and semi-urban areas

PROFAMILIA's Achievement of Goals

During the first four years of the current Project (1994-1997), PROFAMILIA expanded its efforts to reach and to educate the community, increasing the level (volume) of services provided and establishing a marketing system for family planning methods, which has resulted in a self-sufficiency level of 48 percent (a percentage that includes the marketing program and the distribution at reasonable prices of products donated for community and clinical programs) In revising the 1997 Action Plan, and based on the three quarterly reports, we found that

PROFAMILIA, as a leading NGO in the community, achieved its goals for 1997, delivering over 230,000 CYPs a year

PROFAMILIA's network includes

- ▶ Three of its own clinics, which provided 140,000 consultations per year, and delivered over 40,000 CYPs per year
- ▶ Approximately 320 community volunteers who sell and distribute FP methods, for a total of 35,000 CYPs/year
- ▶ Approximately 100 associated clinics which offer FP clinical methods and deliver about 50,000 CYPs/year

- ▶ Over 2,000 outlets where FP methods are marketed, including pharmacies, grocery stores, supermarkets and motels. These outlets supply about 80,000 CYPs/year
- ▶ Face-to-face activities with youth and men (condom distribution), for a total over 25,000 CYPs/year

In 1997, PROFAMILIA achieved a sustainability rate (income divided by total costs) of 60%. Counterpart funds accounted for 65% of total Project costs. In general, PROFAMILIA's costs have declined during the last two years.

CYPs delivered reflect a decline in the reaching of goals due to a shift to temporary methods. Approximately 65-68% of the CYPs generated each year by PROFAMILIA are temporary FP methods.

PROFAMILIA occupies an outstanding position in the country's health sector. It is a well-respected institution and is well-thought of in political circles. It implements a wide-range of community programs and has a referral system for services that are offered in two clinics located in Santo Domingo and in Santiago, where health services including cancer detection, maternal-child care, clinical and temporary FP methods (for both women and men) and lab services are offered. PROFAMILIA also provides counseling services in STD/HIV/AIDS, domestic violence and rape. PROFAMILIA has strengthened and extended a successful program with young multipliers, whereby sexual and STDs/HIV/AIDS prevention education is provided.

PROFAMILIA has made clear efforts to accomplish sustainability, and is on the way to achieving a higher degree of self-sufficiency. It has a detailed system for recording statistical and accounting information that distributes processed data at both central and regional levels to be used in service provision and planning. PROFAMILIA has a self-sufficient commercial marketing program, through which it buys, imports, nationalizes and distributes methods by means of a well controlled system.

In addition, PROFAMILIA has a community-based distribution system for selling donated products at popular prices in community and clinical programs and in the Evangelina Rodriguez and Rosa Cisneros Clinics. All of this has resulted in a 48 percent level of sustainability or self-sufficiency, which demonstrates the commitment and interest of PROFAMILIA's management. While the marketing program does not need support, the community-based distribution system needs to be supported with donations of contraceptives.

PROFAMILIA competes with other NGOs for community markets and clients through its community and commercial distribution programs and also competes with the method distribution system of the Ministry of Health, which provides products for free. It also faces a considerable market of contraband FP products.

PROFAMILIA is concerned about the negative publicity regarding Norplant and the IUD, and provides counseling to counteract this publicity. Unfortunately, information concerning the side effects of injectables is not yet complete, and IEC materials are not available.

The *Clinica del Hombre* continues to be underutilized, particularly regarding vasectomies and FP services.

There is a large amount of volunteer supervision, thus increasing costs. While FP is not the core activity in which young multipliers are trained, they exhibit insufficient didactic skills and knowledge in responding to participants' questions. The strictness in the conducting of meetings, though avoiding the risk of informality and vulgarity, limits the young people's participation and the creation of a more pleasant environment for questions.

2. Asociación Dominicana de Planificación Familiar (ADOPLAFAM)

ADOPLAFAM, Asociación Dominicana de Planificación Familiar, Inc., is a private, not-for-profit organization (non-governmental organization), established 12 years ago, whose mission is "to offer timely information, training and quality services in maternal-child care, family planning, and sexual and reproductive health, as well as proper management of the environment, by promoting community participation in improving the quality of life of the (Dominican) population, with emphasis on lower income groups."

To provide services in the regions where ADOPLAFAM works, it has 58 associated medical offices and clinics, 454 voluntary community health assistants (AVSCs), 420 beauty salon operators and 110 barbers.

Clinics and physician's offices are the basis for community work and are the headquarters for Community Health Workers (CHWs), who provide support services to physicians and undertake community activities.

In 1996 the program provided a total 38,459 CYPs, of which 20,735 were oral contraceptives, 9,590 VSCs, 4,613 condoms, 2,295 IUDs, 1,225 vaginal tablets and Depoprovera

Other programs are implemented with support from the United Nations World Food Program (WFP) and the United Nations Population Fund. These programs include the participation and training of traditional midwives and youth clubs. The IEC and training components play a key role in all programs, as well as at the institutional level.

In 1996, a strategic plan was developed for the entity and systematized accounting programs were established.

ADOPLAFAM's Target Population

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— To accomplish its mission, ADOPLAFAM offers services in health regions 0, I, III and V (which correspond to those of SESPAS). The Family Planning and Health Project is implemented within these four regions. In addition, a Responsible Fatherhood and STD and AIDS Prevention Program is implemented there, and in Regions "0" and "I" a Basic Sanitation and Housing Improvement Training Project is implemented.

The Responsible Fatherhood and STD and AIDS Prevention Project is implemented in Regions IV, VI and VII (on the Haitian border).

The Grant Agreement and program description established a target population in the marginal urban and rural areas where clinical and community services should be provided, with the following goals:

ADOPLAFAM's Achievement of Goals

According to the information supplied by ADOPLAFAM, it was projected to

deliver 107,712 CYPs during the first four years of the Project, a goal that had been surpassed by September 30, 1997, when 137,229, that is, 127% of what was projected, had been provided in a period of major reduction in goals for the number of volunteer community assistants, Community Health Workers, and medical offices.

We found that the most significant goals and accomplishments included in the report for the period January-June 1997, are the following:

ACCOMPLISHMENTS DURING 1ST SEMESTER	PLANNED FOR THE YEAR	
62	65	Community doctors providing Family Planning and Maternal-Child health services
1,236	1410	Volunteers
19,714	42,408	Couple-Years Protection

As can be noted, the fulfillment of goals is possible, as analyzed in the self-evaluation workshop conducted last October 23 and 24. In general, during the self-evaluation some problems arose regarding the number of promoters and with those having contraceptives and educational materials, and concerning their interest in promoting condoms. The expected number of participating doctors was not achieved, especially due to problems in Region III, where neither the projected number of consultations nor the level of sustainability were achieved.

The most outstanding positive characteristic of ADOPLAFAM in the development of the Project is its network of volunteers, some with many years of experience working in economically depressed zones, where the Project and volunteers are welcomed and accepted. Within the network of volunteers there is an unrecognized but important group consisting of their husbands and children, who function as promoters. Eighty percent of the work is carried out in the most populated neighborhoods and 20% in smaller communities, and the various activities and programs ADOPLAFAM provides in addition to family planning, improve its image in the community, which allows it to receive additional resources from other donors, such as FNUAP and WFP.

ADOPLAFAM possesses good administrative personnel and the general staff is trained and interested in the work they perform. They make an effort to achieve Project self-sufficiency and sustainability with the marketing of beauty products and the

distribution of contraceptives delivered by motorcycle. However, these efforts have not been very effective and their sustainability level continues to be low. This is in spite of the existence of effective and interesting programs, such as the use of volunteers in clinics and with associated doctors, which makes the activity attractive for doctors and small clinics. However, an accreditation program is not available to guarantee adequate quality of service for users.

ADOPLIFAM provides a service that meets the needs of FP users regarding the free selection of desired methods and by providing supplementary services such as STD testing in high-risk populations, however, the quality of care observed in one of the few medical service facilities visited was high in personal attention, but low in the area of technology.

The administrative structure has a limited capacity for conducting new activities and little capacity for institutional growth. The automated MIS has just been initiated, and in spite of many years of experience with the manual system, they still do not make adequate use of information in the decision-making process. There is little information or consciousness of costs, and it seems that there is more interest in reaching goals than in reaching them efficiently, which results in high costs.

Strategy design still corresponds to Project characteristics as they were when activities were begun and has not sufficiently taken into consideration the maturity of the Project, of the market or of society, or the changes that have occurred in the community, such as the fact that today women work outside the home in communities where traditionally they did not. Although the multiplicity of programs can explain some program actions, such as the insistence on home visits, this results in higher costs.

In one of the rural or semi-rural zones that was visited, an apparently high geographic dispersion was noted, with significant distances among volunteers, or at least very limited number of users per volunteer, which can raise the cost of supervision, especially when frequent visits are made to bring supplies and to supervise. There may be a population with a location permitting greater institutional efficiency, but the ET did not have the time to conduct this type of study, and visits do not cover (nor was it an objective) a cross-section of the population in question.

In spite of the administration's efforts to avoid it, there is competition with other entities for users and volunteers, and the necessary coordination and cooperation with other programs, especially with government entities, has not been observed.

3. Mujeres en Desarrollo Dominicana, Inc. (MUDE)

MUDE is a non-governmental organization founded in 1980 whose mission is to contribute to the integral development of rural women

In 1993 with the signing of a grant agreement with DA, it became an implementing agency of the Family Planning and Health Project sponsored by the USAID/DR Mission. Thus, its efforts were combined with other implementing agencies for the purpose of accelerating the decrease in fertility in the Dominican Republic, of improving the health of women and children, and of increasing the efforts of the Ministry of Health to prevent the spread of AIDS and other sexually transmitted diseases

The period established for the grant was October of 1993 to September of 1998, with a possible two-year extension that would end in September of the year 2000

MUDE's Target Population

MUDE works with rural communities located in the municipalities of Agua, Baní, Santiago La Vega, Constanza, Jarabacoa, Moca, Bonao, Salcedo, Villa Tapia, Cayetano Germosen Montecristi, Villa Vásquez, Santiago Rodríguez, and Villa Los Almácigos. A total of 400 rural communities is proposed in their grant

This agency has 2 sub-components to be implemented

1) Family Planning and STD/HIV/AIDS Prevention, in order to a) Increase prevalence in the use of contraceptive methods in rural communities through the sale, at subsidized prices, of temporary methods, b) Make referrals for clinical contraceptive methods and c) Provide information and education to community residents regarding Family Planning and STD/HIV/AIDS prevention

2) Maternal-Child Health, for the purpose of improving maternal-child health in designated communities by providing information and education in the following areas: breastfeeding, prenatal care, the control of diarrhea and acute respiratory diseases. Also contemplated is the offer of oral rehydration salts and testing for diagnosing cervical and breast cancer

MUDE's community structure consists of a National Coordinator, three Area Coordinators, 12 Community Technicians and 278 active volunteers in 19 areas and 284 communities

MUDE's Achievement of Goals

Regarding the achievement of expected results, MUDE's goals for 1996 exceeded the number of CYPs delivered, the number of referrals for clinical reproductive health services, the percentage of volunteers that have pamphlets on FP, and the percentage of volunteers that have condoms, pills and spermicides

Though demonstrating a clear interest in institutional strengthening, a significant inability to achieve a percentage of direct operating costs covered by counterpart funds has been observed. Twenty-five per cent of operational costs planned for Project NGOs were to be covered by counterpart funds, but sustainability indicates only 13%

The institution has limited human resources for covering such extensive work areas, which makes the cost of supervision very high. Systematization and its cost management system are in the process of being implemented

MUDE enjoys a privileged position regarding access to and presence in rural areas, and has achieved a high level of penetration and acceptance by rural communities. In addition to its involvement in Family Planning activities, it has components for micro-enterprises and micro-credit, training, organization and the environment, which places it in a special "niche" for the GODR and donors, and also provides quality training services for rural areas

MUDE has a good relationship with the government and donors, and is making a concerted effort to coordinate with the government, as in the case of the agreement with CONAPO/A to provide clinical contraceptive methods. There is a good system for recording activities at the volunteer level, and it has done adequate work in the empowering of women

The users' free choice of temporary method and MUDE's efforts to incorporate information from the women's and children's nutrition component into their educational actions, characterize their programs. The network of volunteers' families is put to good use, especially in the sale of condoms

The radius of geographic coverage is extensive and costly. The goal of carrying out activities in 400 communities at the end of the project is very ambitious, especially when those communities are in remote areas.

MUDE competes for users with other institutions that offer sporadic services, which when offered, put obstacles in the way of the volunteers. Perhaps this competition is the result of problems that arise from rotating volunteers in their communities and in the Project. Due to the lack of access to VSC, IUD and implants that resulted from the discontinuing of the coupons, and even with the agreement with CONAPOFA, MUDE has no control over referrals made in relation to services provided.

MUDE uses a strict system of supervision. The question that should be asked regarding this point is whether or not the institution has acquired sufficient maturity, which would result in the network of volunteers and community technicians knowing how to do their work.

Supervision should be timely and specific. For example, not all volunteers are handing in their reports. This means that they need help, whatever the problem may be. TA should be offered to these volunteers. Supervisors can help with problem solving, and can identify possible causes.

On the other hand, problems with volunteers staying in their communities have been observed. It seems that economic factors force them to exchange this activity for more lucrative ones, and at times to leave the community in search of new opportunities. It should be noted that the sale of contraceptive methods does not provide a sufficient income for volunteers to be able to support themselves. MUDE's technical staff is aware of this.

Another important aspect to highlight is the effort made by the institution with respect to the AQV, IUD and other implants. Although their CYPs are not planned to include these methods, the educational work that leads MUDE's users to seek these methods should be recognized, although MUDE itself does not benefit institutionally from this.

4. Instituto Nacional de Salud - INSALUD.

Instituto Nacional de Salud (INSALUD) is a non-governmental organization created in 1991 to contribute to the development of health sector policies and strategies.

In that same year, the institution organized the First National Health Forum as a precedent for future activities in the defining of health policies. Representatives from the public and private sectors, professional associations, community groups, and universities and learning centers, as well as from international organizations, attended this event.

In 1993 INSALUD signed a grant agreement with DA that ends in 1998, with a two year extension period (until the year 2000). Under this agreement, the institution received support for the development of its institutional capability, for expanding its membership (other member-institutions that are active in the health field) and for achieving greater financial sustainability.

This grant agreement had the following three components:

1) Policy and reform dialogue to facilitate health policy and lobbying activities for reforms based on health needs and problems in a rational manner and with cost-effective elements.

2) To develop university curricula to improve and develop curricula in university medical schools in the area of reproductive and maternal-child health.

3) To disseminate information in the health sector for the purpose of disseminating information regarding work done, such as the results of research, scientific literature and policies, and for organizing lectures, debates and conferences related to the various aspects of health issues.

INSALUD's Achievement of Goals

In INSALUD, there is a clear example of inadequate goals, either because they were not well-established initially, because performance was extraordinarily efficient, or because the goals were not revised and adapted in a timely manner to the changing conditions of the country or of the Project. In achieving the proposed indicators, for the year 1996 they had already reached all their goals, and in many cases had exceeded them, demonstrating the need for revision.

INSALUD includes a good number of NGOs from the health sector, has political support and the support of AID, and is well-looked upon in its role of

coordinator. It is interested in institutional growth and strengthening, and is making important efforts to introduce and develop family planning curricula into the health science departments of the various universities of the country.

It is active in the dissemination of information through the organization of forums, conferences, seminars, and workshops, and played an important and key role in the development of the National Plan for Women and AIDS and in the approval of the AIDS law.

It possesses a sound structure consisting of technical committees for the discussion and formulation of health policies, promotes the democratic participation of its members, and establishes adequate communication between its members and the Dominican government.

INSALUD has poor sustainability, which demonstrates the need for control over its self-sufficiency both internally and by donors. AID covers 93% of operational expenses. At the present time, INSALUD does not sell services or charge for its services, however, it is attempting to introduce a credit card for health services, the VISA-INSALUD CARD, and is making an effort to act as the credit-granting organization for health entities that receive assistance from the GODR, which would provide them with an income. Unfortunately, INSALUD demonstrates low levels of clarity and transparency regarding its possible future role in accrediting the NGOs that provide health services to its members. There is a lack of socialization of criteria to be implemented. Although this activity has nothing to do with the area financed by USAID, it is broadly related to INSALUD's financial sustainability and its lobbying activities.

Although, according to the perception of INSALUD'S member NGOs, there is no clarity regarding its statutory ability to collect and administer funds, and although INSALUD is not perceived by the member institutions as an administrator of funds, the possibility exists of having INSALUD assume the role of intermediary between the NGOS, SESPAS, and IDSS. Little clarity is perceived by the members of INSALUD regarding its plan to collect 1.5 per thousand of the funds subsidized by the GODR and received by its membership.

There is no agreement concerning the importance for INSALUD of the amounts to be collected through this activity or concerning its administrative ability. According to INSALUD estimates, the collection of 1.5 per thousand of the government subsidy received by the members could generate RD\$250,000, which in addition to current grant funds would amount RD\$490,000, and would help INSALUD to achieve

sustainability

Another interesting role that has been suggested for INSALUD is participation in the accreditation system for health entities that receive funds from the GODR, however, this would mean developing its human resources, which are still too limited to cover the proposed diversification of services. Although there are no specific plans, the strategy mentioned to the ET is based on the training and contracting of personnel as new resources from the projected activities are generated.

INSALUD reaches its goals and surpasses them, and although it has improved its structure and accounting system with the support of its membership, additional strengthening is required in this area, as well as for the consolidation of its administrative ability.

There is no clear prioritization of efforts in the area of medical school curricular reform for including universities that cater to Dominican students who can stay in the country and serve as multipliers. Of the four universities INSALUD works with, two have a significant number of foreign students who are not supposed to remain in the country.

For INSALUD's various current and future activities, it is not only necessary that the institution be trustworthy, but also that it be able to count on the positive attitude of its members. This positive attitude must come from the trust of its members, and in particular, from the trust of the Project NGOs, supported by a high degree of transparency in procedures and by the political independence of the entity and its operational, technical and administrative capability.

5. Oficina Nacional de Planificación, ONAPLAN

The Oficina Nacional de Planificación (ONAPLAN), a government institution under the Technical Secretariat to the Presidency, created in 1986, within the Social Planning Office, a population unit, which at present is known as the Division of Population and Employment (DPE).

The United States Agency for International Development (USAID) and the Dominican Government signed a cooperation agreement in 1993. Among actions envisaged, ONAPLAN is responsible for those intended to formulate, design and coordinate the execution of a national population policy in the DR, as well as the

programs and projects necessary for its implementation

ONAPLAN would contribute to the improvement of the quality of the national statistics system in order to have more reliable data bases, which would allow for better guidance and monitoring of State policies in the various fields of development. In addition, ONAPLAN would undertake actions on a regular basis to produce and disseminate information from data bases to users.

Within this framework, ONAPLAN has produced a preliminary report on the Social Development Plan which includes proposals for family planning and population policy to be adopted by the new government.

With technical assistance from DA, ONAPLAN established a socio-demographic data bank and a socio-demographic survey inventory. It also actively participated in ENDESA '96.

The Evaluating Team decided not to include evaluating elements concerning ONAPLAN, as time was limited and the interview with ONAPLAN personnel was conducted the day before the delivery of this report.

RECOMMENDATIONS FOR PROJECT NGOS

a PROFAMILIA

1 To maintain its primary role as provider and promoter of FP services and to expand this role preparing to serve as contractor for the GODR in the provision of TA for RH issues and in the provision and management of contraceptives, taking advantage of its contacts, structure and marketing program experience. Its role can be that of an independent NGO, or it can assume a leading role in a health sector NGO group or "cartel," specializing in RH and FP.

2 To conduct feasibility and need-assessment studies, and to obtain TA regarding the convenience and feasibility of expanding its own clinics, both in size and in number, with respect to the contracting of additional services to current associated clinics, or to increasing the number of associated clinics.

3 To participate actively in the "Hombre Ponte en Eso" program both in the

promotional aspects and in the counseling and provision of clinical and surgical services, which can improve the occupancy and income-yielding capacity of the current Clínica del Hombre (Men's Clinic) in Santo Domingo To prepare to meet the increased demand for men's services throughout the country

4 To expand and develop new mechanisms and controls for improving self-sufficiency in the various programs, not only in social marketing

5 Based on limited observations, it seems necessary to improve several aspects of the training for multiplier agents, offering more fundamentals in technical aspects and didactic processes

6 To improve counselling regarding methods such as Norplant, injectables, and the IUD, about which the community has doubts and misconceptions (myths and beliefs), to remove these doubts among users and to promote these methods

b ADOPLAFAM

1 To strengthen the administrative and financial structure by making better use of the recently installed automated MIS and of the concepts of strategic planning already developed

This strengthening should be with a view toward training as a service contractor for the public sector according to the Health Sector Reform, taking into account the participation and support of an NGO "cartel" that could collectively contract out RH service delivery, should this be considered more efficient

2 To adjust procedures for service delivery (frequency of visits, system and frequency for resupplying volunteers, number of users per volunteer, etc), according to the maturity of the program, community evolution, and programs and activities being implemented seeking greater efficiency, self-sufficiency and sustainability

3 To improve the level of institutional sustainability and self-sufficiency To improve cost awareness using the cost information yielded

4 To improve counselling regarding methods such as Norplant, injectables, and the IUD, about which the community has doubts and misconceptions (myths and beliefs), to better respond to these doubts among users and to promote these methods

5 To establish a system for the accreditation of associated clinics and doctors to guarantee the quality of services delivered in the name of the entity

6 To concentrate its efforts in areas and on groups in which ADOPLAFAM may be more efficient, e.g. areas of high population density, such as free zones, universities, etc., to determine where the various programs being implemented by the entity can be more efficient

7 To coordinate efforts with other entities and to clearly define which communities and services should be covered, to avoid competition with other NGOs, the duplication of efforts and the inefficient use of resources

c MUDE

1 To make the agreement with CONAPOFA more operative in providing users with clinical and surgical methods

2 To revise methodology and parameters for the supervision of volunteers To find a way to reduce supervision and service delivery costs Supervision must be done on a non-routine, timely basis, according to situations as they arise

3 To improve counseling regarding methods such as Norplant, injectables, and the IUD, about which the community has doubts and misconceptions (myths and beliefs), to better respond to these doubts among users and to promote these methods

4 To concentrate its efforts in the areas where it is most efficient In any case, greater program sustainability and self-sufficiency levels must be pursued

5 To strengthen and make better use of their cost management system

6 To analyze and determine the areas that can be addressed efficiently with the available human resources, since these are not sufficient for covering extensive work areas

7 To concentrate its efforts in areas and on groups in which MUDE can be most efficient for example, in areas of high population density, such as free zones, universities, etc. Determine in which areas the various entity's programs can best be carried out

8 To coordinate its efforts with other entities and clearly define the services and communities to be focussed on, to avoid competition with other NGOs, the duplication of efforts and the inefficient use of resources

9 To review volunteer profiles, identifying variables and conditions that will ensure that volunteers remain in the community

10 Although the institution calculates the CYP indicator based on the types of methods provided, the effort made by the institution regarding referrals for VSCs, IUDs and implants should be recognized in some way, whether crediting it with a percentage of the CYP or by making cost calculations per referral. These are just suggestions

d INSALUD

1 To conduct an institutional study to determine its available resources, ability and needs in order to offer the wide range of services proposed, establishing a plan for institutional strengthening

2 To make improvements in the areas of administrative, financial and programmatic sustainability and self-sufficiency

3 To provide information and an explanation regarding its participation in the accreditation process, demonstrating the transparency of the method, and that it will not be affected by political issues

4 To determine if it possesses the institutional capacity, according to its statutes, to administer resources and to collect the 1.5 per thousand of the resources received from the GODR by its members in the form of donations or contributions. It should

explore the possibility of this idea being accepted by its members

5 To accomplish this ambitious program of projected activities, its human resources should be augmented and its physical facilities expanded. There is already a need to strengthen its administrative and financial structure.

6 To demonstrate to its members that it will not be influenced by political issues, guaranteeing transparency in its operations.

7 To increase staff in order to fulfill current commitments.

e OTHER GOVERNMENT ENTITIES SUCH AS ONAPLAN,
CONAPOFA

1 To improve its system of planning by developing programs and projects to be presented to potential donors in a timely fashion.

2 To utilize available TA resources to develop well-informed, cost-effective organizations that are self-sufficient and self-sustainable, if possible.

3 To expand and enhance training in the management of the ENDESA 96 data and of other available resources, ensuring their efficient use in planning and in the decision-making process.