

BIBLIOGRAPHIC DATA SHEET

1. CONTROL NUMBER
PN-AAH-626

2. SUBJECT CLASSIFICATION (695)
PC00-0000-G356

3. TITLE AND SUBTITLE (240)

Management assistance to the Asociacion Pro-Bienestar de la Familia

4. PERSONAL AUTHORS (100)

Bernhart, M. H.

5. CORPORATE AUTHORS (101)

Am. Public Health Assn.

6. DOCUMENT DATE (110)

1979

7. NUMBER OF PAGES (120)

24p.

8. ARC NUMBER (170)

GT301.32.B527

9. REFERENCE ORGANIZATION (130)

APHA

10. SUPPLEMENTARY NOTES (500)

11. ABSTRACT (950)

12. DESCRIPTORS (920)

Organization development
Management
Family planning
Decentralization
Guatemala

13. PROJECT NUMBER (150)

932087700

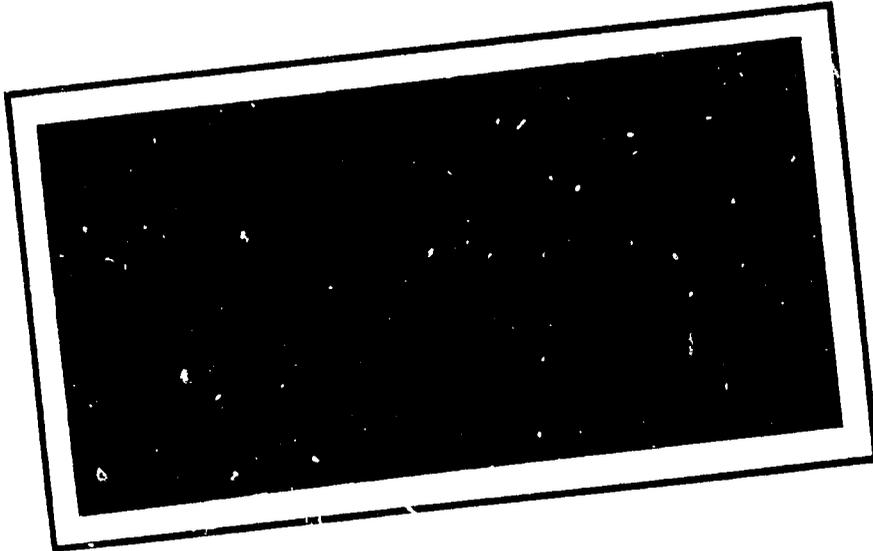
14. CONTRACT NO.(140)

AID/pha-C-1100

15. CONTRACT TYPE (140)

GTS

16. TYPE OF DOCUMENT (160)



AMERICAN PUBLIC HEALTH ASSOCIATION
International Health Programs
1015 Fifteenth Street, N.W.
Washington, D.C. 20005

MANAGEMENT ASSISTANCE TO THE
ASOCIACION PRO-BIENESTAR DE LA FAMILIA

A Report Prepared By:
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During The Period:
OCTOBER 14-20, 1979

Under The Auspices Of The:
AMERICAN PUBLIC HEALTH ASSOCIATION

Supported By The:
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT
OFFICE OF POPULATION, AID/pha/C-1100

Agency for International Development
Library
Room 105 SA-18
Washington, D.C. 20523

AUTHORIZATION:
Ltr. POP/FPS: 9/3/79
Assgn. No. 1100-177

Development Information Center
Bureau for Development Support
Agency for International Development
Washington, D.C. 20523

PREFACE

For five years it has been the consultant's unparalleled professional joy to work with APROFAM. The accolades delivered in person to that group of dedicated, intelligent people cannot be improved upon here. Thanks to Scott Edmonds of USAID/Guatemala and the APHA/International Staff for facilitating an enjoyable and useful trip.

Michael H. Bernhart, Ph.D.
Asst. Professor of Management
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EXECUTIVE SUMMARY

The consultant visited APROFAM to assist in the regionalization of the Association. This restructuring, begun early this year, is intended to facilitate a more cost-effective provision of expanded family planning services throughout Guatemala. Decentralization of operational responsibility to four regions entails the development of new systems and definition of new relationships. The following administrative systems were modified for the regions: budget planning, environmental analysis, logistics, performance evaluation/service statistics, payments, incentives, and planning. Examples of forms and procedures were left with APROFAM personnel for budget preparation and control and performance evaluation.

The chief thrust of these systems is to provide regional personnel with simple and effective mechanisms for program implementation and control. The results of the pilot region in the southwest of the country were studied and key personnel were briefed on the problems and issues perceived by the consultant.

Recommendations are directed at the steps needed to establish the three additional regions in March 1980.

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I. INTRODUCTION AND BACKGROUND

A. Purpose of the Assignment

The purpose of this assignment was to provide technical assistance to the Asociacion Pro-Bienestar de la Familia de Guatemala (APROFAM) in the ongoing restructuring of that organization and the regionalization of its activities within Guatemala. Specifically, the consultant was requested to study the pilot region in the regionalization program and to assist APROFAM personnel who would be implementing regionalization.

B. Itinerary

The consultant visited the Asociacion on the dates of October 15 through October 20, 1979. One day was spent in Coatepeque, the seat of the pilot region; the remaining days were spent with central office staff in Guatemala City.

C. Background of the Project

APROFAM's pioneering efforts in family planning in Guatemala go back fourteen years to 1965. Although the Ministry of Health has, during some of those fourteen years, also offered family planning services, the inconsistency of the government's attitude regarding family planning has made the Ministry an uncertain ally in efforts to extend contraceptive protection throughout the country. Either the government has been unable or unwilling on occasion to provide contraceptive protection to couples that have no other access to the service. As a consequence, this has left a lacuna in coverage which the private association, APROFAM, has moved in to fill.

Uncertainty regarding the role that the Ministry was playing or would play in the immediate future has often prevented APROFAM from developing a national strategy for providing contraceptive protection. On the one hand, APROFAM has not always been able to determine, with any precision, the acceptable boundaries of its own activities in a national program and, on the other hand, international donors have clung to the often forlorn hope that the Ministry would adopt a more vigorous role in the provision of contraceptive service. This has led to a situation in 1979 where perhaps a majority of Guatemalan couples do not enjoy ready access to family planning services, and the private association has developed its independent delivery capability largely in the capital city; projects and programs outside of the Capital either depended upon the active involvement of the Ministry or, where they were exclusively APROFAM projects, tended to be small and somewhat experimental in nature. It thus became incumbent upon the private association to develop a national strategy with an eye to consolidating those small projects and programs already in place outside of Guatemala City and to develop the base for expanding contraceptive coverage in as many areas of the country as political feasibility and resources permitted.

This task is greatly complicated by the vicissitudes of Guatemalan politics, the transient priorities of major international donors, and the physical and personnel resource limitations of the Asociacion. These constraints must be added to the peculiar nature of Guatemalan society, which is remarkable more

for its heterogeneity than for any other characteristic. Variations in terrain, ethnography, and language demand not one but an arsenal of operational strategies to increase user acceptance of contraceptives and provide easy access to services. This great heterogeneity, more than any other factor, argues strongly for a regional organization of services as opposed to centralized organization.

Against this spectrum of problems and obstacles is arrayed the quality and dynamism of APROFAM's personnel. The consultant has, on several previous occasions, asserted that APROFAM is the best led, most dynamic family planning program in Central America. This positive endorsement was corroborated by a recent AID-requested assessment of the bilateral population program in Guatemala. The second bright spot in the panorama is the timeliness and extent of the support provided by the USAID mission to APROFAM in meeting both its resource as well as political problems.

1. Regionalization

The absence of a regional structure has given rise to a variety of small problems. First, there is the cost and inconvenience of running a program from the capital city in a country as large as Guatemala. Second, the projects and programs that exist outside of the capital operate largely in isolation from one another. The coordinating mechanisms in place often fail to provide the synergy that one would hope for in a program of this type. Third, the distance between projects and their complexity has led, on occasion, to sporadic supervision, and the structure of the organization - by project - can easily give rise to rivalry between projects. Consequently, it is to be hoped that regional organization will overcome the previously observed tendency to fragmentation of projects and to duplication of effort in the field. Additionally, it is anticipated that a regional organization will allow a better fit between programs and opportunities in each area of the country.

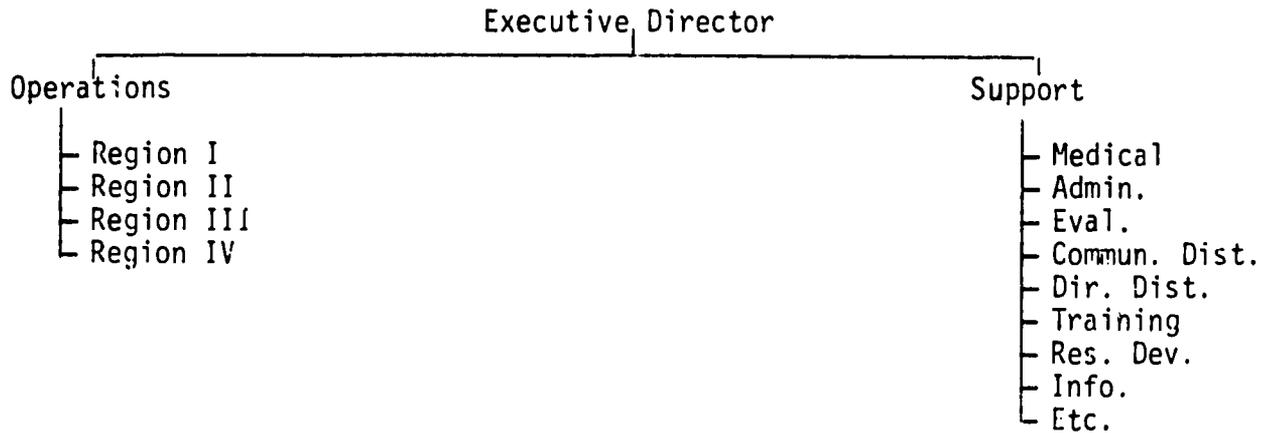
There are some practical problems to be overcome in regionalizing an organization such as APROFAM. First, and common to most social service organizations in the developing world, regionalization or decentralization shifts the administrative load on to those least prepared to bear it. Secondly, decentralization can decrease control over policy-sensitive issues; this, of course, is a major concern in a political environment as unstable as that found in Guatemala. Third, as in any change, new relationships must be forged, which creates uncertainty, and the existence of an entrenched system leads to a tendency, not pronounced in APROFAM, to protect existing turf. Finally, it might be feared that the government would view the regionalization of the provision of services by APROFAM as a major effort on the part of the Asociacion to preempt family planning activities in Guatemala; this could provide yet another excuse for the traditional foes of family planning to attack the program. In a conceptual sense, the most difficult of these practical issues is how to maintain close policy control at the central level yet give sufficient autonomy to regional directors so that they can consolidate and execute programs at the operational level.

2. Previous Work

The consultant has been involved in previous work on the management and structure of the organization. However, only during the past eighteen months has it become clear to the consultant that perhaps a regional structure would be the best response to the emergent demands upon APROFAM; consequently, some initial work has taken place to ease the transition from centralized to regionalized organization.

In December of 1978, it was proposed that four criteria be employed to define the regions through which the program would operate. First, it was deemed desirable to incorporate only complete departments (analogous to states or provinces) within a region. This was to facilitate communication and interaction between health and public officials with departmental responsibilities. Second, it is certainly appropriate that ethnic and linguistic homogeneity be maximized within any one region in that information and motivation programs would be strongly influenced by this factor. Third, it was contemplated that similar potential, receptivity, and problems for the introduction of family planning would coexist in a region. And fourth, where possible, that transportation facilities would provide easy movement to all areas of the region. The first attempt to apply these criteria resulted in the creation of six regions. The personnel resources of the association, as well as the potential for funding regional sites, made this an unrealistic number of regions, and the total was subsequently reduced to four.

To deal with the problems of maintaining centralized policy control while granting local operational autonomy, it was decided very early on to ask current program directors to perform the dual function of regional direction and program direction. There are some obvious problems with this type of dual assignment: most notably, it asks an individual to play two roles, that of line manager as well as staff on almost alternate days and confusion between the two roles can have unfortunate results at the operating level. Weighing heavily against this disadvantage is close control on policy; only the program directors were judged to be intimately in tune with the political realities of the environment as well as the policies of the organization. It might also be observed in passing that this double assignment allows the association to side-step the tricky personnel issue of stripping authority from those individuals who presently occupy the posts of program directors; in point of fact, their authority is slightly enhanced by the change. Given that the director of each region could not dedicate full time to the operational problems within the region, it was further decided to name a sub-director within each region. The sub-director would live at the regional site and would handle the daily supervision and administration of the programs within the region. The resulting organizational structure, when reduced to an organization chart, looks something as follows.



One further post was created, a post that has long been lobbied for by different donors, which is that of programmer. The job of programmer is to mediate between the regional directors and the programs in order to facilitate the orderly and equitable distribution of programmatic resources among the regions. It was not contemplated that resource allocation would lead to conflict due to the necessity for program directors to aid one another in order to receive resources in their own regions and because of the history of harmonious teamwork within the association among the same individuals. Nevertheless, a programmer was thought desirable to facilitate, if only in a mechanical sense, the orderly planning of resource utilization throughout the association.

Logic as well as resource limitations dictated that a pilot project be employed first to provide organizational learning to the association and the southwestern area of the country, with Coatepeque as its regional seat, was selected. The six departments comprising the area are San Marcos, Retalhuleu, Quetzaltenango, Totonicapan, Solola, and Suchitepequez. Pre-regionalization activity in the area includes some community distribution projects, a mobile sterilization unit, a clinic and direct distribution of contraceptives to those Ministry of Health clinics still participating in the national family planning program. The Medical Director was selected to head up this region because of his stature within the organization and his prestige in the family planning/medical community in the country. In June and July, an ambitious inventory of the region was conducted by the Medical Director and the Programmer (see Appendix B for a listing of the factors inventoried in the region). Efforts were begun to recruit a sub-director for the region and at the time of the consultant's visit, interviewing of candidates for that position was well advanced. Work plans for new activities in the region had also been developed in a previous consulting visit, but it was not contemplated that any action would be taken to initiate new projects within the region until existing ones have been consolidated.

II. OBSERVATIONS AND ACTIVITIES

During this consulting visit, special attention was given to development of administrative systems. As noted above, a primary concern in the process of decentralization is the presumed lesser capacity of regional offices to support sophisticated administrative systems, thus the need to design administrative procedures that do not require formal preparation as an accountant, administrator, etc., yet provide sufficient operating control to regional staff. Each system is discussed below.

A. Budget

Family planning programs seem to develop elaborate budget and control systems, owing perhaps to the differing reporting requirements of various funders and their rules concerning reassignment across line items, the repeatedly demonstrated irreality of auditor recommendations (Price-Waterhouse of Guatemala proposed depreciation reserves and complex expensing procedures for donated assets), and the expectation by program staff that actual control grows in proportion to the cross-checks, authorizing signatures, and forms required by the system. One may dismantle this edifice with little concern for violence done to fiscal morality; creating its replacement then becomes a simple matter.

The first task is to separate reporting from control requirements. The former are dictated by the donors, the latter by reason. Reporting must be centralized, control decentralized, and this, combined with the differing administrative sophistication found at the regional and central levels, leads to two different systems. It was determined that regional managers would utilize only five line items which would contain all of the direct and controllable (e.g., fringe benefits do not appear as they are a function of other decisions and not independently controllable) costs incurrable in the regions. The charging of costs against a given project would be done at the central level - normally a pro rata share would be charged against each project. The regional people need only keep track of total amounts of funds available. The requirements to utilize one donor's/project's resources only for specified activities is simple in concept and impossible in practice. Consolidation of projects requires that the distinction between funding sources be somewhat blurred or the fact that a vehicle is filled with IPPF-purchased gasoline would preclude its being used in support of a Pathfinder Fund project until the appropriate ledger corrections had been made.

The five line items are salaries, per diem, transport, contracted services (payments to private MDs and nurses for sterilizations performed), and general expenses. This last item does not open the door to loss of control as might be feared: general expenses are comparatively small - 7 percent of the total pilot region budget - and restricted in use; almost half will go to rental of the clinic (see Appendix C).

It is no secret that underspending a budget is nearly as egregious a crime as exceeding it in donor-supported programs. Thus, the presentation of variances to facilitate complete absorption of available monies becomes of

major importance. Commonly, managers are presented figures on unspent monies for the budgeting period (a year) and must then determine if they should accelerate or reduce expenditures; such a determination requires a straight-forward mixture of sense and arithmetic - not a taxing exercise - but it is an additional step which might deter some managers whose chief concerns (and formal preparation) are not administrative. Thus, it was decided to progressively accumulate variances in the regional budgets and adjust a month's budget for over- or underspending in previous months. For example, if a director overspends on per diem by \$400 in January, that amount is deducted from February's budget for that line item. Obviously, the director does not need to absorb the entire over-run in February; the residual deficit is mechanically and simply carried forward (see Appendix D).

B. Payments

All payments are presently made from the central offices of the Association. It has been recommended that any expenses contemplated in regional budgets be made by the regional office; to not do so violates the logic of a regional budget. The mechanism would be for regional sub-directors to prepare checks for the signature of the regional director. (The administrator is aware of the needed change to the appropriate internal regulations.) As always, the director can not sign his or her own pay or per diem checks; these will continue to come from the central office.

At the end of each month all paid invoices, requests for payment, and carbon copies of issued checks would be sent to the central office for assignment of charges to various projects and donor accounts. Once the region's monthly account has been closed by central accounting, a deposit would be made to the region's checking account to restore its balance to an amount equal to two months' budget.

Petty cash would be used for purchases and expenses in the amount of \$15 or less - from a rotating fund of \$100 to be closed weekly.

C. Performance Statistics

Family planning programs, among social service programs, enjoy the rare luxury of easy performance evaluation. The widely accepted relation between fertility levels and contraceptive use permits a family planning program to assess its effectiveness on the basis of currently active enrollees. Some minor practical problems in determining the currently active couples (particularly with regard to IUD users) has encouraged development of proxy measures based on the extent of contraceptive protection. Recourse to measures of couple-years (or months) of protection also facilitates comparison between different methods and delivery systems within a program once the relative protection of each contraceptive method has been agreed upon. Protection equivalents, their derivation, and methods for improving their accuracy are presented in Appendix E.

Program performance takes on meaning when compared to a standard; conventionally we assess a program's effectiveness by observing the ratio between

results and objectives. Unhappily, "objectives" has become an overworked device in recent times. It has been supposed that the presence of objectives enhances organizational clarity, taps new wellsprings of human motivation, and puts accountability into program review. Program officials might also add that talk of objectives is pleasing to donor ears. The realism of program objectives has moved inversely to the interest and hype devoted to them. Rather than redefine the term, it appeared most expedient to supplant it with another, less-abused term; we selected "expectations" for two reasons: first, there seemed to be little need to motivate APROFAM personnel to strive harder (if, in fact, difficult objectives motivate); three of the top six program officials have already collapsed from overwork and been carted from their offices on stretchers (an interesting performance statistic in itself). Second, objectives were usually set with an eye only to what was possible if everything went right. Expectations include a more sober appraisal of what might go wrong; in Guatemala much can go wrong.

Complementing measures of effectiveness are those of efficiency. The latter is the ratio of program inputs (normally money) to program outputs (here couple-months of protection). Again, comparisons between methods and delivery modes are facilitated by the presence of a common denominator (couple-months of protection).

D. Logistics

APROFAM's logistics system is unique in several regards - the foremost of which is that it works quite well. Additionally, the same system serves as the supervisory system for family planning in Ministry of Health clinics, the service statistics system, the financial control and collection system for contraceptive sales, and the accounting, purchasing, and distribution system for special family planning-related products purchased by Ministry clinics. Centralization has facilitated the performance of plural functions but has also led to excessive travel time for the detailmen who operate in the field. It was ultimately determined that a more productive arrangement could be worked out if the detailmen were to move to regional sites and support operational units from there. The resultant savings in travel time permits the initiation of supply to private physicians and pharmacies - a hitherto underexploited extension of access points for contraceptive service and supplies.

The basic working structure of the logistics system is quite simple. An estimated two month's supply of contraceptives will be maintained at the regional level and resupplied on a monthly basis. The detailman will work out his program of visits with the director and sub-director and, as in the past, will collect service statistics, monies from contraceptive sales, and will supervise (read motivate) and resupply clinics and other distribution points. The only change worth remarking is in the handling of the 40 percent. This figure refers to that portion of the income from contraceptive sales that becomes available to the Ministry of Health (MOH) clinic or area that produced the sale. APROFAM maintains an accounting of the sales of each MOH unit participating in the contraceptive distribution program; MOH clinics or areas (which of the two depends upon decisions made by the Area Chiefs) may then "purchase" family planning-related equipment from a prepared list in amounts

up to 40 percent of the total sales. Unspent monies are carried forward for future use by the clinic or area. Requests for purchases trickle in from the field; note that as many as 500 clinics have participated in the distribution program which can generate a formidable number of requests to an already overburdened purchasing system. The resulting overload translates into slow response times which, in turn, produces frustration in the operating units and whatever goodwill APROFAM might glean from the practice is comprised. Consequently, it has been proposed that the "40 percent" requests be processed in a batch.

On the twentieth of the month all participating units are advised of the status of their accounts and provided a list of authorized supplies and estimated prices (estimated as all APROFAM purchases require at least three quotations and prices change continually). Units wishing equipment or supplies notify the regional office by the first of the following month at which time all requests are sent to the Direct Distribution (DD) office in Guatemala City. DD checks that the requests are within available monies for each unit and emits a purchase request which then follows the normal procedures already established. Upon purchase of the requested supplies, a copy of the executed purchase request is sent to DD; this performs two functions: it notifies DD that the materials are in the warehouse and available for dispatching, and it also informs DD of the exact purchase price so that the accounts of each unit may be correctly charged. At this point, the twentieth of the month is inevitably at hand and a new status of accounts form is prepared and sent to the regions.

E. Incentives

The incentive system, if such formally exists, requires modification to accommodate the regional structure. One of the benefits expected from regionalization is reduced travel and per diem costs for supervisors, detailmen and promoters. This saving to the organization will also be a reduction in income to the individuals who have previously done considerable travel, and as a consequence, may well ask from where the compensating income will come. It appears, however, that the recipients of per diem are the victims of a "money illusion." In comparing per diem levels paid by the Asociacion with costs of food and lodging in the field, it seems unlikely that even the most frugal individual could realize discretionary income from this source. Nevertheless, the perception that these per diem checks represent additional wealth is widespread in the Asociacion and will have to be dealt with; late recognition of this problem and an already full agenda prevented the consultant from dealing with this issue during the visit.

A second incentive/motivation issue must be addressed, and that concerns the setting of targets for sterilization. Cost effective utilization of the mobile sterilization units requires that ten volunteers be available for the operation to justify travel to remote sites. These targets were misinterpreted as quotas by some governmental officials in June; the resulting flap saw a severe reduction in the number of MOH clinics providing family planning services. Thus, good management became bad politics. The logical resolution to this problem lies in discretion when dealing with targets; however, this may not be adequate to prevent future misunderstanding. Consequently, it is well to reconsider the

advisability of the ten operation minimum under the regional arrangement. Noting that the mobil unit will travel shorter distances and closer contact will be maintained between the regional direction and field promoters, it may be possible to program two sites a day or to bring volunteers from other villages. At a minimum, these options should be actively considered from the outset of regional activities.

A third, and chronic, incentive problem is that posed by providing equitable supplies to all distribution points. The detailmen receive a small commission on contraceptive sales which leads them to give priority to high volume sites. Sincere efforts at the central level to alleviate this problem have been impeded (although generally successful) by the fact that requests for resupply must often move hierarchically and then laterally to another program director. Consolidation of all operational supervision at the regional level should do much to improve the responsiveness of the supply system and the scheduling of resupply visits.

F. Planning

Given that coordinated implementation of activities is facilitated by integration at the regional level, detailed planning becomes a more realistic activity. It may also be noted that the Asociacion is in possession of increasingly sophisticated information (Prevalence Survey, Environmental Analysis) to support the planning process. At the present stage of planning for the pilot region, increased emphasis needs to be given planning for coverage. As an example of this need, note Appendix F, which illustrates the need to anticipate possible undercoverage problems in Coatepeque.

III. RECOMMENDATIONS

The first region - although there are currently activities on site - will not be fully operational until January 1980. Funds will be available to open three more regions two months later in March. Time, obviously, is short for the number of activities that need to be accomplished.

1. Final determination should be made of the composition of the three new regions.
2. Directors for each should be formally notified.
3. Sub-directors for each should be identified.
4. The environmental analysis of each region should be conducted by the Regional Director, Sub-director, and Programmer.
5. A work program consolidating current activities and projecting new ones needs to be developed for each region.
6. Likewise a budget.
7. Decisions on assignment and transfer of personnel will have to be made and individuals notified.
8. Reporting forms for the consolidated service statistics system need to be created.
9. Clinic space should be negotiated in each region and furnishings ordered.
10. For those sub-directors that are new hires, an orientation program will have to be conducted. The simplest might be a week with Direct Distribution, another with Community Distribution, a third with the Mobile Unit, and a final week with Administration and Accounting.

APPENDIX A

Individuals Contacted

APROFAM

Roberto Santiso G.
Executive Director

Luis Galich
Medical Director

Victor Hugo Fernandez
Administrative Director

Ma. Antonietta Pineda
Evaluation Director

Rolando Sanchez
Director Distribution Director

Sara C. de Molina
Community Distribution Director

Enrique Soto
Information Director

Rebeca de Montalvan
Education Director

Antonio de Leon
Programmer

Cesar Aguirre
Administrator, Consolidadas Program

Julio Suarez S.
Asst. Director, CBD

Marco Antonio Celada
Physician, Coatepeque Clinic

Colomba de Escobar
Receptionist, Coatepeque Clinic

Yolanda de Valdez
Auxiliary Nurse, Coatepeque Clinic

Antonio Barrios
Watchman, Coatepeque Clinic

James Mondloch
Director, Indian Community Project

USAID/Guatemala

Scott Edmonds

APPENDIX B

List of Items in Environmental Inventory of Region

A. Demographic Aspects

Total population
Seasonal population variation (number of migrants)
Women of fertile age
Average income per capita
Percent population in urban areas
Percent population literate
Number of towns 1,000-5,000 inhabitants
Number of towns 5,000-25,000 inhabitants
Number of towns 25,000+ inhabitants
Linguistic composition
 Language/percent population that speaks it

B. Current APROFAM Activities

Sterilizations
 Sites/number laparoscopies per month/number vasectomies per month
MOH clinics
 Number collaborating clinics
 Number users in direct distribution
 Number users/clinic (average for region)
Community distribution
 Description of programs
 Number of distributors
 Number of active users

C. Private Sector Family Planning Activities

Private hospitals offering family planning
 Estimated number of users
Private clinics offering family planning
 Estimated number of users
Number physicians providing family planning
Other private programs
Number pharmacies offering contraceptives
 Estimated volume/month

D. Summary of Population Contracepting

E. Opposition to Family Planning

Names and positions of opponents to:
 Birth control
 Non-"natural" methods
 Sterilization
 Use of paramedical personnel
 Community distribution
 Commerical distribution

List of Items in Environmental Inventory of Region (Continued)

- F. Posture of Influential Institutions and Individuals - by position, attitude, probable sphere of influence
Government
Church
Medical community
Press/media
- G. Summary of Attitudes of Influential Elements in Region and Implications for Nature and Extent of APROFAM Programs
- H. Popular Attitudes
Ethnic differences
Special preoccupations or concerns
Differential receptivity by method
Differential receptivity by purveyor
Number and percent of couples uninformed regarding family planning
Number and percent not contracepting due to access limitation
- I. Media
Newspapers
Radio stations (and language)
Other (popular theatre, cinema, etc.)
- J. Summary of Needs, Obstacles and Potential
- K. Proposed Programs
1. Central clinic (site)
Women fertile age in that town
Women fertile age one hour by public transport
Summary of attitudes of government, church, physicians in this city to family planning
Evidence of demand for sterilization in this town
2. Hospitals and clinics offering sterilization
3. MOH facilities
Number clinics
Number health posts
Number women utilizing above
Note "problem" areas and clinics
4. Community distribution
Other social programs, possible collaboration
Number fincas and their receptivity to family planning
Association that might support family planning
5. Commercial distribution
Number of pharmacies
Number that would accept 15¢ margin

List of Items in Environmental Inventory of Region (Continued)

L. Goals (First Year)

- Number female sterilizations
- Number male sterilizations
- Number users in MOH facilities
- Number distributors (CBD)
- Number users (CBD)
- Number participating pharmacies
- Number users via pharmacies

M. Resources Required

- Medical
- Nursing
- Supervisory
- Promotion/Motivation
- Detailmen
- Publicity

APPENDIX C

Desglose-Presupuesto Preliminar '80

Región Sur-Occidental

Salarios	<u>Programa Consolidado (Con)</u>	
	Médico-Laparoscopista	\$ 7,200
	Enfermera Graduada	3,300
	2 Enf. Aux. (TP)* 2 x \$1,500	3,000
	Cito-Tecnólogo (TP)	1,800
	Supervisora de Promotores	3,300
	5 Promotores	13,500
	Médico-Laparoscopista (Unidad Movil)	8,400
	Enfermera Graduada (Unidad Movil)	3,000
	Sub-Director	4,800
	Secretaria	2,160
	Guardian	1,800
	<u>Programa Distribución Directa (DD)</u>	
	Visitador Médico	3,600
	<u>Distribución Comunitaria (DCA)</u>	
	2 Promotores	3,864
		<u>\$59,724</u>
Transporte	<u>Con</u>	
	Alquiler de Vehículo	\$ 7,380
	Gasolina	2,400
	Transporte, Pacientes**	600
	<u>DD</u>	
	Gasolina (\$80/semana)	3,840
	Mantenimiento y reparaciones (\$75/mes)	900
	<u>DCA</u>	
	Transporte	840
		<u>\$15,960</u>

*TP - tiempo parcial

**Primera sexta (1/6) parte del presupuesto total de esta actividad

Viaticos	<u>Con</u>	
	5 Promotores	\$ 3,000
	Supervisor	1,800
	Personel Unidad Movil (\$200 x 12)	2,400
	<u>DD</u>	
	Visitador Medico (\$18 x 10 dias x 12 meses)	2,160
	<u>DCA</u>	
	Promotores	1,440
		<u>\$ 10,800</u>
Servicios Profesionales	<u>Con</u>	
	Medicos	\$ 10,800
	Enfermeras	1,800
	Alquiler de Clinicas	12,000
		<u>\$ 24,600</u>
General	<u>Con</u>	
	Alquiler	\$ 3,600
	Servicios de agua, luz, etc.	1,200
	Suministros de Oficina*	500
	Alimentos, Pacientes*	500
	Suministros, Mantenimiento y Limpieza	900
	Medicinas	1,200
	<u>DD</u>	
	Telegramas	60
	Papelería, Mostradores, etc.	1,000
	Miscelanea	100
	<u>DCA</u>	
	Gastos generales	983
		<u>\$ 10,043</u>
	TOTAL	<u>\$121,127</u>

*Primera sexta (1/6) parte del presupuesto total de esta actividad

APPENDIX D

PRESUPUESTO REGIONAL (EJEMPLO)

	<u>Enero</u>			<u>Febrero</u>			<u>Marzo</u>		
	<u>Pres.</u>	<u>Gast.</u>	<u>Var.</u>	<u>Pres.</u>	<u>Gast.</u>	<u>Var.</u>	<u>Pres.</u>	<u>Gast.</u>	<u>Var.</u> .
Salarios	2000	2000	-	2000	2000	-	2000		
Viáticos	800	650	150	1350	1020	330	1430*		
Transporte	400	640	(240)	260	450	(190)	610*		
Serv. Prof.	1000	800	200	1200	1050	150	1150		
Gen'l.	<u>500</u>	<u>650</u>	<u>(150)</u>	<u>350</u>	<u>450</u>	<u>(100)</u>	<u>400</u>		
	4700	4740	(40)	5160	4970	290	5400		

*Reasignación de Q.300 de Viáticos a Transporte. Vea Memo 80-103.

APPENDIX E

Cálculo de Meses de Protección de Pareja

La evaluación de un programa de planificación familiar tiene sus raíces en los objetivos y fines del programa. Como denominador común, se nota que la gran mayoría de los programas contempla como objetivo la provisión de protección contra embarazos no deseados. Por consiguiente, una medida que refleja el alcance de dicha protección es una valiosa ayuda en la evaluación del programa.

Meses de Protección de Parejas (MPP)

Una dificultad siempre ha sido la comparación de las contribuciones de diferentes métodos de anticoncepción. La utilización de MPP facilita estas comparaciones porque se mide el impacto de los diversos métodos y no solo sus incidencias. Para hacer esto, hay que identificar la protección de cada aplicación de un método. Por ejemplo, para calcular la protección de un ciclo de anticonceptivos orales se observa que cada ciclo cubre 28 días o .92 de un mes ($365/12 \times 28 = .9205$). Luego, hay una tasa de fallo de método. La efectividad teórica de la pastilla es alta (0.34 embarazos por 100 años-mujer); sin embargo, en la práctica se estima una tasa de efectividad menor por razones de mal uso por clientes. Contraceptive Technology, 8th ed., recomienda una tasa de falla de 5-10 embarazos por 100 años-mujer, que convierte en una valorización final de .85 mes de protección (5 embarazos = $.95 \times .92 = .874$; 10 embarazos = $.90 \times .92 = .828$ — el promedio de las dos cifras sale en .856).

Es fácil de averiguar la protección brindada por esterilización. La fórmula es la multiplicación del número de años de fecundidad que queda a la operada por doce. Es conveniente considerar que la edad de menopausa promedio es 45. Por consiguiente, si una operada tiene 32 años de edad, la contribución a MPP sería 156 ($(45-32) \times 12$). En el caso de hombres esterilizados, la presunción más conservadora es de asignarles una tasa de protección que corresponde a la vida fértil de sus esposas (hasta 45 años). Para simplificar el cálculo, en vez de calcular la protección exacta por cada cliente (45 menor edad, etc.), yo recomendaría que se averigüe la edad promedio (de un muestreo de registros de operadas) y utilice esta cifra.

El DIU pone problemas especiales. Durante discusiones con el Director Médico en 1975 sobre la retención de DIU en la Zona 5 acordamos en 18 meses (Helbig propone esta cifra también basado en su experiencia en Paquistán). Luego hice "pruebas de sensibilidad," utilizando tasas de 9 y 27 meses. Debido a la uniformidad de utilización del DIU en los diferentes entidades de la Asociación, las comparaciones no cambiarán. Dado la poca utilización del DIU actualmente, un error en la estimación de cobertura no tendrá gran influencia en los totales ni en comparaciones entre unidades.

Lo mismo obtiene en cuanto a condones. Por el presente la dependencia en condones permite una estimación aproximada como .25/paquete de tres. Si la demanda para condones sube en el futuro, se justificaría un pequeño estudio de los registros de ellos/ellas que prefieren este método (para sacar datos sobre consumo del artículo por mes por pareja) complementado con entrevistas.

APPENDIX F

Cubertura-Coatepeque

Como ejemplo del nivel de detalle que la planeación regional requiere, incluyo estas observaciones sobre la clínica en Coatepeque.

Si 20 por ciento de la mujeres en edad fértil de Coatepeque optarían por la pastilla, esto involucraría 35 visitas de reabastamiento (una visita cada tres meses) por día y alrededor de 17 consultas médicas por día. El congestionamiento y la absorción de la mitad de las horas médicas que resulta impide la propia función de la clínica - esterilización. Obviamente, hay que planear la demedicalización del servicio. Posibles alternativas son:

1. "Despachos" de APROFAM manejados por auxiliares quienes reciben el 40 por ciento, toman papanicalaus, hacen exámenes, etc.
2. Distribución comunitaria.
3. Promoción del producto a través farmacias y/o tiendas.

Lo que la Asociación quiere evitar por esta planeación es la necesidad de cambiar un servicio ya establecido cuando la clínica se sobrecarga con la confusión que resulta entre las clientes.