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**FEMAP: PROVIDE THE FOUNDATION FOR THE
DEVELOPMENT OF SELF-SUSTAINING FAMILY
PLANNING SERVICES**

**A COLLABORATIVE PROJECT WITH THE POPULATION
COUNCIL/INOPAL II**

AUGUST, 1992

Nancy Murray

FAMILY PLANNING MANAGEMENT DEVELOPMENT

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I. EXECUTIVE SUMMARY

The Family Planning Management Development Project (FPMD)'s Program Analyst for Latin America and the Caribbean (LAC), Ms. Nancy Murray, travelled to Mexico from August 13-22, 1992, to meet with FEMAP and the Population Council and to further develop a collaborative proposal initially discussed in April of this year. Additional meetings were held with MEXFAM and Pathfinder International.

FPMD Collaboration with The Population Council and FEMAP: Strengthening the Foundation for Self-Sustaining Family Planning Services with FEMAP.

Under an Operations Research project with FEMAP, the Population Council's INOPAL II project will support a full time accountant within FEMAP to undertake the costing of the services currently provided by five FEMAP affiliates, as well an assessment of the revenues generated by those same affiliates through different revenue generating schemes. FPMD will complement the costing of services and income-generating activities by supporting a client profile in the same five affiliates. The cost and income information together with information on FEMAP's client population should provide FEMAP with a basis to determine what kinds of self-sufficiency strategies are practical, and with systems and tools which will allow the organization to monitor its progress in the areas of financial self-sufficiency and client satisfaction over time.

The majority of Ms. Murray's time in Mexico (August 17-20th) was spent visiting FEMAP affiliates in Irapuato, Guanajuato and in Veracruz, Veracruz and finalizing the Scope of Work (SOW) for FPMD's collaborative work with FEMAP and The Population Council's INOPAL II project on "Strengthening The Foundation for Self-Sustaining Family Planning Services with FEMAP". See attached project proposal.

MEXFAM: Total Quality Management (TQM)

On August 14-15th meetings were held with Dr. Ricardo Vernon, The Population Council, and Dr. Pedro Manuel Acosta and Lic. Jesus Vertiz of MEXFAM to review the project's accomplishments to date, and to write up a case example for a forthcoming issue of *The Family Planning Manager* on experiences with Total Quality Management (TQM). Ricardo Vernon of The Population Council, INOPAL II project has been invited to be a guest editor for the TQM issue, and the format of *The Family Planning Manager*, the draft text, and the proposed cases were reviewed with him and Pedro Manuel Acosta and his assistant, Jesus Vertiz.

Regional Collaboration: FPMD and Pathfinder International

On August 21st, a meeting was held with Pathfinder's Regional Vice-President for Latin America, Carlos Aramburu to discuss proposed FPMD/Pathfinder collaboration in Mexico, Brazil, Bolivia, and Peru. These discussions are summarized in an attached letter of understanding to Mr. Aramburu.

II. Providing the Foundation for the Development of Self-Sustaining Family Planning Services: FEMAP

A. Background

In a previous trip, Ms. Murray had visited with USAID/Mexico in Mexico City, and FEMAP senior management in Ciudad Juarez to discuss opportunities for collaboration. As mentioned in Ms. Murray's April 1992 trip report, USAID/Mexico felt that FPMD's comparative advantage under the Mission's new population strategy was most immediately in the private sector effort to help the NGOs, particularly FEMAP, to be more self-sufficient (i.e., less financially dependent on AID support).

At the time of FPMD's visit in April, The Population Council's INOPAL II project had a well-developed proposal to work with FEMAP to help them analyze the cost of the Federation's service delivery and income generation activities and the extent of the utilization of installed physical and human resources. Any other activity which hoped to deal with self-sufficiency issues with FEMAP would need to be implemented in close collaboration with the Population Council's work.

In order to provide information on the way FEMAP's services and prices were viewed by the client population, as well as to determine where that client population is getting information about FEMAP's services (both at the clinic and at the CBD level), FPMD offered to assist FEMAP in conducting a client profile and a market analysis; studies which would provide FEMAP with information complementary to that to be generated by the cost study so that FEMAP program managers would have all the elements to make the decisions necessary to reach self-sufficiency.

By June 1992, a draft proposal outlining the main ideas had been prepared and shared with Carlos Brambila of The Population Council, Enrique Suarez, Executive Director of FEMAP, and USAID/Mexico. Once concurrence was received from USAID/Mexico, FPMD scheduled a joint visit with The Population Council and FEMAP to Irapuato and Veracruz, two of the five FEMAP affiliates to be included in the study. See Appendix 1 for draft proposal. See Appendix 2 for Map of FEMAP's Affiliates and proposed study sites.

Since the initial proposal had been written based on a brief meeting at FEMAP's headquarters and separate conversations with Carlos Brambila of the Population Council, Ms. Murray felt that it was important to meet with the Population Council and FEMAP to coordinate inputs and activities, and actually visit some of the FEMAP affiliates to be included in the study. This is particularly important in the case of FEMAP due to the extremely independent nature of the affiliates. Thus, the objective of the most recent visit was to actually get to know some of the affiliates that are going to participate in the study and to see how clinical and community-based family planning and other services are currently delivered: how costs are calculated, prices set, and what information is available on the client population. In addition, the study was explained to affiliate directors, and they were asked to comment on the proposed activities.

B. Activities

1. Superación Familiar de Irapuato Materno Infantil

August 17-18 the team visited the Superación Familiar de Irapuato Maternal and Child Health Care Clinic and Family Planning Program in the state of Guanajuato. The program has been in existence for eight years, but has recently undergone a change in its management and as a result has begun to expand its

activities. Irapuato acts as one of FEMAP's regional training center for other affiliates located in the area. It is a ten bed clinic which provides a range of reproductive and other health services. Male and female sterilization, IUD insertions and other temporary methods are available at the clinic, while the CBD program through its network of voluntary health promoters, voluntary coordinators, and social workers (supervisors) offers pills, condoms, vaginal foaming tablets and referrals to those clients wanting IUDs or sterilizations.

Currently, family planning visits at the clinic level are registered, although in some cases the records do not indicate whether a method was provided or if the visit was simply a follow-up visit. At the community level, detailed records are kept at the client level of method use, units supplied by date, and changes in methods or family planning use status. According to the CBD program records, the community outreach program currently serves some 7,502 continuing users via its 6 social workers, 15 coordinators, and 250 promoters. While only accounting for approximately 3 percent of FEMAPs total users, after the larger affiliates in Ciudad Juarez and Monterrey, Irapuato is one of the larger regional training centers, with a total number of users well above the median. (See Appendix 3 for 1990 data on family planning users by Affiliate). Also, due to the financial accounting background of the Clinic Administrator, a great deal of attention is paid to maintaining good financial records. The clinic has a computer which it currently uses to track financial and other administrative information, but which it would like to use to track program performance as well.

The team spent Monday evening, August 17th, explaining the nature of the study to the clinic administrator, Contador Vallejos. On August 18th, the social workers described the work that they carry out at the community level, as well as the training and monitoring and evaluation which they are responsible for at the training center. Training is provided to all interested promoters and coordinators on the services provided by the clinic, family planning and other primary health care themes such as breastfeeding, human sexuality, etc. Course participants are required to take pre- and post-tests, and their achievement is monitored by subject area so that the social workers can provide follow-up in-service training on selected topics in which the promoter/coordinator is most in need of reinforcement.

The afternoon was spent discussing the details of how the cost study and the client profile would be conducted. After a fairly lengthy discussion about whether or not Irapuato would benefit from doing the cost study, it was decided that Irapuato would not only participate, but probably provide important lessons to other FEMAP affiliates who are not as advanced in their accounting and price-setting procedures. Mr. Vallejos also seemed to feel that the idea of conducting the client profile would be useful to them, particularly if it resulted in the establishment of a simple data base which could be used on a somewhat regular basis (i.e., once every six months or once every year) to monitor the client perspective on the fees and the quality of the services being provided. The staff at Irapuato also felt that an analysis of the potential market/demand for their services at the community-wide level would also be useful, but for reasons to be mentioned later, this option will not be pursued at this point in time. (See Section II, C).

2. Centro de Orientación Familiar de Veracruz (COFAV)

On August 19, Ms. Murray, Dr. Suarez, and Dr. Brambila visited the Centro de Orientación Familiar de Veracruz (COFAV) in the Port of Veracruz, the capital city of the state of Veracruz.

COFAV is another regional training center for FEMAP, providing training services to the nearby affiliate in Xialapa as well as to its own CBD personnel. It also offers a range of dental, reproductive and primary

health and laboratory services, but it does not have hospital beds or the sterile facilities with which to perform sterilizations (although it does perform IUD insertions). The program has only been operational for two years, and has been at its present locale for under a year. In spite of the relative youth of the program, it has 3 social workers who oversee the CBD program which works through 4 coordinators and 119 promoters. It has a total of 5,108 continuing users.

As in the case of Irapuato, the bulk of family planning users are to be found in the CBD program. The clinic has a very low average of 6-8 continuing users who specifically seek family planning services out of an average of nearly 350 clinic visits a month. While clinic staff mentioned that they believe the number of clients seeking FP services at the clinic is low, they attribute this to an assumption that the clients of the clinical services are referred by the promoters, and already have their FP needs covered. This assumption will be empirically tested by the client profile study to be financed by FPMD. Overall, the program keeps excellent records, both financial, and in terms of family planning users, but it does not have computer equipment.

In a recent monitoring visit by FPIA, a small convenient sample of 100 patients was interviewed regarding the quality of the services, their cost, whether or not they were using a family planning method, and where the method was obtained. The survey was designed by FPIA and the results were analyzed by the FPIA representative, and the clinic staff felt that the results were quite informative (see Appendix 4 for results and recommendations).

In our subsequent discussions regarding the utility of the cost study and the client profile, the Clinic Administrator felt strongly that both would be quite useful. She admitted that prices were set somewhat arbitrarily, with an attempt to set laboratory analysis prices for example, at 50% lower than those of the cheaper labs in the area. Fees for a medical consultation are currently set at 10,000 pesos, the equivalent of approximately \$3.00 which even the clients thought was quite low. In our discussions, the consensus was that a uniform methodology for costing services and other activities would be of great interest to Veracruz, as well as a database and training of the Program staff providing them with the means to continuously assess their clients and their reactions to the services would also be quite useful for programmatic decision-making.

C. Findings/Conclusions

The site visits and time spent afterwards in discussion with Carlos Brambila and Enrique Suarez were quite helpful in determining the real needs of the Affiliates and in further defining FPMD's role in this collaborative efforts.

Essentially, both Affiliates visited felt a need for the cost study, the client profile and the analysis of the prevailing market prices for services similar to those offered by FEMAP. In addition, the affiliates felt that a larger community-based survey to assess the potential market for their services would also be helpful.

However, based on the fact that FEMAP will be using local Affiliate staff to help conduct a large scale survey of representative community level samples of the areas in which it has active programs, it is not feasible for FPMD to do a similarly large scale community level survey to determine potential demand for FEMAP services. Therefore, FPMD has decided to concentrate its efforts on just the client profile for both clinic and CBD program clients. Also, since the Population Council will be hiring a full time accountant for FEMAP under its OR program, it was agreed upon with the Population Council representative that this same individual would be responsible for surveying other local providers of similar services in the areas in

which the five affiliates currently operate, so that they would have a good idea of what their competitors are charging in the private sector for the same services.

During the site visits however, FPMD observed that while some Affiliates currently have the computer equipment necessary for on-site training of staff in simple word and data processing, others do not. Therefore, some of the money which had initially been budgeted for the larger survey, and the market analysis activities will instead be spent on computer equipment and software for those affiliates which do not currently have computers (Mazatlan, Acapulco, and Veracruz). In the interests of institutional development and strengthening FEMAP Affiliates' ability to collect, analyze and interpret its own administrative, programmatic and other special interest data, this is probably the most appropriate investment.

As detailed in the modified proposal and budget (See Appendix 5), FPMD will also support a local consultant who will provide training to FEMAP social workers and other staff in questionnaire design, effective interviewing and other data collection techniques, as well as assistance in the ultimate analysis, interpretation, and presentation of the findings of the client profile study. FPMD will also provide basic training to the affiliates in simple software applications, including Word Perfect (Spanish version), DBASE 3+, QUATTRO Pro, and Harvard Graphics.

III. Total Quality Management (TQM) MEXFAM

A. Background:

The Fundación Mexicana para la Planeación Familiar (MEXFAM) was founded in 1965. A private sector agency and affiliate of IPPF/WHF, MEXFAM is an important provider of family planning services, information and training in México with 41 local and regional offices. MEXFAM has a number of educational outreach activities, including seminars on sexuality and reproduction targeted toward semi-urban youngsters, adult men, and couples; video and film productions; and medical counseling in contraceptive services.

In April, 1991 MEXFAM began a Total Quality Management (TQM) initiative in collaboration with The Population Council's INOPAL II project with the purpose of using this innovative management technique to improve its structure and internal processes, its organizational effectiveness, and ultimately its movement towards greater sustainability.

The project consists of training all MEXFAM staff in the philosophy of Total Quality Control or Total Quality Management and then applying this technique to MEXFAM.

FPMD was invited to participate in this project by The Population Council and MEXFAM to support the development of the TQM materials for use in the context of family planning service delivery organizations, and to support the dissemination of this unique experience to other family planning organizations.

For further background information, please refer to FPMD Senior Program Officer M. Gutiérrez' April 1991 and April 1992 trip reports on the TQM project.

B. Purpose and Activities:

While the main purpose of this visit was not to monitor the MEXFAM project, the Regional Program Analyst took advantage of the time in Mexico to visit with MEXFAM staff and to begin writing a case study of the MEXFAM TQM project for a future issue of *The Family Planning Manager* dedicated to the topic.

Dr. Ricardo Vernon from the Population Council, and Dr. Pedro Manuel Acosta and Lic. Jesus Vertiz from MEXFAM provided their input to a draft version of the TQM issue, as well as assisted in preparing a description of the MEXFAM TQM project as a case study.

See Appendices 6-9 for the draft version of *The Family Planning Manager*, R. Vernon and P.M. Acosta's comments on the draft version, and descriptions of the MEXFAM TQM project and an additional INOPAL project in Guatemala using a TQM approach.

IV. Collaborative Agreement with Pathfinder International

On August 21st, a meeting was held with Pathfinder's Regional Vice-President for Latin America, Carlos Aramburu to discuss proposed FPMD/Pathfinder collaboration in Mexico, Brazil, Bolivia, and Peru. These discussions are summarized in an attached letter of understanding to Mr. Aramburu (Appendix 10).

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The Population Council

Appendix 1
Draft Collaboration Proposal

PROVIDING THE FOUNDATION FOR THE DEVELOPMENT OF SELF-SUSTAINING FAMILY PLANNING SERVICES WITH FEMAP

FPMD Collaboration with The Population Council and FEMAP

EXECUTIVE SUMMARY:

In accordance with AID/Mexico's new population strategy and its emphasis on the self-sufficiency of the private family planning sector, The Population Council's INOPAL project in collaboration with MSH's FPMD project propose to work with FEMAP to assist the organization in its transition towards total self-sufficiency.

As a first step in the process of helping FEMAP to gather the information necessary to devise strategies which will improve the organization's ability to generate income or to better utilize its existing resources, INOPAL proposes the establishment of a cost-based accounting system and an analysis of current use of installed capacity which will allow FEMAP to gauge the potential for increasing its current client load without additional investments in its physical or human resources. In addition, FPMD proposes to complement the cost analysis with two other activities. The first of these will be an analysis of the existing alternate sources of family planning services and their costs (market study). The market analysis, in conjunction with the data generated by the cost analysis will allow FEMAP to price itself realistically (based on its real costs) as well as competitively (as compared to other providers). Finally, a profile of current as well as potential consumers will be conducted. The results of this study could be used to complement the cost and market studies, particularly in the determination of whether or not some clients could afford and would be willing to pay more than others.

The aforementioned activities, once conducted, will permit FEMAP to think strategically about implementing different cost recovery or cross subsidization strategies so that it can continue to fulfill its mission without being dependent on donor funds.

FEMAP: Self-Sufficiency/Sustainability

Founded in 1981, the Mexican Federation of Private Family Planning Associations (FEMAP), is a private, non-profit organization dedicated to enhancing the quality of life among Mexico's most disadvantaged populations. FEMAP is involved in a wide range of activities including: education, research, maternal and child health (MCH) and family planning services, sex education, primary health care, nutrition and family gardening, AIDS prevention, drug abuse prevention, water chlorination, environmental health, economic development: micro enterprises and community banks. Based in Ciudad Juarez, on the northern border of México and the United States, FEMAP coordinates the operations of 44 affiliates providing services to 69 different cities and hundreds of rural communities in 25 of the 31 states of México.

In the last two years the support that FEMAP had received from AID/México was reduced from a high of \$1,200,000 to a low of \$300,000 annually. AID funding had represented nearly 65% of FEMAP's total annual budget at its peak. AID/Mexico has identified FEMAP as a priority institution in its private sector strategy to receive TA in sustainability.

THE POPULATION COUNCIL/INOPAL II (See attached proposal for more details)

1. The costing of FEMAP's Service-Delivery Activities

The Population Council's INOPAL II project will be assisting FEMAP to undertake a cost analysis of both service provision and income generation activities to help FEMAP get a more accurate idea of how much it really costs the institution to provide services, as well as how much some of their income generating activities actually net for subsidizing other services after the costs are considered. In addition, the extent of current use of installed capacity will be analyzed, another extremely important consideration in looking at the effectiveness side of the cost-effectiveness equation.

The costing of FEMAP's activities, and a look at the utilization of installed capacity is a critical first step in helping FEMAP to take control of its financial future. However, the cost study and assistance in helping FEMAP adjust its accounting system to include all real costs in providing services, is only one of several steps which need to be taken to help FEMAP think strategically about the challenge of financing family planning services to populations least able to pay for them without donor assistance. FPMD proposes to complement the Population Council's initiative with two additional activities which will provide additional information to FEMAP senior management on potentially effective strategies to improve the institution's viability.

FPMD IN COLLABORATION WITH INOPAL II

2. Client Profile (Ability and Willingness to Pay)

FPMD proposes to complement the Population Council's Project by profiling the current client population or perhaps the potential client population at the community level. A representative sample of individuals seeking services at the FEMAP institutions in which the cost accounting is conducted, and perhaps a community level sample as well, will be selected, and those individuals' socio-economic status and reason for choosing/not choosing FEMAP as a service provider will be assessed. This simple study will help FEMAP to determine whether or not some of their clients could actually afford to pay higher fees than those currently being charged and who their alternate service providers are. It could also assess whether the existing constellation of services provided by FEMAP meets its clients needs. If some of FEMAP's current clients do have a greater ability to pay than is currently assumed, some sort of sliding fee could be implemented based on the client's income. Similarly, if FEMAP decides to actively try and attract a better-off clientele based on under-utilization of installed capacity (once the cost analyses are completed), they could guarantee their lower income clients' access by the use of such a fee scale.

Depending on the sample size at the community and service delivery site levels and numbers of interviewers available, the time necessary to carry out this survey will vary from site to site (in the four regions in which the study is to be implemented). It is estimated that data collection will take approximately one month per site. However, prerequisite activities include: design and pretesting of the questionnaire, training of FEMAP volunteers or supervisors in the implementation of the questionnaire, and the creation of a small data base for the data entry and easy analysis of the data collected in the survey. The overall time period contemplated for this activity is approximately 3-4 months:

- 2 weeks for the design of the survey instruments and their pretesting;
- 1-2 weeks for training of interviewers;
- 1 week for the design of the data base and the plan for analysis;
- 1-2 months for data collection;
- 1 month for data analysis and report writing.

This activity could be conducted concurrently with the cost analyses and will start within the first six months of the project.

Since the principal investigator to be supported by the project is an individual with experience in surveys/data collection and analysis, he or she will be responsible for oversight of this component, with technical support from FPMD in design of the questionnaire, training of interviewers and analysis of data. The Population Council will provide technical assistance in the selection of the samples in the four cities to be included.

FPMD will provide support for the printing of the questionnaires, and for the per diems and transportation of the interviewers. If the interviewers are not volunteer promoters, salary may be provided as well. Total amount to be spent on this component is approximately: \$33,296, including FPMD travel and per diem costs for TA and supervision.

3. Market Analysis

Complementary to the client profile and/or the study of potential demand for FEMAP's services, is a proposed market analysis of the competition. While FEMAP sees its main competitor to be the MOH and has priced its services accordingly, this does not necessarily have to be true. Perhaps clients which might normally go to private providers are taking advantage of FEMAP's high quality services and low prices. In this instance, in order to price its services competitively, yet maximize income, FEMAP should consider private provider prices for similar services and price its services only somewhat lower than those, rather than only somewhat higher than the Ministry of Health. Thus, market studies of the competition in the four locations in which the study is to be conducted are suggested.

FPMD will contract a local consultant/firm to conduct the market analysis. This work will consist of identifying other local providers of the kinds of services provided by FEMAP (FP, MCH, and other curative services) and in assessing what they charge for similar services. It will take place concurrently with the cost analysis.

A total of approximately \$5,000-\$7,000 is budgeted for the subcontracting of this work to a local consultant. In addition, the FPMD LAC program analyst will have at least one trip for discussion of the information desired and the SOW. One trip of approximately 7 days will cost: $\$1,550 + \$132 \times 7 = \$2,474.00$. Total amount budgeted for this activity is: \$7,474.00-9,474.00.

4. Institutionalization/Utilization of Results of 1-3.

In addition to the activities outlined in this document, FPMD's Evaluation Unit will also be budgeting time and funds (total amount to be determined) to establish indicators for the monitoring of the abovementioned FPMD activities.

An additional \$5,000 is available for work with FEMAP to ensure that the organization utilizes the information made available by the abovementioned studies. A representative of FPMD will meet with FEMAP senior management to discuss the implications of the results of these activities. In conjunction with The Population Council's INOPAL II project, FPMD would be available to help FEMAP design new strategies or interventions for generating income/cross-subsidizing services, once the initial information gathering stage has been completed.

FPMD will collaborate with and complement the Population Council's work with FEMAP. Important lessons can be learned through this collaborative activity in the important area of sustainability.

Appendix 2
Map of FEMAP Affiliates

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ASOCIADOS A FEMAP (1991)



Appendix 3

**Couple Years of Protection and FP Users by Affiliate:
1990-1991**

6. CONCENTRADO DE APP's y USUARIOS DE FEMAP (1990-1991):

| CONCEN- TRADO: | APP NUEV. | APP CONT. | APP N + C: | APP REFER | APP TOTAL. | U. NVOS. | U. CONT. | U. N + C: | U. REFER | U. TOTAL. |
|-------------------|--------------|---------------|---------------|--------------|---------------|--------------|---------------|---------------|-------------|---------------|
| TIJUANA | 1714 | 2973 | 4687 | 3360 | 8047 | 1479 | 3234 | 4713 | 224 | 4937 |
| TECATE | 233 | 175 | 408 | 120 | 528 | 198 | 218 | 416 | 8 | 424 |
| MEXICAL | 1649 | 3473 | 5122 | 1305 | 6427 | 1463 | 3665 | 5128 | 87 | 5215 |
| NOGALES | 2774 | 23407 | 26181 | 840 | 27021 | 2803 | 9432 | 12235 | 56 | 12291 |
| JUAREZ | 29959 | 267913 | 297872 | 0 | 297872 | 13843 | 55501 | 69344 | 0 | 69344 |
| V. AHUM. | 197 | 1235 | 1432 | 2100 | 3532 | 213 | 1259 | 1472 | 140 | 1612 |
| NVO. CA | 373 | 684 | 1057 | 1050 | 2107 | 359 | 637 | 996 | 70 | 1066 |
| ZARAGOZ | 1789 | 5226 | 7015 | 2730 | 9745 | 1617 | 5430 | 7047 | 182 | 7229 |
| V. JUAR. | 1157 | 4466 | 5623 | 2280 | 7903 | 1174 | 4511 | 5685 | 152 | 5837 |
| CHIHUA. | 2085 | 4110 | 6195 | 6465 | 12660 | 1954 | 4443 | 6397 | 443 | 6840 |
| CUAUHTE | 1305 | 3115 | 4420 | 3450 | 7870 | 1311 | 3196 | 4507 | 230 | 4737 |
| GUERRER | 1214 | 3352 | 4566 | 2010 | 6576 | 1231 | 3330 | 4561 | 134 | 4695 |
| URIQUE | 149 | 654 | 803 | 384 | 1187 | 134 | 599 | 733 | 44 | 777 |
| SALTILL | 5770 | 20634 | 26404 | 5850 | 32254 | 3831 | 18166 | 21997 | 390 | 22387 |
| MONTE 1 | 3049 | 135061 | 138110 | 6840 | 144950 | 3743 | 16224 | 19967 | 456 | 20423 |
| MONTE 2 | 1929 | 2172 | 4101 | 1560 | 5661 | 1735 | 1943 | 3678 | 104 | 3782 |
| MATAMOR | 4045 | 29954 | 33999 | 0 | 33999 | 3572 | 14945 | 18517 | 0 | 18517 |
| REYNOSA | 378 | 1281 | 1659 | 1815 | 3474 | 396 | 1362 | 1758 | 145 | 1903 |
| M. ALEM. | 193 | 494 | 687 | 480 | 1167 | 187 | 465 | 652 | 32 | 684 |
| VICTOR. | 658 | 1471 | 2129 | 735 | 2864 | 645 | 1259 | 1904 | 49 | 1953 |
| MAZATL. | 2740 | 4410 | 7150 | 5115 | 12265 | 2658 | 3730 | 6388 | 341 | 6729 |
| DURANGO | 2759 | 4103 | 6862 | 4365 | 11227 | 2407 | 3568 | 5975 | 291 | 6266 |
| SUBTOT: | 66119 | 520363 | 586482 | 52854 | 639336 | 46953 | 157117 | 204070 | 3578 | 207648 |

CONCENTRADO DE APP's y USUARIOS DE FEMAP (CONTINUACION...)

| CONCEN- TRADO: | APP NUEV. | APP CONT. | APP N + C: | APP REFER | APP TOTAL. | U. NVOS. | U. CONT. | U. N + C: | U. REFER | U. TOTAL. |
|-------------------|--------------|--------------|---------------|--------------|---------------|-------------|-------------|--------------|-------------|--------------|
| SUBTOT: | 66119 | 520363 | 586482 | 52854 | 639336 | 46953 | 157117 | 204070 | 3578 | 207648 |
| AGUASCA | 3218 | 3616 | 6834 | 1380 | 8214 | 3235 | 3331 | 6566 | 108 | 6674 |
| GUADAL. | 4356 | 9188 | 13544 | 6300 | 19844 | 4311 | 8257 | 12568 | 420 | 12988 |
| IRAPUAT | 6612 | 25110 | 31722 | 11310 | 43032 | 2856 | 7629 | 10485 | 802 | 11287 |
| QUERETA | 1347 | 3684 | 5031 | 3525 | 8556 | 1339 | 2904 | 4243 | 235 | 4478 |
| S.J.RIO | 355 | 1631 | 1986 | 480 | 2466 | 329 | 1559 | 1888 | 32 | 1920 |
| CHAMAPA | 2904 | 8164 | 11068 | 3000 | 14068 | 2349 | 5363 | 7712 | 200 | 7912 |
| STA. BAR | 851 | 718 | 1569 | 1380 | 2949 | 862 | 704 | 1566 | 140 | 1706 |
| CUERNAV | 462 | 890 | 1352 | 0 | 1352 | 462 | 890 | 1352 | 0 | 1352 |
| ACAPULC | 1916 | 4676 | 6592 | 4365 | 10957 | 1923 | 2917 | 4840 | 291 | 5131 |
| XALAPA | 3821 | 9267 | 13088 | 8925 | 22013 | 3846 | 9227 | 13073 | 659 | 13732 |
| VERACRU | 23439 | 11462 | 34901 | 0 | 34901 | 3839 | 4628 | 8467 | 0 | 8467 |
| TAPACHU | 1303 | 5421 | 6724 | 4635 | 11359 | 1349 | 5129 | 6478 | 309 | 6787 |

| CONCEN- TRADO: | APP NUEV. | APP CONT. | APP N + C: | APP REFER | APP TOTAL. | U. NVOS. | U. CONT. | U. N + C: | U. REFER | U. TOTAL. |
|-------------------|--------------|--------------|---------------|--------------|---------------|-------------|-------------|--------------|-------------|--------------|
| TOTAL: | 116703 | 604190 | 720893 | 98184 | 819077 | 73653 | 209655 | 283308 | 6774 | 290082 |
| PORCENT | 14.20 | 73.80 | -- | 12.00 | 100.00 | 25.39 | 72.27 | -- | 2.34 | 100.00 |

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Appendix 4

**FPIA Review of Service Statistics and Survey of 100
Users of COFAV**

NML

SABADO

9 HRS.- ESTANCIA EN COFAV , REUNION CON PERSONAL DE COFAV PARA EVALUACION DEL PROGRAMA.

| | | |
|---------------------------|-----------------|----------------|
| EL PERIODO "A" POR D.S.C. | | CLINICA |
| METAS.- "A" | 168 % | 36% |
| "B" | 145 % NUEVOS | 31 % NUEVOS |
| | 168 % CONTINUOS | 37 % CONTINUOS |
| "C" | 32 % NUEVOS | 15 % NUEVOS |
| | 74% CONTINUOS | 12 % CONTINUOS |

METAS D.S.C. EN 8 MESES 291 POR MES PARA CUMPLIR LA META EN USUARIOS NUEVOS

EN USUARIOS CONTINUOS 461 POR MES PARA CUMPLIR LA META

EN USUARIOS CONTINUOS DE CLINICA 43

EN USUARIOS NUEVOS DE CLINICA 19

| | | | |
|----------------------|-----|------|-----|
| RETENCION DE D.S.C. | "A" | 82 % | "B" |
| RETENCION DE CLINICA | "A" | 24 % | "B" |
| RETENCION D.S.C. | "B" | 53 % | "C" |
| SI SE CUMPLE | | 72 % | |
| CLINICA | "B" | 6 % | |
| SE DEBE LLEGAR AL | | 54 % | |

PERIODO "C"

NO. DE CONSULTAS 1419 34 %

COMO PROMEDIO 355 CONSULTAS POR MES

AUMENTAR 573 POR MES

SALUD GRAL 26 %

PEDIATRICAS 30 %

PRENATAL 23 %

20

TRATO AL PERSONAL 100 % BUENO

REGRESAN A LA CLINICA 100 %

ESTAN USANDO METODOS DE

PLAN. FAM. 46 %

NO ESTAN USANDO METODOS

DE PLAN. FAM. 54 %

CONSEGUEN METODOS DE PLANIFICACION FAMILIAR

30 % I.M.S.S

22 % HOSP. GRAL

21 % FARMACIA

3 % COFAV

UN 91 % CONTESTO QUE LAS TARIFAS ERAN BAJAS

UN 9 % REGULARES

AMBIENTE DE LA CLINICA:

AGRADABLE 69 %

MUY AGRADABLE 31 %

SUBERENCIAS Y RECOMENDACIONES:

SERVICIOS DE PARTOS 30 %

ESPECIALISTAS 25 %

AIRE ACONDICIONADO 10 %

RAYOS X 18 %

CONTEO DE CLINICA

USUARIOS NUEVOS 26

USUARIOS CONTINUOS 9

USUARIOS CONTINUOS DE PERIODO "B" 2

USUARIOS CONTINUOS DEL PERIODO "A" 0

PROMEDIO DE HIJOS AL INGRESAR AL PROGRAMA 2.1 HIJOS CON RANGLO

DE 0 A 13

21

PROMEDIO DE EDAD AL INGRESAR 25.5

CON UN RANGO DE 17 A 48 AÑOS

METODO

DIU 46 %

PASTILLA 43 %

TAB. VAG. 5.5 %

CONDON 5.5 %

USUARIOS EN PERIODO "C" DE CLINICA

PASTILLA 46 %

DIU 43 %

D.E.C.

TARJETAS 484

DE ZONAS NORTE, SUR, CENTRO, RURAL

AL INGRESAR 25.2 % DE 25 A 26 AÑOS

NO. DE HIJOS 2.1 % 0.1

DE 2 A 2.2. CUANDO INGRESA AL PROGRAMA

RANGO DE EDADES AL INGRESAR AL PROGRAMA

| EDAD | NO. DE HIJOS | % DE ASUARIOS |
|--------|--------------|---------------|
| 15 -19 | 0.96 | 15.6 % |
| 20-24 | 1.44 | 32 % |
| 25-29 | 2.34 | 26% |
| 30-34 | 2.55 | 13.3 % |
| 35-39 | 4.00 | 7.7 % |
| 40-44 | 4.53 | 3.9 % |
| 45 + | 7.00 | 0.6 % |

SELECCION DE METODOS DE PLANIF. FAM. DE USUARIOS

QUE INICIARON EN EL PROGRAMA:

PASTILLAS 66 % MAS O MENOS 4 %

CONDONES 20 % MAS O MENOS 4 %

22

PERIODO "C"

2.9 MAS O MENOS 9.1 VISITAS O CONTACTOS CON USUARIOS

DESGLÓSE DE METODOS

USUARIOS DE PASTILLAS 58 % MAS O MENOS 4 %
USUARIOS DE CONDON 28 % MAS O MENOS 4 %
USUARIOS DE TABLETA VAG 14 % MAS O MENOS 3 %

INFORME FINANCIERO:

EN BASE DE SALIDAS MAS

PONER FECHA DE ELABORACION

INGRESOS POR PERIODO

A 155 %

B 107 %

C 148 % HASTA EL ULTIMO PERIODO

EVALUACION DE ENTREVISTAS:

ZONA CENTRO 6 CARPETAS

" SUR 5 "

" NORTE 3 "

" RURAL 6 "

RANGO DE EDADES DE PROMOTORAS

ZONA NORTE 21 AÑOS

METODO PASTILLA

VISITA A USUARIOS EN PERIODOS B Y C

CONOCEN SUS FUNCIONES

ZONA SUR:

COYOL Y LAGOS

DE 21 A 72

METODO DEFINITIVO

23

ZONA RURAL: EDAD: 27 A 30 AÑOS

FRUITARON 2* AÑOS

METODO DEFINITIVO

METODO ORAL

NUCLEO DEPORTIVO:

DE 20 A 25 AÑOS

41 AÑOS PASTILLAS

VISITA ALAS USUARIAS DE 1 A 2 VECES AL MES

CUMPLEN SUS FUNCIONES, DESEMPEÑAN CONTRAINDICACIONES

NO NECESITAN MAS ATENCION

TARJETAS QUE NO ESTAN ACTUALIZADAS PERIODOS "A" Y "C", FALTA SECUENCIA

USUARIOS VISITADOS EN ZONAS CENTRO, SUR, NORTE Y RURAL: 12

EDAD DE 22 A 34 AÑOS

VISITAS 1 AL MES

SOL 3 USUARIOS NO ACUDIDO A LA CLINICA

SE VISITARON 4 COORDINADORAS

RANGO DE EDADES: DE 23 A 25

PROMEDIO DE EDAD 29

METODO DEFINITIVO

SE LES VISITA 1 VEZ POR SEMANA

DUDAS SOBRE EL CONDON

" " EL PRIMER DIA DE PASTILLAS

CORREN RIESGO DE EMBARAZO

SE REALIZARON ENTREVISTAS AL PERSONAL DE COFAV.

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RECOMENDACIONES

- 1.- EL PROYECTO DEBE FUNDARSE EN CAPTACION DE USUARIOS ENTRENADOS DE D.O.C. Y CLINICA.
- 2.- EL PROYECTO DEBE AUMENTAR EN USUARIOS NUEVOS DE CLINICA, CON BRIGADAS ANUNCIOS POR LA RADIO, Y MEJOR ORIENTACION DENTRO DE LA CLINICA.
- 3.- LA CLINICA DEBE AUMENTAR SUS CONSULTAS DE 3 A 4 CONSULTAS POR HORA. --
O BAJAR HORAS
- 4.- EL PROYECTO DEBE HACER 2 PRECIOS DE CONSULTA.
- 5.- EL PROYECTO DEBE OFRECER PLANIFICACION FAMILIAR EN TODAS SUS CONSULTAS
- 6.- UTILIZAR LA REFERENCIA
DAR TARJETAS A PACIENTES QUE VENGAN POR PRIMERA VEZ DEL 50 % PARA QUE LAS DEN A OTRA PERSONA , SI VIENEN A PLANIFICACION FAMILIAR SERA GRATIS
- 7.- VISITAR ZONAS EN ATENCION POR EL PROYECTO CON EQUIPO DE 2 TRAB. SOC.
CHECAR CALENDARIOS QUE ESTEN ACTUALIZADOS Y SUS DATOS GENERALES.
- 8.- REVISAR PRECIOS DE ANALISIS, TOMAR EN CUENTA LA CAPACITACION DE LA QUIMICA, PARA LA LECTURA DEL D.O.C. (PAPANICOLAU)
- 9.- ASEGURARSE DE QUE LOS USUARIOS OBTENGAN LOS BENEFICIOS, QUE OFRECE COFA
- 10.- CAPACITACION CONSTANTE EN MANEJO DE FERRODOS.
- 11.- ENFASIS EN CONTRAINDICACIONES DE PASTILLA , CON COORDINADORAS Y PROMOTC URGENTE.
- 12.- ESTRATEGIAS PARA BUSCAR CONTINUOS, REVISAR DATOS
MANDAR A FEMAF INFORMACION DE SAJAS , DE CONTINUOS.

25

Appendix 5

**Modified Proposal and Budget for Collaboration
with FEMAP and The Population Council**

PROVIDING THE FOUNDATION FOR THE DEVELOPMENT OF SELF-SUSTAINING FAMILY PLANNING SERVICES WITH FEMAP ¹

FPMD Collaboration with The Population Council and FEMAP

EXECUTIVE SUMMARY:

In accordance with AID/Mexico's new population strategy and its emphasis on the self-sufficiency of the private family planning sector, The Population Council's INOPAL project in collaboration with MSH's FPMD project propose to work with FEMAP to assist the organization in its transition towards total self-sufficiency.

As a first step in the process of helping FEMAP to gather the information necessary to devise strategies which will improve the organization's ability to generate income or to better utilize its existing resources, INOPAL proposes the establishment of a cost-based accounting system and an analysis of current use of installed capacity which will allow FEMAP to gauge the potential for increasing its current client load without additional investments in its physical or human resources. FPMD initially proposed to complement the cost analysis with two other activities, but upon further discussion (see N. Murray's trip report, August, 1992), it was decided to limit FPMD's activities to one. The other proposed activity, an analysis of the existing alternate sources of family planning services and their costs (market study), will be overseen by the Population Council supported accountant who will work full time with FEMAP over the next year on the costing of FEMAP's activities. The market analysis, in conjunction with the data generated by the cost analysis will allow FEMAP to price itself realistically (based on its real costs) as well as competitively (as compared to other providers). FPMD's activities will be limited to a profile of current clients of both the clinic-based and CBD programs. The results of this study will be used to complement the cost and market studies, particularly in the determination of whether or not some clients could afford and would be willing to pay more than others or more than the prices FEMAP currently charges for its services. In addition, important variables related to client satisfaction with the services will also be measured.

The aforementioned activities, once conducted, will permit FEMAP to think strategically about implementing different cost recovery or cross subsidization strategies so that it can continue to fulfill its mission without being dependent on donor funds.

¹ September 4, 1992 (Revised version of June, 1992 proposal)

FEMAP: Self-Sufficiency/Sustainability

Founded in 1981, the Mexican Federation of Private Family Planning Associations (FEMAP), is a private, non-profit organization dedicated to enhancing the quality of life among Mexico's most disadvantaged populations. FEMAP is involved in a wide range of activities including: education, research, maternal and child health (MCH) and family planning services, sex education, primary health care, nutrition and family gardening, AIDS prevention, drug abuse prevention, water chlorination, environmental health, economic development: micro enterprises and community banks. Based in Ciudad Juarez, on the northern border of México and the United States, FEMAP coordinates the operations of 44 affiliates providing services to 69 different cities and hundreds of rural communities in 25 of the 31 states of México.

In the last two years the support that FEMAP had received from AID/México was reduced from a high of \$1,200,000 to a low of \$300,000 annually. AID funding had represented nearly 65% of FEMAP's total annual budget at its peak. AID/Mexico has identified FEMAP as a priority institution in its private sector strategy to receive TA in sustainability.

THE POPULATION COUNCIL/INOPAL II (See attached proposal for more details)

1. The costing of FEMAP's Service-Delivery Activities

The Population Council's INOPAL II project will be assisting FEMAP to undertake a cost analysis of both service provision and income generation activities to help FEMAP get a more accurate idea of how much it really costs the institution to provide services, as well as how much some of their income generating activities actually net for subsidizing other services after the costs are considered. In addition, the extent of current use of installed capacity will be analyzed, another extremely important consideration in looking at the effectiveness side of the cost-effectiveness equation.

The costing of FEMAP's activities, and a look at the utilization of installed capacity is a critical first step in helping FEMAP to take control of its financial future. However, the cost study and assistance in helping FEMAP adjust its accounting system to include all real costs in providing services, is only one of several steps which need to be taken to help FEMAP think strategically about the challenge of financing family planning services to populations least able to pay for them without donor assistance.

FPMD initially proposed to complement the Population Council's initiative with two additional activities which will provide additional information to FEMAP senior management on potentially effective strategies to improve the institution's viability.

FPMD IN COLLABORATION WITH INOPAL II

2. Client Profile (Ability and Willingness to Pay)

FPMD proposes to complement the Population Council's Project by profiling the current client population both for clinical services as well as for the CBD program. A representative sample of individuals seeking services at the FEMAP institutions in which the cost accounting is conducted will be selected in each of the five areas participating in the study: Ciudad Juarez, Irapuato, Veracruz, Mazatlan, and Acapulco. In this study individuals' socio-economic status and reason for choosing FEMAP as a service provider will be assessed. Questions on the quality of care offered by FEMAP as well as the kinds of services offered by FEMAP will also be asked. Both CBD and clinical services' clients will be asked if they seek services in other health care establishments in addition to FEMAP, and why. Finally, they will be asked to compare the prices as well as the quality of FEMAP's services with other institutions.

This simple study will help FEMAP to determine whether or not some of their clients could actually afford to pay higher fees than those currently being charged and who their alternate service providers are. It will enable FEMAP to determine whether or not the efforts and investments it is making in terms of its CBD programs actually generates business for the clinic. It could also assess whether the existing constellation of services provided by FEMAP meets its clients needs. If some of FEMAP's current clients do have a greater ability to pay than is currently assumed, some sort of differentiated fee schedule could be implemented based on the client's income or ability to pay. Similarly, if FEMAP decides to actively try and attract a better-off clientele based on under-utilization of installed capacity (once the cost analyses are completed), they could guarantee their lower income clients' access by the use of a fee scale or some kind of discount coupon for less well-off clients.

Depending on the sample size at the CBD and clinic levels, and the numbers of interviewers (social workers) available, the time necessary to carry out this survey will vary from site to site (in the five regions in which the study is to be implemented). It is estimated that data collection will take approximately one month per site.

However, prerequisite activities include: design and pretesting of the questionnaire (1 month) training of FEMAP social workers and program coordinators (trabajadoras sociales and coordinadoras) in the implementation of the questionnaire (5 weeks), and the creation of a small data base for the data entry and easy analysis of the data collected in the survey (2 months). The overall time period contemplated for this activity is approximately 6-7 months.

Client Profile: will be conducted over the next year, beginning in October/November of this year.

1 month for the design of the survey instruments- draft to be done in Boston, reviewed and modified with INOPAL and FEMAP;
1-2 months for training of interviewers and pretesting of the instruments;
1 month for the design of the data base and the plan for analysis;
2 months for data collection;
1 month for data analysis and report writing.

This activity could be conducted concurrently with the cost analyses and will start within the first six months of the project.

Since the principal investigator to be supported by the INOPAL project will be an individual with more experience in cost-analysis and accounting than in surveys, FPMD and The Population Council will provide the technical assistance to the Affiliates in the design of the questionnaire to be used in assessing the client profile. However, FPMD will be responsible for contracting a local consultant with experience in training interviewers as well as with experience in data analysis. This individual will be responsible for the training and analysis components of this activity, with technical support and oversight from FPMD. It is envisioned that the consultant will spend a total of 10 days with each of the five affiliates for a total of 60 days (including travel time). The first five days would be dedicated to initial training of the social workers (and perhaps the coordinators) in basic interviewing techniques and data collection) and the second five-day period at the end of the data collection would be spent training the staff in the review of the data for analysis and presentation. FPMD will provide basic training of Affiliate personnel in the use of the computers and/or software to be provided by FPMD, and in the construction and use of the data base designed for the capture of the client profile information.

The Population Council will provide technical assistance in the selection of the samples in the five cities to be included.

FPMD will provide support for the printing of the questionnaires, and for the per diems and transportation of the interviewers (if necessary). Since the interviewers will be FEMAP staff, they will not be paid a salary. Total amount to be spent on this component is approximately:

3. Market Analysis

Complementary to the client profile, is a proposed market analysis of the competition. While FEMAP sees its main competitor to be the MOH and has priced its services accordingly, this does not

necessarily have to be true. Perhaps clients which might normally go to private providers are taking advantage of FEMAP's high quality services and low prices. In this instance, in order to price its services competitively, yet maximize income, FEMAP should consider private provider prices for similar services and price its services only somewhat lower than those, rather than only somewhat higher than the Ministry of Health. Thus, market studies of the competition in the five locations in which the study is to be conducted are suggested.

The Population Council has suggested that the accountant to be supported by INOPAL would be an appropriate person to conduct this analysis, and it will be included in his scope of work for the first year of the project. This work will consist of working with the local Affiliate Directors to identify other local providers of the kinds of services provided by FEMAP (FP, MCH, and other curative services) and in assessing what they charge for similar services. It will take place concurrently with the cost analysis.

4. Institutionalization/Utilization of Results of 1-3.

In addition to the activities outlined in this document, FPMD's Evaluation Unit will also be budgeting time and funds (total amount to be determined) to establish indicators for the monitoring of the abovementioned FPMD activities.

An additional \$5,000 is available for work with FEMAP to ensure that the organization utilizes the information made available by the abovementioned studies. FPMD will meet with FEMAP senior management to discuss the implications of the results of these activities. In conjunction with The Population Council's INOPAL II project, FPMD would be available to help FEMAP design new strategies or interventions for generating income/cross-subsidizing services, once the initial information gathering stage has been completed.

FPMD will collaborate with and complement the Population Council's work with FEMAP. Important lessons can be learned through this collaborative activity in the important area of sustainability.

Illustrative Budget for this activity (to be confirmed):

| Client Profile | |
|---|--------|
| 1. TA (FPMD/BOSTON) | |
| 8 RT Boston-Ciudad Juarez-Mexico-Boston: (TA in design of survey instrument, training of interviewers, data analysis) 1,000 X 8 | 8,000 |
| Local Travel (Irapuato, Veracruz, Acapulco, Mazatlan) (@ 200 X 4=\$800 per trip to Mexico) X 8 trips to Mexico | 6,400 |
| Per diem X 56 days (\$132.00) | 7,392 |
| SUBTOTAL: | 21,792 |
| 2. Materials and Equipment (FEMAP)* | |
| Printing of Questionnaire* | 500 |
| Printing of Results* | 1,000 |
| Computers x 3 Printers x 3 Software: X 5?? WP5.1 (Spanish) HG Quatro DBASE SPSS (?) | 15,000 |
| Other Supplies (Diskettes, ribbons, etc.)* | 1,000 |
| Communications (Phone/FAX/Mail)* | 1,000 |
| Maintenance for Computers (3 x 1,000)* | 3,000 |
| SUBTOTAL: | 21,500 |
| 3. Local Personnel | |
| Consultant X 60 days (@ \$150/day) | 9,000 |
| Transportation of FEMAP staff to conduct interviews (\$3.00/day x 5=\$15.00 x 20 days X 5 sites= \$1,500)* | 1,500 |
| SUBTOTAL: | 10,500 |
| TOTAL: | 53,792 |

* Money to be reimbursed to FEMAP for their costs

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| Follow-up/Utilization of Results | |
|----------------------------------|-------|
| EVALUATION (INDICATORS) | ?? |
| TA (FPMD/BOSTON): | 4,250 |

| | |
|--------|--------|
| | |
| TOTAL: | 58,042 |

Appendix 6

Draft Text for *Family Planning Manager* on TQM

Intro

There is something new and exciting afoot in the management of family planning programs. It goes by many names, the most common being "total quality management" and "continuous quality improvement." Whatever it is called, this approach to management embodies the ideas of [here a couple of sentences about Deming, about participatory management and increased productivity, whatever else we need to establish the value of CQI].

The principles and tools advanced by Deming and his colleagues are being applied in private-sector corporations all over the world, but they are not limited to the business environment. They can cast a fresh, new light on the management of public health services, including those offered by family planning programs. In this issue, we introduce you to continuous quality improvement (CQI), a process you can use to motivate your staff and bring a spirit of commitment and energy to your clinic or organization. We offer a series of steps and practical suggestions for introducing and maintaining a CQI system.

CQI: Exactly what is it and how does it work?

CQI is a process that helps organizations and facilities improve the quality of services and strengthen the administrative processes that affect these services, resulting in higher staff morale, quality of care, and client satisfaction. In the context of family planning organizations, satisfied clients and staff can increase the number of family planning acceptors, the continuity of contraceptive use, and, ultimately, the impact of family planning programs on fertility.

Because of different applications of CQI in industrial and service organizations, there are varied definitions and interpretations. But it is generally accepted that CQI relies on systematically gathering information about how employees are ~~doing so~~ they can constantly strengthen their performance. at the highest possible level. CQI can be used by the staff as a whole and by individual staff members through four main activities:

1/3

- o establishing standards or norms of services;
- o monitoring how well those standards are being met;
- o identifying deviations from the standards (problems);
and
- o taking action to correct the deviations (solve the problems).

What it takes to carry out these activities is teamwork. In the most effective CQI systems, all staff members participate in the process, and all their contributions are valued. But no staff, even the most highly motivated, can begin to work as a self-monitoring, problem-solving team without training and guidance. CQI also requires leadership from a manager or organizational official who is committed to improving quality, who is willing to set standards, and who genuinely trusts the ability of his or her staff to find ways to meet those standards. This leader should be willing to act as a facilitator, to train the staff in team work, monitoring techniques, and problem-solving, and to be available to them when they need help solving a problem or getting over a hurdle.

With this combination of team and leader/facilitator, CQI can be carried out throughout the various levels of a family planning organization, within a single family planning clinic, or within a department or group in a large facility. In this discussion, we are focusing on the clinic setting (see ***Box for an analysis of CQI at the organizational level).

How is CQI different from traditional supervision?

Until recently, in health service delivery systems throughout the world, the accepted way to maintain and improve quality has been through supervisory visits, usually from the next higher level of the organization. This traditional approach differs in several important ways from the CQI system:

The supervisory process focuses on improving individual performance through periodic visits from a superior. It is a process of monitoring according to checklists imposed by some higher authority. When it works best -- a technically-competent, sensitive supervisor who fully understands the clinic situation.

and who comes regularly, on schedule -- it can foster a long-term, supportive, collaborative relationship that helps the staff member gain knowledge and skill. But in the great majority of cases it is more likely to be seen by the clinic staff as judgmental and threatening. Because it occurs only periodically (and often irregularly), it lends itself more to superficial observation than to on-going, in-depth analysis and problem-solving.

The CQI system focuses on clinic output, rather than individual performance. It depends on self-monitoring according to standards agreed to by the staff. It builds on respect for the staff's commitment to serving their clients and their ability to improve the quality of services. It is based on groups working together to solve problems rather than individuals working alone to remedy their deficiencies. It is on-going rather than sporadic, allowing for a more substantive analysis of problems, more thoughtful solutions, and opportunities to review these solutions and change practices as new knowledge emerges.

Steps

There are ten steps to take in introducing, implementing, and maintaining a CQI system in a clinic. Because CQI is an ongoing process, some steps will be repeated many times as changes are introduced, tested, and adapted, and as new problems are identified and addressed.

Step 1: Assign responsibility

Like other management systems, CQI works best if one person is ultimately responsible for seeing that it is carefully designed and carried out. In most clinics, this will be the clinic manager -- often a doctor or highly-experienced nurse -- who has that responsibility. The leader must define the elements of the system and lay out the steps in the ongoing process of monitoring the quality of clinic activities.

But this doesn't mean that you, the manager, must bear the entire burden; it would be impossible to do so without neglecting all other duties. The trick is to strike the balance between your

personal responsibility for ensuring quality and the responsibility of the rest of your staff for providing high-quality services. The most effective managers authorize competent staff members to carry out various aspects and phases of the process; you will find that this is not only necessary but desirable, since involvement in the monitoring process alerts staff members to how they are carrying out their own tasks in the context of clinic standards. Your job will be to see that your staff are oriented and trained to fulfill their roles in the CQI process; that CQI responsibilities are included in their job descriptions; that their performance in this area is monitored and rewarded just as their clinical performance is; that they are helped to grow in the job through in-service education and regular meetings and conferences.

Many managers find it useful to appoint a mature, dependable staff member as CQI manager, to oversee the monitoring process. If the facility has a large enough staff to apportion parts of the process, the CQI manager may work with an ongoing committee whose members carry out the remaining [nine] [eight] steps in the process. But in the end, the monitoring committee and its manager are assisted, directed and guided by the clinic manager.

Step 2: Set standards

The clinical standards against which activities are monitored must be widely accepted by the professional family planning community. They are often based on written curricula for pre-service and in-service training, articles in professional journals, guidelines established by the government or the clinic's parent organization. Standards that pertain more to clinic appearance, atmosphere, and administrative procedures may be decided at the clinic level, although there are often checklists and guidelines to use in establishing these standards.

You, the clinic manager, can direct the team in developing the standards, or you may assign this leadership role to the CQI manager. Whoever takes the lead in developing them, you will want to give them final approval and be sure that all members of the staff fully understand and accept responsibility for adhering to them. The standards must be written out clearly, widely

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circulated, and referred to often in meetings and discussions. It is only in this way that the entire staff can keep them in mind and be held accountable for meeting them.

Step 3: Identify aspects of care to be monitored

It is, of course, impossible for any manager, supervisor, or committee to monitor every activity that takes place in a busy family planning facility. If the goal is to improve the quality of services and strengthen the administrative processes that affect these services, it is essential to monitor the aspects of care -- the clinical and administrative activities, events, processes -- that most directly affect this goal. These are likely to include:

- o high-volume services (services that are provided to large numbers of clients);
- o high-risk procedures (FP methods that have great potential for side effects or failure, that are new to the staff, or that are technically complex);
- o patient-dependent procedures (methods whose effectiveness relies on patient understanding and compliance);
- o previously-identified problems (often administrative: waiting times, record-keeping, availability of commodities).

Among these aspects, the clinic manager and selected staff should agree on a few [2? 3?] priorities for the first exercise in monitoring. [do we need guidelines for setting priorities?] The selection of aspects of clinic practice for monitoring will continue throughout the CQI process. Some aspects may be dropped from regular monitoring as the staff takes action to solve the problems, and new ones may be added.

Step 4: Define indicators for each aspect of care

Indicators are elements of an aspect of care that can be measured

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to see whether procedures and activities are meeting the established standards. Taken together, indicators help you and your staff know whether the activity, event, or process is enhancing or impeding quality. They can address on clinical procedures or administrative operations, but should always relate clearly to one of the high-priority aspects of care.

Indicators are not in themselves measures of quality. Rather, they serve as "markers" to alert you and your staff to situations that need to be addressed if quality is to be improved. You can monitor two kinds of indicators: sentinel events and rate-based indicators. **Sentinel events** are serious, undesirable, and avoidable practices or outcomes. In the case of IUD insertion, sentinel events would include such indicators as improper insertion, non-sterile technique, etc. They are so important that they must be reviewed and corrected whenever they occur. **Rate-based indicators** for IUD insertion might include infections, requests for removal, expulsion, or pregnancy.

These indicators should be reviewed continuously but investigated only if:

- o the rates at which they occur show a significant trend over time;
- o the rates of their occurrence differ markedly from rates of similar institutions;
- o the rates of their occurrence exceed a pre-determined threshold.

It is not always easy to establish the levels at which rate-based indicators become warning signals. [Need some discussion here; might use some examples to illustrate simple, common-sense definitions of "significant trend," "marked difference," and "pre-determined threshold." Perhaps a list of questions to help clarify these.]

Step 5: Collect data

Once you and your staff have decided on the aspects of care that

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are most important in your clinic and the indicators that can serve as "markers" of each, you and your staff will need to collect data about each indicator, using a standard procedure and forms. There are five questions to answer at this stage:

- a. What data do we need?

It is tempting, when introducing a new monitoring process, to want to know everything possible about the activities in the clinic and to gather more data than can be used. It is important to temper this enthusiasm by considering whether collecting any piece of data is efficient (worth the time, energy, and resources needed to monitor it) and effective (giving real evidence of the existence or absence of the indicator).

- b. Where will we find the data we need?

There are three common sources of data for monitoring: medical records, client feedback, and direct observation.

- o Medical records

If individual client records are filed in some systematic manner (alphabetically, by an assigned number, or by date of visit), they are easy to use and can yield valuable information about clinical procedures. The record of the physical examination or of answers to questions asked by the provider (or blank spaces where the answers should be) can show whether the proper choice of contraceptive method has been made [examples -- orals? any others?]

- o Client feedback

You can discover the opinions of your clients in several ways. Many clinic managers obtain information through "exit interviews" -- questionnaires that address pre-determined aspects of care, administered by trained staff members. [Example of exit interview]. If a large proportion of the clinic population can read and write, written questionnaires can yield useful data. To ensure a large number of responses, it is best to keep the questionnaires brief and simple, with "yes" or "no" answers, and

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to have clients fill them out before leaving the clinic.

Another very useful mechanism for feedback is the "focus group." Focus groups are ...[we need a good definition and example in the context of rural clinics].

o Direct observation

This is probably the most common form of monitoring. The process is most useful when it is guided by checklists, reflecting the selected indicators and referred to by all staff members involved in a given activity. [Need some samples: for medical, administrative, and housekeeping procedures]

c. How will we collect the data?

This is one of the most critical parts of the process. If all those who collect the data do not have a common understanding of what they are looking for, they may get data that are inconsistent and misleading. If the collection methods are haphazard, the information will not be worth the time spent gathering it. It is essential to develop simple, standardized tools; train the collectors in their use; and check periodically to be sure the collectors are using the tools correctly.

d. How often should we collect data about any given indicator?

The size of the clinic and number of clients will have some effect on how often to collect data. [Need more here, with examples]

e. What should be the size of our sample?

It is not always easy to decide how many events to review to learn whether or not there is a problem. To determine the number of records to pull, interviews to hold, or observations to make, you and your staff will want to review enough situations or events to recognize persistent problems as opposed to occasional lapses. [Here some **simple** discussion of sampling techniques, estimates of #s of records or reports to review re: client

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population.]

Step 6: Analyze data to evaluate clinic services

It is at this point that many monitoring systems falter. In order to provide guidance to your staff for improving quality, the data should be made accessible: organized and presented in a way that allows the staff to identify patterns, investigate likely causes, and explore possible solutions. [Do we want a discussion here on summarizing, analyzing, preparing reports? It's in the Handbook.]

Using charts or graphs in reports is a powerful way to bring to life the results of monitoring, to reveal the extent of positive and negative practices throughout the clinic, and to demonstrate improvements in practices over time. Simple graphic displays of information can motivate your staff to maintain their involvement in the CQI process and can help advocate with higher-level officials for needed resources. [graphic examples]

Step 7: Identify and prioritize problems and choose solutions

When you and your staff have discovered, analyzed, and understood the information revealed through monitoring, you will be better able to pinpoint problems -- areas where clinic practice differs from the standards -- and agree on practical changes to solve them. If the monitoring has revealed many problems in one area, you will want to set priorities and select [one? two?] problem[s] to work on, avoiding the frustration of taking on too many changes at one time.

There are many criteria you and your staff may apply in prioritizing the problems to be solved. At the start of your CQI initiative, it will be helpful to concentrate on a problem that appears relatively easy to solve. This will give you and your staff a chance to practice problem solving, action planning, implementation, and assessment with a minimum of frustration in an atmosphere of optimism and with a great chance of early success. Later, when the process is ingrained and the staff have sharpened their CQI skills, you and they can take on the problems that affect the most clients or staff and are most disruptive to

the delivery of quality services.

Once a problem has been chosen for correction, it is often tempting to quickly pick the most obvious solution that comes to mind, only to realize later that the chosen solution does not address the real causes of the problem; that the proposed changes cannot be implemented with the available resources within the normal clinic routine; or that there were other potential solutions that have been overlooked. To choose the best and most realistic solutions to each identified problem, you can engage the staff in a simple problem-solving process [do we want to do a quick run-thru of the process? perhaps in a box?].

Step 8: Plan the actions needed to solve the problem

For each solution, you and your staff will need to develop an action plan naming the problem and the proposed changes that will solve it, and specifying what actions are to be taken, who has primary responsibility for each action, when it should be begun and completed, and how it will be monitored. Each action plan should be integrated with clinic workplans and schedules, to be certain that it is realistic in view of the other obligations of the staff. Only then are you ready to implement and monitor the plan.

Step 9: Carry out and monitor the plan

There are many ways to monitor the extent to which the actions taken adhere to the plan. Two of the simplest and most practical are direct observation and interim reviews.

Direct observation is perhaps the most common way of monitoring the plan. Informal observation is already ingrained in most clinics: managers often walk through the clinic to see what is going on, and service providers take mental notes of their own and other people's performance. You and your staff can enhance this informal process by drawing up checklists that reflect the activities in the action plan and using these checklists at regular intervals.

Interim reviews are measurements or observations of indicators

that are seen as stages in the solution of the problem. Interim indicators can be set by dividing the total time period into segments and measuring results at the end of each segment, or by identifying key events and observing whether or not they occur by an agreed-upon date.

It is reasonable to expect that monitoring will reveal changes during implementation: dates may slip, different staff members may become involved, intervening events may suggest adding or removing an activity. These changes should be communicated and agreed to by the staff and written into the plan, so that it always reflects reality and provides an accurate record of the implementation process.

Step 9: Assess the effectiveness of actions

Monitoring the plan will show whether the actions agreed to are taking place as intended, but it will not show whether they are having the desired impact: bringing clinic practice up to the agreed-upon standards and solving the problem. To determine the impact of the new actions, you will want to return to the indicators (Step 4) that alerted you and your staff to the problem in the first place. The same process of data collection and analysis (Step 5) will show whether the frequency of unacceptable practices or outcomes has changed in the desired direction and to the extent anticipated.

If the level of performance has improved, you and your staff will want to decide whether to work towards further improvements in the same area, or to move on to a new area and new problem. Whichever way you decide, it is important to continue monitoring this area to ensure that the improvements are maintained over time.

If the level of performance has not improved, there is no reason to be discouraged and abandon CQI. You can remind your staff that CQI is not a computer program or a scientific formula. It is a skill that harnesses the combined contributions of the entire team, and, like all skills, it must be built through experimentation and practice. The inability to reach a goal the first time provides an opportunity to re-analyze the defined

problem, causes, and solutions (Step 7) and to develop a new action plan accordingly (Step 8), incorporating the experience of the first effort.

CQI and staff creativity

Some managers have found that a new emphasis on standard-setting and monitoring can increase tension and rigidity in some staff members. It is important to encourage flexibility within the CQI process. Individual ideas and work styles can enrich the process and enhance the likelihood of success. In the final analysis, CQI depends on the involvement of the staff in sifting through a variety of problems, causes, and potential solutions to find and carry out creative changes.

Suggested boxes and side discussions

- o Checklists: standards/protocols for selected clinical and administrative procedures; for elements of the CQI process itself (see Wolfie's suggestions)
- o Bruce's 6 elements of quality of care linked to CQI as standards (Vernon)
- o CQI across the organization: how support from the top can help clinic-level CQI happen; how to get this support; how senior manager becomes facilitator and trainer vis-a-vis clinic manager and staff; longer time required for implementation than at clinic level; potential for changes in organizational structure, reward system, etc
- o Problem-solving steps and mechanisms
- o Country studies from Guatemala and Mexico (Nancy)
- o Techniques for team-building

Appendix 7

Population Council and MEXFAM comments on *Family Planning Manager* Draft

COMMENTS TO TQM MSH DRAFT PAPER
(Ricardo Vernon and Pedro M. Acosta)

Introduction: Ishikawa defines TQM as "developing, designing, producing and service a quality product (or service) which is most economical, most useful and always satisfactory for the consumer." TQM embodies the idea of a) satisfying the consumer b) having quality as your first priority c) working with your fellow employees to improve processes and prevent occurrence of problems, d) using facts and data to make decisions, e) full participation of management and respect for the abilities of employees (see Ishikawa, What is total quality control? Prentice Hall. Also, Walton, Mary: The Deming Management Method, Dodd, Mead and Co, Inc. she explains Deming in a simple way.

1. Page 1, last paragraph. Data is collected about processes, not about people. In fact, one of the main ideas underlying TQM is that workers are not responsible for the results, the system set by management is. Thus, you collect data about processes.

Page 2. What it takes to carry out these activities is teamwork. In CQI, the employees meet regularly and work together to identify problems and solve them in order to improve their organization and the services it provides. For this reason, TQM requires training of all the employees in basic problem solving and data analysis techniques. Furthermore, TQM requires managers who are sincerely committed to improving quality and to implementing the changes proposed by employees in order to improve working conditions and services. (I'm not sure that setting standards should be mentioned at this point. Further, by no means you should demand of top managers-leaders to work as trainers. What you should demand is that they show their commitment to quality, that they communicate the importance of quality as the top most goal, that they devote resources to implement the system, that they implement the solutions generated, etc. In conclusion, that they lead the implementation process. Further, (3d paragraph) several would disagree that you can implement TQM in a department of an organization. TQM needs by definition to be an all-encompassing system, even though you may start working in a few facilities)

2. pps. 2-3, TQM vs supervision: this section should be eliminated. I think a better question is what is similar between CQI and supervision? not much, really. It only confuses the issues. If you want to compare TQM, the reference point would be traditional management, where managers think out solutions and direct their employees efforts towards complying their orders to achieve a result, vs TQM, where employees study the processes they work in, they think their own solution to problems and they implement the solutions to improve their work. Thus, TQM is more participatory in nature.

Further, CQI does not primarily focus on clinic output. It focuses on process producing services to meet the requirement of clients. By working on the process you increase output and produce greater quality by reducing waste, re-work, mistakes, etc.

3. page 3, steps: the first step is planning. The second step is training. Training of managers and workers is essential. Planning involves identifying organizational values that need to be changed, define the role of management, thinking who will conduct which activities, what will be expected of groups, how much time will be devoted to these activities, etc.

4. PP 4, step 1. Management needs to assume the responsibility for the CQI process. That cannot be delegated. The top manager can delegate coordination, training, development of materials and planning activities to one person. "The most effective managers..." It is always a good idea to set-up a team to plan and overview the process. That way, you involve people from the beginning. This same team can be in charge of implementing different subsystems or work as facilitators (leaders) in quality improvement teams. In case a person is designed as the leader, it is of the utmost importance that he gets the full support of the director, and that he keeps informed all top officials of the development of the TQM system.

Perhaps a better approach is to say that the manager is ultimately responsible in supervising that the system is implemented. The system requires training of all employees, forming groups and have the groups work in improving processes to better meet the requirement of consumers. To have groups function well, the manager should seek to prepare some employees as experts in problem identification and measurement techniques. In very large organizations these may be a full time employee, but this is not necessary. Ultimately, the manager must see that proposed improvements are implemented.

5. pp4, set standards: the paper here seems to assume a quality assurance viewpoint rather than a TQM approach, since you seem to be discussing standard of final results (unless I misunderstood the section).

In TQM, the first step is to formalize the most important processes and set standards for critical checkpoints. Formalizing a process essentially means charting the flow of activities and for each step asking what are the requirements needed so that the activity can be carried out and what are the desired outcomes of that activity. In TQM, what you control are the requirements of the process so that the final standard of the service or product is met. The standard is defined partly be the professional community in the case of clinic services, but also and most often in terms of client satisfaction. Bringing a process under control means meeting the requirements in all process steps. The first order of business

is to bring the process under control to meet a given standard. If you are not meeting the desired standard you have the alternatives of lowering your standard, modifying your process requirements in order to meet it or changing all together your process. If the standard is being met, you may work on how to achieve a better result in terms of cost or any other quality attribute by modifying the process. Obviously, most organizations start by focusing in the most "problematic" processes to begin their work.

Usually, when TQM begins, very few processes are formalized and few standards are explicit. Thus, the first step is doing a flow chart, try to determine what is being done and what standards are being achieved.

Thus, this step should be study your process and determine which factors must be controled in achieve a consistent result. Then you ask yourself if this result (the given standard) meets the requirements of your clients (accepted or desired standard). If not, you work on the process to improve it.

6. pp 5. Identify aspects of care to be monitored: this is almost identical to the previous step. You effectively select your main headaches and start working on the process or processes in which that problem is located. First you observe the process and determine its flow. Then you measure critical points. Then you think a solution and test it, and see if you are consistently achieving better results (i.e., meeting higher standards). I suggest you eliminate this step.

Step 4: Indicators: You seem to call "sentinel indicators" what we have been referring to as "requirements". We think that it is important that you make clear that you need to establish the requirements of process steps and you measure compliance with the requirements. Non-compliance is a call for corrective action, i.e, a warning signal. We think these "indicators" should be discussed above. These requirements are usually set by the organization itself. These requirements are validated by the standard achieved by the process.

"Rate-based indicators" are what we call "standards" that need to be met. Once a standard of care is selected, you again measure compliance or non-compliance. You are supposed to monitor compliance with your standard as well as the acceptability of that standard.

Your discussion of Rate based and sentinel indicators reaffirms your quality assurance view point. These indicators are very important to identify problems. The question in TQM is how to prevent this occurances. In your examples, one may ask what may lead to, say, such a rate of IUD expulsions. If under study one finds that it is improper insertion techniques, then one may have questions about the process leading to that improper technique. Is

training inadequate? are certification procedures inadequate? etc. The thing would be to study the process leading to that result and modify the process so that those events will not occur again. If certification is the problem, new requirements are set, if a particular training module is not performing, new requirements are set. Prevention is the basis of TQM problem solving.

Your statements of when to review and investigate rates are valid only once processes are under control.

Step 5: Collect data: this section is typical quality assurance. The section is correct, but maybe you should shorten the section to keep the document simple. Other comments on 5:

5b.: also, the service statistics system, but very frequently, the data needs to be collected especially for the quality improvement team's project.

c: usually, the same staff collects the data. That is, among other reasons, why initial training of all the personnel is essential.

d, e: You need to collect data until you are able to decide whether your process is under control or not, or until you are able to observe if your intervention was successful in improving a given outcome. I guess this is rather a technical issue heavily dependent on what you are measuring. Your current statement is true, but not very informative. This is a technical issue. Again, we suggest you shorten the section. As it is, you get involved in technical issues without addressing them properly.

Step 6: again, training is essential and most employees should have a basic understanding of simple statistical techniques. Since they usually collect the data themselves and discuss the results with fellow employees, it is not so difficult to motivate them. Usually, in large organizations, there is one or more experts that serves as a provider of technical assistance to groups and that helps them to select indicators, develop measuring instruments, and conduct the analysis.

Step 9. Suggest you change this. You monitor the plan with the same indicators discussed above, including the same indicators that you used in the first place to determine the problem. An instrument to monitor compliance with requirements may include checklists, but we would not advise using "informal observation" except in very particular cases. The indicators used should give information about properties of critical process steps.

STEP 10 (listed as nine also. there are two step 9s): Discuss your two steps 9 together. You monitor simultaneously compliance with requirements and outcomes. This step with an introduction on

monitoring compliance should be enough. The problem is you seem to think of indicators only as outcome measures. That is incorrect. You select indicators that provide data of different steps in the process leading to the given outcome. As mentioned earlier, when you formalize a process, you select requirements and outcomes for the different steps.

It is correct to advise selecting simple problems at the beginning. Also, through all the paper you talk about CQI, but you devote a small paragraph to repeating the improvement process. I wonder how this can be emphasized. Perhaps in page 2, the four steps you can add a fifth "do it all over again" or repeating the process.

Your discussion in page 11 can underline the importance of persistence. Ask any consultant and (unless he is trying to sell you his services) he is likely to tell you that establishing TQM is not easy. It takes time, it takes effort and commitment from people, especially top managers. Furthermore, results are observed only in the long term, after several small improvements begin to be making a real difference. Thus, unless you persist in the effort, you will not see results.

FURTHER COMMENTS:

My main concern with the paper is that the basic idea that TQM is working on processes to achieve better results is not very clear. As it is, it gives somewhat the impression that your concern is rather quality assurance, which is a useful approach but different from TQM. Perhaps that will be solved by means of examples.

Appendix 8
Description of MEXFAM TQM Project

MEXFAM: ESTABLISHING A CONTINUOUS QUALITY IMPROVEMENT PROCESS

In April, 1991, MEXFAM began to use a CQI approach to improve the quality of its family planning services in its headquarters and in six logistic regions, the administrative and geographic areas in which MEXFAM is organized.

The first year of this process was devoted to sensitizing MEXFAM personnel to the basic principals of CQI (a focus on the satisfaction of internal and external clients, the participation of everyone, prevention, and the institutionalization of the idea of continuous improvement), preparing training materials and training the personnel in basic CQI diagnostic and measurement techniques.

The initial sensitizing stage consisted of the participation of MEXFAM's Executive Director and the Chief of Evaluation in a one-week course organized by Crosby Associates for managers. Following this training, the Executive Director and top management began to incorporate brief messages about the importance of quality improvement in general staff meetings and in occasional articles in MEXFAM's bulletins. During this stage, top managers also visited other organizations that had implemented CQI processes and conducted interviews with several consultants in CQI for a better understanding of how to implement the CQI approach. These visits were critical in establishing a network of technical resources and in obtaining training materials that could be adapted for MEXFAM's purposes at a later stage.

In preparation for the implementation stage, MEXFAM's Chief of Evaluation attended a six-month course on Total Quality in the Instituto Tecnologico de Estudios Superiores de Monterrey. In addition, the Chief of Evaluation and seven department heads and regional logistical coordinators who later became members of MEXFAM's CQI Support Team received a one week training course on the basic principles of CQI as well as training in process analysis and measurement. The CQI Support Team became responsible for establishing the CQI system, providing technical assistance to Quality Improvement Teams, developing training materials and proposing strategies for improvement.

The training materials developed consisted of a set of overheads that presented the main features of the project, a manual on team work, and a manual on CQI implementation in MEXFAM.

At the same time that materials were being developed, and the model for implementation of CQI in MEXFAM was being conceptualized, Quality Improvement Teams (QITs) began to be formed in different work areas and Departments. Unfortunately, the formation of QITs at this time turned out to be premature. Meetings were held in the logistical regions, sometimes without the presence of a member of the CQI Support Team. The QIT members and the Support Team members were unsure about their role in these meetings. Most of the meetings were devoted to discussions on how to organize the group activities. Thus, each group started to work according to its

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own understanding of CQI implementation, the information received by the members of the different QITs was different. As a result, some QITs began by analyzing problems, some QITs began by analyzing processes, and others simply used their meetings to talk about their work in a very general sense. After several months of working in this fashion, the CQI Support Team and the Regional Coordinators realized that very little was being accomplished because of a need for a conceptual model, standardized training for all MEXFAM employees, and clarification of roles and responsibilities at the level of the QITs as well as at the level of senior management.

By the beginning of 1992, almost a year after the beginning of the project, MEXFAM decided to reintroduce the CQI process. With the help of an outside consultant, a model for the implementation of CQI in MEXFAM was developed (See Figure 1). In this model, the role of senior management was made more explicit by the creation of a Senior Management Team. This Management Team is composed of the Executive Director, the Subdirectors, and the Unit Chiefs. It is responsible for providing leadership, support and recognition in the process of implementation of CQI in MEXFAM. The model also clarified the different stages through which each QIT needed to pass in order to successfully begin to improve their work.

As an outgrowth of the conceptual model, the CQI Support Team standardized their training approach as well. It was decided that each QIT would receive ten one-hour or three three-hour sessions of group integration, definition of mission, and training in problem identification and process analysis. QITs were given clear instructions to select the most important processes with which they worked.

As currently defined by the CQI Support Team, the identification and analysis of processes involves charting the flow of the activities which define the process, identifying the necessary conditions for the implementation of each activity, and the desired outcome of each activity. Then, for each process, providers and clients are identified as well as the inputs and outputs or outcomes with quality specifications and possible ways to improve the process. Figure 2 presents an example of an initial visit to a community health post.

Once the analysis of the process is complete with the desired results and the conditions necessary to achieve them identified, a simple baseline measurement of the actual situation should be conducted. This measurement can be as simple as a textual description or as complicated as a small survey of client satisfaction. In either case, sufficient information for determining the impact of the improvement activities must be collected.

The improvement activities begin once the initial assessment or measurement is complete. Where the factors necessary for the successful completion of a particular activity do not exist, they

must be put in place.

Again, there must be a measurement of the prevailing situation. If there has been no improvement, the factors necessary for the achievement of specific activities may need to be reexamined, or further improved. Even if there has been improvement, the group may decide to try and further improve on desired outcomes.

As of August, 1992, there are 130 MEXFAM staff participating in 20 QITs with an average number of seven members each. Among the twenty teams are included the Senior Management Team, five interfunctional teams. All of the teams have completed the integration stage, 17 have a clearly defined mission, and have received training in the identification, analysis and formalization of their principal processes. 11 have diagrammed their most important processes and five have already begun measuring results.

Figure 3 presents an example of improvements obtained by the QIT of the Systems Department. This team identified as a necessary factor for the completion of their work, the need to spend less time troubleshooting software needs and more time upgrading important MIS systems. However, the staff found that it was spending nearly 75% of its time resolving printer interface and hardware/software compatibility problems on an ad hoc basis and consequently could devote only one-fourth of their time to the development and improvement of systems. As a first step, they analyzed the training process of software users. The needs of software users were reviewed and the necessary factors for meeting those needs identified. They then tested a training program of two weekly hours for six weeks in an attempt to improve the necessary conditions, but no change in the proportion of time devoted to ad hoc technical support was observed. Since absenteeism had been a problem, a new training strategy was devised. Depending on the software application, a one-week 10 to 20 hour training program was established. In addition, the training was provided to members of a given working area instead of heterogeneous groups with members of different areas who did not share common needs. Figure 3 shows that after this strategy was implemented, the proportion of time devoted to attending technical assistance requests decreased to under 50%, with a concomitant increase in the time devoted to systems development and other technical activities. Before this project was conducted, the systems area had developed in the previous year two new systems. In the three months elapsed after the beginning of this project conducted by the systems QIT, three new systems have been developed and three critical systems have been improved. Meanwhile, the systems personnel continue studying ways to further decrease the requests for technical assistance requests.

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MEXFAM IMPLEMENTATION PLAN FOR TQM

Stage 1: Preparation

**Commitment of top leadership
Formation of "Support Group"
Production of training materials**

Stage 2: Initiation of Activities

**Formation of quality circles
Training on identification and analysis of processes**

Stage 3: Consolidation

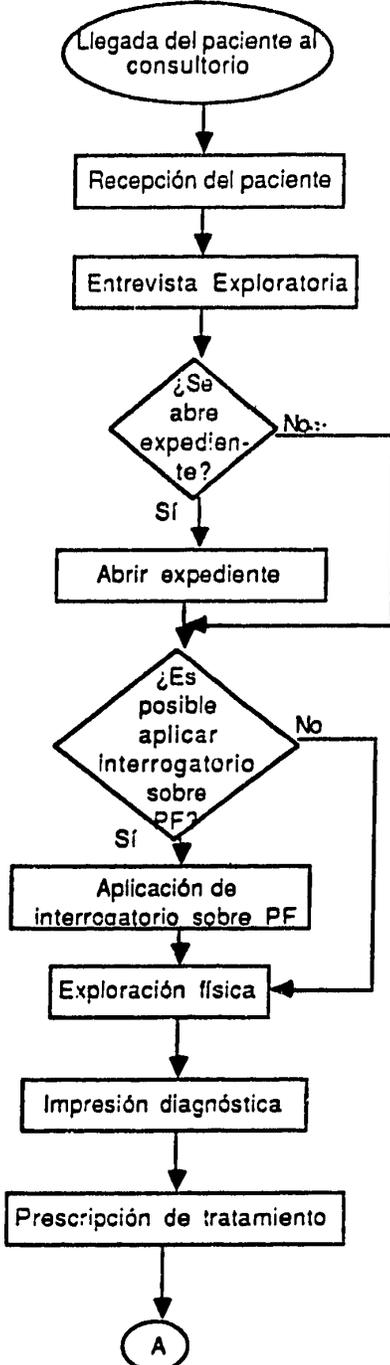
**Measurement and control of processes
Proposed improvements in processes**

Stage 4: Expansion

Formation of quality circles in all Logistic Centers

CARTA DE PROCESO

Proceso Consulta General en un Consultorio Comunitario primera vez
Equipo API's Cuauimaloa

| Factores a controlar | Diagrama de flujo | Resultados esperados |
|--|--|---|
| <p>Folletos, carteles, periódicos murales, Inf al paciente sobre qué debe hacer. Sala de espera limpia y cómoda</p> <p>Presentación amable Sonreír</p> <p>Tarjeta de la usuaria, formato HCG. Abrir expediente. Cuidar relación médico-paciente</p> <p>Seguir criterios para abrir expediente</p> <p>Tarjeta de la usuaria, formato HCG.</p> <p>Conocer interrogatorio básico sobre PF</p> <p>Equipo, estuche de Dx, respeto, amabilidad, seguir reglas de la pro-pedéutica médica</p> <p>Conocimientos técnicos sobre el caso</p> <p>Conocimiento de fármacos y medidas generales adecuadas al padecimiento</p> |  <pre> graph TD A([Llegada del paciente al consultorio]) --> B[Recepción del paciente] B --> C[Entrevista Exploratoria] C --> D{¿Se abre expediente?} D -- Sí --> E[Abrir expediente] D -- No --> F{¿Es posible aplicar interrogatorio sobre PF?} E --> F F -- Sí --> G[Aplicación de interrogatorio sobre PF] F -- No --> H[Exploración física] G --> H H --> I[Impresión diagnóstica] I --> J[Prescripción de tratamiento] J --> K((A)) </pre> | <p>Que sienta confianza. Que se sienta bienvenido.</p> <p>Contar con información suficiente para Dx correcto.</p> <p>Tener un registro técnicamente adecuado de cada paciente que lo requiera</p> <p>Obtener información sobre las necesidades del usuario en cuanto a PF</p> <p>Comprobar hallazgos de la entrevista y el interrogatorio</p> <p>Proporcionar seguridad al paciente por medio de inf. adecuada sobre el padecimiento</p> <p>Curación del paciente</p> |

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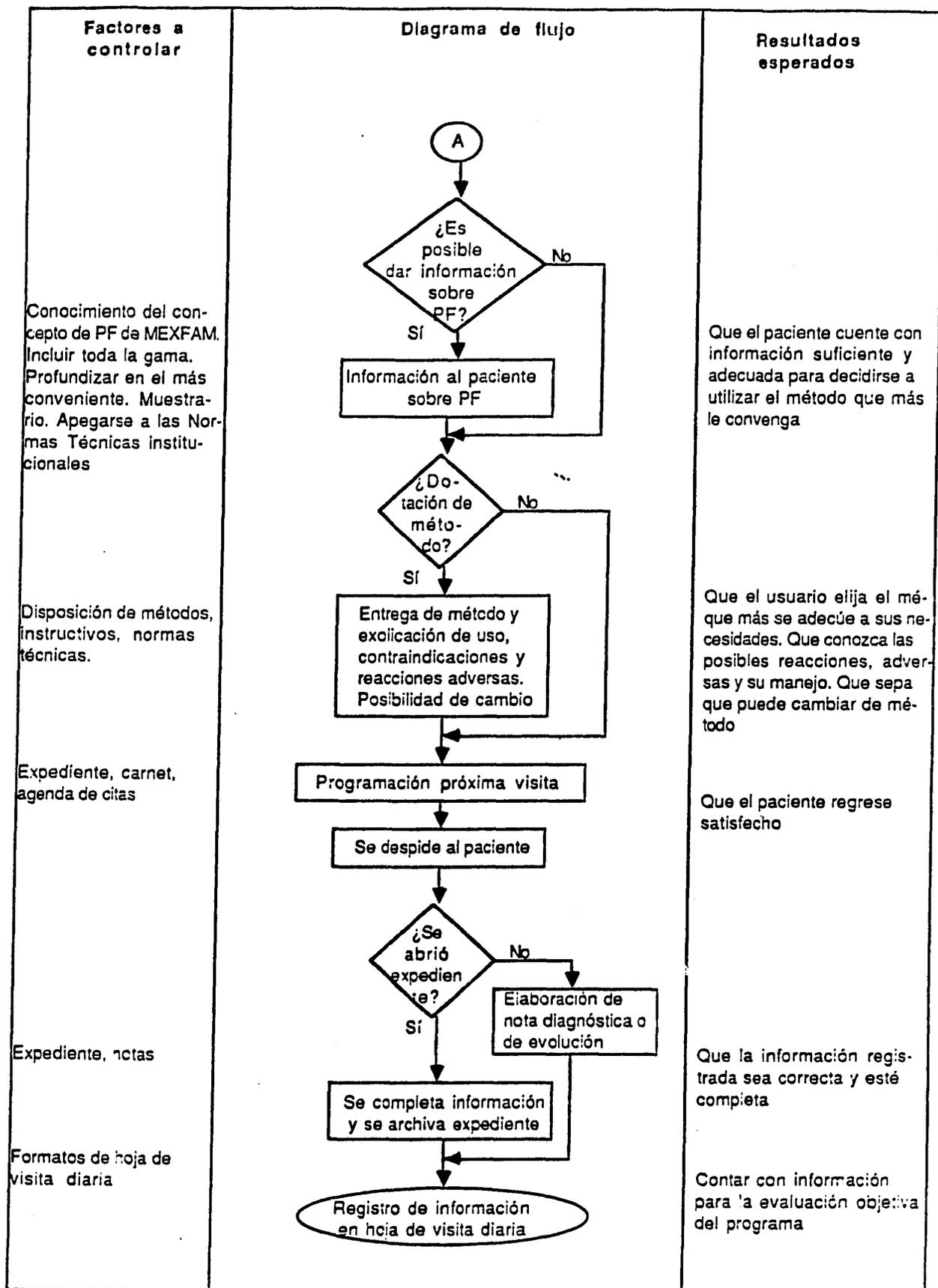
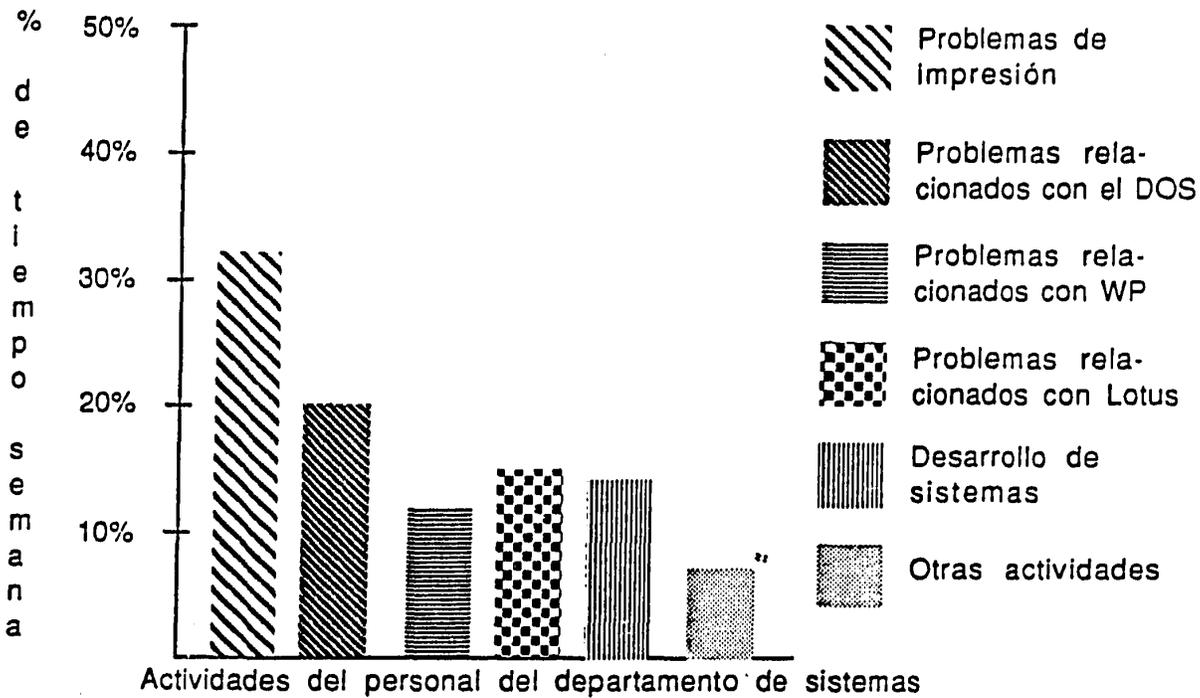


Fig. 1. Ejemplo de una carta utilizada para formalizar procesos..

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ACTIVIDADES SEMANALES DEL PERSONAL DEL DEPARTAMENTO DE SISTEMAS ANTES DE LA CAPACITACION A LOS USUARIOS



ACTIVIDADES SEMANALES DEL PERSONAL DEL DEPARTAMENTO DE SISTEMAS DESPUES DE LA CAPACITACION A LOS USUARIOS

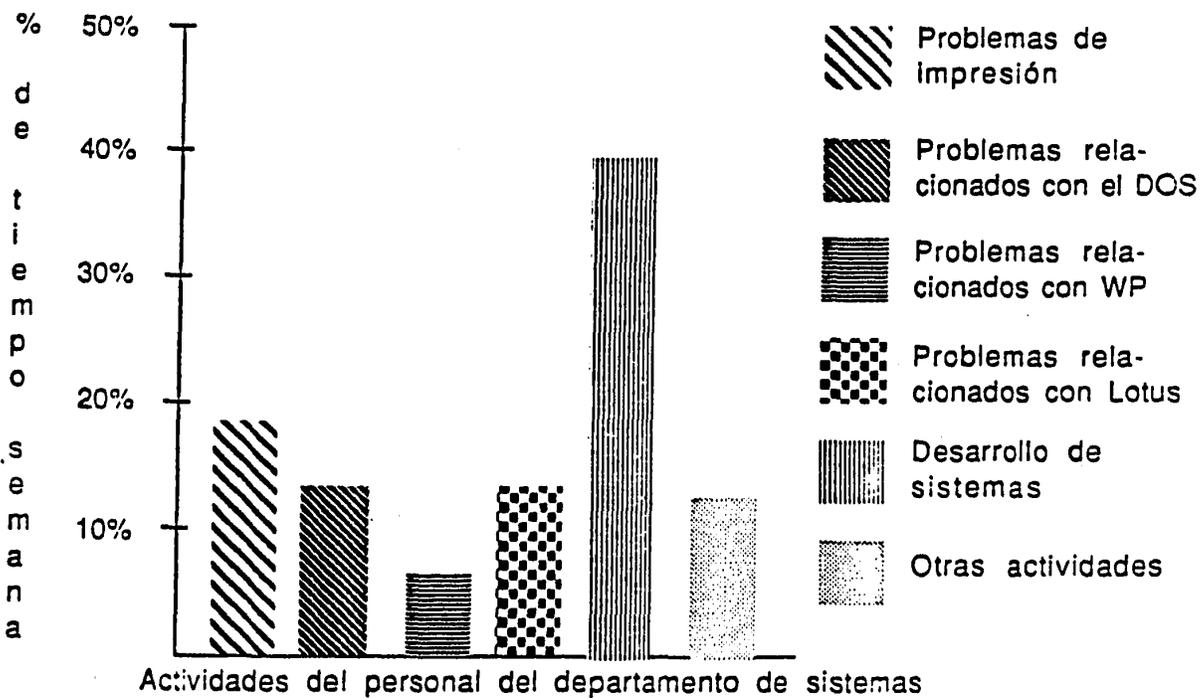


Fig. 3. Ejemplo de graficación antes y después de aplicar una propuesta de mejora

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Appendix 9

Description of Ministry of Health, Guatemala TQM Project

**WORKING SOLUTIONS:
The Ministry of Health, Guatemala**

Background:

Guatemala is a country of approximately nine million inhabitants with a growth rate of 3.2%. It is one of the least urbanized countries in Central America with only 31% of the population residing in localities greater than 2,500 inhabitants.

The contraceptive prevalence rate in Guatemala is one of the lowest in Latin America, with only 23% of MWRA using a contraceptive method, as compared to an average of 54% for all of Latin America and 39% for Central America.

The MOH

In spite of the fact that the Ministry of Health has a physical infrastructure which includes 29 general hospitals, 218 health centers with at least one physician and one or more nurses, and 667 health posts attended by auxiliary nurses, it has only recently begun to emphasize its family planning program. In 1986 a Family Planning Unit was created and family planning has begun to be accepted as a health service necessary for the improvement of maternal and child health.

The Family Planning Unit (FPU) is responsible for supervising the delivery of family planning services in hospitals, health centers, and health posts of the MOH, as well as for the training of service personnel and volunteers. During 1990, the nine FPU supervisors actually managed to complete 88.5% of their programmed visits of two per year, to each health unit (hospital, health center and health post) in the country. In addition, the Family Planning Unit organized 381 training courses and workshops for MOH employees and volunteers.

In the supervision of the service delivery sites, due to their heavy work load and the fact that service delivery sites are dispersed, in hard to reach, rural areas, the supervisors are able to spend only two to three hours at each unit visited. The supervisor must: a) review registration forms of family planning clients to calculate numbers of new and active users; b) establish personnel goals to be achieved during the next six months; and c) check on storage and supply of contraceptives and other program materials. Although the supervisors try to review other kinds of problems and potential solutions, given the short time available and quantity of administrative tasks they have to complete it is often difficult to actually do so.

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Use of Self Evaluation Forms for Continuous Quality Improvement

In order to free up supervisor time from administrative and logistic tasks to address other service delivery concerns the MOH, with technical assistance from INOPAL II, is testing a CQI approach. Self-evaluation forms or checklists organized around Bruce's Quality of Care Framework have been designed to assist service providers in identifying program weakness or problems. (SEE ATTACHED). A sample of six of the twenty four Health Areas in Guatemala have been selected for the initial test of the strategy with two Districts within each of the six Health Areas testing the use of the self-assessment forms and one District serving as the control group. (A District can contain anywhere from 7-15 health units for a total of nearly 1000 units in the final sample).

In February of 1992 all of the UPF supervisors were trained in the concept of quality of care and in the application of the self-evaluation forms. Between April and June of this year they began meeting with health area and district personnel. During these meetings the participants assessed the quality of care in their own service delivery sites, identified and prioritized their most important problems, and have elaborated timelines and designated staff members to implement the proposed solutions. PREDOMINANT PROBLEMS IDENTIFIED/ PRLIMINARY RESULTS TO BE PROVIDED BY RICARDO FOLLOWING HIS TRIP TO GUATE IN AUGUST.

In the experimental and control groups progress will continue to be monitored during the regular semi-annual supervision visits and/or meetings. Ultimately, the effectiveness of the CQI approach will be measured both quantitatively and qualitatively. The most frequently encountered problems and the most important will be identified, and the most effective solutions, as well as the impact of the improvements in service delivery in terms of cost-effectiveness, number of users and CYPs, client and worker satisfaction, and quality of care conditions at the service delivery outlets.

Appendix 10

Correspondence with Pathfinder Re: Collaborative Efforts in LAC

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INTERNATIONAL
Latin America Regional Office

Mexico, June 25, 1992

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Dr. Sara Seims Ph.D.

Director

Population Program

Management Sciences for Health

400 Centre St.

Newton, MA 02158

Dear Sara,

It was a pleasure to talk to you and your staff during my recent visit to Boston. This is to follow up some of our discussions of June 11.

a) Collaboration of MSH-FPMD & PATHFINDER in selected countries: At this point I would like to confirm our interest in pursuing a joint effort to develop a needs assessment of public sector service providers in Mexico, Bolivia and Brazil (Peru might be the fourth case pending the development of the SDES program in that country). As mentioned during our conversation, PATHFINDER will provide technical assistance in institutional building to nine key institutions in the region, of these 5 are public sector institutions: IMSS and SSA in Mexico, MOH in Peru, Caja Nacional de Salud (CNS) in Bolivia and the State Health Secretariat in Bahia, Brazil.

I discussed our possible collaboration with Deirdre Strachan at Headquarters and she supported the idea. Each institution has of course very different requirements; the mexican public institutions are quite sophisticated and we need to focus at the state level on the link between the clinical services and the rural outreach program to improve supervision and referrals for the expansion of clinical services and long lasting methods among populations with low contraceptive prevalence. As you may know, we are now in the process of drafting the general program document for the next 5 to 6 years. The next step will be developing service delivery expansion sub-projects with IMSS and SSA. At that point we will define what is required in terms of needs assessment of the management of the family planning program and will contact you to pursue activities. Ms. Esperanza Delgado, our Mexico rep. is the key person for this program.

In Bolivia, you are already working with the CNS through Sandy Wilcox and our plans for this fiscal year call for expanded support to this Institution. We are also in the process of hiring a resident advisor for Bolivia. I suggest Sandy gets in contact with Dr. Alfredo Guzman, our Latin America South rep. in Lima to coordinate our joint effort. The CNS needs support in almost every area, specially in logistics and planning.

In Brazil, we will concentrate our efforts in the municipal clinics of the Northeast,

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specifically in the State of Bahia. Performance among these clinics, specially regarding the provision of IUDs is very uneven. We would like to determine the factors behind success of the few and poor performance of the many so that solid institutional building programs can be developed. Our Brazil rep. Dr. Jose de Codes should be contacted to work together in this endeavor.

Finally in Peru, when SDES gets started, PATHFINDER has proposed a service delivery strategy focused on 22 of the largest public hospitals throughout the country and based in delivering family planning services to post-partum and post-abortion patients. We would be interested in a needs assessment of the FP program in these public hospitals geared to increase sustainability and improved coverage and quality. Dr Guzman is also responsible for this program.

I expect that during this fiscal year our joint efforts should concentrate in needs assessments of the service delivery systems of these public health institutions that could then be followed with specific interventions to improve performance and sustainability. As discussed we might consider covering your travel costs wherever necessary and FPMD could provide staff time for the needs assessments. Please follow up these ideas with Deirdre and myself so that we can later on contact the AID missions for their approval. We are pleased and enthusiastic with the possibility of joining efforts to advance family planning in the public institutions of these countries.

b) Private Funds for Documenting and Disseminating the Abortion Problem in Mexico: We will be expecting your news about fund availability to conduct a study of the socio-demographic profile of patients and costs of incomplete abortion treatment in the Gea Gonzalez hospital in Mexico city. A copy of the proposal was left with you during my visit. I have spoken with K. Tolbert from the Pop. Council and she is also eager to collaborate but has no funds available at this moment. However she will include this proposal in her request for funding from private donors during October in N.Y.

c) Translation & Adaptation of FPMD manual; I have just received a fax from Christine Fowler following up our conversation with Janice Miller and other members of your staff. I will respond to it by early next week and she will keep you informed.

This is all I can think of at this point, please keep in touch and send my regards to Nancy. I will be waiting for your thoughts on these issues.

Best regards



Carlos Aramburú
Regional Vicepresident for L.A.

cc. D. Stractchan, C. Fowler, E. Delgado, A. Guzman, J. de Codes

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MEXICO

August 24, 1992

Dear Carlos,

Thank you for taking the time to meet with me during my recent visit to México. I am writing to confirm my understanding of our discussions, and to send you some of the materials which I promised you.

I understand that there are different timelines and different political considerations in each of the four countries (México, Bolivia, Brazil, and Peru) in which we would collaborate. However, I think that your idea of building in FPMD participation into the country and institution-level proposals is an excellent one. In this way, FPMD's travel and per diem costs will be covered under the Pathfinder country proposals, and, as we discussed, FPMD will provide either FPMD staff or consultant time for the time period proposed for each activity.

In summary, in the case of Mexico, I will expect a copy of Pathfinder's report on its recent site visits to Public Sector Institutions, along with the proposed project activities referencing FPMD's participation, in the next two or three weeks.

Similarly, with respect to Brazil, I will look forward to receiving a copy of the proposal to be developed by Pathfinder for activities with State of Bahia's Ministry of Health sometime in October.

In the case of Bolivia, I am enclosing the background materials which you requested. These include FPMD's Needs Assessment at the national level and the Management Development Plan (MDP) for the Caja. I have also included a copy of Manuel Olave's most recent report on his work with the Caja. As I mentioned to you, the MDP is somewhat sensitive, and we are sharing it with you in the interests of our collaboration. Please mention to Alfredo and to Dr. Arifez that it is a confidential document.

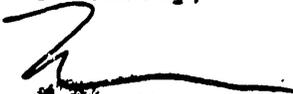
Due to the fact that both Pathfinder and FPMD have resident advisors in Bolivia, and buy-in support, our collaborative work should be able to begin fairly quickly there. I agree with your observation, however, that it would be a good idea for Pathfinder and FPMD's regional representatives to coordinate a visit in Bolivia with our respective resident advisors. We would be happy to time a visit to coincide with the trip you are planning to take in January of 1993.

In the meantime, we will alert Sandy Wilcox, our resident advisor, that Alfredo Guzman will be visiting Bolivia in the next two weeks, and that together with Dr. Arifez, they should discuss collaboration in our technical assistance efforts with the Caja Nacional.

Finally, we can only hope that by the beginning of 1993, there will be some possibility of our working with the Public Sector in Peru.

Again, I would like to thank you for considering FPMD in your regional institutional strengthening effort. I am certain that our relationship will be quite fruitful.

Sincerely,



Nancy Murray
Regional Program Analyst, LAC

cc: Dick Sturgis, Director, FPMD
Marc Mitchell, Deputy Director, FPMD
Peg Hume, Deputy Director, FPMD
Melanie Powers, Contract Officer, FPMD
Susan Ross, R&D/POP/IT
Sandra Wilcox, Bolivia Resident Advisor, FPMD

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