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**FINAL EVALUATION OF THE PRIVATE
VOLUNTARY ORGANIZATION FAMILY
PLANNING PROJECT**

Executive Summary

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Final Evaluation of the Private Voluntary Organization Family Planning Project

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STRATEGIC OBJECTIVE

SO3 - Improved Health including Family Planning of High-Risk Populations

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Since 1989, USAID-Peru financed the PVO Family Planning Service Expansion project that was implemented by AB-PRISMA, as an umbrella institution. Its responsibilities were to administrate the funding and to monitor, supervise and evaluate the programs supported in the following PVOs: PRISMA-Trujillo (Initially, CENPROF in La Libertad), INPPARES (Lima, Junin and San Martin), PLANIFAM (Cusco) and PLANFAMI (Puno). Early on 1994, a new project extension was approved in order to expand family planning and reproductive health services to rural areas, especially to those most in need, at the departments of La Libertad, Junin, San Martin, Puno y Cusco.

Along the project implementation and its extensions, several studies were done, such as ENSAMIR I & II (Mother and Child Health Rural Survey), Qualitative Research and Cost Studies. The studies might allow institutional decision-makers to optimize strategies and resources in order to achieve effectiveness, efficiency and quality.

This ex-post evaluation looks to complement and to integrate the experiences developed during the project implementation. Its objectives are to deepen on the organizational & managerial, cultural and quality of health care issues at the PVO's community clinics, focusing on the extension period and at both provider and supplier perspective. The positive and negative experiences are to be learned, emphasizing on successful strategies and processes so they can give valuable information for the ALCANCE project.

The objectives were (i) to determine the level of success achieved by the PVOs on the provision of the reproductive health services in urban, peri-urban and rural areas, (ii) to revise the organization, administration, and managerial techniques used by each PVO during the project, to determine those that achieve the best results, (iii) to evaluate community attitudes towards health services provided by PVOs and how they have tackled users health needs.

This ex-post evaluation is a descriptive, retrospective cross-sectional study. A convenient sample size was determined considering the following criteria: place (urban/rural), number of reported activities and coverage and accessibility.

Questionnaires were used to measure organizational and managerial issues, and quality of care, focus groups and in-depth interviews were applied to measure users' perceptions and cultural issues, and observation of provider-user & user-user interaction were done. Finally, all the documents generated during the project (i.e. cost studies, qualitative research, operational plans, etc) were revised.

The evaluation has the following limitations:

- Once the PVFP project ended in June 1997, shortages on budget and personnel occurred, so the data collected for the present evaluation does not necessarily show the reality on which the project was developed. However, it allows us to assess PVO convoking capacity and sustainability.
- Shortages on time and budget for this evaluation don't allow a full-team visit to all the clinics and the duration of the visits was short, especially in the farthest areas.

ORGANIZATION AND MANAGEMENT

The project organization was (i) USAID-Peru as the financing institution, (ii) AB PRISMA as the umbrella institution, responsible of the project administration, and (iii) PVOs, responsible of the implementation and organization of the community clinic network. There were no defined limits of rights and responsibilities of each institution, that generated several role problems such as delayed funding for the programmed activities, managerial problems at community clinics, and resistance of some PVOs to accept decisions suggested by PRISMA (i.e. cost studies).

Keeping in mind the new project, it is highly recommended that a new organizational structure may have a horizontal orientation. This may involve all the institutions in the project management and therefore promote sustainability and empowerment of the PVOs. It should also be emphasized the strategies that diversify funding sources (PVOs revenues or through projects funded by other agencies).

PVOs are small health institutions greatly involved on reproductive health issues, with quick adaptation to a changing context (such as modification on population policies and the Health Sector Reform process) Adaptability is expressed from coordinated strategies (to avoid duplication of health provision) to displacement of their facilities to farther areas, where no other health provider works PVOs should not be competing with the Ministry of Health on issues such as coverage, but they must develop newer and innovative strategies for a successful community work (using their knowledge and closeness with the population) and to target particular age groups, as the youth

The PVO with its Central Office located at the area of influence had developed better personnel relationship, community communication and acceptability Coordination and agreements exist between PVOs and the Ministry of Health (central, regional and local level), municipalities and communities at their area of influence, however, only few of them showed written agreements Moreover, successes vary depending on the PVOs and commitment of personnel of the other institutions mentioned

The community clinics had a common structural and functional organization (i) Local coordinator, (ii) Physician and (iii) Auxiliary Around 27% (4/15) of the community clinics didn't have medical staff due constant physician re-exchange, which occurred with other personnel This situation is associated with the project financial instability as well as with the implementation of a Ministry of Health program called Basic Health for All Program The latter offered significantly higher salaries, especially to physicians working in some rural areas This may explain that 93% of the community clinics have only full-time midwives and auxiliaries

An efficient staffing pattern needs to consider the mission and vision of the strategic plan The supply side (e.g. considering all the health providers in an area), the diversity of services to be provided, the population health needs and their geographic and cultural accessibility are also to be considered It is better if the personnel understand the local language, favoring a better relationship with the community Personnel also need to be trained on personal relationship that has proven to be very important for community and institutional work

It was reported that the facilities had their Manuals of Organization and Function, and Manual of Procedures 45% of the personnel did not know about them and 60% did not know about their content The percentages were higher among those recently contracted

An existing Management Information System (MIS) at the PVOs allows evaluating human and financial resources distribution, logistics and statistics This system was implemented at the PVO Central Offices with limitations due to obsolete computing equipment and lack of training for its use and its application for decision making Other weakness was the lack of feedback to personnel at the local and community levels This did not allow them to value the information and to have an overall vision of the project and its progress We did not find users' socio-economic data on the MIS, as expected according to the Amendment 4

There was no formal referral system within each PVO, and between a PVO and any other health provider -public or private- with which they established any coordination level

In order to assess institutional performance, strategic plans are needed These plans were not available Moreover, the personnel didn't know about them so the viability is questioned Operational plans that are also needed were prepared at the central level without including the intermediate and operational level This process weakened personnel skills to develop strategic, monitoring and supervision plans Finally, those at the local level didn't have the technical skills to prepare and implement operational plans, elaborating only a schedule of activities

PRISMA had two types of supervision (i) Technical, to assess the progress of the Operational Plan, and (ii) Financial, to assess finance reports Both were to be done every three months Its quality depends in who did it, some of them were like an audit Therefore, supervisions should be integral and coordinated from its very beginning with the institutions involved At the end of any supervision, a written report should be given detailing the findings and recommendations, there must also be a follow up of the strategies implemented to solve the problems

In relation to training, most of them focused on technical issues (i.e. family planning, contraceptives and sexually transmitted diseases), only few activities tackled management or personal relationship issues. Participants were selected at the central level and sometimes with lack of coordination "selection was done by personal influence", affecting the success of this strategy. Another aspect that influenced the training success was the re-exchange of personnel. Felt training needs included issues on family planning, service management (70% of the interviewed mentioned them), quality of care, personal relationship, and Ministry of Health preventive programs. These felt needs reinforce the need to diversify health care provision at the Primary Care level in order to satisfy felt needs of the population.

There was no stated personnel evaluation policy, however PVOs have similar formats and criteria to evaluate their personnel. Results showed that the evaluation at the community clinics was done monthly, every three months or twice a year looking to their production, coverage or goals achieved. Also, there was no standardized method to evaluate the activities developed, however that doesn't affect personnel performance. PVOs' personnel and managers and PRISMA's personnel, suggested that the evaluation has to be regulated so it can be used to assess technical skills and therefore to assure quality of care.

During the 1989-1994, the emphasis was on production and goal achievement measured as couple year protected -CYP-, contraceptives distributed, among others. This implicitly promoted the utilization of long-lasting contraceptive methods and an extended distribution of barrier and oral contraceptives via community health promoters. During 1994-1996, the former goals were maintained but an emphasis was put on quality of care (i.e. utilization of installed capacity, cost-effectiveness analysis, recovery cost and patient permanence in the program). This double message was observed in all the project levels.

During 1996 the first cost studies were done to implement a costing system. The recovery cost ranged from 17% to 21.4% (PLANFAMI) and from 41% to 47.8% (PLANIFAM) at the central clinics, but were 0% (PLANFAMI) and from 3.6% to 13.1% (PLANIFAM) for the rural and rotating services. Interviewed personnel didn't know about these studies therefore it shouldn't surprise us if they were not used for

decision making at the local level. Moreover, no activities were done to transfer technical skills to PVO's personnel. It is a highly positive issue the generation of a culture of costing. It should be clearly stated that changes on the organizational culture are a long-term process. And these changes are easier to be done at smaller institutions as the PVOs. Therefore, the cost studies and the costing system should be considered as the first steps of this process.

Based on the Amendment 4, the utilization of installed capacity (UIC) should be a minimum of 70%. Cost studies at Puno and Cusco showed that UIC was 35.2% in average (51.5% in the peak month) and 14.7% (23.7% in the peak month), respectively. PRISMA - Trujillo self-reported an increase on UIC between January 1996 and May 1997, from 40% to 80%. No data was given from INPPARES. The low utilization of installed capacity, low rate of recovery cost added to the percentage of extremely poor and poor in rural areas, make practically unsustainable this project in the short and long term. Paradoxically, the population in rural areas is the greater in need on health and reproductive health.

The lack of utilization of the information about recovery cost and utilization of installed capacity, added to the implemented strategies make the project and institutions practically unsustainable, in the short and long term. The new project must develop strategies to achieve better indexes. Moreover, in the context of the Health Sector Reform, PVO's health provision should be more competitive than the ones of the Ministry of Health on quality of care and accessibility (economic, geographic and cultural).

Finally, it is necessary to define a target population per health facility and cultural characteristics of each area (differences between urban and rural, and between coast, Andean and jungle areas) in order to do a more in-depth analysis. These factors maybe influencing on the number of activities expected and the degree of acceptability and accessibility.

QUALITY OF CARE ON FAMILY PLANNING SERVICES

Patient interviews, observation of provider-user interaction and tests of knowledge to providers were done. To assess quality of care we used the six elements proposed by Judith Bruce and a seventh one proposed by PAHO.

The professionals had an acceptable level of knowledge, however, some deficiencies can be overcome if a permanent education system is implemented, not only based on formal courses but on more creative methods such as self-education manuals and periodic evaluation. These deficiencies may be associated with personnel re-exchange.

Generally, the professionals' mistakes are related to medical concepts. Patients referred "I want tubal ligation, but the doctor says that I can't because I had cesarean section", "I want injections but the doctor says that it can cause infertility and because I have only one child, he suggested another method", "if while you use a condom it bothers, put some grease". Midwives are better up-dated than physician on counseling issues. They obtained the highest score on anatomical issues, at the other hand, auxiliaries and promoters need reinforcements on these issues.

Despite the courses on asepsis, their practices on sterilization and asepsis preservation are not adequate at peripheral or itinerant consultation. The providers' ability to bring and to collect information is quite good, although there is a need to improve on what the users should know previously to the examination and medical procedure, in order to avoid fears and discomfort.

The consulting rooms allowed adequate privacy (never more than two persons, physician, nurse or midwife), also the users perceived this as valuable. However, there is a need for privacy in reception, where the patients are asked about the reasons for consultation and obstetric & gynecologic history.

Consulting rooms' implementation is adequate. In few cases it is necessary to improve some aspects on asepsis (i.e. there are no boxes to keep and transport IUD medical

equipment) In consulting rooms at local communities or at houses we observed a need for portable washbasins and sterile camps, among others

It was observed a cordial and affective relationship to users, allowing them to express some of their doubts and fears. Users consider ideal that family planning providers are women (midwives or nurses). However when patients health needs are different from family planning they preferred to be treated by a physician

Better communication was observed when the provider speaks the local language (quechua or aymara). At the other and, the relation may be considered is a bit paternal, where the providers used terms such as "hijita", "mamita", "cholita", "gordita" and the users talk to providers more formal way. However, this type of relationship and the used terms are not out of the local context

Several strategies have been implemented to include new users and keep them up. Some of them are not sustainable (i.e. PLANFAMI followed up patients providing them with pills or inserting IUDs at their houses). All the PVOs make rotating consultations at the communities and peri-urban areas of influence. These strategies are used to motivate and to promote their health services. However, if these strategies are to be permanent, they will be quite expensive and unsustainable

The variety of services offered by the PVOs is not too broad, because they mainly work on family planning and are recognized by the communities like that. However, diversification of services has occurred to other areas of reproductive health and in a lesser extent to other health areas

The patients' time required to arrive to a facility are less than thirty minutes, in average, which is perceived by the users as a benefit, this suggests that the 'extension of use' is an indicator to be aware of. Also waiting time is less than half an hour, which can be related to the low demand for health services. Both are perceived as extra benefits compared with other health facilities

Counseling prior to consultation is institutionalized, however bi-directional information as superficial in some issues. It seems to be inadequate knowledge of

users' needs, their knowledge, myths and beliefs that may influence on issues such as contraception and family planning. Counseling information is generally based on the provider's memory, usually adverse effects of contraceptives are not mentioned, as well as the attitude of patient's partner towards family planning and contraception.

The information about the chosen method is more detailed and complete, despite the fact that there is no established order on the given information. There is also no checklist that can guarantee completeness of information of the chosen method, neither it is verified if the patient knows how to use it. Moreover, patients are not assessed on their reproductive risk and its relation with the contraceptive effectiveness and safety.

The users showed deficiencies on their knowledge about symptoms and signs that they have to be aware of. Sexually Transmitted Diseases (STDs) are not an issue during consultation, unless the patient refers a symptom. Moreover, although the interviewed patients knew about STDs as existing diseases, they didn't know their symptoms.

CULTURAL AND GENDER ISSUES

The project focused explicitly on low-income male and female population, offering them a wide variety of contraceptive methods including the natural ones in order to satisfy their health needs and expectations. The work on rural areas has difficulties, some of them are related to population dispersion, percentage of extremely poor and a different culture.

Fieldwork teams invested a great effort to relate adequately with the communities via mobile health provision focusing on reproductive health, information and educational activities. The strategies directed to involve the community have been different according to each PVO's development and its context. Despite these most of them

are recognized by the population as the first institutions on dissemination and provision of family planning services

During the evaluation some PVOs have planned to diversify their family planning services into a broader perspective on reproductive health and other health services. In some cases, they have achieved successfully a compromised team of voluntary community health promoters

Promoters' participation have mainly focused on the supply, dissemination and promotion of family planning services, without taking into account that in them occurred a synthesis of western medicine and the cosmovision of their own traditional culture. There is a need to assess the mechanisms to motivate and recognize the effort of voluntary community promoters, in order to diminish their desertion and to improve their quality of work

At the other hand, it seems to be no purpose to encourage community empowerment and to allow promoters' participation on the design of the operational plans at the local and institutional level. The project instability due to the lack of finance continuity might have affected the work in some communities where PVOs invested some efforts and generated some expectations that they couldn't satisfy

During the project implementation, qualitative research were done to generate a better understanding of cultural, social and gender issues that affect the reproductive health of the population, both men and women. These studies targeted on the need to understand the different cosmovision and cultures, and to build communicational bridges focusing on the native languages. The qualitative research as well as ENSAMIR II showed problems on gender relations, most of them are violent a notion that a husband "can use his woman", and have sexual intercourse against her will. Women in union may be censured if she doesn't perform her "wife obligations". Sexual violation and abortion are also referred in these studies. The qualitative research also reported that many women and their partners preferred to use natural methods

Despite the valuable information available, we found that the field team and some directors have not internalized these findings or couldn't implement a conceptual and methodological gender framework, integrating the cultural dimensions. As well as the other research results, the lack of personnel knowledge may be related to its re-exchange.

Few PVOs have developed important dissemination activities to teachers and school students. This strategy may be highly positive in the long run favoring changes in attitudes among the youth.