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COMMUNITY DOCTORS HANDBOOK

The Enterprise Program

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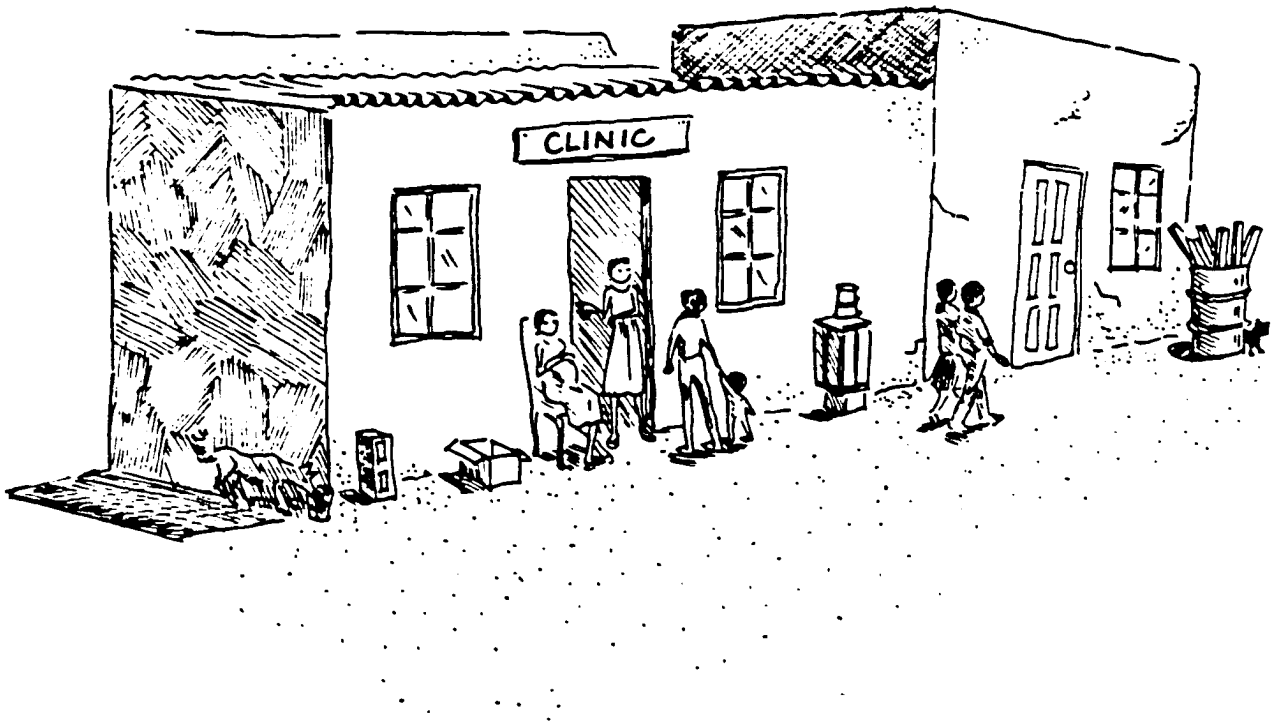

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October 1991

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Community Doctors Handbook

Introduction

A. About This Handbook

As a response to the gradual and inevitable reduction in financial assistance to many of the poor areas of the world as well as to accelerated population growth, an innovative model of health and family planning services emerged: the Community Doctor. The Enterprise Program, a United States Agency for International Development (USAID) project, contracted to John Snow Inc. financed three Community Doctors Programs from 1987 to 1991.

The Community Doctors model was started in 1986 by the Mexican Family Planning Foundation (MEXFAM) with funding from the International Planned Parenthood Federation (IPPF). The Enterprise Program provided financial support to MEXFAM from 1987 through 1990 when it designed two projects to fund 30 new Community Doctors. Enterprise transplanted the model to the Dominican Republic in conjunction with the Dominican Family Planning Association (ADOPLAFAM). One of the attractions of the model was that it would be self-sustaining within a period of two years.

The Community Doctors model (called "community-based clinics" by MEXFAM) has also been adopted by FEMAP in Mexico, as well as by groups in Honduras and Colombia, with mixed results. Considerable interest has been shown in replicating the model, in Latin America, Asia, and the Middle East. Consequently, the Enterprise Program prepared this Handbook, which summarizes the experiences obtained and presents recommendations for groups interested in setting up similar programs.

In developing this Handbook, the authors interviewed with top management in each of the associations, carried out direct observations and interviews in the field, reviewed internal documents and studies, and took into account the views of individuals who in one form or another have worked directly or indirectly with this model.

B. Who Should Use This Handbook?

The authors hope that this Handbook will serve as a guide for non-governmental organizations (NGOs), health ministries, administrative agencies and international

donors considering the possibility of using the Community Doctors model presented here, or some variation thereof. The "funding/managing institution" will be referred to as an NGO for the sake of simplicity, but this "institution" may take any form as long as it has the funds, experience, technical support and personnel to provide the necessary support for success.

The first section of the Handbook serves as a guide for determining whether the model would be applicable to a given country, geographic region or environment. The second section reviews the steps required to implement the program on the basis of the experience of the Enterprise Program. The third section covers matters related to training the doctor and his team, and the last section reviews the costs associated with setting up a clinic.

C. Background of the Community Doctors Models

In most developing countries, migration movements from rural to urban areas have resulted in the rapid development of a large number of poor urban neighborhoods, with a total absence of public services (safe water, electricity, drainage and paved streets). This in turn creates unhealthy environmental conditions and, above all, high levels of water and air pollution, which lead to significantly higher rates of morbidity and mortality. These precarious living conditions are also negatively affected by the lack of health services, including, in most cases, primary health care.

In many developing countries, governments are making efforts to provide services to these populations groups. However, the rate at which these settlements are established is markedly greater than the ability of the government to satisfy their basic needs.

In addition, the population of such settlements exhibit reproductive patterns which are typical of the rural areas from which they come, including multiple pregnancies with little spacing in between. Thus, each new pregnancy reduces the probability of survival of those children already born and decreases the level of health of the mother.

One of the alternatives which has been implemented with a view toward contributing to the improvement of the health status of underprivileged population groups in developing countries is the introduction of a model for medical service delivery by means of small clinics located in the communities themselves. This model is popularly known as "Community Doctors."

MEXFAM's Community Doctors program started in 1986 and now includes some 180 Community Doctors. ADOPLAFAM's first community-based clinics were established in March 1989, in the peri-urban areas of Santo Domingo, the capital of the

Dominican Republic. Through June 1991, this organization had a total of 30 Community Doctors.

During these years of "trial and error," both NGOs have learned lessons and made modifications to their original concept. ADOPLAFAM developed two new variations of the model and tested their basic concepts. Thus, this Handbook contains valuable insights based on the experience acquired by Enterprise through these institutions in the course of the evolution of this health care model.

D. Description of the Basic Model

The objective of the model is to reach the point of operating like a small private clinic, i.e., charging fees for the services provided. The basic difference is that the community-based clinics stress the provision of services in the areas of primary health care, family planning and maternal-child health.

The physician selected to implement the model receives training from the NGO and support in the form of furniture and equipment provided on a loan basis, with an option to buy at some future date. Some community doctors are paid fees by the NGO based on the number of new family planning acceptors, others have received subsidies in the form of a base salary or payment of rent. In addition, the NGO assists the doctor by continuing to provide technical assistance, IEC materials, follow-up training and supervision. The relationship is established through a formal agreement with a duration of two years, during which time the doctor must generate enough income to achieve a degree of financial self-sufficiency which will allow him or her to cover all of the operating expenses of the clinic, pay back the loan, and satisfy personal income needs.

As we proceed to review the major components of the basic model, the reader should keep in mind that any organization interested in establishing community-based clinics will need to develop its own operating model. The specific conditions prevailing in a given region or community will determine the particular set of characteristics to be adopted. Nevertheless, it will be helpful to gain insight into the components of the basic model and variations which have already been implemented and modified in the field.

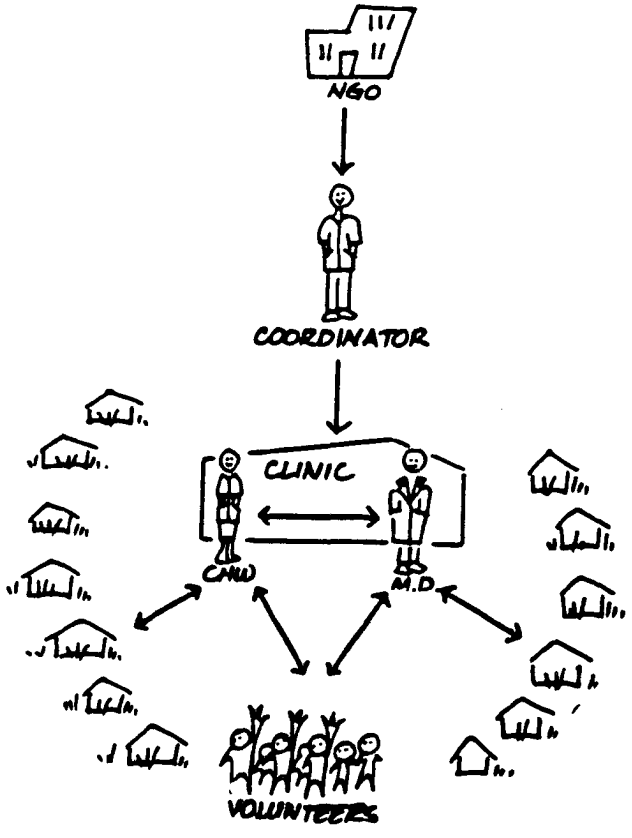
Thus, the major components of the model are as follows:

An Underprivileged Community

~~The model is designed to provide very low-cost primary health care and family~~ planning services in peri-urban, suburban and rural underprivileged communities where low-cost public or private primary health care services are not available.

The Central Office of the NGO or Managing Institution

Through its various organizational units, the central office of the NGO provides technical, logistical and financial support to the community-based clinics. This central office is charged with carrying out tasks in the areas of administration, accounting, information systems, logistics and others in order to facilitate the proper functioning of the clinic.



A Community-Based Clinic

The community-based clinic, which serves as the center of operations for the Community Doctor and community health worker, typically consists of one or two rooms and a bathroom. On very rare occasions, some clinics have added a small hospital, with two to five beds for in-patients, together with a small operating room.

A Community Doctor

Under a two-year "agreement", a general practitioner agrees to provide permanent primary health care services (with emphasis on family planning and

maternal-child health activities) in an underprivileged community. The NGO provides support in the form of material and equipment, training, technical assistance and supervision. In exchange, the doctor agrees to achieve, over a short period of time (no longer than two years), a level of financial self-sufficiency for the clinic.

A Community Doctor Coordinator

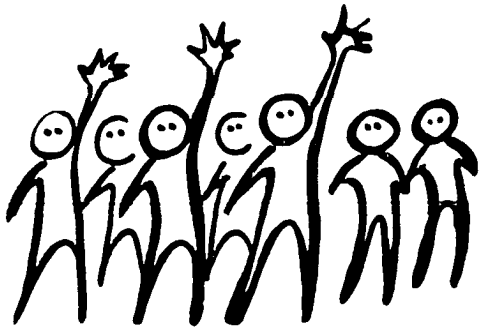
A professional trained in the area of medicine or social work and with headquarters in the offices of the NGO is responsible for supervising and providing assistance and advisory support to the Community Doctors program.

A Community Health Worker (CHW) or Coordinator of Promotional Activities (CP)

This individual (who is usually a woman), may have technical training in "auxiliary nursing," "social work," or "health education," or simply a basic education in general studies. The CHW/CP is responsible for establishing a network of volunteer promoters to carry out most of the IEC activities and for actively promoting the services of the clinic in the community. On the average, each CHW/CP is responsible for two regions in which community-based clinics have been established.

A Network of Volunteer Promoters

The CHW/CP selects volunteers from the community who are willing to carry out family planning information activities, distribute contraceptives and promote the services of the Community Doctors among their family and neighbors. They essentially form a community-based distribution system.



E. Variations on the Model

Strictly speaking, no community-based clinic functions exactly like any other, but in general terms the characteristics and method of operation from one clinic to another are similar.

Both MEXFAM and ADOPLAFAM have developed variations on the model for community doctors. These variations are described below:

■ MEXFAM: Doctors linked to public institutions

This type of model is developed when a public institution which already has facilities operating in disadvantaged communities signs an agreement with the NGO to establish community-based clinics in those facilities. This has been the case with MEXFAM community clinics linked to the National Pediatrics Institute of Mexico and the Autonomous University of Guerrero (a Mexican state). In this latter case, MEXFAM has ten clinics which are staffed by medical students completing their social service requirements. They are rotated every year and the clinic continues to provide uninterrupted services to the community.

■ ADOPLAFAM: Doctors in "Agreement"

A doctor who already has a private practice in a priority target area, has achieved self-sufficiency, and has an established clientele, signs a cooperative agreement with ADOPLAFAM, whereby the latter provides the doctor with complementary medical equipment and instruments as well as the contraceptive supplies necessary to provide family planning and maternal-child health services, together with training and technical assistance. The doctor, on the other hand, agrees to charge low fees (which are set by ADOPLAFAM) to all those clients referred by the volunteer promoters in that community.

In addition to testing the basic model developed in Mexico, ADOPLAFAM adapted it to the region's special characteristics and to the background and financial constraints of the organization. Two new "subsidy levels" were tested: one decreased the subsidies offered by the NGO on a quarterly or monthly basis; the second offered the physician no subsidies for rent, salary or fix-up costs -- the physician used money from savings accounts and sometimes borrowed money from friends or relatives to pay costs. Doctors opening clinics under this latter version were often the most successful.

Part One

I. Objectives of a Community Doctors Program

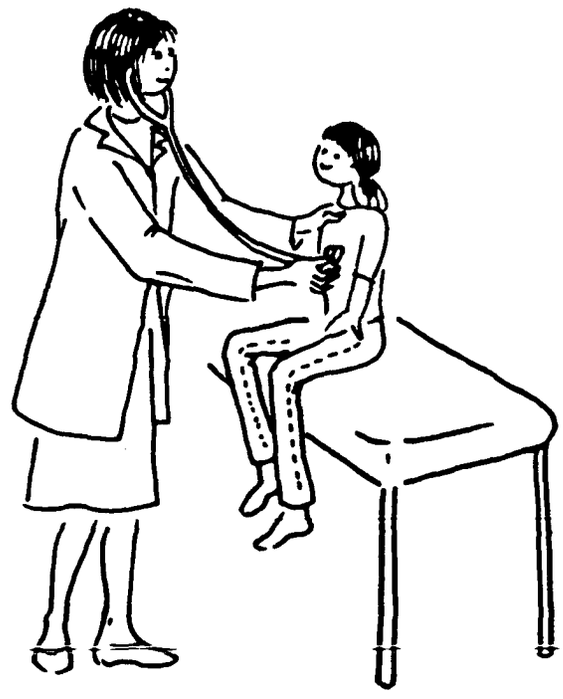
A Community Doctors program can be an effective strategy when the NGO adopts the following objectives:

a) Providing primary health care and family planning services;

b) Establishing self-sufficient programs.

A. Providing Primary Health Care and Family Planning Services

One of the two objectives justifying the establishment of a Community Doctors program is that of improving the general health status of a low-income community. Since the most serious consequences of depressed socio-economic conditions on family health are most frequently and most intensely felt by mothers and children, the reduction in the number and spacing of pregnancies, as well as the increase in the level of child health care, become key elements in a community health strategy.



The Community Doctors programs have proven to be effective in providing maternal/child health and family planning services in these low-income areas. The model has functioned as a center for primary health care delivery, linked to a network of promoters under the direction of a community health worker. The

"network" concept is important because it produces a large number of users in addition to assuring high quality service; the community promoter, who generates a large number of users, forms a part of the clinic and distributes contraceptives under the supervision of the Community Doctor and community health worker; the Community Doctor, who does not produce a large number of users (an average of 10 per cent of the total number of patients are family planning consultations), responds to the basic health care needs of the community, particularly those involving family planning and maternal/child health.

Thus, a Community Doctors program achieves the objective of providing quality medical service, information, and education in family planning and maternal child health to sectors not covered by either public systems or private medical practice.

B. Establishing Self-Sufficient Programs

In developing countries economic problems have gradually reduced the ability of public and private organizations to subsidize social assistance programs. For this reason, it has become increasingly necessary to resort to assistance strategies aimed at establishing programs which operate with a view toward achieving financial self-sufficiency. Consequently, the basic premise of the model is to attain financial self-sufficiency in a short period of time.

The following conclusions can be drawn with respect to attainment of financial self-sufficiency by the community doctors associated with the two organizations whose experiences are documented in this Handbook:

1) It is not possible to talk of total self-sufficiency, but rather of partial self-sufficiency. As a result of the economic conditions prevailing in the community as well as those of the doctor himself, it is quite difficult to generate income levels sufficient to eliminate altogether the need for financial assistance from the NGO, at least for the first three to five years. Accordingly, we shall speak of "levels" of self-sufficiency, and we shall refer to the "basic level of self-sufficiency" as being achieved at that time at which the doctor receives no further direct financial support (rent, salaries, etc.) from the NGO, and to the "optimum level of self-sufficiency" as that time at which the doctor requires no further support of any kind. Both cases assume the continuous need for subsidized contraceptives.

   In the case of MEXFAM, a recent study has shown that, in general, the doctors were able to attain the basic level of self-sufficiency within the two-year period established by the model. In most cases, beginning in the third year of operation the community doctor is generating income which is sufficient to eliminate the need to depend on the direct contributions of the

NGO. Moreover, this association now has doctors who have even attained the optimum level of self-sufficiency.

In the case of ADOPLAFAM, the basic level of self-sufficiency is attained by most of the community doctors during the second year of operation. A few doctors have reached that level within the first six months following establishment of the clinic.

2) The speed and ease with which a doctor attains the basic level of self-sufficiency will depend on the ability of the residents of the area to pay for the services, in addition to the doctor's competence and degree of integration into the community. Many times, when we speak of a "low-income population" we are grouping distinct socio-economic segments or strata under a single term. Any NGO interested in establishing a Community Doctors program must identify communities within these population groups which have the ability to pay for the doctors' services. Otherwise, it will be impossible to achieve the objective of self-sufficiency.

II. Conditions Favoring the Establishment of a Community Doctors Model

As an organization considers the establishment of a Community Doctors program, it should become familiar with those factors which have contributed to successful results in the past. Following are the principal conditions favoring program implementation based on experience of Community Doctors which the Enterprise Program funded.

A. Favorable Position of the Government Vis-a-Vis Family Planning

The favorable position of the government with respect to family planning programs has facilitated the establishment of the Community Doctors model. And although an indifferent stance adopted by the government with respect to this type of program may not favor the program, it will at least not endanger program implementation. Nevertheless, it is worth evaluating the feasibility of such a program in those countries in which the government shows opposition to the concept, as this may become a major constraint.

B. Favorable Position of Religious Institutions Vis-a-Vis Family Planning

Other institutions may exert a positive or negative influence on the development of the model (largely as a result of the emphasis placed on family planning

activities). Among these institutions, those which tend to be most influential in most developing countries are religious organizations.

Traditionally, some religions oppose the use of contraceptives. However, on occasion, the reason behind the opposition is concern for the health of the individual as a result of the lack of adequate information. In these cases, favorable results have been obtained when the Community Doctor establishes personal contact with the head of the local church or temple and provides that person with information aimed at alleviating any fears with respect to the use of contraceptives.

At any rate, the position of local churches or religious groups is a factor which may become crucially important, and it is wise not to start from a fixed assumption (whether positive or negative) but rather consider this issue in each individual region, since there have also been cases where surprisingly positive responses have been given by certain churches. For example, a Community Doctor from ADOPLAFAM operates his clinic from the facilities of an Adventist Church, and the chief collaborator of another doctor affiliated with the same NGO is a member of the Mormon Church.

C. Unemployment or Underemployment of General Practitioners

The un- or under-employment of physicians is conducive to the success of a Community Doctors model.

If general, when practitioners are unemployed, that is, when they are unable to join hospitals or establish medical practices on their own, there will be a greater supply of labor and consequently it will be easier to identify individuals eager to join the program. However, when a physician agrees to join the program solely because of unemployment, but has neither the motivation nor the conviction to provide services to the community, that person becomes a good candidate for eventual drop-out.

In addition, when doctors working for the various public health services have agreed to work part-time in the community-based program, the experience has been negative -- a full-time doctor is required.

D. Community Acceptance

Prior to establishing any Community Doctors program, one must ascertain the willingness of the community to support a program of this type. Since one of the goals implicit in the model is that the doctor eventually should achieve independence from its funding source, one condition which is essential for

bringing this about is that the community accept this medical service as something of its very own, so that following withdrawal of financial support, the area residents will continue to be a source of support and, above all, a source of income generation for the doctor.

This acceptance by the community is such a complex phenomenon that it can be affected by a variety of different factors, the most important of which are the particular values of the community itself. Hence, for example, the residents of certain communities, above all rural communities, may prefer women doctors, whereas in others they may prefer men. Some communities have rejected doctors because they were too young, whereas others have readily accepted them. In conclusion, there is no hard and fast rule to indicate what type of doctor is preferred by the residents, which makes it necessary to investigate this issue in each particular case. One method would be to interview a few chosen individuals from the community and ask them to identify what they feel are the most important characteristics in a doctor.

A key element in acceptance is provided by the community leaders: all those individuals exerting influence on the population at large -- the school teacher, religious leaders, the head of the neighborhood council, the representative of the regional authorities, and so forth. Accordingly, a doctor who devotes considerable initial efforts to gaining the acceptance of these leaders will make considerable progress toward the goal of becoming a part of the community.

E. Institutional Support from a Strong and Stable NGO

The Community Doctor needs intensive and permanent support in a number of areas -- without it, the Community Doctor will fail. In addition to financial support, equipment, and supplies the NGO must provide the doctor with training and refresher courses, promotion and dissemination efforts within the community, technical assistance, and educational and dissemination materials. A Community Doctors program demands constant monitoring, evaluation and assistance. The larger the program, the greater the demand for coordination and staffing. An NGO which does not have both financial and human resources available will not be able to implement and operate a successful program.

F. Lack of Health Service Providers in the Area

The absence of other providers of medical services in the region is an additional factor favoring future success. In fact, the recommended procedure is to ensure that a particular area is lacking in coverage before the doctor sets up his clinic, as otherwise there will be a risk of not attaining the desired level of income as a result of the existing competition.

Even so, each specific situation must be considered individually, as there have also been cases in which the new community-based clinic was successful in spite of the presence of a previously existing health service provider in the area. In this case, the following factors contribute to the competitive advantage of the Community Doctor:

- High service fees charged by the competitor relative to the economic capacity of the local population;
- Inefficient service, or "phantom service," provided by public sector providers (i.e., the health center exists but has no personnel to staff it);
- Negative attitude or incompatible personality of the other provider vis-a-vis the community;
- Work stoppage and strikes by the medical personnel of the government public health centers;
- Reduced or inconvenient office hours imposed by the competition.

G. Clients Who Can Pay

All of the Community Doctors who have succeeded in reaching a break-even point at their clinic and are generating excess income are located in areas where the residents have some purchasing power and the ability to pay a fee for health services. While all doctors have at one time or another cared for individuals free-of-charge, payment for services is crucial for success.

H. Access to Free or Subsidized Contraceptives

As mentioned previously, doctors who have attained a "base or "optimum" level of sustainability will still rely on the purchase of contraceptives at a subsidized price. Most "funding" institutions, such as NGOs, receive free or subsidized contraceptives and sell these to the Community Doctors that belong to their network, at cost.

While it would be incorrect to state that Community Doctors would not consider purchasing contraceptives at "market price," one of the attractions of the community clinic is prices which are accessible to its target population. An increase in prices would be a disincentive to use the clinic, resulting in a high drop out rate. On the other hand, if the doctor does not pass on an increase profit is reduced and the incentive for the doctor to continue in the program.

I. Non-competing Government Services

Most of the community clinics were located in areas with no health service providers. When government health services were available they were not usually perceived as competition by the Community Doctor. Government services in the countries reviewed in this Handbook were usually of very low quality and were irregular due to strikes, impractical working hours, and high absenteeism on the part of the health workers.

The clients of the Community Doctors usually preferred to pay a basic fee for services than stand in long lines and receive impersonal and sometimes unsatisfactory services.

Part Two

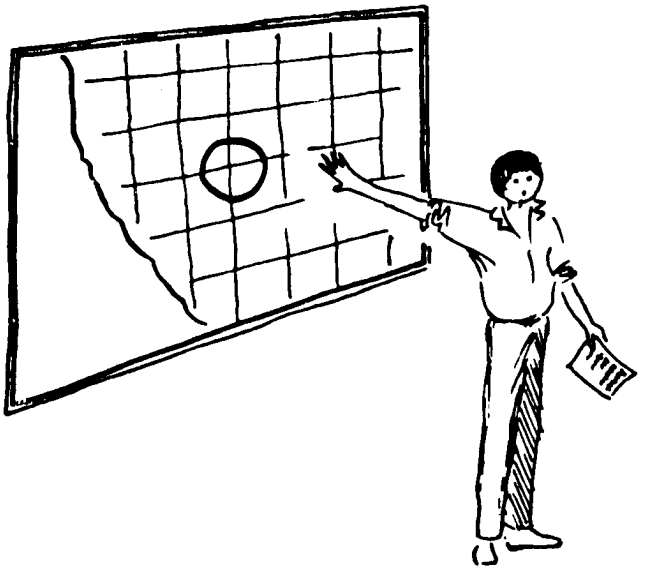
I. How to Set Up a Community Doctors Program

Following the preceding analysis of all factors which might favor or enhance the prospects for success in a Community Doctors program, this section describes the recommended steps to implement the model.

A. Selection of the Site

The selection of the site where the community-based clinic is to be set up can be based on a number of different events or actions:

- A market study;
- A proposal presented by a doctor wishing to set up a community-based clinic;
- A request made by the community itself;
- A proposal for a clinic in a given area presented by the technical or field personnel of the NGO;
- A request by health authorities.



After a site has been proposed, a physical reconnaissance is carried out to verify that no other provider of the same type of services currently exists in the area and to ascertain that the number of residents and households is sufficient to guarantee the future income of the Community Doctor.

Once the physical reconnaissance has been carried out with respect to the ~~potential service area, NGOs may follow different procedures for developing their~~ respective models:

> *ADOPLAFAM proceeds directly to the selection of the doctor and community support personnel. Since there is a single coordinator for the entire Community Doctors program and the*

relatively small size of the metropolitan area of Santo Domingo allows greater familiarity with depressed zones, the physical reconnaissance together with certain demographic data have proven sufficient to properly locate the clinics.

MEXFAM carries out a "viability or feasibility study" (for a detailed description, see Annex I at the end of this Handbook). This study is carried out in order to permit more detailed information to be obtained regarding the cultural aspects of the community, establish baseline data for a subsequent evaluation, and make it easier to secure a locale. If the study confirms the feasibility, the site is selected.

A market study is extremely important as it can ascertain whether the size of the population will be sufficient to generate a level of demand for services which will lead to self-sufficiency and it will identify existing competition. The study should be carried out by trained personnel under the direction of an independent agency.

In addition, interviews can be staged with members of the general public in order to determine their feelings with regard to medical services and make a preliminary evaluation of the health status of area residents (as specific as possible, such as the most prevalent illnesses, nutritional status, and schooling).

We should stress that the perception of demand should always be verified by means of an independent study. An unsubstantiated market has led more than one clinic down the road to failure.

B. Selection of the Community Doctor and Integration into the Community

Candidates for Community Doctor can be identified in a number of different ways:

- Public advertising through print and media channels (newspapers, radio, television);
- Recommendation of another Community Doctor or other person familiar with the program;
- Spontaneous request presented by a doctor to join the program.

Candidates for Community Doctor should be interviewed by the program coordinator and other members directly involved in the program, such as the director of operations. Through this process of interviews, an attempt is made to

identify in the candidate those characteristics which will ensure success as a Community Doctor.

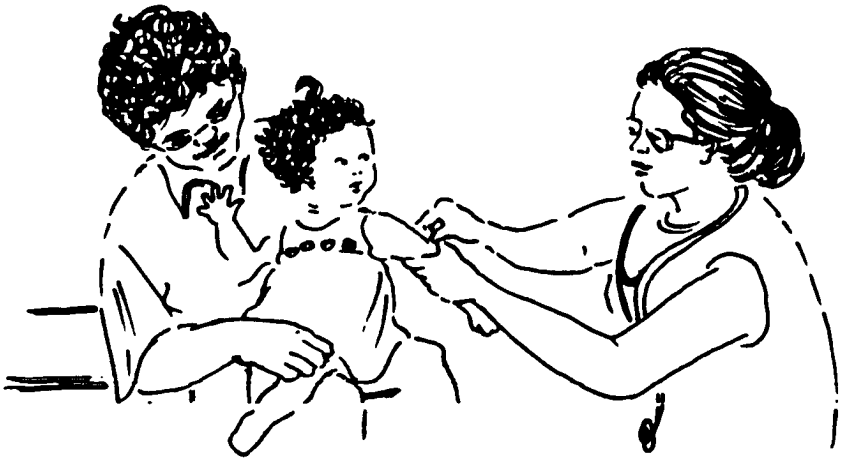
Careful selection is critical because the most serious problem with the Community Doctors programs is the high rate of turnover among doctors. Although the exact cause is not known, it is believed that some of the factors which most influence the longevity of doctors in the program are their own education, personality, and attitudes, as well as the "expectations" with which they approach their new job. Various characteristics and factors which are critically important for the proper selection of a doctor are presented below, together with a review of the "expectations" of the Community Doctor:

1. Basic Requirements

In addition to the labor law requirements which are peculiar to each individual country and each individual organization, the following additional requirements are recommended:

a. Each doctor should hold a degree, whether as a general practitioner or physician specializing in community health;

b. The doctor should be willing to live entirely on the income generated by the services provided in the clinic which would be establish in a disadvantaged community;



c. The doctor should be interested in community endeavors and in providing medical services at the primary health care level.

During the selection process, preference should be given to doctors already experienced in community work, family planning, and maternal/child health services.

ADOPLAFAM has had very positive experiences when a doctor approaches the NGO with a request to participate in the

program. The motivation shown by this type of candidate is very high, and this quality must be considered to be of crucial importance among the qualifications for selection.

2. Profile of the Community Doctor

Based on experience, the ideal Community Doctor is, in addition to a doctor, an entrepreneur, a salesperson, a psychologist, an anthropologist, a teacher and a businessperson. The doctor must practice of medicine, sell ideas and projects, provide counseling with regard to emotional and psychological problems, show an understanding of the cultural traditions and social relationships existing in the community, inform and educate, and, lastly, run the clinic as a personal business.

A list of some of the personality traits which work in favor of the eventual success of a program of this type are listed below:

Profile Checklist

- ✓ Service oriented, since on occasion the doctor will have to carry out unremunerated activities or activities requiring more work than normal;
- ✓ Optimism, a positive attitude, and above all faith in the success of his business;
- ✓ Initiative and creativity in developing new forms of promotion and education, as well as originality in problem solving;
- ✓ Adaptability, that is, the ability to respond to a wide variety of constantly changing situations;
- ✓ Ability to socialize, as it will be necessary to establish a wide variety of contacts with different groups and local organizations;
- ✓ Self-assurance and persuasiveness, as on many occasions it will be necessary to enthuse others;
- ✓ Easy going nature, fluency of speech and ability to speak in public, as the doctor's role as community educator is extremely important;
- ✓ Openness to other ideas, customs or values, since with certain frequency it will be necessary to face community resistance to family planning or other health interventions;
- ✓ Ability to negotiate, since it will be necessary from time to time to make trade-offs and concessions, rather than impose one's will, in order to achieve an objective;
- ✓ Receptiveness and the ability to listen to others and show interest in their opinions;
- ✓ To be fully convinced of the benefits of family planning on a personal level, since the interaction of the doctor with the community projects the doctor's individual beliefs.

3. Expectations of the Community Doctor

In addition to satisfying all of the expectations of the NGO, it is essential that the doctor satisfy all personal expectations, feel content in the work, and not be plagued by high levels of frustration. In analyzing the reasons behind the drop-out levels observed in the program, several physical and psychological obstacles were discovered. The expectations found in doctors were as follows:

- To enjoy freedom in carrying out their work;
- To feel authority or influence over groups;
- To enjoy prestige and recognition in the community;
- To have support from the NGO or administrative institution;
- To benefit from continuous training and refresher courses;
- To have the opportunity to grow financially.

Some doctors have dropped out of the program because all their expectations have not been fully met.

4. Entrepreneurial Mentality

In addition to the above personality traits and attitudes, to the extent possible one should determine whether the candidate possesses an "entrepreneurial mentality," i.e., whether there is a willingness to consider the clinic as a microenterprise, and on this basis develop a strategy and a work plan. In addition, one may attempt to identify in the doctor a positive attitude toward nonmedical training and an ability to "sell ideas".

There are certain characteristics which are of key importance to success. Among them, the following stand out:

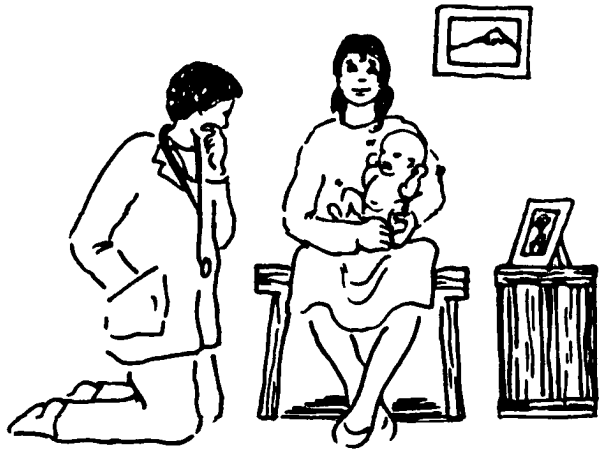
- A positive attitude toward income generation and the attainment of self-sufficiency;
- The potential to adopt an entrepreneurial operating style;
- A willingness and ability to compete with private providers already operating in the community;
- Realistic financial goals and expectations.

5. Integration into the Community

Beginning a few weeks prior to actual installation of the clinic and for sometime thereafter, the new doctor should launch an intensive campaign to promote the clinic's services and become fully integrated into the community. In addition to the doctor's own efforts in carrying out this task, the model provides for hiring a community health worker, as well as establishing networks of volunteer promoters.

The steps which the doctor can take toward full integration into the community and developing IEC activities are unlimited. Those which have most frequently produced favorable results in the existing programs are as follows:

- Contact with community leaders;
- Dissemination of information in assemblies and gatherings;
- Attendance at sporting, civic and social events in the area;
- Home visits;
- Educational talks in schools at all levels;
- Discounts in the fees charged to volunteer promoters for personal consultations in exchange for referring clients to the clinic;



- Provision of certain health services without charge outside the clinic, such as vaccinations and diagnosing chronic illnesses.

C. Selection of the "Team" and Summary of Responsibilities

1. The Direct Supervisor of the Community Doctor: the Program Coordinator

i. Selection

Another key element in the functioning of the Community Doctors model is the staff member directly responsible for supervision, i.e., the program coordinator. A positive relationship between the doctor and the coordinator, and the attitude of the latter with respect to the program, have been shown to exert a strong influence on the proper operation of the program.

Elsewhere in this Handbook a more detailed description is provided of the way in which the Community Doctors are to be supervised. However, certain observations regarding the program coordinator should be made at this time, based on experience to date.

The most important qualities the program coordinator needs to have is to be willing to give priority attention to the program and to dedicate sufficient time to it. Exhibiting a positive attitude about being available and accessible to the doctors is also very important.

Another qualification which has favored the success of community-based clinics is that the program coordinator have prior experience in community work, project administration, and/or supervision of social work.

In practice, the best performance has been obtained from coordinators having a university education and an orientation towards social or administrative work. In some cases, coordinators have been nurses with experience in administration.

Assurance of the quality of the medical service provided can be carried out by the program coordinator if he or she has a knowledge of medicine; alternatively, this task could be assigned to a consultant physician advisor, who could make periodic visits to the clinics.

ii. Responsibilities

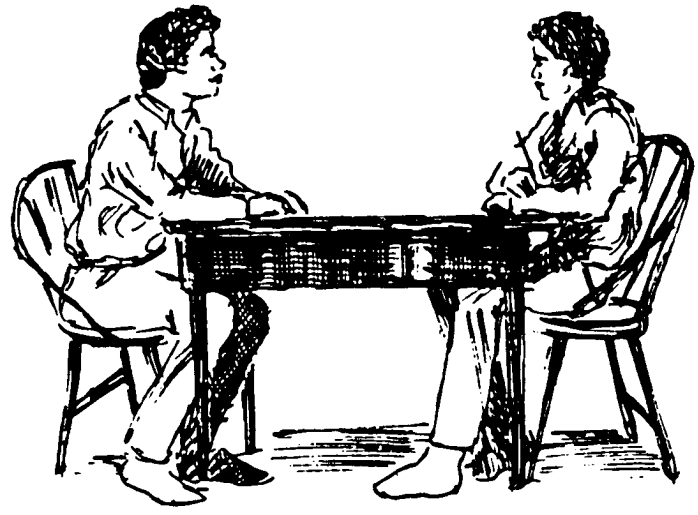
Those activities which are characteristic of the supervision and advisory assistance provided to the Community Doctors involve:

- Organization;

- Planning;
- Community relations;
- Relationships with the organization.

Supervision should be provided regularly and its purpose should be to:

- Identify problems and take steps to solve them;
- Get to know the doctor – areas of interest, frustrations, successes and failures;
- Identify the degree to which the clinic has been integrated into the community;
- Select subjects of interest to be included in monthly refresher meetings;



- Distribute dissemination and education materials;
- Maintain an acceptable level of contraceptives;
- Gather data for evaluating the program.

Advisory assistance is indispensable and is a necessary factor in the success of the clinic. Such assistance is generally required in the following areas, although it is by no means limited to this list:

- Technical-medical concerns;
- Interpersonal relationships with the community health worker, volunteer promoters or the community itself;
- Concerns of an accounting or financial nature;

- Data gathering -- how to collect and report data;

- The area of dissemination -- how to become better known in the community.

The two NGOs whose experiences are documented in this Handbook are in agreement with respect to the basic responsibilities of the coordinator but assume differing stances with regard to the time which the coordinator should dedicate to the medical staff:

> *In the MEXFAM model, program supervision is carried out by a "Local Coordinator" who is responsible for a number of programs in addition to the Community Doctors program within a given geographic area.*
>
> *The ADOPLAFAM model employs a "Physician Coordinator," who dedicates 100 per cent time to the Community Doctors. Contact between the coordinator and the doctor is frequent and close, which allows everyone to be kept well-informed, and provides immediate follow-up attention to program-related matters.*

A problem that may come up with the Program Coordinator is that the time and priority attention given to the Community Doctors will depend to a large degree on personal inclinations and preferences as well as on availability, as determined by the time dedicated to other program strategies.

2. The Community Health Worker or Coordinator of Promotional Activities (CHW/CP)

i. Selection

Within the Community Doctors model, the heaviest workload in community-related work generally falls to an individual whose job it is to coordinate the activities of volunteer groups and to promote the activities of the community-based clinics. In addition, this person (which is usually a woman) is the "catalyst" for positive relations between the doctor and the community, an educator.

Some of the more salient traits of this individual have been as follows:

- Dynamic personality;

- Community leader -- someone who is already active and well-known in the community;

- An individual with the ability to coordinate and motivate.

In the case of ADOPLAFAM, the CHW is ordinarily an auxiliary nurse or health educator and is an employee of the organization, carrying out a variety of activities in addition to those involving promotional support to the community doctors. On the average, a community health worker is charged with performing promotional work for two Community Doctors, one of which is almost always a recently recruited physician and the other a longer time participant in the program.

In the MEXFAM model, the CP is sometimes a social worker but usually comes from the community itself, often a volunteer promoter exhibiting a high degree of performance and responsibility. THe CP is not hired by the organization, but rather receives financial remuneration on the basis of incentives which vary in accordance with performance indicators, such as the number of community talks delivered, number of family planning users inscribed by the network of volunteer promoters, IEC activities, etc. This individual is also responsible for other programs and can, on occasion, have as many as three Community Doctors to whom she must provide support.

ii. Responsibilities

The CHW/CP represents the contact between the doctor and the community and is responsible for promoting the microenterprise through innumerable IEC activities. Likewise, it is the CHW who selects, coordinates and supervises the network of volunteer promoters who collaborate with the program.

In the opinion of the program coordinators and of the doctors themselves, the cooperation of this individual is indispensable in the initial stages and continues to be most useful thereafter, although to a lesser extent. The role is to identify all possible means of establishing a closer relationship with the community and the community leaders, identifying their needs, and strengthening the image of the doctor in the eyes of the community.

A list of the activities and responsibilities of a CHW/CP might include the following:

Administration and Supervision

- Assisting the doctor in the selection of volunteer promoters;

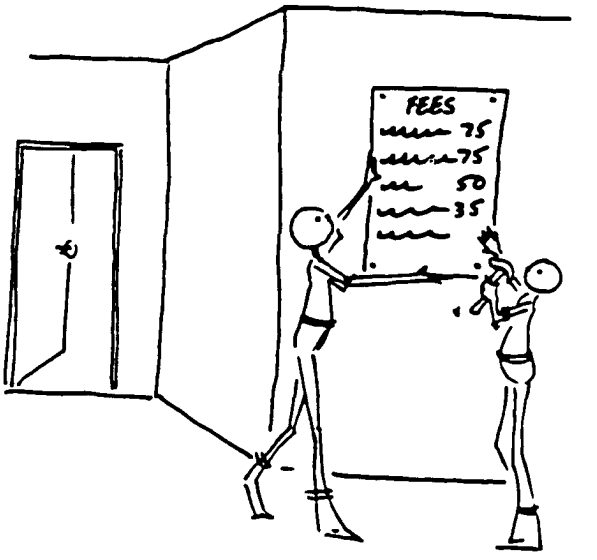
- Supervising, through regular meetings, the activities of the promoters;

- Delivering to the promoters, standard forms for the collection of statistical data necessary to prepare and submit monthly reports;

- Preparing reports for the NGO which cover activities carried out by the promoters and the CHW/CP herself, as well as recommending changes for improving the efficiency of the program;

- Maintaining an up-to-date map of the area of influence of the clinic;

- Serving as a link between the doctor and the volunteer promoters as well as between the promoters and the community.



Education

- Participating in the training of the promoters;

- Providing continuing education (in family planning, interpersonal relationships, and promotion) to the promoters under her supervision.

Community Activities

- Visiting community members and leaders in support of the activities carried out by the doctor and promoters;

- Organizing educational talks on health subjects in the schools and organized groups existing in the community;

- Distributing posters and pamphlets.

3. The Volunteer Promoters

i. Selection

The final link in the Community Doctors model and one which can contribute considerably to the success of the program is the volunteer

promoter. This is an individual from the community itself who promotes the services provided by the community-based clinic, provides information on family planning and forms a part of a network for the distribution of temporary contraceptive methods among family and neighbors. A positive relationship with the Community Doctor is indispensable inasmuch as she must become a permanent source for referring of clients to the clinic.

Precisely because they are members of the community, the degree to which the promoters are accepted by the doctor will impact on the clientele of the clinic. ADOPLAFAM developed a system of referrals and discounts for clients referred to the community-based clinics by the promoters:

> *The system consists of "referral tickets" which the promoter distributes to the network of volunteer promoters and which the latter hand out to each community member that they refer to the Community Doctor. When a patient hands this "ticket" to the doctor, the doctor offers a discount of between 30 and 50 per cent to the consultation fee. This system benefits both parties and statistics confirm the increase in the volume of patients referred to the doctor by promoters. This has generated excellent results in some cases where, during the start-up phase of the clinic, referrals from promoters constituted the bulk of the doctor's total volume of consultations.*
>
> *MEXFAM also works with a network of supporters who promote the services of the doctor, although sometimes this relationship is less formal and no special references or discounts are involved except in isolated, individual cases.*

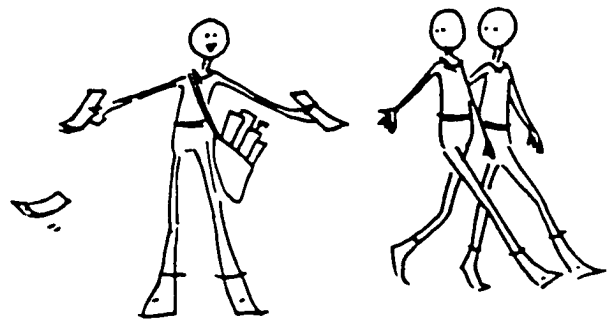
Although most promoters are women, they tend to come from a wide variety of different age groups, educational levels, and geographic areas. This mix of ages and professions (student, housewife, factory worker) generally plays an important positive role, as users tend to feel more comfortable talking about family planning with someone of their own age or profession.

ii. Responsibilities

As a general rule, the promoter:

- Promotes the establishment of the clinic in the community, the services it provides, and its hours of operation;
- Distributes temporary contraceptive methods;

- Distributes pamphlets and posters on family planning and reproductive health in general;



- Keeps the doctor informed with regard to community needs;

- Keeps detailed files on users and ensures that they make regular visits to the doctor.

D. Responsibilities and Activities of the NGO

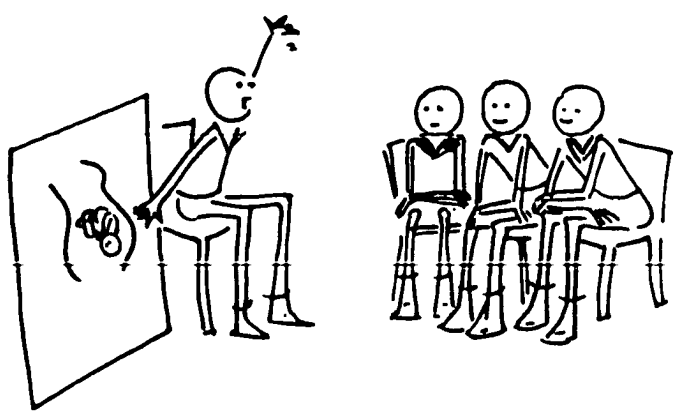
1) Direct Financial Support

A Community Doctors program demands a considerable degree of financial liquidity, the extent of which will depend on the financial aid strategy developed by the funding institution. For both MEXFAM and ADOPLAFAM, the amount originally established for the initial cash disbursement has gradually decreased as the model has improved. Nevertheless, it is still necessary to have available funds for seed capital when setting up a clinic (Section IV deals in greater detail with the costs of implementing this program).

2) Training and Refresher Courses

The Community Doctor will require both on-going and refresher training. Activities should include both formal and in-service training and deal with both finance/business topics as well as medical matters (physician training is described in detail in Section III). For this reason, an "institution" having the human and financial capacity to satisfy this need will be more likely to establish a successful program.

The same can be said regarding the ability to provide refresher courses, in terms of both quantity and quality. Doctors interviewed emphatically stated their need to be provided with printed materials on subjects dealing with current trends and developments in medicine,



inasmuch as their work schedule prevents them from seeking such information in libraries or
information clearing houses.

3) Promotion and Dissemination of Services in the Community

This activity has turned out to be one of the most important elements in the Community Doctors model. A doctor can benefit enormously if provided support in the area of promotional activities. This assistance normally consists of activities carried out by support staff on the payroll of the NGO.

The NGO should also make clear to the community that the Community Doctor enjoys institutional support, either by accompanying the doctor to meetings with community leaders, providing a sign containing the NGO's official logo, assisting in the development of IEC material for distribution, or providing supplies.

Promotional and marketing activities can include the following:

- Developing a marketing strategy aimed at community members and groups;

- Designing pamphlets on family planning and general health aimed at residents of disadvantaged communities;

- Giving talks to civic groups, schools and groups of housewives;

- Providing free services, such as taking blood pressure, in order to get to know community residents and consolidate integration into the community;

- Putting up signs to help identify the location of the clinic – in many residential areas, streets do not have names and a sign or a red or yellow arrow helps to guide residents to the clinic;

- Distributing posters and pamphlets to the community and putting them up on the clinic walls;

- Posting a list of services offered by the doctor and the fees charged;

- Producing a logo to distinguish the community-based clinic from other clinics. Often, the NGO provides this logo to the clinic as part of the cooperation agreement.

4) Educational Materials and their Dissemination

In order to properly carry out information, education and communication activities (IEC), the doctor will require both printed materials as well as audio-visual aids. Although the NGO should insist that the doctor develop basic promotional materials, the doctor will not always have the time or talent necessary to do so. Thus, the NGO should start from the premise that the doctor will require previously prepared and printed materials and provide them, since in the absence of the widest possible range of visual aids (posters, pamphlets, flyers and flip charts), the prospects for an effective community promotion campaign decrease considerably.

Pamphlet and poster designs should be field tested to confirm that the message is understood, that the colors are attractive, and that the pictures are correctly interpreted.

These materials can also be obtained from other NGOs which have produced flip charts and posters and offer them for sale.

5) Technical Assistance

With some degree of frequency, and especially during the start-up phase, the Community Doctor will face situations for which no immediate solution will be apparent. As a result, advisory assistance will be required.

In these cases, the intensive activity of a "coordinator" becomes necessary to supervise and provide advisory assistance to the doctors in the program. In this regard, favorable results have been obtained by hiring an individual for the exclusive purpose of providing advisory assistance to this program. When this is not possible, i.e., when the individual assigned to assist the doctors must also dedicate time and effort to other programs, both the quality and quantity of the technical assistance decrease. Experience shows that doctor motivation and efficiency increase in direct proportion to the degree of advisory assistance and technical support received.

Many times the advisor supports the Community Doctors with technical assistance provided through specialists in other areas of activity: a director of medical services can advise the doctor in matters involving health care, someone from the area of administration can assist in matters involving finance and organization, a member of the community promotion division can provide advisory assistance in situations marked by difficulties in

communicating with the general public or problems involving dissemination needs, and so forth.

6) Equipment and Supplies

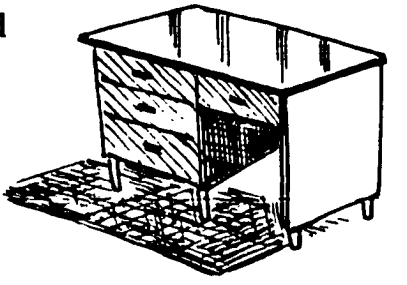
In order to facilitate the task of providing primary health care and family planning services, an efficient system for supplying basic equipment (furniture and instruments) and supplies (contraceptives and other medication) is required.

The ability of the NGO to make bulk purchases leads to a decrease in the costs of operating the model, as well as to a better functioning supply system since a good inventory will ensure that equipment and supplies are always available for the program. Accordingly, for those NGOs which already have sufficient liquidity, and large, well-conditioned warehouses, large volume purchases can greatly enhance the success of the Community Doctors program.

Once the equipment and furniture have been distributed, the NGO must maintain a list of the fixed assets, by clinic, and periodically verify their location. If budgetary concerns permit, these assets should be insured against theft, fire and vandalism. They should also be recorded by the accountant, together with the appropriate calculation of depreciation.

The doctor will be able to function better when necessary supplies for carrying out tasks are delivered in a timely fashion. For this reason, those NGOs which have a greater capability in the areas of purchasing and inventory management, and an efficient distribution system, will be able to satisfy the needs of their Community Doctors programs on a more timely basis.

It is also important to establish an inventory control system, including the design of requisition forms and procedures for their use and control. Contraceptives and medicines represent an asset to the NGO and accordingly must always be reflected either in accounts receivable or inventory accounts. Proper control is even more important when, as in the case of ADOPLAFAM, the clinics are used as regional depositories for distributing contraceptives to volunteer promoters.



7) Monitoring and Evaluation

The Community Doctors model represents a rich source of data which will permit the continuous monitoring and evaluation of program implementation, quality of care and progress made by the Community Doctors. A good

monitoring system will allow the NGO to make corrections if the project loses direction and review the program strategy and objectives in relation to field results. Although a computerized system facilitates comparative studies, particularly financial analysis, manual data collection and analysis have also provided good results.

John Snow, Inc. is developing a Quality of Care Manual that moves beyond basic "medical monitoring." It is an integrated framework for assessing and operationalizing improvement in the quality of service delivery. It is in the process of being field tested and should be available in 1992.

Following is a general supervision guide and evaluation plan which may be of use to an NGO interested in establishing a Community Doctors program:

a. Program Monitoring

Information to be used for evaluations must be gathered periodically through a continuous process of monitoring or supervision, largely by the following means:

i. Direct Observation in the Clinic

These observations are made principally by the program coordinator, although another NGO staff member may also be charged with this task. A written guide should be developed which should include, at a minimum, the following:

- Physical: general conditions prevailing at the site (cleanliness, distribution of printed material); inventory (existence of supplies and storage conditions).

- Operating: orderliness and content of the patients' clinical files. Spot check of some files to verify the technical quality of the medical care given.

- Administrative: review of financial and service information.

- Observation of patients: number of clients, waiting time between consultations, and general patient attitude toward the doctor.

ii. Conversations with Members of the Community

From time to time, the coordinator or the CHW should visit with community members, both clients and nonclients, to determine their opinion with respect to the services provided by the Community Doctor.

iii. Statistical Information on the Services Provided

The analysis of monthly statistics should serve as one indicator of the performance of the clinic, although not the most important. Quantitative data must always be accompanied by qualitative information on the performance of the Community Doctors.

When analyzing statistics, it is advisable to "read between the lines" in order to determine things such as the breakdown of consultations by type or the contraceptive mix employed by each doctor. For example, a clinic which for several consecutive months reflects a low rate of family planning users should draw the attention of the coordinator as should a low rate of IUDs in the contraceptive mix of that clinic. In these cases, prior to rating performance, a visit should be made to the doctor to identify the underlying reasons and recommend corrective measures.

It is very important that in addition to preparing numerical reports on service statistics, graphs of trends should also be prepared to aid in analyzing the evolution of the services over time. Computer software programs currently available in the market greatly facilitate this task.

iv. Information on the Financial Status of the Clinics

Each Community Doctor should submit monthly reports on the financial situation of the clinic. As with the service statistics, a doctor who reports figures which depart radically from their normal tendency warrants a visit from the coordinator to determine the causes.

It is worth pointing out that in most NGOs involved in the field of health, monitoring of the financial situation is carried out by an administrative unit other than the area coordinating program operations. Although it is not our intention to suggest that modifications be made to organizational procedures, it is advisable, in the case of Community Doctors, for a copy of the financial reports to be sent to the program coordinator so as to facilitate the joint analysis of service statistics.

v. Information Received from Other Individuals Involved in the Program (CHWs, Volunteer Promoters)

Lastly, program supervision should include the opinions (which may be requested either directly or indirectly) of the CHW and volunteer promoters with regard to the clinic.

Proper monitoring is a useful control tool and a valuable source of material for evaluation and decision-making.

b. Program Evaluation

For a program of this type, two types of evaluation are recommended: formative and summative.

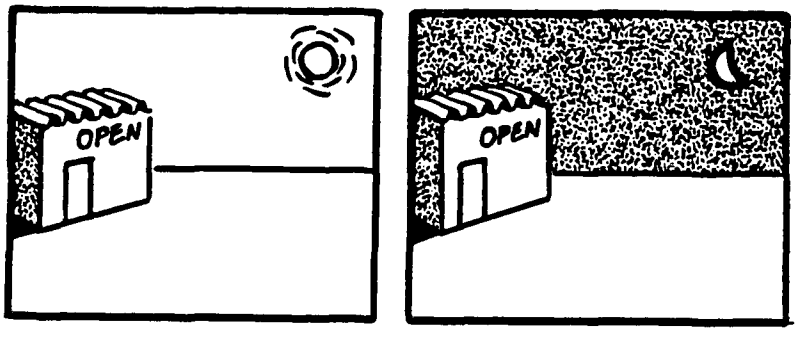
The NGO will certainly need to know whether the implementation of its Community Doctors program is achieving the objectives and goals established at the outset. It is wise not to wait too long to begin evaluation activities, but rather to make evaluation an integral part of the program implementation process (formative evaluation).

c. Monitoring and Evaluation of the Quality of Medical Service

As occurs with any other product or service, the level of the quality of medical services (as perceived by the client) will greatly influence the decision to continue using that service in the future and recommending it to others.

The clients of a community-based clinic perceive the quality of service principally through the following:

i. Availability of the Doctor.



In the two NGOs who have documented their experience, one of the variables shared by their most successful Community Doctors is round-the-clock availability of medical service. This availability represents both greater income and greater community trust. In order to achieve this degree of availability, the doctor lives either in the medical center or in the community itself, and has another doctor who substitutes during part of the day.

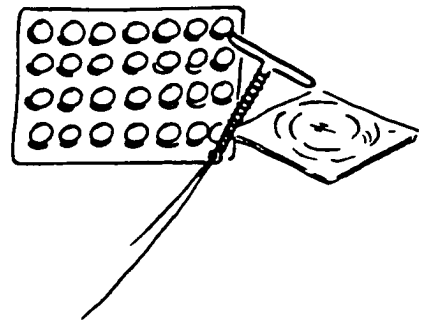
ii. Doctor-Patient Relationship.

The client perceives greater quality when he or she is treated in a friendly, cordial manner and when information and explanations are provided in addition to prescriptions for medications.

iii. Technical Level of the Doctor.

When people perceive errors of a medical nature, it greatly affects their trust in the person committing the errors. The NGO must carefully monitor the quality of medical procedures to ensure the health and safety of clients and, as an added benefit, to ensure the success of the program.

iv. Availability of Contraceptives and Medicine.



Something else which will dampen a client's motivation is if the doctor does not have the medication recommended, especially if that medication is a contraceptive. Of course, the doctor cannot be expected to carry every possible type of pharmaceutical supply, but to the extent that it is possible, clients will be much more satisfied. The doctor should have on hand, at the very least, basic medications commonly used in maternal/child health and family planning.

v. Physical Conditions of the Site and Equipment.

Another important point is for the clinic to be kept in the best physical condition possible. Sometimes, the difficulty in finding a locale in which to install the clinic makes it necessary for the doctor to rent rooms with insufficient lighting or ventilation. Such a situation can be offset by painting the walls white and keeping the site scrupulously clean. In other instances, there may not be sufficient water available in the area and the doctor will have to put forth even greater efforts in order to keep the facilities clean and suitable for service delivery.

In order to achieve the above goals, evaluation parameters should be established from the outset. These parameters represent the specific objectives and goals of the program -- essentially, what is to be done, how it is to be done and over what period of time. The data and information obtained from continuous monitoring should be regularly compared against these parameters: "Are we achieving what we set out to achieve, in the time frame which we established, and in the way in which we planned?"

Although there is no formula for determining how often a health program should be evaluated, we can state that, as a result of the specific characteristics of this model, one evaluation should be carried out after the first six months, a second after one year of operation and a third following two complete years of operation. This will allow timely corrections to be made to both trends and strategies.

In addition, it will also be necessary to perform a retrospective analysis of the situation at the end of the first period. This is know as a summative evaluation, and it is absolutely essential that a determination be made at the outset as to exactly what will be required at the end of the project.

One very important recommendation is that, prior to program start-up, information be obtained which will serve as "base-line data", i.e., it is necessary to have a photograph of the situation "BEFORE" in order to be able to compare it with the situation "AFTER", which will be obtained following completion of the evaluation. Some NGOs have experienced problems when, after two or three years of operation, they decide to undertake an evaluation of their Community Doctors programs and find that they have no data against which to compare the results.

E. Cooperative Agreement

Once the selection process has been taken care of, the Community Doctor signs a cooperative agreement with the NGO which establishes the bases for the work relationship between both parties. Even though the doctor works independently and merely forms a part of a franchise operation, the agreement must allow the NGO to recover its furniture and equipment if the doctor does not live up to his commitments or if the clinic does not show progress. In spite of the existence of individual variations, the following premises may be established:

- The NGO provides the doctor with a loan of furniture, equipment and medical instruments for a period of two years. At the end of this period, the doctor will have the option of purchasing these articles based on a partial payment plan. It is very important for the doctor to know exactly how much to repay the NGO, and that the faster the equipment is paid, the sooner the clinic will be "independent." There have been several cases in which the doctor has begun to pay off the loan before completion of the two-year period.

- Generally speaking, the equipment is fully depreciated during the first two years of use, which means that the doctor pays the NGO approximately 50 per cent of the original purchase value. In theory, the NGO would have to receive payments from two existing clinics in order to open one new clinic. However, our experience indicates that if inflation during those two years is very high, less equipment will be bought with the same amount of

money and if the purchasing power of the foreign currency used to acquire equipment decreases, the amount that can be purchased will also decrease. In many cases, payment for the equipment, after a period of two years, covers the cost of only a small percentage of a new set of equipment. The NGO will have to carefully analyze its strategy – if it wishes to create a rotating fund with which to open new clinics using payments for equipment loaned to existing clinics, it will, at the very least, have to adjust for inflation or assume a businesslike attitude and charge a minimum interest on the "loan" being offered to the doctor.

- The NGO may decide to assist the doctor during the first year with rent payments. In many cases, the NGO begins by subsidizing the locale for the first three months, and then gradually reduces the subsidy over the following quarters. In other cases, 50 per cent of the rent is paid using the same formula.

- The NGO may even decide to pay the doctor for certain family planning consultations (first-time visits) during the initial months of operation. In the beginning, ADOPLAFAM guaranteed the doctor a monthly income equivalent to so many "minimum salaries", but quickly discovered that this reduced the incentive for the doctor to go out and attempt to build up a clientele as there already was a "guaranteed" salary. In addition, MEXFAM offers financial assistance to some of its doctors, and pays them an estimated amount based on an average number of monthly consultations, based on the judgement of the program coordinator. In order to ensure that the doctor does not entertain the notion that the NGO is paying a fixed salary, the economic benefits are distributed based on promotional activities. For example, for each community talk given, the doctor receives the equivalent of five family planning consultations. The coordinator gradually withdraws this type of incentive as medical services begin to increase.

- The NGO may decide to take on the responsibility of getting the clinic physically ready for operation and providing it with identifying signs and the like. Funds are often available for painting the clinic and complying with health department regulations.

- The NGO agrees to deliver contraceptive supplies to the doctor at cost and provide free educational materials, including posters and brochures.

- The NGO agrees to train the doctor and provide technical assistance and supervisory support, as well as to coordinate the activities of the community health worker and the volunteer promoters.

In exchange for the above support, the doctor agrees to:

- Promote primary health care services in the community;
- Make special efforts to disseminate information on the availability of family planning and maternal-child health services;
- Abide by the legal and administrative rules and regulations of the NGO;
- Consolidate integration into the community by means of meetings, talks and visits to community members, including civic groups, schools and associations;
- Maintain hours of operation which are accessible to the community;
- Adhere to the plan for repaying furniture and equipment.

Termination of a Contract with a Community Doctor

When a contract signed with a Community Doctor expires, the NGO generally assesses, through the program coordinator, whether the doctor has reached the basic level of self-sufficiency required to operate independently. Although the NGO agrees to support the doctor for a period of two years, this does not mean that at the end of that period assistance will be abruptly cut off. The coordinator determines whether constraints unrelated to doctor performance have hindered the doctor from achieving self-sufficiency, in which case an extension of a few more months may be granted. MEXFAM goes so far as to feel that even if self-sufficiency is not attained, the doctor and the clinic continue to represent, in many cases, an efficient way of serving a disadvantaged community.

Upon expiration of the two-year contract (or in certain cases prior to the expiration date), the NGO offers to sell the furniture and equipment to the doctor, based on the payment plan established in the contract, together with adjustments made for any changes in the established time frame.

After the contract has expired and basic self-sufficiency has been attained, the doctors are formally integrated into the program: they are visited with a certain degree of frequency, they receive support in the form of contraceptives which are provided to them at cost, they are given educational materials, and they continue to receive invitations to attend training events.

If the doctor is unable to complete the two-year period, all equipment, furniture and materials must be immediately returned to the NGO.

F. Installation of the Clinic and Start-up of Services

Once the training has concluded and the agreement has been signed, the doctor and the NGO prepare their strategy for opening a clinic in an area recommended by the feasibility study. A rental contract is signed with the owner of the building (if it has not been possible to obtain this service in the form of a donation), the NGO purchases and installs the equipment (Annex II at the end of this document contains a list of equipment, furniture, and basic medical instruments), and the opening of the clinic is announced. Dissemination of information about the clinic opening can be accomplished by distributing fliers among the community as well as with an opening ceremony. Another possibility is to form a support committee which would be in charge of announcing the arrival of the doctor in the community.

In this stage, the program coordinator confirms with the doctor the program goals, the hours the clinic will be open to the public, and the fees to be charged. Since the NGO and the doctor both have goals to be achieved based on projected cash flow, the doctor is assigned a numerical goal which must be met. While in the beginning it is important to have flexibility with regard to compliance with quantitative goals, it is important for the doctor to work with a numeric parameter as a reference point. The criteria set by the coordinator constitute a mechanism designed to avoid extreme situations of laxness or intransigence.

With regard to hours of operation, these will be determined by the doctor based on the needs of the community, and especially the needs of women and mothers, who make up the bulk of the doctor's clientele. This is an important point because clinic hours must coincide with the hours during which the community is able to attend the clinic. Naturally, round-the-clock service (identified by a sign indicating "24-HOUR MEDICAL CARE" has shown itself to be most effective.

With regard to fees,

> *MEXFAM assigns a fixed fee which the clinic must charge for family planning consultations (US$1.00), and has a flexible policy allowing the doctor to establish fees for all other consultations. At the time this Handbook was being prepared, the average consultation fee under this program ranged between US$1.00 - $5.00.*
>
> *ADOPLAFAM grants their doctors the freedom to set their own fee policy within reasonable parameters, with the exception of clients referred by the network of volunteer promoters, who are charged a reduced fixed fee of approximately US$1.00. At the time this Handbook was being prepared, the average fee for doctor's services provided under this program ranged between US$1.50 - $2.00.*

Part Three

I. Training of the Community Doctor

Training, both formal and in-service, as well as continuous refresher courses are indispensable to the success of a Community Doctors program.

There are three broad groups of subject matter in which Community Doctors require training:

A. Subjects dealing with health (medical practice, sexuality and family planning, reproductive health, maternal-child health);

B. Subjects involving small business administration (basic accounting, break-even calculations, advertising and sales techniques, cash flow, interpersonal relationships);

C. Subjects related to information, education and communication.

In addition to the above, the NGO also decides when to provide training in other areas, such as how to track information, which may be necessary for smooth operations in the clinic.

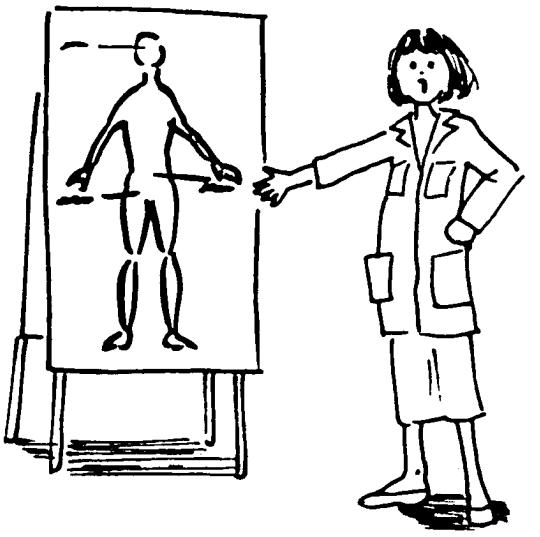
With respect to the appropriate way to implement the training process, both NGOs have made use of formal courses. ADOPLAFAM began with a version consisting of a total of 70 hours, half of which dealt with theory and the other half with practice in IUD insertion. It has recently modified this process, by opting to keep the theoretical portion at 35 hours and reducing the practical sessions to a total of 20 hours, for a total of 55 hours. MEXFAM, on the other hand, works with a formal training scheme of 56 hours, with 41 hours dedicated to theory and 15 to practice.

A. Training in Medicine

Both NGOs have focused their efforts on basic health-related subjects. A typical agenda for training community doctors might include the following:

- Community medicine and health indicators
- Responsible parenthood and family planning
- Reproductive risk

- Contraception
- Side effects and their management
- Reproductive health
- Sexually transmitted diseases
- Prevention of cervical-uterine cancer
- Maternal/child health
- Sexuality
- Practice in IUD insertion
- Counsellling
- Referrals
- Client followup



Summarized below are some observations and general recommendations with respect to the training of Community Doctors which were compiled during the process of documenting this Handbook:

1. The way in which doctors are invited to attend a course is critically important. The doctors should be advised of the training event considerably ahead of time and be provided with details regarding course content. Although attendance at the initial training activities presents no problems, the doctor's work day does not facilitate attendance at follow-up courses and attendance at these courses is crucial to decreasing the recent high turnover rate.

2. It is best to program several short sessions (4-6 hours) to be held separately (weekly, monthly or bimonthly) than to give an entire course all at once.

3. The course should include subjects of interest to doctors, whether or not they are related directly to the development of the program, as this encourages them to participate.

4. Since training budgets are generally small, effective means should be found to invite well-known medical specialists to participate in the training programs without charging a fee.

5. When it is not possible to secure the participation of such specialists, one method which has been most effective is to develop seminars and workshops where the doctors themselves prepare the topics in small groups and present those topics to the rest of the participants. In this case, the key to a successful seminar is to provide the doctors with all necessary material prior to the beginning of the workshop (including previously prepared audio-visual aids) and sufficient time to prepare their presentations.

6. Finally, it is advisable that the training content include certain basic aspects of demographics and population-related topics. In this way, some of the prevailing myths involving family planning can be dispelled if information on the demographic situation and general health status of the population is provided from a broader, more integrated perspective.

B. Training in Administration and Finance

Basic financial and business training for Community Doctors is essential for the success of the clinic. A knowledge of the financial health of the clinic and how it can be improved is of key importance to the doctor. ADOPLAFAM provided a short course in microenterprise administration where the participants expressed interest in and need for such training. The absence of such training in the past, has hindered the success of a community clinic on more than one occasion.

Neither of the two NGOs which served as models for the development of this Handbook provide a systematic approach to this type of training. The following recommendations, therefore, reflect experience acquired in the management and supervision of community-based programs. (Annex III provides a sample agenda).

The training areas we recommend for Community Doctors include the following:

1) Small Business Administration

- Importance of administration in managing a clinic.
- The planning process (includes concepts of strategic planning).
- Decision-making with regard to enterprise management.
- Task organization.
- Elements of control - administrative follow-up.

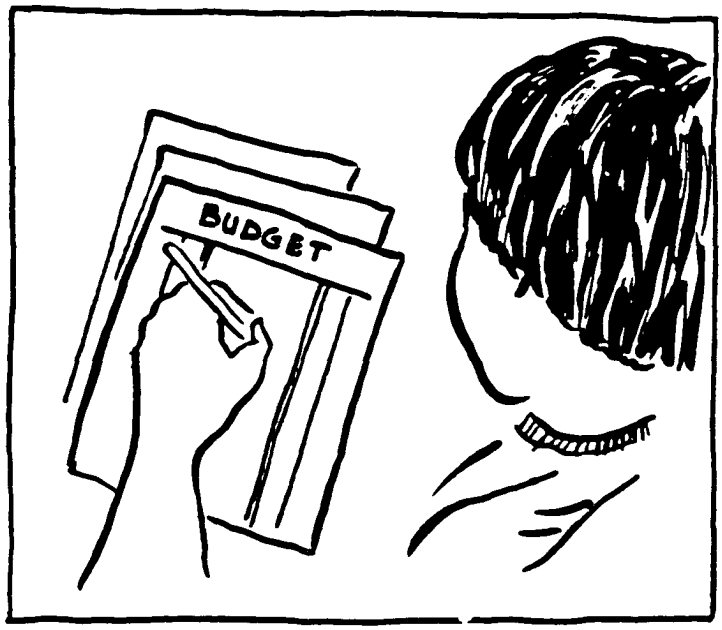
2) Basic Accounting

Accounting is a subject which often is frightening to most doctors but is nonetheless indispensable for the proper management of a clinic. What a

Community Doctor needs to know about accounting is only the basics, and care must be taken not to be overwhelming with too many different concepts. Every effort should be made to properly motivate the doctor in this regard, by stressing the usefulness of this training.

Some of the topics which might be presented in a training program in basic accounting include the following:

- Importance and usefulness of accounting in the management of a medical clinic.
- Management of liquid assets.
- Cash - petty cash and fees collection.
- Income register.
- Expense register.
- Accounts receivable register.
- Accounts payable register.
- Monthly balance sheet and preparation of financial statements for the clinic.



3) Preparation and Management of the Operating Budget

Although Community Doctors manage small operations and will not see an immediate need to develop a budget, others have expanded the clinics and have shown interest in further developing their entrepreneurial skills.

4) Calculation of the Volume of Services to be Provided

In preparing a twelve-month cash flow statement, the variables that determine the number of patients per month must be taken into consideration, such as holidays, religious feast days and seasonal changes. By using a cash flow statement, the doctor can measure progress and compare income and expenses to the final goal, which is to reach the break-even point.

5) Calculation of the Break-Even Point

It is important to know how many patients are needed to cover operating costs and how much to charge for each consultation. The monitoring of these numbers motivates the doctor to be more active if the programmed weekly or

monthly goal is not being met and offers encouragement when the goal is approached, since this points to the eventual self-sufficiency of the clinic.

6) Costing and Pricing Services

Almost every doctor will require technical assistance in calculating costs and determining the price of services. Since NGOs generally allow the doctor to establish fees, the doctor will have to determine the "market price" in the neighborhood and make any necessary adjustments.

7) Considerations with Respect to Inflation

In particular, information should be provided on the way in which inflation affects prices, volume of patients, and the purchase of equipment or materials.

8) Loans

Neither of the two countries whose experiences are documented in this Handbook have commercial banking policies which encourage banks to grant loans to Community Doctors who are at the same time members of a low-income population group. Nevertheless, ADOPLAFAM has assisted its Community Doctors attain small loans from a private community development organization. In these cases, the NGO acts as guarantor for the doctor.

Other topics include the following:

9) Determining Working Capital Requirements - How Big a Reserve is Necessary

10) Determination of Earnings and How to Increase Them

11) Prospects for Financial Growth

12) Inventory Register

13) Asset Register

14) Sources of Supplies Including Free/Subsidized Contraceptives and Drugs (name brand and generics)

15) Supply Management

The course should be designed as a workshop, using practical exercises for each subject together with examples and cases related to medical practice, preferably taken from other community-based clinics. One should avoid attempting to give

in-depth treatment to any concept; likewise, highly technical vocabulary should also be avoided.

The Enterprise Program has developed a handbook entitled *Basic Business Management Manual - A Handbook for Small Family Planning Enterprises* to assist owners and administrators of maternity clinics, health clinics and other small medical service establishments providing family planning services. Basically, the handbook covers the areas of basic accounting, business planning, and financial decision-making, which every administrator should understand to successfully manage a business.

C. Training in Information, Education and Communication

In addition to training the doctor in financial management, and methods for organizing and controlling the activities of a small enterprise, it is essential that the doctor understand the techniques of sales and marketing, since the activities of the Community Doctor involve a continuous process involving the purchase and sale of services.

The following subject areas are suggested for discussion:

- Importance of the role of marketing in the "optimum" development of the clinic.
- Definition of "market" in the doctor's environment.
- The marketing process:
  - Market analysis (real and potential demand)
  - Market segmentation
  - Analysis of the competition
  - Development of promotional and advertisement strategies aimed at increasing the demand for health services
  - Development of promotional materials including use of colors, layout, and graphics
  - Field-testing and production of the above-mentioned promotional materials
- Evaluation and refocussing of marketing strategy.

II. Training of the Community Health Worker

The community worker in many cases will be the catalyst for activities carried out in the clinic. Solid training and leadership qualities will be key factors in the output of the community health worker and the success of the clinic.

There are three broad areas of subject matter in which the community health worker will require training:

A. Health-related subjects (family planning and maternal-child health, responsible parenthood, and reproductive health)

B. Subjects involving administration of the clinic and supervision of the volunteer promoters

C. Subjects dealing with community integration, information, education, and communication.

ADOPLAFAM offers a largely theoretical training course with a duration of 70 hours, which includes frequent classroom demonstrations.

A. Training in Health

Health training must prepare the community health worker to carry out the following:

- Identify each of the contraceptive methods, together with their respective contraindications and side effects.
- Develop the ability to manage nonclinical methods.
- Describe the most important aspects of common maternal-child health problems.
- Distinguish between vaccines to be given to pregnant women and those to be given to children.

- Describe the signs and symptoms of dehydration in children.
- Develop the ability to prepare a homemade oral rehydration solution.
- Develop the art of counselling and side-effect management.
- Create a referral system and a follow-up protocol

B. Training in Administration

Many times, the community health worker is both the administrative assistant to the doctor as well as the person who selects, trains and supervises the Volunteer promoters; accordingly, the individual must receive training in the following subject areas:

- Program administration.
- Procedures for filling out the statistical forms of the community-based program.
- Procedures for selecting and supervising promoters.
- Procedures for maintaining an inventory register.
- Methods for decreasing costs.
- Supply management.

C. Training in Community Integration, Information, Education and Communication

The following subject areas should be included for discussion:

- The importance of community integration.
- Managing educational talks.
- The most important aspects of conducting an interview.
- Ways to motivate the community and volunteer promoters.
- The importance of marketing in promoting the clinic.
- Development of promotional materials.

A typical agenda to cover the above areas might include the following subjects:

- The importance of family medicine
- Maternal/child health problems
- Anatomy and physiology of human reproduction
- Human sexuality

- Responsible parenthood - case studies
- Contraceptive methods - definition and classification
- Oral contraceptives - action mechanism, effectiveness, contraindications, side effects, and demonstrations
- Contraceptive methods using chemical barriers - vaginal foam, vaginal tablets - action mechanism, use, demonstrations
- Condoms - their use
- Voluntary feminine and masculine surgical contraception
- Intrauterine devices (IUD) - Lippes' loop, copper T, contraindications, side effects, effectiveness
- Breast feeding and its importance
- Infectious-contagious diseases
- Diarrhea - prevention and treatment - signs of dehydration, oral rehydration, preparation of homemade rehydration solution
- Pregnancy, importance of control, immunizations, hygiene during pregnancy
- Control of child health - immunizations
- Aspects of national demographics
- Community integration and its importance
- Responsibilities of the community health worker
- The educational talk - preparation, delivery, and evaluation
- Techniques of interviewing
- Administrative program management
- Forms - how to fill them out correctly
- How to supervise and motivate
- Orientation and discussion of field work

A test can be administered before and after the training course and participants can be given an opportunity to evaluate the course.

III. Training of the Volunteer Promoter

The volunteer promoter promotes the services provided by the clinic in the community and distributes temporary contraceptive methods. Training must provide information about community health and guidelines to allow the systematization of education and information in the area of primary health care. As a rule, the course covers a total of 40 hours over a period of five days. There are two general areas of subject matter in which the volunteer promoter will require training:

A. Subjects involving a basic knowledge of health (disease prevention, signs and ~~symptoms of major diseases, child survival, environmental sanitation and~~ family planning).

B. Subjects involving community motivation and methods for gathering data on clientele.

A. Training in Primary Health Care

At the conclusion of their training, the Volunteer Promoters should be able to do the following:

- Describe the "how to" mechanism of the most commonly utilized contraceptive methods in the country.
- Identify the contraindications and side effects of contraceptive methods.
- Identify the signs and symptoms of common diseases.
- Make referrals to community health clinics for health care and contraceptive use.
- Teach mothers how to prepare oral rehydration solution.

B. Training in Community Integration and Methods for Gathering Data on Clientele

The training should enable the Volunteer Promoters to do the following:

- Organize the community.
- Develop community informational activities in disease prevention, responsible parenthood, breastfeeding, environmental sanitation and family planning.
- Describe the phases of an interview.
- Fill out user identification cards, control books and forms.
- Provide detailed information on each contraceptive method they sell.

A typical agenda covering these two areas might include the following topics:

- Why do we get sick?.
- General hygiene
- Respiratory infections
- Diarrheal disease
- Expanded immunization programs
- Prenatal and postnatal care

- Low birth weight
- Breastfeeding
- Child feeding and malnutrition
- Growth and development
- Principal causes of maternal and child death
- Responsible parenthood
- Family planning
- Anatomy and physiology of human reproduction
- Sexually transmitted diseases and AIDS
- Contraceptive methods - definition and classification
- Oral contraceptives - use, indications, contraindications, side effects, and demonstrations
- Barrier contraceptive methods - condoms, vaginal foam, vaginal tablets, others
- Feminine and masculine sterilization
- Intrauterine devices (IUD)
- The role of the leader and the community
- The community and the volunteer
- The home visit
- The census - the map - the referral system
- Techniques of interviewing, talks and debates
- Theory and practice of program administrative management

Part Four

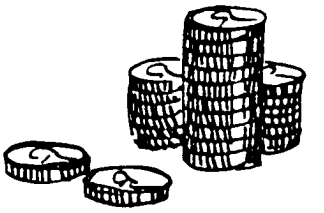
I. Costs of Establishing a Community Doctors Program

The costs of establishing a Community Doctors program can be divided into the following categories:

A. Start-up costs

B. Operating costs

C. Turnover costs



A. Start-up Costs

These may include:

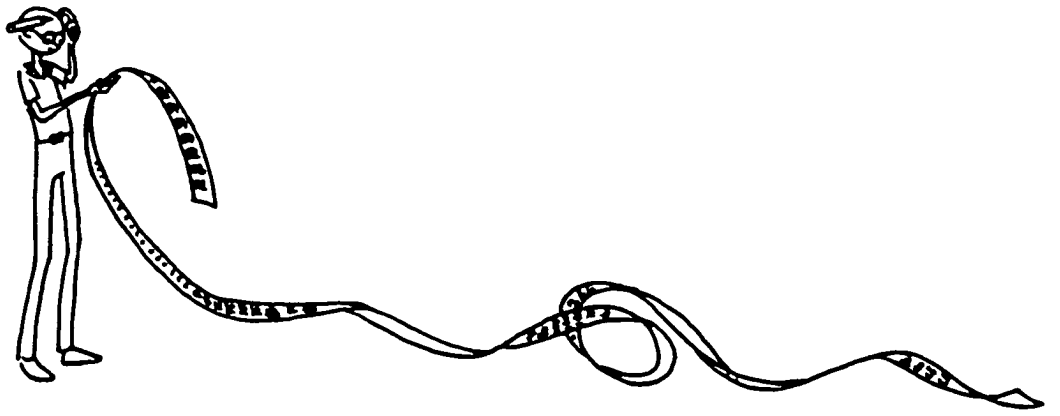
- A market/feasibility study;
- Staff time to assess the viability of a location, interview candidates for Community Doctor and health worker, negotiate and secure a location for the clinic, and prepare forms and guidelines;
- The purchase of equipment, furniture and medical supplies;
- Rent advances;
- Preparation of site (paint, department of health requirements, logo preparation, flyers).

B. Operating Costs

These usually include:

- Salaries for "funding institution's" staff (Director, Program Coordinator, Accountant);
- Salary or in-kind payment for the Community Health Worker or Coordinator of Promotional Activities;

- Transportation, which at a minimum includes maintenance, gasoline, and spare parts, but which may also include the purchase of a vehicle;
- Rent and maintenance of clinics and warehouse;
- Office supplies;
- Overhead;
- Design and production of IEC material;



C. Turnover Costs

This cost is much more difficult to identify and quantify. Based on Enterprise's experience, a high turnover rate among doctors can, in addition to being a financial drain on the "funding institution" cause a morale problem among the doctors. It may also result in lower client satisfaction and a high drop-out rate among family planning users.

Every time a Community Doctor leaves the program, it implies higher program costs: a new recruitment process, additional staff time, training in health and business issues, developing a new working relationship with the CHW/CP and volunteers, and a new processs of integration into the community.

A careful recruitment process addressed in section B of Part II should help eliminate high turnover among doctors.

II. The Enterprise Program Experience

This part will refer to the estimates prepared by MEXFAM and ADOPLAFAM with regard to the costs of installing a community-based clinic, as well as to certain data and observations regarding operating costs.

In the case of MEXFAM, the numbers represent the cost of a community clinic during the two years it usually takes to reach a sustainable point. In ADOPLAFAM's case the numbers are somewhat misleading because "average" numbers have been used since the program is too new to have tracked clinics for two to three years. Therefore, numbers include costs associated with doctors that are no longer in the program as well as doctors that reach a break-even point in one year or less.

With respect to the purchase of equipment and supplies, an NGO which has the necessary financial and logistical capabilities may, providing that the economic situation of the country will allow it, significantly decrease its costs by employing the following methods:

- Bulk purchase of supplies
- Special agreements with manufacturers
- Special discounts (for cash payment or prompt payment).

In the following tables, we have detailed the direct and indirect costs incurred by MEXFAM and ADOPLAFAM in installing a medical clinic.

MEXFAM
Cost of a Community-Based Clinic

Start up Costs:

Line Item	U.S. Dollars (US$ 1.00 = 2,500.00)
a. MEXFAM coordinator's time	152.00
b. CHW's time	134.00
c. Preparation of site/beds	552.00
d. Medical equipment and instruments	2,614.00
e. Stationery	443.00
f. Rent advance	120.00
g. Cleaning supplies	40.00
Subtotal	4,055.00

Operating Costs:

a. Doctor fees paid by MEXFAM	3,055.00
b. Community Health Worker expenses (payments in cash and food)	2,808.00
c. Program Coordinator	911.00
d. Percentage of the salary of the social worker	1,206.00
e. Transportation	240.00
f. Stationery	80.00
g. Rent and maintenance	960.00
Subtotal	10,046.00
Total	14,101.00
15 per cent indirect expenses	2,115.00
TOTAL COST PER CLINIC	16,216.00
Recovery of 50 per cent of furniture and equipment	1,307.00
NET TOTAL	14,909.00

ADOPLAFAM
Cost of a Community-Based Clinic
Models I* and II**

Start up Costs:

Line Item	U.S. Dollars (US$ 1.00 = 11.20)
a. Salary of ADOPLAFAM staff	250.00
b. Medical equipment/instruments	1,240.00
c. Educational and office materials	63.00
d. Rent advance***	282.00
Subtotal	1,835.00

Operating Costs:

a. Doctors Fees	676.00
b. Community Health Worker Salary	461.00
c. Transportation	12.00
d. Rent and maintenance	419.00
Subtotal	1,568.00
Total	3,403.00
15 per cent indirect expenses	510.00
TOTAL COST PER CLINIC	3,913.00
Recovery of 50 per cent of furniture and equipment	620.00
FINAL TOTAL	3,293.00

* Model I was the "basic model" which provided financial support to the doctor in the form of a base salary, rent, equipment and furniture, and the community health worker's salary for a period of one to two years;

** Model II provided support for these same expenditures but on a decreasing scale during the two years. Both models were relatively expensive.

*** Of a total of 11 clinics opened, 7 had to pay the following amounts to cover rent advances: $125, $174, $133, $437, $383, $535, and $187.

ADOPLAFAM
Cost of a Community-Based Clinic
Model III* and "Doctors in Agreement" **

Start up Costs:

Line Item	U.S. Dollars (US$ 1.00 = 11.20)
a. Salary of ADOPLAFAM staff	250.00
b. Medical equipment/instruments	453.00
c. Educational and office materials	92.00
Subtotal	795.00

Operating Costs:

a. Community Health Worker	273.00
b. Transportation	12.00
c. Supplies	50.00
Subtotal	335.00
Total	1130.00
15 per cent indirect expenses	169.00
TOTAL COST PER CLINIC	1299.00
Recovery of 50 per cent of furniture and equipment	226.00
NET TOTAL	1073.00

* Model III provides furniture and medical equipment but does not guarantee a base salary or payment of rent.

** ADOPLAFAM established a working relationship with existing private clinics located in disadvantaged neighborhoods providing them with medical equipment related to family planning and maternal-child health care services.

Annex I

MEXFAM'S Short Feasibility Study for a Community Doctors Program

MEXFAM has developed a quick and inexpensive way of carrying out a study to determine the feasibility of a future Community Doctor's clinic.

The study consists of three stages: 1) observation and definition of the service area, 2) interviews with community leaders, and 3) interviews with the general public.

1) Observation and Definition of the Service Area

After an area has been proposed for establishing a clinic, the coordinator carries out a physical inspection to ensure that the characteristics of the area meet the requirements of the Community Doctors program, (i.e., it must contain a low-income population with insufficient availability of health services).

MEXFAM has settled on a range of between 20,000 and 50,000 residents as being an optimum population size to generate sufficient demand for primary health care and family planning services. This figure can be substantiated in two ways:

1) By consulting demographic data for the zone and delineating the borders of the area on a map; or

2) When data are not available, an estimate can be made on the basis of an average measure: each "block" or group of dwellings has an average of 40 houses, and each house as a rule has five members. Accordingly, each block has at least 200 inhabitants. A physical inspection is carried out of the area in order to determine the number of blocks which will provide a range of between 20,000 and 50,000 inhabitants, and a hand-drawn map of the area is prepared.

This delimitation of the area should lead to the production of a map indicating the key sites where community promotion activities are to be carried out: the civic center, the sports' field, the school, the church, the park, the market place, men's meeting places (for example, billiard parlors) and others which will need to be identified during the feasibility study and will impact heavily on the subsequent operation of the clinic.

Subsequently, interviews are conducted with area residents, based on a random selection of 110 households.

2) Interviews with Community Leaders

Once the service area has been delineated, visits are made to the community leaders: local authorities, teachers, heads of neighborhood councils, religious leaders, labor leaders or members of the staff of other associations whose influence on the target population will be a determining factor in the success of the program.

The purpose of these interviews is:

- To identify the concerns, priorities and needs of the population;
- To disseminate information from direct sources regarding the purpose of the program in order to dispel rumors and avoid misunderstandings;
- To establish a relationship with individuals who represent a potential source of support for the Community Doctor.

It is advisable that a written guide be prepared to assist the person designated to conduct the interviews. This guide should include as a minimum the following:

- A clear explanation of exactly what the NGO is and its method of operation as well as of the concrete objectives it has established with respect to program development in that area;
- The opinion of these individuals regarding the best procedure for setting up the program, the best location for the clinic, and the most efficient way to approach community residents.

3) Interviews with Community Households

The goal of the NGO is to cover at least 100 families during this stage. The interviews are aimed at developing a profile of the socio-economic and health status of the population. However, this also represents an invaluable opportunity to evaluate the opinions of community members regarding the possible establishment of a Community Doctors program.

Prior to initiating the interview process, the guides must be "validated" or tested on a sample consisting of a minimum of five families, in order to substantiate aspects involving the language and structure of the questions.

Both members of the couple should be interviewed, or at the very least, the mother of the family.

Interviews with the general public are an important part of the feasibility study. During the conversation, the interviewer must work to create an atmosphere of trust

and security, by using appropriate language and explaining in detail to the respondent why he or she is being interviewed.

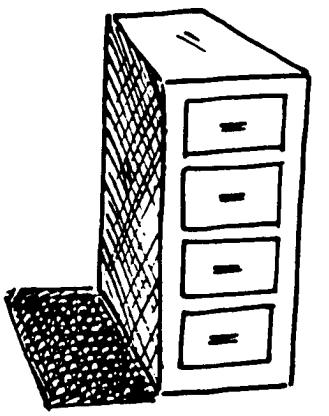
In this way, MEXFAM obtains detailed information on the residents of a given area, establishes contact with community leaders, and begins the process of disseminating information on the future functioning of the clinic.

Annex II

List of the Minimum Furniture and Equipment Required for Establishing a Community-based Clinic

1. Furniture and Equipment

- Examining table with stirrups
- Gooseneck lamp
- Cabinet for medicine
- Cabinet for medical instruments
- Swivel stool
- Pediatric scale
- Adult scale
- Sterilizer
- Two desks (secretarial) and two chairs
- Waste paper basket
- Chrome step ladder
- Benches for the waiting room
- Table "Pasteur"
- File cabinet
- Letter board with letters
- Chairs for patients



2. **Medical Instruments**

- Sphygmomanometer
- Stethoscope
- Two large vaginal mirrors
- Two medium-sized vaginal mirrors
- Two hysterometers
- Complete kit for IUD insertion
- Tape measure
- Large "Mayo" tray
- Stainless steel Kidney-shaped tray
- Biopsy clamps
- Sterilizer
- Two trays for sterilized instruments

3. **Expendable Clinical Materials**

- Disposable gloves
- Tongue depressors
- Slides
- Disposable syringes

Annex III

Sample Business Training Agenda

I. Administration

a. Definition of an enterprise
b. Businesslike conduct
c. Characteristics of a successful businessperson
d. Planning, management, control

II. Accounting

a. Importance of the income and expense register
b. Preparing the income and expense statement
c. Taking inventory
   i. Equipment
   ii. Materials

III. Costs

a. Defining fixed and variable costs
b. Calculating costs
c. Estimating the break-even point

IV. Financing

a. Sources of financing
   i. Commercial banks
   ii. Development programs
   iii. Informal sources
b. Loan terms and conditions
c. Calculating interest rates
d. Causes and consequences of improper loan management

V. Marketing

a. Definition of clientele
   i. Current client
   ii. Potential client
b. Defining client needs
c. Geographic coverage
d. Competition
e. Importance of promotion and advertising
f. Designing a promotion strategy
   i. Defining objectives
   ii. Establishing goals which are quantifiable as to time and amount
   iii. Budget