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IMPACT OF SUSTAINABILITY POLICIES ON ACCESS TO VOLUNTARY STERILIZATION
SERVICES AT NON-GOVERNMENTAL ORGANIZATIONS IN LATIN AMERICA

Report prepared for the Agency for International Development's Office of
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EXECUTIVE SUMMARY

In an effort to determine how grantee agencies can best deal with decreasing funds from international donor organizations, the Association for Voluntary Surgical Contraception (AVSC) studied the impact of funding decreases on access to sterilization services at 22 non-governmental family planning clinics in four Latin American countries. As the first phase of a two-part study to address this issue, this retrospective study examined how grantees reacted to past decreases in AVSC funding for sterilization services, what the impact of the strategy was on caseload and socioeconomic characteristics of clients, and which of these strategies the clinics employed have been the most successful in ensuring continued access to services and self-sufficiency.

Fifteen of the sites shared the same strategy: they increased client fees as a response to the funding decrease. All but one of these sites experienced a decline in caseload, and nine of them noticed fewer lower-income clients coming forward for sterilization services as a result of the fee increase. Four sites employed a successful strategy of seeking out contracts with government or private sector companies to provide sterilization and family planning services; each of these sites experienced increased caseloads. Also successful was an attempt to diversify services -- offer other services at the family planning clinic that could subsidize female sterilization services.

NGOs that were successful in keeping caseload high and obtaining self-sufficiency shared three elements (defined earlier in a manual published by the Enterprise Program): they have a diversity of funding sources, take a businesslike approach to managing funds (including making a careful assessment of the costs of services), and demonstrate an entrepreneurial spirit as they pursue opportunities for other sources of income. A fourth element crucial to a program's success after funding withdrawal is careful planning by donor agencies in conjunction with grantees, to program funding cutbacks from the beginning of the program, and working with grantees to plan and prepare strategies for dealing with the cuts.

The second phase of this study will be a prospective study to test the different cost-recovery schemes which were the most popular in this first study. It will be designed in an evaluative framework, with careful technical assistance from a management consultant who will work with selected grantees from the beginning to design and test different strategies for dealing with anticipated funding cutbacks. Strategies tested will include a comparison of different methods of instituting fees for services, obtaining contracts from government or private companies, and diversifying services.

Introduction

"Sustainability" and "financial self-reliance" are popular concepts discussed by the family planning donor community these days. As the need for family planning assistance continues to increase, and is not met with a commensurate increase in funds available to meet the need, donor agencies are looking for ways to help grantees become less reliant on outside assistance, and more capable of sustaining services as donor funds decline.

The Association for Voluntary Surgical Contraception (AVSC) currently supports voluntary sterilization services in 51 countries. Projections suggest that in the developing world (excluding China) population growth and modernization will lead to a need for 82 million sterilizations (male and female) between now and the year 2000. In light of the limited resources available to meet this need for sterilization services, AVSC has become increasingly concerned with fostering the sustainability of voluntary sterilization services. As part of this concern, AVSC commissioned studies with non-governmental family planning service providers at 22 sites in Mexico, the Dominican Republic, Colombia and Brazil in 1989.¹ The purpose of the studies is to identify the specific trade-offs between two seemingly conflicting policies: policies promoting access to quality services by those who need them, and policies promoting long-term financial sustainability of services. In effect, we want to be able to answer the question "How does the change in funding policy (notably, the increased emphasis on sustainability) affect access to services?" Specifically, we want to know how grantees react to the sustainability policy, what strategies to address the emphasis on self-sufficiency were successful and why, and which of the successful strategies should we try to replicate. By looking more closely at the issues surrounding sustainability of family planning services in these four countries, we hope to come up with some recommendations for program managers on how to develop cost-recovery measures while not adversely affecting access to services.

This report of the four case studies will begin by setting the context for the study: How AVSC defines sustainability, and why we decided to look at this issue. Next will come a brief discussion of the methodology of the study, followed by the findings, and a discussion of the results. We will finish with some conclusions and recommendations based on the study.

Background

AVSC shares with other family planning donor organizations a concern about sustainability. As pointed out by the Enterprise Program in their manual for non-governmental organizations (NGOs) involved in family planning (The Enterprise Program, 1990: 1), family planning NGOs have all, until recently, enjoyed fairly regular funding. However, as the manual points out,

¹This study is being supported with funding from the Agency for International Development's Bureau of Policy and Program Coordination ~~in the Office of Population~~ *for*

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because of rising costs and increasing demands for family planning services, donor support can no longer meet this growing need.

AVSC's early support to developing countries (beginning in 1971) focused on transferring resources such as funds, supplies, and equipment to in-country institutions in order to initiate sterilization services. The "classic" service introduction project in these early years consisted of funding a number of start-up costs including staff training, equipment procurement and installation, renovation of facilities, technical assistance, and information and education activities. In addition, AVSC would contribute significantly to recurrent costs such as salaries, expendable supplies, and services, rent and utilities -- and sometimes would also include a per case subsidy to help cover the costs of delivering voluntary sterilization services. We soon learned, however, that heavy subsidy of recurrent costs creates a dependency that is often difficult to overcome. As a result, the emphasis of AVSC funding gradually shifted to one of technology and skill transfer, focusing on helping to institutionalize the provision of quality voluntary surgical contraception services in private and governmental health and family planning services.

In 1983, AVSC's board issued a policy stating that a primary purpose of AVSC's financial and technical assistance is "to enable programs and institutions to become self-sustaining, either through the generation of local resources or by having the government, another local agency, or the recipient itself assume full financial responsibility for the voluntary surgical contraception activity" (AVSC, 1983). Implicit in this policy is the expectation that the costs of the local institution with which AVSC works will eventually shift from AVSC to a more stable source of revenue, preferably the source that supports similar, already institutionalized services. This policy guides AVSC's funding actions as we try to focus our support, to the extent possible, on nonrecurrent costs like equipment, facility renovation and training, and getting the institution with which we are working to cover recurrent costs like personnel and consumable supplies. This is integral to AVSC's commitment to the principle of "ownership": that grantees consider the project their own and demonstrate their willingness to the success of their program by committing time, enthusiasm, and resources. In this way, the project is more likely to be able to continue after AVSC support ends. We also try to build institutionalization steps and goals into the project document and to get agreement to them at the outset. Typically this would involve such things as a gradual assumption of project costs by the collaborating institution and a gradual reduction of AVSC support. Whenever possible, AVSC encourages the grantee to cover an increasingly larger share of service delivery costs through local resources and efforts.

In Latin America and Asia especially, AVSC has been involved in long-standing relationships with non-governmental organizations in which we have been supporting their recurring costs. In some cases, AVSC is the primary donor and, while we have provided technical assistance for institutional development, cost recovery, and other activities, we need to learn more about the most effective ways to help program managers identify the strategies to move them toward self-sufficiency. Given our increasing emphasis on sustainability, we need to learn more about how to help these NGOs continue to

provide high quality services while at the same time working to achieve sustainability. Responding to this need, AVSC undertook a two-phase study of the impact of sustainability policies on family planning service access in four countries in Latin America. This report will focus on these countries and the effects of AVSC's sustainability policy on their funding. The second phase will be an operations research project to test alternative cost recovery approaches identified through this first phase study.

In a paper on cost-effectiveness prepared for the International Operations Research Conference and Workshop held in 1990, Eric R. Jensen, an economist in USAID's Office of Population Research Division, noted that comparatively little work has been done on sustainability, which he defines as "the ability of a program to carry on its operations in the absence of donor support" (Jensen, 1990). As the first part of our study on sustainability, we conducted a review of the literature on sustainability which yielded several interesting findings about self-sufficiency in family planning programs (Weeden, 1988). Some of the findings are relevant to these case studies, namely: 1) there is little difference in demand between free and moderately priced family planning services in developing country programs, although sterilization services tend to be more vulnerable to pricing and fee changes; 2) user fees rarely cover the full cost of service delivery, and cannot be effective unless services are accessible and perceived to be of high quality; and 3) administration of client fees, particularly sliding fee scales, is costly and difficult to implement. Moreover, much of the research does not adequately control for differences in client socioeconomic status, access, client satisfaction, and other important variables. And, methodologies for estimating costs vary widely.

Methodology

The literature review on sustainability was the first step in helping AVSC design a retrospective and qualitative study of the impact of AVSC's sustainability policy on the access of voluntary sterilization services in four Latin American countries. AVSC limited the study to Latin America for several reasons. First, as family planning donors are turning to underserved regions -- notably sub-Saharan Africa -- family planning programs in Latin America have been living with the realities of the withdrawal of outside donor support for the past several years. Second, AVSC has had a long history of support to several multisite family planning programs in the region at various stages of sustainability. Finally, focusing on Latin America has enabled us to examine a large number of clinics in a relatively short period of time so that we will be able to proceed with the next phase in early 1991.

AVSC chose Mexico, Brazil, the Dominican Republic, and Colombia because in each country AVSC has been supporting an in-country family planning organization responsible for supporting services at private sector clinics. AVSC support in all cases included (but was not limited to) a per-case subsidy for sterilization services and each clinic studied (except the two in Colombia) was receiving either a reduced subsidy or no subsidy at all. The objective was to review how access and quality were affected by these decreases or withdrawals of subsidies, and by declining overall financial support for sterilization programs. Service access and quality were examined

by analyzing fees and service statistics both before and after the funding changes, and through discussions with clinic personnel. For the purposes of these case studies, we focused exclusively on voluntary sterilization delivery because these service statistics were easily available, and also because it is the focus of AVSC assistance to these organizations and these are the services most directly affected by AVSC policies to reduce funds.

It is worth noting that for all of the facilities visited in Mexico, the Dominican Republic and Brazil, AVSC funding has been decreasing over time. However, in the PROFAMILIA male services program studied in Colombia, AVSC funding has been increasing. PROFAMILIA/Colombia was included in the study because their male-only clinics have initiated strategies which have been successful in furthering their move toward self-sufficiency.

The information used in the studies was gathered through interviews with clinic staff, using a questionnaire designed in New York by AVSC's research and evaluation department, with input from the international programs division. Tested at the first country to be studied (Mexico), the questionnaire was found to be satisfactory and only minimal changes were made when it was used in the other three countries. The questionnaire consisted of several parts: the first part was general information collected at headquarters on financing and service statistics. The second part consisted of more specific questions and were posed at individual service facilities. In this second part, there were five sections. These sections focused on financing, service statistics, client profile, alternative service sites, and referral for services. Under the section on financing, information collected included the operating budget of the facility, the cost of operating the family planning/voluntary sterilization clinic, the fee structure for all services and how those fees are collected, all sources of income and any changes in income that have occurred in the past several years (and, specifically, information on changes resulting from reductions in AVSC funding). Also included in the section on financing is the facility's reaction to the decreased funding, i.e., changes that took place as a result of the decrease in funding, and changes planned for the future to lead to greater self-sufficiency. In the section on service statistics, information collected focused on method mix, and how the demand for various methods has changed over the years, specifically, in response to funding changes. The section on the sociodemographic and socioeconomic profile of the "typical" family planning user at the clinic looked at whether this profile has changed as a result of any change in funding, in order to determine the effect of funding changes on access to services. The section of the questionnaire on alternative family planning and voluntary sterilization service sources investigated how clients at the clinic differ from those served at alternative service sites, and to determine whether clients sought services at alternative sites in response to changes arising from funding cutbacks. In the final section information was collected on sources of referral, and how clients are referred to the clinic. A copy of the questionnaire used is appended to this report (attachment one).

As mentioned, the questionnaire was designed in New York. The individual chiefly responsible for the design of the questionnaire used it to conduct the interviews in Mexico and the Dominican Republic. Consultants were

hired to conduct the study in Brazil and Colombia, and they used virtually the same questionnaire to conduct interviews at those sites.

Some problems encountered with the design of the study include the fact that in some places (notably ABEPF affiliates in Brazil and PROFAMILIA/Dominican Republic clinics), the places visited were small clinics or family-owned private physicians' offices. In these cases, the clinics were not set up with sophisticated accounting systems. As a result, it was difficult to get good cost information and no set system exists for client charges. In addition, some clinics were found to have underestimated profits in order to avoid high taxes. Finally, the information collected on funding at the two male-only clinics in Colombia was difficult to extract from information on funding provided to the entire male- and female-supported services of PROFAMILIA/Colombia. Thus, some information may not be completely accurate. In addition, Colombia was the one country where the study focused on the male services -- and AVSC support for male services in Colombia has been increasing in comparison to other support, which has been on the decline.

Background on sites selected

In Mexico, we studied four clinics which have been receiving AVSC support since 1984 via the Mexican Federation of Private Family Planning Associations (FEMAP). FEMAP, created in 1981, is a federation of over 25 private, voluntary, community-based family planning organizations that exists to unite the energies and resources of the affiliates in order to better serve their individual communities. The purpose of AVSC funding was to help FEMAP's affiliates establish or strengthen voluntary sterilization services and to improve quality. Funding to the affiliates consisted of a per case subsidy, although equipment and training for clinic personnel was sometimes provided as well. The four clinics visited were in Juarez, Celaya, Irapuato and Saltillo. Juarez is a high-volume clinic relative to the others, Celaya is low-volume, and Irapuato and Saltillo refer requestors elsewhere.

In the Dominican Republic, AVSC visited eight PROFAMILIA clinics. Since 1979, AVSC has supported PROFAMILIA/DR, an International Planned Parenthood Federation affiliate, to assist between 25 to 35 private clinics to provide voluntary sterilization services. These clinics differ from those studied in Mexico in that they are private, for-profit doctors' clinics. PROFAMILIA/DR's strategy is to find interested private practice physicians who are willing to provide family planning services to the community. They are provided with training, equipment and a per case subsidy, and are asked to keep their fees for clients referred by PROFAMILIA/DR to a specified limit. They benefit not only by receiving good will for providing a community service, but also because family planning clients generate business for their other medical practices.

In Brazil, an AVSC consultant visited seven clinics receiving support from Associacao Brasileira de Entidades de Planejamento Familiar (ABEPF), and one Promocao de Paternidade Responsavel (PROPATER) clinic. ABEPF is a national-level association of family planning service providers, founded in 1981. ABEPF's members are generally private, legally incorporated entities, some of which operate in close cooperation with university or governmental

(state or municipal) facilities. For the most part, their members are private clinics or primarily obstetrician/gynecologist practitioners. ABEPF channels grant assistance to its 140 members, 35 of which have received AVSC funds for voluntary sterilization services. The seven sites selected for inclusion in the study were chosen with assistance from ABEPF in order to insure cross-representation of voluntary sterilization programs in terms of service volume, size, location, duration of AVSC support, and whether or not AVSC currently supports the program. All sites selected provide predominantly female voluntary sterilization services. The other Brazil site, PROPATER, is a private, non-profit organization founded in 1980 for the purpose of providing reproductive health care services for men. AVSC was the first and sole source of support to PROPATER for its vasectomy service program, which began in 1981. As in the case of Mexico and the Dominican Republic, the eight Brazil sites all received equipment, training, and a per case subsidy from AVSC for voluntary sterilization services. In the case of the ABEPF sites, the subsidy was withdrawn entirely in February, 1987. At PROPATER, the subsidy has been substantially reduced over the years to a level of \$25 for the first 100 vasectomies performed per month (PROPATER performs approximately 500 vasectomies per month) in 1989-90. The subsidy has been entirely eliminated in 1991.

In Colombia, an AVSC consultant visited two male-only PROFAMILIA clinics in Bogotá and Medellín. As in the Dominican Republic, PROFAMILIA/Colombia is an IPPF affiliate which has been receiving support from AVSC since 1972. It is the major family planning service provider in the country, providing approximately 72% of all female sterilization procedures and nearly all of the vasectomies performed in Colombia. In late 1985, with AVSC's support, PROFAMILIA/Colombia launched a pilot project to establish male clinics in Bogotá and Medellín. From 1985-1988, PROFAMILIA/Colombia provided 9,278 vasectomies, the large majority of which were performed at these two male clinics. In addition to the support provided to male services at these two clinics (which included equipment, training, and a per case subsidy), AVSC funded a mass media campaign to promote responsibility for family planning in 1988 and, until 1989 provided ongoing support for female voluntary sterilization services to PROFAMILIA/Colombia's 47 family planning clinics. As mentioned, the Colombia case study is different than in the other countries. In Colombia, the per case subsidy for male services decreased, but then increased. However, we chose this site because the AVSC contribution to the program is minimal and alternative structures are in place to cover the full cost of the vasectomy procedures. We chose PROFAMILIA/Colombia because we wanted to look more closely at what those alternative strategies are.

Results

Mexico

In Mexico, the amount of the per case subsidy was initially \$40, and was reduced to \$35 in May 1987 and further reduced to \$20 or \$12.50 in September 1988 (depending on the site). The current subsidy differentials reflect the fact that some affiliates are providing services directly (\$20 subsidy) while the others refer requestors to other providers (\$12.50 subsidy). Prior to September 1988, all affiliates received the same subsidy regardless of whether

they were the providers or the referrers. Each clinic's response to the funding change is summarized in appendix two, table I.

In Juárez, Celaya and Irapuato, funding reductions were accompanied by an increase in client fees and an increased effort to collect fees. This in turn resulted in a decreased caseload. The effects were greatest for Celaya and slight for Juárez and Irapuato in the case of the first subsidy reduction of \$40 to \$35, but much more pronounced for the second reduction to \$20/case (Juárez) and \$12.50/referral (Irapuato).

The case of the high volume clinic in Juárez best illustrates the effects on the funding changes on service access. Both decreases in subsidy were preceded by increases in price. Since Juárez is the seat of FEMAP headquarters, the clinic knew well in advance the reduction in funding would occur and acted accordingly by increasing fees. Prices increased dramatically (from \$43 to \$55) in January 1987, a few months before the \$40 subsidy was decreased by \$5 in May 1987. Again, in May 1988, prior to the second, more drastic reduction in the subsidy in September 1988 (from \$35 to \$20), the clinic increased fees by another \$5 to \$60. This is the point at which the volume of procedures was most affected: average monthly caseload was reduced only by 10% following the first price increase, but fell by another 58% with the second price increase.

The size of the caseload was not the only noticeable change after the price increase; also affected was the client profile. Although data was not available to support the claim, clinic personnel at Celaya and Juárez felt that the client profile had been altered markedly: since the fee increase, fewer lower economic clients are requesting sterilization services, presumably due to an inability to pay.

It is interesting to note that the increase in fees at the Juárez clinic came well before the largest reduction in the subsidy and the effect on caseload. The explanation, according to clinic staff, is that collection policies were lax prior to September 1988. Although fees were fixed and payment was requested up front, exceptions were made, the clinic allowed payments in installments and little pressure was applied to collect from clients in arrears. Since the reduction in the service subsidy, this policy has changed: payments are now collected in full and up front and few, if any, exceptions are made.

The Saltillo clinic responded differently to the funding decrease. Since joining the program in 1987, the Saltillo clinic had received a \$35 per case subsidy to refer voluntary sterilization requestors. The subsidy (which covered the cost of expendable supplies) was paid to Saltillo, which turned the money over to the hospital performing the sterilization (University Hospital). When the subsidy was lowered in September 1988 to \$12.50, it became too expensive to refer clients to the University Hospital. The clinic had two choices: ask clients to pay the balance of the University Hospital's fees (above \$12.50), or send them to a government facility, which charged less. They chose the latter option so that clients would continue to pay virtually nothing. This has not affected the number of referrals at all; in fact, referrals have increased since AVSC's reduction in funding. However, it

is worth noting that clinic personnel feel that, although services at the government facility are adequate, they are not of the same quality as those at the University Hospital. Thus, it is possible that quality is somewhat being compromised by the change.

Dominican Republic

Prior to July 1988, all clinics under AVSC's support to PROFAMILIA/DR received a per case subsidy equivalent to \$8.30 or \$7.43 (for each client referred by PROFAMILIA/DR promoters or for those who requested services on their own, respectively). In July 1988, as part of a new funding agreement with AVSC, PROFAMILIA/DR changed its strategy. It created two categories of support, and the doctors' clinics were able to choose from these two support schemes:

- Type 1: Per case subsidy of US\$4.37, plus expendable surgical supplies
- Type 2: Per case subsidy of US\$6.99, but no surgical supplies.²

Of the eight clinics visited, four are Type 1 (Azua, Santo Domingo, Las Matas de Farfán, and La Romana), one is Type 2 (Santiago), and three were dropped and are no longer receiving support under the program (San Juan, San Pedro de Macorís, and Bani). A summary of each clinic's response to the funding change is summarized in appendix two, table II.

In all cases except one (Azua), fees increased regardless of funding category. And the fee increases had the expected effect on reducing the demand for services. It seems that the higher the prices, the more the effect on demand. The most dramatic examples were those clinics dropped from the program. In these three cases, fees increased more than threefold and caseloads dropped significantly. While the other clinics said that they continued to serve the same type of client, those clinics that no longer received support all noticed a strong shift toward middle income clientele.

Conversely, in the one case where fees did not increase (Azua), caseload actually increased. And, because this clinic received expendable supplies as well as the reduced subsidy, it appears to have benefitted financially. For all clinics receiving Type 1 assistance, the net result was an actual increase in assistance: because of the high inflation rate, the present subsidy is worth less than in the past -- yet the expendable supplies have more than compensated for the lower value of the subsidy (at lower cost to the donor). This enabled Azua to maintain relatively low fees for clients and, in turn, has not adversely affected demand. The other sites, however, proceeded to raise fees despite the net gain in support resulting from the Type 1 assistance. This is partly due to the fact that these clinics did not know how to analyze their costs except on a rudimentary basis; thus, most reacted to the reduced subsidy by increasing prices. At these sites, caseload fell.

²The per case subsidy is based on an exchange rate of DR\$5.72 to US\$1.00. The Type 1 clinics were receiving a DR\$25 per case subsidy plus supplies, and the Type 2 clinics were receiving a DR\$40 per case subsidy (without supplies).

Brazil

At the seven ABEPF sites, AVSC phased out its per case subsidy to each site over a period of several years from an initial subsidy of \$15-\$20 per case to \$0. A summary of the funding changes over time at each site, along with each site's response to the change, is summarized in appendix two, table III.

At every site the decrease in the subsidy was met with an increase in client fees; fees increased anywhere from \$14 to \$92. In all cases but one where fees were increased, client caseload fell. At some sites the decrease was dramatic: at Instituto de Reproducao Humana de Pernambuco (IRHPE), the monthly caseload dropped from 29.2 to 12.1; at Centro de Estudos e Pesquisas Clovis Salgado (CEPECS) it dropped from 132.9 to 36.1; and at Conselho Londrinense de Assistencia a Mulher (CLAM) it dropped from 63.2 to 14.4. At the one site where caseload did not fall, Centro de Pesquisas e Assistencia em Reproducao Humana (CePARH), caseload actually increased during the period of AVSC decrease in funding: from 101.9 to 138.3 clients/month.

The reason for the CePARH increase in client load was the result of that clinic's attempt to deal with the decrease in funding by searching out alternative revenue sources. Realizing that a decrease in assistance was imminent, CePARH went out and obtained service contracts with private enterprises and city governments for family planning services. They also sought donations from community and local groups. In addition, they planned to supplement their income by obtaining client fees. The success of the strategy is demonstrated by the fact that CePARH supports its clinical and surgical family planning program exclusively from these three sources of local support, while continuing to serve the poor. Since withdrawal of AVSC funds, the monthly number of tubal ligations has increased 4% and the monthly number of vasectomies has nearly tripled. The fees from tubal ligation and vasectomy generate 4.8% of the clinic's total revenue and range from no payment to a maximum of \$14, based on the client's ability to pay. Service access has widened as a result of the move to a larger facility, and service quality has also improved.

One other site, Hospital Sofia Feldman (HSF) also succeeded in obtaining a government services contract authorizing payment for voluntary sterilization. While no information is available on client fees before the elimination of AVSC funding and the awarding of the contract, the current fee for sterilization is on a sliding scale, and clients pay between \$41 and \$82. The caseload dropped from 81.5 during the period of AVSC support to 75.6; however, the decline in the number of sterilizations is not due to the decrease in funding but, rather, from the hospital management's decision to slow the pace of sterilizations in order to guarantee service quality. The termination of AVSC funding for female procedures did not significantly reduce the volume, accessibility or quality of voluntary sterilization services or the type of clientele served. AVSC still funds HSF's vasectomy services which have more than quadrupled since AVSC first began to provide support in 1984. Service quality appears to have improved as more revenue has been generated by the institution to up-grade its facilities and purchase supplies and

equipment. With the availability of government funding, HSF continues to provide care to the same poor and underserved clientele that received services during the period that AVSC funding was received.

One other alternative to raising client fees and obtaining government contracts was pursued by two clinics: IRHPE and CEPECS. Upon termination of AVSC subsidies, both sites began to lease their outpatient surgical clinic to physicians who, in exchange, cover the operating costs of the day hospital and the family planning clinic. This poses a problem at IRHPE because they can only use the day hospital for voluntary sterilization services two mornings per month. IRHPE also tried scheduling tubal ligations only during training sessions as the institution supporting the training would pay for those sterilizations performed during training. However, as the number of training sessions supported has decreased over the years, so has this activity. Despite these activities, both sites experienced a decline in caseload upon cessation of AVSC support (a 60% decline for IRHPE and an 82% decline for CEPECS). The underlying problem with regard to sustainability of IRHPE as an institution is not the lack of funds for services but the lack of management staff to plan for the future. When funding was abundant, consideration was not given to preparing senior staff for a future without international funds. Because of the funding cutback, IRHPE lost several key staff members (the technical director and psychologist). In the case of CEPECS, in spite of the sliding fee scale, the \$73 minimum fee is still too high for most clients (during AVSC funding, nearly one-half of all clients did not pay for services). Moreover, under the terms of the lease agreement, only a small number of women per month can be referred to surgery without paying. CEPECS management feels that a large proportion of CEPECS clients choose IUDs because they can't afford a sterilization. The decline in caseload can also be attributed to the two deaths which occurred in 1986, and the resulting loss of morale of the staff. In addition, from March - May 1987 and in July 1988 services were suspended entirely as the CEPECS management searched for alternative revenue sources. Again, CEPECS seems to have suffered from the poor management problems of IRHPE. It is worth noting, however, that CEPECS instituted a strategy of promoting vasectomy during the time of decreased support for female services, and has seen an increase in the number of vasectomy acceptors at the clinic.

Almost all sites noted that, as a result of the need to increase fees, they were no longer providing services to lower income women. The case of Centro Materno Infantil do Nordeste (CEMINE) clinic illustrates this point: as a result of the termination of funding, CEMINE no longer serves the poorest women in the community, but instead those who can afford to pay the full cost of the voluntary sterilization. During AVSC funding, 10% of the clients received free services, 50% paid small fees, and 40% paid fees that covered costs. Upon termination of AVSC funding, CEMINE can no longer provide services free of charge, and all clients must pay fees that at least cover costs. A review of payments in December 1989 showed that of the 20 tubal ligations performed, fees paid ranged from \$214 (paid by half of all clients) to \$247 (paid by 15% of clients). In order to reverse CEMINE's inability to serve the poor and continued low revenue, plans are underway to move CEMINE to a new location that has access to low-to-middle-income women.

PROPATER in Brazil experienced a slow but considerable decrease in AVSC support; from 1980 through the present, the per case subsidy decreased eight times from a high of \$118 in 1980 to \$25 in 1990. During that time, client fees increased from \$7 to \$99. Also during that time, the average number of vasectomies performed per month increased tenfold from 47.8 to 496.8. In addition to raising client fees, PROPATER was successful in its financing plan by instituting a two-tiered payment plan in which wealthier clients pay roughly two-and-a-half times what the poorer clients pay, thereby subsidizing services to the poor. In addition, PROPATER opened an additional clinic and, with funding from the Population Council, conducted a mass media campaign promoting its services in Sao Paulo. All of these strategies have been successful in making PROPATER more self-sufficient than in the past.

AVSC was initially the only donor agency to provide support in PROPATER's early years; during that time, client fees were an insignificant source of revenue for PROPATER. By 1985, AVSC support comprised little more than half (54%) of all revenue, with client fees contributing 32% and other donor agencies making up the balance. In 1989, AVSC contributed 10% of the total revenue, and client fees comprised approximately 84% of all revenue.

PROPATER is a promising example of successful transition from near complete reliance on a USAID cooperating agency for service funds to almost complete self-sufficiency, without untoward effects on service volume, quality or access, or significant changes in the target population. The key to the success of PROPATER's financing strategy is that it has implemented a sliding scale fee payment system where each client pays according to his financial ability. Some pay more than the cost of the service; others pay less. In the end, the mean payment basically covers the per-procedure service costs. This financing scheme has also been successful because of the great demand for services. This increased demand (from 600 vasectomies performed in the first project year to 5,529 in the seventh project year) is due in part to the USAID-funded mass media campaign promoting vasectomy, but also to the quality of services provided, as well as the general success of the PROPATER program. Service quality has not been affected by the reduction in funding. However, PROPATER is considering transferring the counseling function to physicians and eliminating counseling staff in order to reduce costs. This change is likely to have a negative impact on the quality of PROPATER's counseling services. As the standard fee paid by clients for vasectomies has increased eight- to twelve-fold since 1981, it appears that the clientele is changing from being predominantly low-income to middle-to-low-income.

Colombia

AVSC helped launch PROFAMILIA/Colombia's two male clinics in Bogotá and Medellín in 1985, and has provided substantial support ever since. From October 1986 through September 1987, AVSC provided a per case reimbursement of \$6.25 to the two clinics. In the following two years, no per case subsidy was given; rather, support focused on repair, maintenance, and improvement of the surgical areas. Under the current project, the per case subsidy is renewed and increased to \$12 per vasectomy. The response of PROFAMILIA/Colombia to the funding change is summarized in appendix two, table IV.

The estimated cost of a vasectomy is \$35. Vasectomy clients are charged according to their ability to pay, with the range of fees paid being between \$4 and \$15, with some paying as little as \$.13 and some as high as \$45. No one is denied services because of a lack of ability to pay. The income generated by fees for vasectomy do not cover the cost of the procedure; the balance is subsidized by AVSC donations and fees from other services. Fees for other services are, unlike vasectomy fees, fixed. Furthermore, they are set high enough to earn a substantial profit. As a result of the income derived from these fees for other services, the Bogotá male clinic has been financially self-sufficient for two years, and the Medellín clinic for one year.³ In addition to AVSC support, the two male clinics receive other support, including funds from the Social Security Institute (SSI) and private service contracts with companies.

The keys to success of the PROFAMILIA male clinics in achieving self-sufficiency include the following: diversification of services (providing services other than vasectomy which have a higher profit margin, such as general medical consultations, psychological consultations, and ultrasonography); efficient use of a sliding scale for vasectomy clients to promote higher case load, but a fixed scale for other services, which tend to be more demand inelastic with respect to price; having the male clinics close to the female clinics to allow for cost sharing and referral and promotion from the female clinics; local contracts with the SSI and private industry; and mass media promotion of male involvement.

Conclusions

Organizations are facing difficult choices as they see donor agencies decrease the amount of funds available for family planning assistance. We studied 22 clinics in four Latin American countries which had been receiving AVSC assistance over the years to look at how decreases in funding at 19 of them has affected access to sterilization services. Of the 19 sites that experienced funding reductions from AVSC, five employed strategies that resulted in increased caseloads, while the balance experienced falling numbers of sterilization clients. Fifteen sites raised fees as a result of the funding decrease; the fee increases resulted in reduced caseloads at 14 sites, and rising socioeconomic status of clients coming forward for services at nine sites.

The most common response to the decrease in funding (which, as mentioned, was shared by 15 of the sites) was an increase in client fees. In most cases, this was a "knee jerk" reaction: sterilization fees were increased across the board and immediately upon news of the reduction of funding. In one case (the FEMAP clinic in Juárez), fees were reduced *increased* beforehand in anticipation of the cut. Some sites (PROFAMILIA/Colombia, and most ABEPF sites in Brazil) instituted a sliding scale for fees, instead of making an across-the-board increase. This approach often proved difficult to administer, with the lesson being that a simpler (perhaps, two-tiered) scheme would be easier to implement than a sliding scale system. In another case

³Does not include direct costs borne by the adjacent female clinic.

(the FEMAP clinic in Juárez), clinic staff intensified efforts to collect fees. In all but one of the 15 clinics (save PROPATER), the increase in fees was met with a decline in caseload. Moreover, at nine of these 15 sites, the fee increase effected a change in client mix; though data was not always available, staff at these nine clinics remarked that more middle income and fewer lower-income clients were coming forward for sterilization services as a result of the fee increases.

The next most popular response to the funding decrease was to seek out and obtain contracts with government or private sector companies to provide sterilization and family planning services. This was the response chosen by two ABEPF sites, Hospital Sofia Feldman and CePARH. (Though they didn't experience the funding decrease, the PROFAMILIA/Colombia clinics also chose this route.) This was the most successful strategy chosen, as both ABEPF sites have experienced improved services after AVSC funding decreased. Hospital Sofia Feldman saw service quality improve after funding decreased as a result of the government contract they obtain authorizing payment for voluntary sterilization services. While caseload at Hospital Sofia Feldman dropped, this was due not to a reduction in clients, but to the management's decision to slow the pace of procedures performed in order to guarantee service quality. At CePARH, not only were service contracts with private enterprises and city governments obtained, but the clinic also instituted fees for service and obtained donations from other sources. They experienced a 36% increase in client caseload after the decrease in funding as a result of this strategy. Finally, though PROFAMILIA/Colombia did not experience a funding decrease, they have instituted a three-part strategy over the past three years which has been successful in keeping the number of vasectomy acceptors current at the level of 200/year. This includes not only contracts with companies and the social security institute for voluntary sterilization services, but also a mass media campaign to promote male responsibility for family planning, and a fee schedule for other services at the clinic that are high enough to earn a profit subsidizing vasectomy services.

Two clinics (CEPECS and IRHPE) in Brazil chose a strategy of leasing the surgical areas in their clinics to other physicians. At CEPECS, these physicians provide tubal ligations and are responsible for collecting fees -- 10% of which goes to CEPECS. At IRHPE, the outpatient surgical clinic is now leased to nearby physicians whose rental of the unit covers the cost of the family planning clinic. However, in both cases, these strategies were accompanied by fee increases -- increases which put the procedure out of financial reach of many of the clinics' clients. As a result, caseload decreased and has resulted in overall declines in income for these two sites.

CEPECS had another strategy in addition to increasing fees and leasing the surgical area: it also started promoting vasectomy services. The promotion of vasectomy, coupled with the increased fees for female sterilization, resulted in a 69% increase in the number of vasectomy acceptors at the CEPECS clinic. This decision to diversify services was shared by PROPATER which, in addition to providing vasectomy, branched out to include infertility treatment among the services offered. And, as mentioned, PROFAMILIA/Colombia offers a number of other services to male clients, which subsidizes its vasectomy program.

PROPATER also shared with PROFAMILIA/Colombia the institution of a mass media campaign to promote its services. Also similar to PROFAMILIA/Colombia's subsidization program is PROPATER's two-tiered payment system, which, in effect, allows the higher fees collected from the wealthier clients to subsidize the services offered at lower fees to poorer clients.

It's worth mentioning the strategies employed by one other site. At the FEMAP site in Saltillo, the decision was made to refer to a government hospital instead of the more expensive University Hospital, to which clients were referred before the funding decrease. In addition, the site hired a staff member who was solely responsible for overseeing and coordinating voluntary sterilization services. This strategy was successful in keeping the client fees at a minimum, and resulted in higher numbers of requestors (up from 6.7/month to 11/month). However, staff at Saltillo did mention their concern that quality of services is lower at the government hospital than at the more expensive University Hospital.

Lessons learned and recommendations

Five sites that saw reduced funds from AVSC were able to continue to provide services -- and actually saw an increase in caseload, thanks to a variety of strategies chosen to deal with the decreased funds, thereby promoting self-reliance. For these five sites, life does exist after withdrawal of funding: the important thing is to identify the strategies most appropriate for the setting. The question we now have to answer is what are the keys to an NGO's ability to achieve self-reliance in the face of decreasing funds?

The Enterprise Program's findings with regards to self-sustainability found that the following three factors are shared by self-reliant NGOs: first, they have a diversity of funding sources, including international and local donors, fees for service, rental of unused space, interest on investment, etc. Second, they take a businesslike approach to managing funds, including careful planning, and a good understanding of costs of services. Finally, the management of self-reliant NGOs demonstrate an entrepreneurial spirit as they aggressively pursue opportunities for income as well as grants and donations.

We would add an additional element to this framework and it would rest on the shoulders of the donors and how they effect reductions in funding. We found that donors need to program any funding phase-outs from the beginning of the program, and need to work with grantees in planning for the eventual cutbacks. In addition, the funding reductions need to be discussed not only at grantee headquarters, but with all affiliates so they understand what to expect in the future.

Our experience in the four Latin American countries studied showed that the successful NGOs shared these four elements. The most successful strategies occurred at sites where there was a clear entrepreneurial spirit, which led management to seek out alternative funding sources (such as

contracts with the government or private sector) and try to diversify services. The "businesslike approach" of knowing costs was also very important. In the case of the Dominican Republic, only the Azua clinic -- where the doctor made sure he knew the costs involved in providing sterilization services -- was able to benefit from the change in funding policy. At that site, the clinic assessed the impact of the change in funding policy, realized that the reduced subsidy plus expendable supplies resulted in an actual net increase and, by passing the savings along in the form of reduced fees to the clients, saw an increase in caseload and income. Also, at sites where costs were understood, different payment schemes could be implemented in order to raise fees for those services less responsive to price increases (or have a two-tiered fee system for wealthy and poor clients) in order to subsidize sterilization services. Sliding scale fees often proved the most problematic in both establishing the fees and enforcing them.

Mass media programs also had a positive effect on client caseload at the two sites where they were instituted. However, mass media programs are costly, and these media programs were implemented at a time when other funds were decreasing. It is thus difficult to compare the effects of decreasing funds when, at the same time, a large influx of money comes in as a result of a mass media campaign. Nevertheless, it is worth noting that these campaigns did have the positive effect of increasing caseload -- even in the case of PROPATER when, at the same time, client fees were increasing.

Given that 15 sites' initial reaction to the funding decrease was to increase client fees -- and 14 of those sites saw a decline in caseload, it is important to point out that this approach is clearly the least successful if it is not accompanied by careful planning and assessment of costs. It is very important to understand cost components from the outset -- which gives further support to the importance of donors communicating funding plans with the grantee at the beginning. In this way, grantees and donors can work together at the beginning to assess costs, and plan appropriate measures to offset planned funding reductions. Furthermore, the grantee often needs time to implement its plan. What is essential is careful management and planning -- the "business-like approach"; well-run programs with high quality services and good reputations should generate high demand and be better able to survive difficult situations -- such as funding reductions -- in the long term.

A final element not mentioned earlier but worth citing is the importance not only of preparing the grantee for funding cutbacks, but also preparing the community for funding increases. Letting clients know that fee increases are anticipated may help them plan accordingly, and not effect the reductions in caseload experienced by almost every clinic studied.

Next steps

The second phase of the sustainability study will be to test ideas generated from this first phase, retrospective study in a prospective manner. We will take the lessons learned during the first phase and implement them by developing service projects in which plans for dealing with funding reductions are developed during the very first project period -- including defining the costs of the sterilization procedure and program. This will include early and

continuing technical assistance from a management consultant who will work with one or two grantees to help them develop appropriate strategies for dealing with anticipated funding reductions over a two to three year period. Different cost-recovery schemes to be tested will be the following:

- instituting fees for services: which are the best strategies (sliding scale vs. two-tiered vs. other?);
- obtaining contracts from government or private companies for sterilization services;
- diversifying services: adding new services which may be able to subsidize sterilization services.

This second phase of the project will be done in an evaluative framework study which will take a prospective and quantitative look at how access, quality, and client characteristics are affected by the implementation of the various cost-recovery activities listed above. As mentioned, we expect this second phase to extend for two to three years.

LIST OF SOURCES

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28 January 1991

Mr. Thomas R. Morris
Economist
Bureau for Program and Policy Coordination
Office of Policy Development and Program Review
Sector Policy Division
Room 3894 NS
Washington, D.C. 20523-0466

Dear Mr. Morris:

As promised, enclosed please find a final report of the sustainability study. If you need any further information on this study, please feel free to contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jeanne M. Haws".

Jeanne M. Haws
Planning and budget coordinator
International Programs Division

enclosure

cc: William Johnson
Roy Jacobstein
Connie Carrino

APPENDIX ONE

SUSTAINABILITY STUDY QUESTIONNAIRE

PART 1-- TO BE FILLED OUT AT HEADQUARTERS

- Name of clinic _____
- Address _____

- Type of clinic:
Private practice _____ Community service _____ Other _____
- Does the clinic still receive per-case financial support from AVSC?
Yes _____ No _____

IF IT DOES RECEIVE FINANCIAL SUPPORT:

- Amount of per-case subsidy by AVSC _____.
- Has a change occurred in AVSC funding policy during the last few years?
Yes _____ No _____
- If yes, how much was the original subsidy? _____
- If yes, when did the change in funding occur? _____
- What types of non-financial support have been provided by AVSC?
(equipment, training, technical assistance, etc.)

IF IT DOES NOT RECEIVE FINANCIAL SUPPORT:

- Period of funding by AVSC _____ to _____
- Time since graduation: years _____ months _____
- According to headquarters, why was this clinic graduated?

- Has the clinic received non-financial technical assistance from AVSC since graduation?
Yes _____ No _____
- If yes, in what form? _____

SERVICE STATISTICS FROM HEADQUARTERS

1. Get service statistics from as far back as possible.
2. Use the statistics to complete table below, but keep all data for future reference (information collected should be on services offered, number of procedures, and prices before the decrease in AVSC funding, and now).

| | Offered? yes/no | | No. of Procedures Monthly Mean | | Mean Price | |
|---------------------------|--------------------|-------|-----------------------------------|-------|------------|-------|
| | Before | Now | Before | Now | Before | Now |
| Minilap | | | | | | |
| postpartum | _____ | _____ | _____ | _____ | _____ | _____ |
| interval | _____ | _____ | _____ | _____ | _____ | _____ |
| other | _____ | _____ | _____ | _____ | _____ | _____ |
| Laparoscopy | | | | | | |
| interval | _____ | _____ | _____ | _____ | _____ | _____ |
| other | _____ | _____ | _____ | _____ | _____ | _____ |
| Vasectomy | _____ | _____ | _____ | _____ | _____ | _____ |
| Temporary Family Planning | | | | | | |
| IUD | _____ | _____ | _____ | _____ | _____ | _____ |
| orals | _____ | _____ | _____ | _____ | _____ | _____ |
| injectibles | _____ | _____ | _____ | _____ | _____ | _____ |
| Norplant | _____ | _____ | _____ | _____ | _____ | _____ |
| condoms | _____ | _____ | _____ | _____ | _____ | _____ |
| spermicides | _____ | _____ | _____ | _____ | _____ | _____ |
| NFP | _____ | _____ | _____ | _____ | _____ | _____ |
| other | _____ | _____ | _____ | _____ | _____ | _____ |
| MCH | _____ | _____ | | | | |
| Prenatal | _____ | _____ | | | | |

- Also try to get sociodemographic/socioeconomic information at this time.
(AGE, PARITY, EDUCATION, SOCIOECONOMIC STATUS)

- What type of anesthesia is used for VSC procedures?

- What is headquarter's explanation of why above changes occurred?

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PART 2-- TO BE FILLED OUT ON SITE

- Name of clinic _____
- Person responding _____
- Title _____
- Date _____

DESCRIPTION OF FACILITY:

- Number of beds _____
- Number of staff _____
 - doctors _____
 - nurses _____
 - counselors _____
- total _____
- When was the clinic opened? _____
- Have new services been added since the clinic opened?
Yes _____ No _____
- If yes, which services? _____
- When were the new services added? _____
- Was this before or after the change in AVSC funding strategy?
Before _____ After _____
- Why were the services added?
- Were they added with the objective of recovering costs?
Yes _____ No _____
- Are there plans to add new services in the future?
Yes _____ No _____
- If yes, which services?

FINANCING

- What is the total operating budget of the facility? _____
- What is the cost of operating the family planning clinic/VSC clinic?
(IF FAMILY PLANNING CLINIC, TRY TO FIND WHAT ARE THE COSTS OF VSC COMPONENT) (cost per sterilization, if possible)

- Please elaborate on sources of income for the facility (for all services but especially for family planning and VSC)

- Please comment on any changes in income sources during the past several years.

- Please elaborate on all forms of past AVSC support.

- Please show fee structure for all services (or verify the information from headquarters).

- Please comment on how fees have changed during the past several years.

- How are fees collected (up front? payments over time? loans? insurance, etc.) ?

- How is the fee structure determined (for VSC and other services)?

- Are the fees posted? Yes _____ No _____
- Is there a sliding scale? Yes _____ No _____
- How is it determined whether and what clients can pay?

- What is the clinic's response if a potential client says she/he cannot pay the fee? (referred elsewhere? service provided anyway?)
(GET ANECDOTAL INFORMATION ON THIS FROM AS MANY SOURCES AS POSSIBLE)

- Since change in AVSC funding, has percentage of non-paying clients increased or decreased? increased _____ decreased _____
To what extent?

- Are there different payment plans for different services?
Yes _____ No _____
If yes, explain.

- Approximately what percent of the cost of a VSC procedure (and other services) is covered by the fees charged? _____ %
If the percent is less than 100%, how is the balance funded? Are you presently receiving funds from other donors?

- Please elaborate on any changes which have taken place which represented an effort towards more cost-effectiveness (i.e., increased fees, new services, scheduling changes for VSC, etc.). How successful have these been?

- More anecdotal accounts of how facility has been affected by decreased funding: (ESPECIALLY QUALITY OF SERVICES, HOW WAS IT AFFECTED?)

Are any changes planned for the future which would lead to greater self-sufficiency? Yes _____ No _____

If yes, specify.

- What do you foresee for the future in terms of service quality, service volume, costs and fee structures, and self-sufficiency?

- What was (and is) the facility's response to the decreased funding?

- Do you feel the cutback in funding was premature?

Yes _____ No _____

Why or why not?

- What type of technical assistance have you received from AVSC during the past several years? (Since change in AVSC funding)

- What type of assistance (other than renewed funding) would be most useful at this point?



SERVICE STATISTICS

- Please comment on all services provided by this clinic over the past several years:

USE THIS OPPORTUNITY TO VERIFY THE DATA FROM HEADQUARTERS.

NOTE: IF SERVICE STATISTICS WERE NOT AVAILABLE FROM HEADQUARTERS, THEN GO BACK NOW AND COMPLETE THE RELEVANT PARTS.

ALSO, GET ANECDOTAL INFORMATION REGARDING METHOD MIX AND DEMAND FOR VARIOUS METHODS (E.G., PERCENTAGE OF VSC RELATIVE TO OTHER METHODS)

- Which anesthesia technique is most often used for VSC procedures?

- How would you account for the present method mix?
(ASK HOW (OR IF) CHOICE OF METHOD DEPENDS ON INCOME)

- How has volume of VSC and other services changed over the past several years (before/after change in funding)? Explain any changes.

General assessment of facility: Clean, well-organized, efficient?

CLIENT PROFILES

- How would you describe the typical client for VSC of this clinic today?
(AGE, EDUCATION, PARITY, SOCIOECONOMIC STATUS)

PLEASE PROVIDE ANY SERVICE STATISTICS AVAILABLE (and check against what was learned at headquarters)

Has the sociodemographic/socioeconomic profile of your "typical" user changed over the past several years? (since the change in AVSC funding)

Yes _____ No _____

If yes, how?

How would you account for any significant changes?

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ALTERNATIVE SERVICE SOURCES

What is the nearest FP service delivery site to this clinic?

How far is it from this clinic?

Does that site also offer services in VSC? Yes _____ No _____
If no, what is nearest site where VSC services are provided?

How far from this clinic?

Is the nearest family planning service site a public or private facility?
Public _____ Private _____ Other _____ Don't know _____

To the best of your knowledge, what FP services are offered there, and at what price?

| Procedure | Offered? Y/N | Mean no. per month | Price |
|---------------------------------|-----------------|-----------------------|-------|
| Minilap | _____ | _____ | _____ |
| Laparoscopy | _____ | _____ | _____ |
| Vasectomy | _____ | _____ | _____ |
| Other temporary family planning | | | |
| IUD | _____ | _____ | _____ |
| orals | _____ | _____ | _____ |
| Norplant | _____ | _____ | _____ |
| injectibles | _____ | _____ | _____ |
| condoms | _____ | _____ | _____ |
| spermicides | _____ | _____ | _____ |
| other | _____ | _____ | _____ |
| Other services | | | |
| _____ | _____ | | |
| _____ | _____ | | |

How would you compare the typical client of this clinic with a typical client from the nearest alternative VSC service site?

Client of THIS clinic relative to neighboring one:

Education: More _____ Less _____ The same _____
Age: Older _____ Younger _____ The same _____
Rural/urban: More rural _____ More urban _____ Similar _____
Socioecon. St: Wealthier _____ Less wealthy _____ Similar _____
Other:

How would you account for any differences?

REFERRAL

How is this clinic promoted?

How are clients referred here?

By whom?

How are referral agents paid?

(PRIVATE DOCTOR CLINICS)

- In your opinion, how many users of VSC are regular clients of this clinic (for other services)? _____ (- _____%)

How many became clients after the VSC operation? _____

APPENDIX TWO

TABLE I: SUMMARY OF IMPACT OF CHANGES ON MEXICO SITES

| <u>Country/Clinic</u> | <u>Per case subsidy</u> | <u>Client fee for VS</u> | <u>Avg. no of VS/month</u> | <u>Policy changes effected</u> | <u>Impact of funding decrease on other areas</u> |
|-------------------------------------|-------------------------|--------------------------|----------------------------|--|---|
| <u>MEXICO: FEMAP</u> | | | | | |
| 1. <u>Celaya</u> | | | | | |
| January, 1987 | \$40 | \$ 0 | 8.3 | 1. Raised client fees for VS, as well as for IUDs. 2. Began charging for all other family planning methods, which are all donated. | More middle income clients. |
| May, 1987 | 35 | 4 | 2.8 | | |
| September, 1988 | 20 | 21 | 2.1 | | |
| 2. <u>Juarez</u> | | | | | |
| January, 1987 | \$40 | \$16 | 69 | 1. Raised client fees for VS. 2. Increased emphasis on fee collection. | More middle income, fewer poor clients coming forward for services. |
| May, 1987 | 35 | ??? | 62 | | |
| September, 1988 | 20 | \$52-62 | 26 | | |
| 3. <u>Irapuato</u> (referrals only) | | | | | |
| January, 1987 | \$40 | \$ 0 | 32.1 | 1. Increased client fees to cover costs (though exact information on what fees was not collected). 2. Added new services to generate funds. 3. Hired a special VSC promoter. | |
| May, 1987 | 35 | ? | 25.4 | | |
| September, 1988 | 12.50 | ? | 6.3 | | |
| 4. <u>Saltillo</u> (referrals only) | | | | | |
| January, 1987 | - | - | - | 1. Started referring clients to less expensive government hospital instead of University Hospital in order to keep client fees to \$0. 2. Hired VS coordinator as subsidy declined. | Service quality considered lower at government than at University Hospital. |
| May, 1987 | \$35 | \$ 0 | 6.7 | | |
| September, 1988 | 12.50 | 0 | 11.7 | | |

TABLE II: SUMMARY OF IMPACT OF CHANGES ON DOMINICAN REPUBLIC SITES

| <u>Country/Clinic</u> | <u>Per case subsidy</u> | <u>Client fee for VS</u> | <u>Avg. no of VS/month</u> | <u>Policy changes effected</u> | <u>Impact of funding decrease on other areas</u> |
|--|-------------------------|--------------------------|----------------------------|---|--|
| DOMINICAN REPUBLIC: | | | | | |
| PROFAMILIA | | | | | |
| Type 1: clinics to which supplies were donated | | | | | |
| a. <u>Azua</u> | | | | | |
| Pre-July 1988 | \$8.30 | \$7.15 | 29.8 | Fees not raised as clinic was able to assess costs and, realizing that the donated supplies plus lower subsidy resulted in a net gain in income, were able to reduce fees to clients. | |
| July 1988 to present | 4.51 | 6.82 | 43.1 | | |
| b. Santo Domingo | | | | | |
| Pre-July 1988 | \$9.53 | \$ 7.42 | 47.8 | Raised client fees. | |
| July 1988 to present | 4.57 | 11.11 | 41.6 | | |
| c. Las Matas de Farfan | | | | | |
| Pre-July 1988 | \$ 8.37 | \$10.95 | 30.6 | Raised client fees. | |
| July 1988 to present | 4.37 | 13.44 | 27.0 | | |
| d. La Romana | | | | | |
| Pre-July 1988 | \$ 7.43 | \$ 9.87 | 33.0 | Raised client fees. | |
| July 1988 to present | 4.37 | 19.56 | 27.2 | | |

TABLE II: (cont'd)

| <u>Country/Clinic</u> | <u>Per case subsidy</u> | <u>Client fee for VS</u> | <u>Avg. no of VS/month</u> | <u>Policy changes effected</u> | <u>Impact of funding decrease on other areas</u> |
|--|-------------------------|--------------------------|----------------------------|--------------------------------|--|
| 2. Type 2 clinic: no supplies donated | | | | | |
| Santiago | \$9.44 | \$ 7.64 | 75.3 | Raised client fees. | |
| Pre-July 1988 | 6.99 | 10.18 | 64.5 | | |
| July 1988 to present | | | | | |
| 3. Clinics dropped from program entirely, i.e., no longer receiving subsidy or supplies | | | | | |
| a. San Juan | | | | | |
| Pre-July 1988 | \$8.24 | \$18.28 | 18.0 | Raised client fees. | |
| July 1988 to present | 0 | 82.94 | 6.5 | | |
| b. San Pedro de Macoris | | | | | |
| Pre-July 1988 | \$7.44 | \$ 7.42 | 22.7 | Raised client fees. | More middle income and fewer lower income women coming forward for services. |
| July 1988 to present | 0 | 62.60 | 15.0 | | |
| c. Bani | | | | | |
| Pre-July 1988 | \$7.76 | \$??? | 14.0 | Raised client fees. | |
| July 1988 to present | 0 | 32.08 | 6.8 | | |

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TABLE III: SUMMARY OF IMPACT OF FUNDING CHANGES ON BRAZIL SITES

| <u>Country/Clinic</u> | <u>Per case subsidy</u> | <u>Client fee for VS</u> | <u>Avg. no of VS/month</u> | <u>Policy changes effected</u> | <u>Impact of funding decrease on other areas</u> |
|--------------------------|-------------------------|------------------------------|----------------------------|---|--|
| BRAZIL: ABEPF | | | | | |
| 1. COMAM | | | | | |
| Feb. 1987 - June 1989 | \$15 | \$ 0 | 8.8 | Raised client fees. | Fewer low income and more middle-income clients. |
| July 1989 - present | 0 | \$89 | 8.0 | | |
| 2. CEMINE | | | | | |
| DATES: | | | | | |
| Sept 1983 - August 1984 | \$20 | 10%-\$0 | 58.6 | Raised client fees -- whereas before, 10% of clients paid \$0 and 40% paid fees to cover costs, after subsidy reduced to \$0, 100% of clients pay fees to cover costs. | No longer serving the "poorest of the poor," but still low income clients. |
| August 1984 - Jan 1987 | 15 | 0 10%-\$0 | 89.1 | | |
| February 1987 - present | | 100% pay fees to cover costs | 35.7 | | |
| 3. IRHPE | | | | | |
| April 1983 - August 1984 | \$20 | \$10-15 | 29.2 | 1. Raised client fees. 2. In February 1987 began to schedule TLs only during training sessions when VS costs covered. 3. Leased outpatient surgical area to physicians as day hospital to cover the cost of family planning clinic. | Let go several key staff members (technical director and psychologist). |
| Sept 1984 - Jan 1987 | 15 | \$18-24 | 30.9 | | |
| February 1987 - present | 0 | \$67-89 | 12.1 | | |

TABLE III: (cont'd)

| <u>Country/Clinic</u> | <u>Per case subsidy</u> | <u>Client fee for VS</u> | <u>Avg. no of VS/month</u> | <u>Policy changes effected</u> | <u>Impact of funding decrease on other areas</u> |
|----------------------------------|-------------------------|--------------------------|----------------------------|---|---|
| 4. CEPECS | | | | | |
| Sept 1984 - Oct 1985 | \$15 | 50%-0 | 155.6 | 1. Raised fees, instituting a sliding scale rate, based on ability to pay (almost no clients pay \$0). 2. Leased surgical areas to physicians who provide TLs are responsible for collecting fees -- 10% of which goes to CEPECS. 3. Promote vasectomy. | Decrease in number of poor clients. Also, clients are choosing IUDs because can't afford sterilization. |
| Nov 1985 - Jan 1987 | 10 | 50%-0 | 212.3 | | |
| February 1987 - present | 0 | \$73-326 | 36.1 | | |
| 5. Hospital Sofia Feldman | | | | | |
| Oct 1984 - February 1988 | \$15 | ???? | 81.5 | 1. Raised client fees. 2. Obtained government services contract authorizing payment for VS. | Service quality said to actually increase; decline in client numbers due not to funding reduction but to management decision to slow pace of TLs in order to guarantee quality. |
| March 1988 - present | 0 | \$41-82 | 75.6 | | |
| 6. CLAM | | | | | |
| March 1980 - Feb 1981 | \$81 | \$0 - | 63.2 | 1. Raise client fees, instituting a sliding scale fee. | Fewer low income women coming forward for services. |
| March 1981 - April 1982 | 40 | small | 120.6 | | |
| May 1982 - April 1983 | 23 | fee | 166.4 | | |
| May 1983 - October 1985 | 10 | | 41.9 | | |
| November 1985 - Jan 1987 | 7.50 | | 28.1 | | |
| February 1987 - present | 0 | \$97-243 | 14.4 | | |

TABLE III: (cont'd)

| <u>Country/Clinic</u> | <u>Per case subsidy</u> | <u>Client fee for VS</u> | <u>Avg. no of VS/month</u> | <u>Policy changes effected</u> | <u>Impact of funding decrease on other areas</u> |
|--------------------------|-------------------------|--------------------------|----------------------------|--|--|
| 7. CePARH | | | | | |
| October 1984 - Nov 1985 | \$15 | \$ 0 | 101.9 | 1. Institute a system of fee for services. 2. Obtained service contracts with private enterprises and city governments. 3. Obtained donations from alternative sources. | |
| December 1985 - Jan 1987 | 10 | 0 | 133.2 | | |
| February 1987 - present | 0 | 0-14 | 138.3 | | |
| BRAZIL: PROPATER | | | | | |
| December 1980 - Feb 1982 | \$118 | \$ 7 | 47.8 | 1. Instituted a two-tiered payment plan, whereby wealthier clients pay 2.5 times what poorer clients pay for services. 2. Conducted mass media campaign for male vasectomy. 3. Opened an additional clinic. 4. Plan to add infertility treatment and other services for men. Are seeing more lower-middle income clients and not so many low income clients as before. | |
| March 1982 - Feb 1983 | 56 | | 118 | | |
| March 1983 - July 1984 | 57 | | 205.4 | | |
| August 1984 - Oct 1985 | 43 | 26 | 251.3 | | |
| November 1985 - Jan 1987 | 35 | 36 | 253.6 | | |
| February 1987 - Feb 1988 | 30 | 56 | 291.3 | | |
| March 1988 - June 1984 | 25 | 79 | 345.5 | | |
| July 1989 - Dec 1990 | 25 | 99 | 496.8 | | |
| 1991 | 0 | ? | ? | | |

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TABLE IV: SUMMARY OF IMPACT OF FUNDING CHANGES ON COLOMBIA SITES

| <u>Country/Clinic</u> | <u>Per case subsidy</u> | <u>Client fee for VS</u> | <u>Avg. no of VS/ month</u> | <u>Policy changes effected</u> | <u>Impact of funding decrease on other areas</u> |
|--------------------------|-------------------------|--------------------------|-----------------------------|---|--|
| <u>COLOMBIA:</u> | | | | | |
| <u>PROFAMILIA</u> | | | | | |
| October 1986 - Sept 1987 | \$6.25 | \$ 5 | 194 | 1. Mass media campaign to promote male responsibility for family planning. 2. Contracts obtained with private companies and social security for VS services. 3. Fees for other services offered at clinic are fixed and high enough to earn a profit that subsidizes vasectomy services. 4. Sliding scale fee implemented. | |
| October 1987 - Oct 1989 | 0 | 5 | 135 | | |
| November 1989 - present | 12.00 | 12 | 196 | | |
| | | (\$4-15) | | | |