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An Assessment of  
Private Sector Family Planning Programs in Peru: 1983

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Part One

Overall Assessment

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## I. Introduction

This report provides an assessment of private sector family planning service programs and organizations in Peru. We have tried to cover all service programs that are considered "major" with the exception of some that are part of the federated system of INPPARES, which is being considered in more detail in a separate evaluational study.

The first part of the report consists of an overall analytical assessment of private sector programs with recommendations for future strategies of support and coordination on the parts of USAID and the Government of Peru, primarily the Consejo Nacional de Poblacion (CNP). In this first part, we consider the political and institutional support for family planning services, the capabilities of existing organizations providing services, the possibilities for alternative program strategies and means by which coordination and cooperation could be enhanced.

In the second part of the report, we provide a brief description of each of 20 family planning service program activities operating under the direction of 15 separate Peruvian organizations.

Field work was carried out during May of 1983. Site visits were conducted in the cities of Lima-Callao, Trujillo, Chiclayo, Arequipa and Cuzco. Interviews were held with persons from the identified organizations and with officials of the Consejo Nacional de Poblacion and USAID. A list of persons contacted is attached. While it was not possible to observe operational activities for each program, personal contacts were made with people who have directed and played a major role in each of them.

As was expected, the quality and the form of data available on the programs were highly variable. The reports and records that were available

took different forms and were collected with varying administrative and accounting needs of the program operators and the several funding agencies that contributed to them. We have tried to corroborate reports where possible and to put data into a form that makes them reasonably comparable from one program to another. In some cases, current records were not available and we were forced to depend on older information and on personal accounts of program administrators. The lack of up-to-date and comparable information from the programs is a weakness of the entire private sector service system that will be discussed later. It also lessens our ability to draw a complete picture of private sector capability, needs and promise in the present study.

## II. Population and Contraception

### Population Characteristics

In mid-1983, Peru is estimated to have 18.5 million people. Of these, 65 percent live in urban areas, 25 percent in greater Lima.

The average rate of natural increase during the 1962-1971 intercensal period was 2.9 percent per year compared with 2.69 percent during the intercensal years of 1971-1981. For the more recent years, the rate of natural increase is believed to have been about 2.6 percent. The continuing decline has been attributed to a drop in fertility that has more than offset mortality reductions. Although a continuing drop in fertility can be assumed, estimates of a further decline to 2.4 percent during the present year take into account the tragically shifting weather conditions and a generally deteriorating economic situation and attribute the bulk of change to increasing mortality, especially of infants and children.

The total fertility rate is about 5.2 children and the crude birth rate stands at about 36 per 1000 population. The trends in these rates since 1940 are shown in Table 1.

### Contraceptive Knowledge and Use

Both contraceptive method knowledge and use have been increasing steadily as shown by surveys conducted between 1969 and 1981. The National Contraceptive Prevalence Survey findings showed that 83 percent of women 15-49 years of age who had at some time been married or living in conjugal union knew of some method of contraception and that 57 percent had used a method at some time. The oral pill was the most widely known and was the most used among modern methods (see Table 2).

TABLE 1

Crude Birth Rate and Total Fertility Rate  
for Selected Dates: Peru 1940-1981

<u>Source</u>	<u>Date of Estimation</u>	<u>Crude Birth Rate</u>	<u>Total Fertility Rate</u>
Census 1941	1940	45.0	6.9
Census 1961	1961	45.4	6.9
PEAL-PECPAL 1968-1969	1967-1968	45.0	6.8
Census 1972	1971	42.0	6.3
EDEN 1974-1976	1974-1976	38.2	5.8
Encuesta Nacional de Fecundidad 1977-1978	1976-1977	37.0	5.7
Encuesta Nacional de Prevalencia Anticonceptivos 1980	1980-1981	36.0	5.2

Source: Encuesta Nacional de Prevalencia de Conceptivos, Capitulo IV  
"Fecundidad" (Preliminary) 1981.

TABLE 2

Knowledge and Use of Contraceptive Methods  
Among Women 15-49 Years of Age Who Have  
at Some Time Lived in a Conjugal Union

<u>Knowledge and Use of Contraception</u>	<u>Percent of Total</u>
1. Know some method of contraception	83
2. Best known methods	
Oral Pill	70
Rhythm	67
Injection	62
Sterilization	60
IUD	52
Condom	39
Withdrawal	38
3. Percent who have used some method	57
4. Percent who have used some modern method	
Oral Pill	18
Condom	8
Injection	8
Vaginal method	7
IUD	6
Sterilization	4

Source: Primeria Encuesta Nacional de Prevalencia de Anticonceptivos 1981  
(Preliminary)

While there has doubtless been some improvement since the National Fertility Study of 1977-1978, data from that survey suggested that there was still a sizable unmet existing demand for contraceptive methods throughout the country. And there was still a larger number of women who would constitute a market for family planning services if we consider those who would like to space their children more widely or will want to stop having more children at some point. The survey found that 61.4 percent of the respondents wanted to have no more children but only 14.7 percent of those women were currently using some method of contraception. The study reported an unmet demand of 38.5 percent of all women currently living in a conjugal union. The 1981 Contraceptive Prevalence Survey found that only about 20 percent of women living in a conjugal union were currently using a modern method of contraception. While these data are not easily comparable, it is evident that there continues to be a large unmet demand for contraceptive services and an even larger potential market for them.

If we consider the potential market for family planning services to consist of all fecund age women (or their partners) who are currently living in a conjugal union in which both partners are fecund, the population of that market is about 2.18 million persons (or couples). If only 20 percent are currently using modern methods, that leaves a potential additional 1,696,000 who are not now being served. While some number of women will always want to be exposed to pregnancy or be pregnant, they could still move into the category of user during different time periods. If we assumed that the results of the 1977-1978 National Fertility Survey are stable, there would now be 830,000 women currently living in conjugal unions whose actual desires for contraceptive methods are not being effectively met.

### Sources of Methods

The majority of users of modern contraceptives obtain their methods through the private sector. As shown in Table 3, the Contraceptive Prevalence Survey of 1981 found that 64 percent of the users accessed private sector sources and 32 percent obtained their methods through the public sector. The Ministry of Health was the largest provider within the public sector with 28 percent of the total (all users). Of all sources listed, private pharmacies offered methods to more users than any other, with clinics and consultorios caring for 24 percent of the users. As would be expected, pharmacies accounted for the bulk of users of vaginal methods and condoms but they accounted for the majority of oral pill and injection users as well (see Table 4). The extent to which some users may have accessed both private and public sector providers is not known, nor can we determine how many began using a method under some program or the care of a medical professional and access pharmacies for method re-supply.

Unfortunately, data from the Contraceptive Prevalence Survey of 1981 do not allow one to determine which users are covered by not-for-profit agencies and which are covered by others in the private sector. On the basis of our own findings discussed later in this report, we estimate that no more than four percent of the potential users of contraception are currently provided services by the not-for-profit programs, which would be something under one-half the percentage covered by the public sector.

TABLE 3

Women Currently Using Modern Contraceptive.  
Methods by Source: 1981

<u>Source of Contraception</u>	<u>Percent of Total</u>
Public	32
MOH	28
IPSS	1
Other public	3
Private	64
Clinics	12
Consultorios	12
Farmacias	40
Other (?)	4
	100%*

\*N.B. This total represents the approximately 20 percent of females 15-49 currently living in union and currently using modern methods of contraception in 1981.

Source: ENPPA, Chapter 8, 1981 (preliminary).

TABLE 4

Sources of Modern Contraceptive Methods by Method and Place of Residence for Women 15-49 Living in Conjugal Union who were Current Users: 1981

Methods of Residence	Sources of Contraception					Total
	Ministry of Health	Other Public Sector	Pharmacy	Other Private Sector	Unknown	
<b>Oral Pill</b>						
MALC	9	3	64	16	8	100
Other Urban	4	2	76	8	10	100
Rural	8	3	52	7	29	100
<b>Injection</b>						
MALC	6	2	68	17	8	100
Other Urban	4	2	77	9	8	100
Rural	10	3	56	10	22	100
<b>Female Sterilization</b>						
MALC	39	8	-	44	9	100
Other Urban	51	5	-	34	10	100
Rural	52	4	-	24	20	100
<b>IUD</b>						
MALC	28	4	9	46	14	100
Other Urban	29	2	7	47	15	100
Rural	27	5	8	41	18	100
<b>Male Sterilization</b>						
MALC	24	9	-	51	16	100
Other Urban	40	6	-	40	14	100
Rural	46	3	-	29	22	100
<b>Condom</b>						
MALC	3	1	71	4	21	100
Other Urban	2	1	77	3	17	100
Rural	2	1	70	4	23	100
<b>Vaginal Methods</b>						
MALC	5	2	73	9	11	100
Other Urban	2	1	81	6	9	100
Rural	7	-	72	7	14	100

Source: ENPPA, Chapter 8, 1981 (preliminary).

### III. The Political Climate and Family Planning

Strong pressures from the Catholic church and both conservative and leftist groups and the varying composition of government leadership have resulted in a widely fluctuating climate for family planning service programs in Peru. Support seems never to have been strong and widespread. Although private physicians offering services to full-fee-paying patients have been tolerated, programs aimed at specific populations of the poor and medically indigent have only sometimes been supported and may more often have been discouraged. Progress in making services broadly available continues to be slow.

The current formal policy of the Government of Peru is based on Supreme Decree No. 100625-76-SA, sections of the penal code and the norms and regulations of the Ministry of Health. The Supreme Decree, also known as "Guidelines for Population Policy in Peru," expresses concern for the development effects of population growth and distribution and for health risks associated with pregnancy. The Guidelines suggest that there should be a decline in population growth rates but they do not specify the means by which fertility should be altered. The Guidelines do not offer any scheme for implementation of fertility control services.

The first set of implementation norms was produced by the Ministry of Health in 1977 but little action was taken and they were replaced by new norms in 1980. These 1980 norms of the Ministry of Health expressly call for increased coverage of family planning services by the Ministry. They set goals and conditions for family planning services within the government system.

While goals are not set for non-governmental individuals and agencies offering family planning services, they are expected to follow the guidelines with respect to quality of care and to the training required of personnel who may provide family planning methods. These norms specifically allow nurses and nurse midwives to prescribe contraceptive oral pills and to insert IUDs. (In practice, it seems that others are also being allowed to distribute pills under the supervision of physicians and nurses.)

Although policy dictates that family planning services are to be available through the MOH, clear plans for implementation of large scale family planning service delivery within government facilities have not been forthcoming. This is true despite some leadership within the MOH, the encouragement of outside donors and statements from the President that he wants to set the reduction of population growth as a national priority. Regional plans tend to speak of making contraceptive methods available and distributing contraceptives among facilities without further specification. There seems to be still strong pressures within the government to discourage such broadly offered services. One obstacle to fuller MOH involvement in family planning has been the National Planning Institute, which has tended to be conservative in providing its required approval for externally funded government programs. The government may be said, at best, to be moving slowly toward the provision of comprehensive family planning services.

Given the inertia within the government, it seems that the private sector may offer greater opportunity to provide family planning methods to large segments of the population, at least in the near future. The willingness of private sector organizations to offer community outreach care suggests that they have an advantage when it comes to penetrating those populations that are

difficult to reach. Private sector organizations also have many obstacles to overcome, however.

Some of the obstacles stem from the sensitive political nature of family planning in Peru. Others stem from feelings on the parts of some who feel that family planning services for the majority of the population should be the responsibility of the government and they react jealously to private sector agencies that want to provide coverage and are able to secure independent outside funding on their own. Private sector agencies often encounter difficulties in obtaining approval of their activities under government norms, in acquiring non-profit status and the easy importation of supplies free of tariff.

A very important factor in the lack of priority given to family planning on the parts of many, who one would think would take leadership roles in insuring the availability of services, has been the way that population problems have been presented in Peru. Both prior to and since the creation of a population policy, educational, information and research activities in the country have tended to emphasize a case for fertility limitation in terms of population as an aggregate, "demographic" problem. While these efforts have had the result of increasing awareness of the dynamics of population and the mitigating effects of high growth rates on national development goals, there has been less concern for fertility control and contraception as health concerns. Nor have they been treated as matters of serving personal needs. Certainly, the Population Policy and the norms for providing contraceptive services mention the health and personal aspects, but the overall emphasis has tended to neglect these. As a result, it seems that those who would be responsible for executing personal care programs within the government tend not to think of family planning as an important component of health services. This may be changing now, but the evidence is not clear. MOH plans in 1982 noted that high

observed rates of maternal mortality were due to high rates of induced abortion and poor care associated with pregnancy and childbirth. They also noted the high rates of pregnancy of younger and older women and the general poor nutritional status of mothers. As a result of these observations, the MOH is planning to offer more medical and educational services in order to facilitate decisions regarding number and spacing of children. Still, the association between health and fertility seems not to be the emphasis and it is not widely appreciated. There still seems to be the thought that population is more the concern of social and economic planners and that it will take care of itself.

Section 165(2) of the Peruvian Penal Code prohibits mutilation that inhibits the function of human organs but does not specify that this would include sterilization. The possible openness of the law is recognized and it has not been applied punitively, although it has probably deterred some medical people from discussing the existing availability of sterilization procedures and from making routine referrals to persons for whom such procedures would, under other conditions, be indicated. The Population Policy of 1976 specifically excludes sterilization as a means of family planning. An amendment to the 1980 MOH Norms, added after printing but prior to publication and included as a detached page, reaffirms that sterilization is not to be considered as a method of family planning. As with other regulations of the MOH, this applies to private sector as well as to government service providers.

Sterilization services are offered for "reasons of health." Private agencies, however, must obtain government approval and agree that they will not use sterilization as a means of family planning. Private institutions that have identified themselves as offering family planning services have had difficulty gaining approval. Referrals are possible but only those who can afford to

pay for the procedures seem to be assured access. Some public hospitals do provide such service, however.

For some years there has been pressure to formalize and to make broad the normative circumstances under which sterilization would be allowed. During the 1970s, there was an attempt by persons within the Ministry of Health to create such norms, but none were produced. There is now some motion toward the generation of guidelines on the part of some members of the National Association of Gynecologists. Those who are participating hope that the guidelines would be incorporated into the norms of the MOH as well. There is apparently no projected date for the production of the guidelines and progress might at best be described as cautious.

#### IV. Background of Private Sector Service Provision

The current period of family planning service interest and initiatives can be dated from the years 1975-1976 when the national population policy was being developed and published. Some of the private sector programs that currently operate are continuations or offspring of some begun earlier, but those years mark the time when expectations began to change and the climate for service initiatives became more hopeful. Since then, progress, if sometimes hesitant, has been generally continuous. Because attitudes and expectations are, in important ways, the result of previous experiences, it is worthwhile to consider briefly prior private sector activities. This is especially true in Peru because so many of the principles now active in population circles were involved in those earlier events. They are aware of the force of political pressures and are conditioned by what happened as a result of shifting governmental policies.

A few private sector family planning programs began and operated on a modest scale during the 1960s. While most of them continued during the 1968-75 period of the military regime, their growth was slow and they seemed to have concentrated on maintenance. It is worth noting that it appears that only the private sector was systematically providing family planning services during that time.

The beginning of private sector programs seems to have come with Church World Services which was distributing contraceptives and informational materials since 1963. While records of what this agency did are not available, it appears that it did play a considerable role in making physicians aware of modern methods of contraception as well as offering services directly to couples in many parts of the country. The major emphasis of the organization was not,

however, family planning and the attention it gave to such services was highly variable, depending on its director and other conditions.

The constitution of Instituto Marcelino, a clinic offering gynecological and family planning services that opened in 1967, marks a beginning by Peruvians to provide modern family planning methods to the population at large. It was conceived by some physicians who had found a high demand among patients they had been serving in a hacienda near Lima and who believed that there would be a broader demand on the parts of the lower income residents of Lima. During the 1968-1975 period, it was certainly the largest clinical operation offering such methods, caring for some seven thousand contraceptors per year. The Instituto has since received grants to provide training in all aspects of family planning to health professionals and it now operates CBD programs in two areas outside Lima.

In 1964, President Belaunde Terry (his first term in office) created the Centro de Estudio de Poblacion y Desarrollo (CEPD). The Centro set out to encourage research and publications that would give substance to means of dealing with population problems. Some physicians associated with the CEPD were also connected to the Cayetano Heredia University, a prestigious private institution with a progressive and well trained faculty. With funding from the CEPD Cayetano Heredia conducted a KAP survey in Lima and at Cerro de Pasco where they had been conducting studies on the effects of high altitude on fertility. Following that, they set up a clinic offering MCH and family planning services in the pueblo joven of Pamplona Alta. That clinic was turned over to the Peruvian Association for Family Protection (APPF) in 1969 when the military government required that CEPD divest itself of family planning service activities.

Also with the support and franchise of CEPD, some faculty members from Cayetano Heredia University set up a family planning clinic within Loayza

Hospital in Lima, a public, government-operated facility. In 1970, the project became independent of CEPD and has operated under an agreement between the university and the government that provides that the university conduct training there. It has been operating continuously since then.

In the mid-1960s, an affiliate of the Christian Family Movement was established in Peru. Beginning in 1967, it was offering family planning and sex education services through its Program of Conjugal and Family Promotion in the Marginal Barrios of Lima. The program encouraged "natural" methods and offered oral contraceptives to married women for up to two years post-partum. It offered these services in a varying number of Catholic parish clinics in poorer areas of Lima. The program was reorganized under the Association for the Integrated Development of the Family (ADIFAM) in 1975. Throughout the 1970s, services were supported with funds from Family Planning International Assistance. It was defunded in 1982 but continues to operate using self-generated monies.

In 1970, some of the people working with the Christian Family Movement program formed another group that began to work in Catholic parish clinics in Callao and other communities outside Lima. This group, known as the Association of Lay Family Work (ATLF), has persisted and largely with FPIA funding as well.

The Peruvian Association for Family Protection (APPF) became affiliated with the International Planned Parenthood Federation and began to promote the provision of family planning services to the poor people of Lima. The organization expanded its scope of operations to include a number of MCH activities including family planning and sex education when the CEPD service program was transferred to APPF in 1969. In 1973 it was ordered by the government to stop all services and in 1975 its offices were closed and its assets were confiscated. It was reported that APPF was serving 15,000 new acceptors per year by 1973.

APPF was reorganized in 1979 as the Peruvian Institute for Responsible Parenthood (INPPARES). It is operated as something of a federation of clinics and private physicians providing services and operating different types of sub-programs in various parts of Peru. INPPARES has been offering a wider range of methods and has not been limited to providing modern methods only during the two-year post partum period.

The creation of a presidential committee to develop Peruvian population policy and the resulting guidelines offered a more favorable climate for family planning service activities under President Morales Bermudez in 1975-1976. Still, the government and various pressure groups seemed continuously to create obstacles. The government complicated matters by making population concerns "multisectoral problems" that resulted in disagreement among agencies and effectively neutralized the policy until 1978 when interest within the Ministry of Health began to develop. That interest has been growing, but, as mentioned above, it is far from fully supportive of family planning service programs in either the public or the private sectors.

Both public and private sector activities seem to be progressing uneasily, producing fragmentary and diverse plans and programs. Most of the service programs that were initiated during the sixties and early seventies are operating, some under reformulated organizations, some with different thrusts than they had earlier. In the past few years, additional organizations have emerged, largely with external support, in different parts of the country. Most of these seem still to be in tentative first stages and none can be considered a large program providing services to even a majority of potential users in any significant catchment area. There is, however, a continuing expansion of coverage with the new programs and an increasing recognition of the existing and potential demand for services. The following section of this report provides an assessment of these current service activities.

## V. Current Private Sector Projects

### Coverage

Although there are numerous projects operated by private sector organizations, their total coverage is very limited. They do not begin to meet the real demand as expressed in recent national surveys or the potential demand as estimated using demographic data. While the data collected from the projects do not allow making precise estimates of continuing users served by the twenty some projects covered in this study, we conclude that a generous estimate of continuing users of modern family planning methods would be 75,000 women. Given the repeated problem organizations have in obtaining supplies, it may be much lower than that.

Assuming that there is a potential demand for contraceptive services that is represented by 90 percent of all conjugally residing women between the ages of 15 and 49 years of age (.57 of all females in that age group), there are some 2,182,000 women who could be users. Again, with the generous estimate of 75,000 active users, this means only 3.4 percent of the population at risk are covered by private sector programs (independent physicians and pharmacies are not included).

Coverage rates of projects designed to serve populations in limited geographical areas are generally low as well. In the CBD/Clinic project of Carmen de la Legua, only 13 percent of the estimated 77,000 potential users are associated with the program as either new or continuing users during the most recent year. Of the larger programs working in a defined area, this is the highest coverage. There is little competition of clients in that area except for local pharmacies. (It should be noted that this 13 percent represents an

important achievement for the brief time that the program has been operating. The project also offers considerable promise for expanded coverage in the future.) Most projects have much lower rates of coverage.

A small project in Cuzco, the Cuzco-Pueblo Jovenes Project, has during its first year of operation gained 721 new acceptors in an area with an estimated population of 14,000. If the estimate of 1650 women at risk of pregnancy in that area is close, these new acceptors represent over 40 percent coverage! This achievement is especially noteworthy because the majority of the population in the area is Quichua-speaking and considered to be particularly difficult to reach.

Project administrators typically do not clearly identify their target populations in quantitative terms and they do not set coverage goals. Instead, they are uniformly more concerned with measurements of activities and outputs. That has tended to lead to consideration of expanded coverage as simply moving into additional geographical areas rather than trying to penetrate more deeply into those areas where they are currently operating. Certainly, there are advantages to the broadening of availability of services, but it means that those segments of the population that are most difficult to reach and probably least able to exploit commercially available services and are least aware of the personal benefits of fertility control are not served.

It can be legitimately argued that the incorporation of CBD and other community contact tactics into family planning programs is in itself an attempt to penetrate more deeply, but even where these are employed numerator concerns tend to dominate planning and self assessment on the parts of project administrators. The result of thinking in this way is that projects are not being compared for their effectiveness in achieving proportional coverage, a critical measure of planning purposes.

One factor that contributes significantly to this primary concern for numerators is the pressure on most of the projects to achieve a sizable degree of self-financing. Such pressure discourages relatively costly patient follow-up, other repeated individualized outreach contacts that could improve coverage rates and would certainly raise continuation rates.

#### Scale of Projects

Again, due to weaknesses in reporting systems, it is difficult to determine with precision the number of continuing users maintained by the several projects that are considered here. It can be said, however, that the majority are very small, either actually covering or setting goals of serving from a few hundred to 2500-3500 users each year. The largest projects operating appear to be the clinic operations of Instituto Marcelino and Loayza Hospital and the CBD/Clinic operation of Carmen de la Legua. The federated system of INPPARES have served relatively greater number of people as well, but they are probably best treated as clusters of more or less independent projects, each of which is small-scale. ADIFAM was also among the larger projects, but since it lost its outside funding in 1982 it is not clear just how many users it is serving.

The Instituto Marcelino in Lima and Loayza Hospital, also in Lima, represent rather sizable clinic operations. Patients come almost exclusively from the metropolitan area. Instituto Marcelino managed about 36,000 consultations during 1982. Of these, about 80% were family planning patients. The rate of new acceptors during 1982 averaged around 210 per month. The number of continuing users under control at any time is probably around 10,000.

Loayza Hospital's family planning clinic estimates that it is maintaining about 12,000 active users. During the most recent eight-month period (September 1982-April 1983), it averaged 716 continuing users and 373 new

acceptors each month.

The Carmen de la Legua program in Lima is maintaining about 10,000 active users now. The majority of these are reached initially and followed up through the CBD program operating in six neighborhoods and pueblos jovenes on the northern end of the metropolitan area. Working in areas that have a total of about 650,000 people, this is currently the largest private sector outreach program in Peru. The outreach is handled by two supervisors, four promoters and 40 distributors. During the next two years, the program anticipates moving into new areas of Lima with additional population of about 800,000 persons. It will add 10 promoters and 80-90 distributors to the system.

ADIFAM was working in four areas of Lima and Chosica until 1982 and was believed to have been maintaining about 8900 users then with four clinics and 36 promoters. The program lost its funding from FPIA in 1982 and has since tried to support itself by increasing the fees for service. It is not clear just what impact this is having on the number of users maintained by the project.

#### Family Planning Services Provided

Almost all the projects encountered provide a range of modern methods of contraception. None, however, offer sterilization as a family planning method per se, but most will make referrals upon request or medical indication. Since 1978, Loayza Hospital has been offering sterilization services and has performed over 700 since then. There seems to be no personal aversion to sterilization on the parts of professionals involved in projects. There are several centers throughout the country that do offer sterilization, but they tend to be wary of indicating that it is a method of family planning. Instituto Marcelino has requested a license to use endoscopy, but it has not been granted despite the fact that the institute has long been providing a broad range of

gynecological services in addition to family planning.

The clinics of the ATLF offer the pill only for a two-year post partum period and stresses natural methods otherwise. Its greatest demand, however, appears to be for oral pills.

Most of the projects are either extensions of clinical programs or are imbedded within a more comprehensive medical treatment center (Loayza). In any case, all projects other than the ATLF project have some routine mechanisms to care for patients who seek IUD insertions and for medical back-up of problem cases.

Many project personnel indicated that they encouraged the use of IUDs in preference to other methods because of the difficulty almost all of the programs have had in importing and maintaining inventories of method supplies of pills and condoms. Available data do not indicate that this is a preferred method on the parts of users, but IUDs do account for an important proportion of the patients in many programs.

The clinics offering family planning methods also provide Pap tests, but do not always require that women have such tests in order to obtain their methods.

#### Project Structure and Strategy

The projects encountered in this study present a variety of means of supplying family planning services to the population. Although it is not now possible to judge the differential effectiveness of the particular strategies used, they do offer the opportunity to test relative advantages that should be exploited.

Basically, there are three types of programs operated by the private sector, with some overlap and some variation within types. These are 1) programs offering clinic services only, 2) programs that offer community-based

distribution with referrals to cooperating clinics and hospitals, and 3) programs that offer a combination of integrated community-based distribution and clinic services.

The largest clinic operations are those of Instituto Marcelino and Loayza Hospital/Cayetano Heredia University mentioned above. Each of these has offered training for medical professionals and students for several years as well as providing family planning services. The clinical objectives of these operations are to provide high quality care to women of Lima and the surrounding area. They do not, however, focus on specific geographical areas within the cities. Administrators at each place indicate that their patients come almost exclusively from among the very poor of Lima. Both of them serve relatively large numbers of women, but the actual number of continuing users is not readily accessible from the data available. Loayza Hospital reports to cover some 13,000 family planning users during the current year. Instituto Marcelino in Lima provided about 36,000 consultations during the last year and reports that some 85 percent of these were for family planning services. The number of individual family patients covered is probably around ten thousand per year. Many of these obtain resupplies from other sources, so it is not possible to determine just how many are maintained by the program.

The CAPRE PROJECT of the midwifery school in Lima also offers clinic services and provides training in family planning care to its students. Since the law allows midwives to insert IUDs and dispense oral pills without supervision, it is not necessary that they have physicians working in their clinic. They estimate that they provided 40 IUD insertions per month during 1982 in addition to 2000 cycles of pills.

We encountered some smaller operations maintained by private physicians as well. The Esperanza Clinic in Lima is one that is operated largely as

a charity by physicians who contribute time and rent to operate a small facility in a central location in the city. They have also managed to obtain contributions in the form of equipment and furnishings from pharmaceutical companies. The operation is a small one, however, treating only about eight patients per day, two of whom are family planning clients.

A private physician operating in the El Agustino area of Lima also offers office consultations to patients from that area. The director of this project was formerly a member of INPPARES, but has become independent recently. The program is self-supporting except that it does obtain supplies from Laoyza Hospital.

The Clinica Medicina Preventiva and Planificacion Familiar in Arequipa is currently tied to INPPARES but expects to become self-supporting by the end of the year. This clinic works largely with business firms and factories in the area and is trying to establish either prepaid or reimbursement procedures for the clinical care of their employees. They also take patients on a fee-for-service basis, but expect the bulk of their income to be derived from these quasi-insurance programs.

The ATLF projects operate only in parish clinics where they offer family planning education services. While they do encourage word-of-mouth promotion and take referrals from church people, they do not offer any formal outreach or promotional services in the community.

Programs with both clinical services and CBE are organized in several different ways. Basically, however, they involve promoters who provide discussion and education sessions in communities and supervise a number of unpaid "distributors" who sell or give family planning supplies to users in their own neighborhoods. These supplies include pills, condoms and vaginal foam. The distributors receive some formal training of a few days and are

given more in the process of supervision and participation in discussions with promoters. The promoters are in turn supervised by staff members who are generally nurses or trained social service persons.

The largest scale operation encountered was that of the Centro Medico Carmen de la Legua in Lima. It currently covers a catchment area with a population of about 650,000 people in six barrios and pueblos jovenes of Lima. It is being funded this year to expand to seven more areas including one and one-half million additional people.

The Carmen de la Legua project operates with three community promoters who lead discussion and information groups and supervise 36 distributors. The distributors provide method supplies at one-half the cost of those same supplies in the medical center itself. The clinic services are provided in minimal facilities in the barrio of Carmen de la Legua and in the private offices of cooperating physicians practicing in the areas where the users live. Using these cooperating physicians (who are not formally linked to the program) allows them to expand with very little capital cost while insuring the availability of back-up physician care when needed. It also reduces the need to pay salaries of additional physicians and other higher paid staff that typically represent high costs, at least during the early phases of implementation. When the project expands, it does not anticipate hiring more physicians but will add ten new promoters and ninety distributors.

The Instituto Hipolito Unanue system represents a structure which appears similar but lacks coordination between the clinic and CBD components of the project. The clinic activities and the CBD activities are administered separately. Instituto Hipolito Unanue operates four health centers in pueblos jovenes in the southern end of Lima. These centers provide general MCH as well as family planning services. Women contacted through the CBD program are

referred to these clinics for IUD insertion and for medical care. Personnel and record systems are maintained separately, however. Physicians and nurses working in the centers do not participate in training or supervision of field workers. This separation of administrative responsibilities appears to offer no benefit to the services.

The CBD component of Instituto Hipolito Unanue includes the development of handicraft production by mothers' clubs in the area. Program designers had the idea that groups of mothers would meet to provide handcrafted goods for sale and would at the same time be encouraged to participate in the family planning program, thus increasing the number of users.

Two clinic/CBD private sector projects that we encountered use Ministry of Health facilities where they provide clinical services. In Trujillo, the project administered by Dr. Guillen uses five government health centers during\*afternoon hours to provide a range of family planning services and has plans to expand to offer these services in nine more centers during the coming year. It also uses offices and a treatment room in the Regional Hospitals where the administrative staff work and where IUDs are inserted. The hospital is connected to the National University in Trujillo as well and offers training to students in family planning methods through this arrangement. The project has also provided training to nearly 200 other physicians, residents and interns. This has been identified as a pilot project which is expected to demonstrate the advantages and possibilities of providing family planning services as a distinct activity within government health centers. The funding arrangements with FPIA indicate that it will be turned over to the government within a few years.

The Cuzco, Pueblo Jovenes Project now operates almost entirely as a CBD operation. It does have links to the Regional Hospital through its director

who has a position there and through its medical consultant who also works there. The physician uses a small treatment room to provide IUD services to women from the project area and to others who request them as hospital out-patients.

These two projects offer an interesting possibility for introducing the full range of family planning services without a great capital investment. They also offer a means for initiating services within government facilities that, once established, can be taken over by the Ministry of Health. At present, the arrangements between the programs and the Ministry of Health are informal but actions are being taken to create a formal agreement in Trujillo. This should be looked at as a means of developing cooperative ventures between the public and private sectors in Peru.

The Instituto Marcelino, with encouragement from outside donors, began outreach programs in Arequipa, Chiclayo and Chimbote in 1981. With outside funding, they set up relatively limited clinic facilities in these cities and developed corps of supervisors, promoters and distributors in the peublos juvenes on the margins of the cities. The local supervisors were provided initial training in Lima at the main facility of Instituto Marcelino and they are expected to be coordinated and broadly administered by central staff personnel. Although the programs continue to operate, they have had difficulty in achieving a satisfactory number of users and in maintaining personnel. This has been attributed to the geographical separation of activities and the difficulties in administration, among other things.

The majority of CBD projects depend on community residents to provide primary contact with potential users and to distribute supplies. These community residents are expected to promote family planning methods and to provide information to their friends and neighbors on an informal basis. In the case of the Cuzco, Pueblo Jovenes Project, however, there are only two promoters

who are supervised by a nurse. The promoters hold meetings with various groups of women in the area, but they also move systematically from house to house themselves, offering individualized promotion to women living there and dispensing supplies. As mentioned earlier, the coverage rate of over 40 percent during the first year of operation suggests that such intense coverage by better trained, perhaps more highly motivated, people promises significant pay-off when the target population consists of women living in pueblos juvenes.

#### Program Costs and Funding

As is generally the case with private organizations that receive funding from outside donors, the requirements for costing the various elements of their projects and services are rather flexibly applied. This means that assessing such things as cost per unit service on patient and cross program effectiveness comparisons is difficult at best. Estimating costs for purposes of large-scale planning will require considerably more time than was available for this assessment. It may require implementing a standardized data system.

We did encounter some reported costs, but in no case is it clear just what are and are not included. For example, how were in-kind contributions calculated? How should we differentiate start-up costs from maintenance costs? How does one separate training costs from those of the services?

Among the estimates we did find was that of the Trujillo project which estimated costs per user at between four and five dollars per year. On the other hand, the project in Loazya Hospital estimated costs at \$30 per user. Both institutions provide training as well as patient services but it is not possible to separate these in either case. Also, both have use of public facilities where they provide care but no recognition is given to this in their accounting. Trujillo claims to be 14 percent self-supporting through fees for

service. In our limited contact with the Loayza Hospital administrator, we could not determine what happened to fees for service or whether they were used to offset actual costs.

The cost per new acceptor in the Cuzco, Pueblo Jovenes Project during its first year of operation was about \$20, excluding the minor contribution of space at the Regional Hospital. The Limoncaro Family Planning Service project claimed a cost of \$33.65 for each new acceptor during its first year and indicated that the cost per user during the second year was \$9.65. It expected costs to drop further during this year. In the Cuzco case, the start-up costs for training and organization were not included. It is not possible to determine what is included in the Limoncaro estimates.

Many projects fail to distinguish between consultations and persons, making it impossible to assess number of persons served, thus costs per person as well. Some calculate procedures and not even consultations so that a woman who receives a Pap test, a physical examination, and an IUD insertion is listed as three consultations. This may show up in some reports as three users.

Many of the projects have the goal of becoming self sufficient at some time in the future. This seems especially true of projects funded by FPIA which generally include an item in their planning documents indicating certain self-financing expectations over a five-year funding period. Programs that have some degree of self-sufficiency now are those that have some clinical component for which fees are charged. The Trujillo project, for example, derives fees only from its clinical services and claims to be providing 14 percent of its own support. The Carmen de la Legua medical center program in Lima claims a 27 percent level of self support. Both of these projects are anticipating sizable expansions during the coming year and it is doubtful that they can maintain these levels during the initial period of expansion.

As mentioned above, other programs are experimenting with different means of generating funds. The Arequipa Clinica Medicina Preventiva y Planificacion Familiar is trying to work out a couple of different types of insurance systems with local businesses and factories so that they can be assured of income. ADIFAM, since being defunded by FPIA, has increased the price it charges for services in order to maintain itself. Although the project director indicates that the program is self-sustaining now, there is no information about the number of persons being served relative to those it was serving earlier.

Apparently, various private physicians are able to sustain themselves through charging fees for service while obtaining donor support only in the form of contraceptive supplies. In a sense, though, it is difficult to consider some of these as "projects" rather than just private practitioners who provide family planning services at a rate that is reduced because they do not have to pay for supplies.

Certainly, one can expect some projects to generate some portion of their own costs through patient fees and a variety of other mechanisms. Those that have large training components or that require larger capital investments in the absence of sharable facilities or available personnel will continue to require relatively sizable outside funding, at least in initial phases. It seems doubtful that many of the projects will expand their coverage greatly without continued donor support.

The various attempts to generate funds within projects should be considered closely. This does not seem to be happening now, although various agencies and consultants have pointed to this need. Further, no investigations have been made regarding client ability and willingness to pay for services.

Concerns of cost, self-financing, and data collection mentioned in this section point to important needs of private sector organizations in Peru.

In each case, additional technical assistance would be useful. It would be especially useful if that technical assistance were coordinated so that the different projects would submit information about themselves in forms that allowed comparison among them and contributed to more informed planning strategies.

As suggested earlier in this document, care should be taken that the pressure for projects to become self-supporting does not cause them to neglect those persons in the population most in need and least able to pay for services. It would be easy for projects to expand and to increase their self-generated income via moving into new areas and "creaming" those most accessible and most able to pay. This would mitigate just those advantages for which private sector, non-profit agencies are encouraged.

#### Cooperation Within the Private Sector

Private sector activities in family planning services have been largely characterized as fragmented and uncoordinated, although there has always been some sharing of interests and information. Most have struggled to maintain their independence. Historically, this independence has not been altogether negative. It has resulted in numerous projects that have not been regarded as a strong threat to pro-natalist government policies or to the emerging mandate for MOH to increase its own activities in family planning. It has also resulted in a healthy pluralism of organizational designs and strategies that can be tested in a variety of cultural, geographical and infrastructural situations.

The current environment is, however, more encouraging of cooperation among private sector groups and cooperation between the government and the private sector. There seems still to be some feeling of trepidation on the parts

of most of the private sector organizations and some real concern that they could lose their integrity if some system of coordination and cooperation were imposed on them. As a result, most cooperative activities have been tentative and informal.

Last year, with outside support, leaders of private organizations were brought together for a series of monthly dinners. Government officials, population researchers and others were invited to participate in these dinners as well, but the primary purpose was to share concerns of interest to the service providers. It was expected that some sort of continuing organization would result but that did not happen. It is expected that more support will be forthcoming, but that it will require that there be greater focus to the meetings and that the group show clear evidence of formalizing some sort of coordinating organizations of private sector providers.

In April of this year, a group of private, influential Peruvians formed the association, "Apoyo a Programas de Poblacion" (APROPO). While the purpose of this group seems now to be primarily that of consciousness raising and influencing other leaders regarding the importance of family planning, it also expects to encourage the coordination of strategies and the dissemination of information and to motivate persons to practice family planning and responsible parenthood.

From among those involved in programs, there seems to be no one who has emerged as a clear leader acceptable to the community at large. Perhaps with the new organization some structure can be created that will allow greater participation of program directors.

At the operational level, there has been some coordination among project personnel and some attempts to share resources. These have generally been tentative and informal. Project personnel, for example, do make referrals

to other projects that offer services that they themselves do not. ATLF, for one, refers clients who desire methods other than oral pills and rhythm to others and most will refer patients who request information regarding sterilization. As mentioned above, the Carmen de la Legua project works cooperatively with privately practicing physicians in its area when that would be more convenient than sending them to its own clinic. To some extent, the INPPARES system may be seen as a set of cooperating physicians working semi-independently and at least some of these expect to "graduate" from the INPPARES system after a time.

The inability to maintain adequate inventory of method supplies has led to some sharing among projects. That has been largely informal and is done on a small scale. Attempts to establish formal mechanisms for this sharing have not worked. AID, for example, expected the Instituto Marcelino in Lima to provide this service when it funded its outreach program three years ago. The institute, however, found that it was not able to import large quantities of supplies either. Despite INPPARES' long history of providing supplies to participating members, it finds that it cannot import them at a rate to sustain even its own needs.

To some extent, there has been some cooperation in the training of family planning service providers. Although some of this has been inadvertant, as in the case of programs offering training to a variety of medical students and other participants, it does represent coordination. With funds from Development Associates, some common training was provided to promoters and supervisors through ALAFARPE last year.

If the lack of coordination among private sector programs persists, it could lead to difficulties. As the programs expand in the future, they could begin to compete for the same clients as they duplicate effort in the

same areas. At the present, the scale of programs is small and this has not yet been a problem.

#### Relationships Between the Private and Public Sectors

There have been some cooperative links between private sector family planning service programs and government health agencies, but there is still a tendency for the private sector to keep its distance. There is concern that involvement of the government in their projects might lead to their demise perhaps and would certainly contribute to an increased burden of monitoring and accountability.

The government has developed relationships with private institutions that have provided training to government personnel. Instituto Marcelino, for example, has long offered family planning service training for physicians and other health professionals from the Ministry of Health and the Social Security Institute. Cayetano Heredia University has also provided such training.

Under an AID-supported project of Integrated Health and Family Planning (PN 527-0230), the Peruvian Association of Medical Faculties (ASPEFAM) was selected as the responsible agency for training of health professionals and to provide technical assistance in management and operational research. The ASPEFAM is to provide and to coordinate training through OB/Gyn Departments in member universities and in university-affiliated hospitals. Participants are expected to include professionals from area hospitals and participating health centers. This project has not yet commenced.

The ATLF has a contract with the MOH to allow it to use AID loan funds to support its project (Loan No. 527-U-076). This is the only private sector project we could find that had such a contractual agreement for service provision support.

The MOH is responsible for assuring that private providers of family planning services conform to the norms established within the Division of MOH. In one case involving Instituto Hipolito Unanue, the MOH did question the qualifications of personnel involved in the provision of methods, but subsequently passed on them. As far as we could tell, there has been no systematic monitoring of personnel or of services or any other aspect of the private sector on the part of the MOH. Private sector projects do not seem to submit routine reports regarding their activities to government agencies.

There have been some informal suggestions that the MOH could provide private sector projects with method supplies, but there seems to have been no positive response from the private sector. Project personnel mentioned concern for the bad inventory procedures used by the government and that they did not want to be committed to the officials.

The government does have to franchise the use of endoscopic devices by private sector agencies and they have been reluctant to allow them. This has generated some worry on the parts of program people who do not want more involvement, even in the form of support.

The attitudes of private sector organizations toward the government is defensive but complicated by the fact that so many of the main characters in the private sector hold appointments in the MOH as well. They argue that they are able to do anything at all because they are not burdened with the same bureaucratic demands that they believe hinder the MOH itself. Presumption of a degree of institutional jealousy is probably reasonable.

The lack of systematic concern on the part of the government represents a potential loss to itself and to the improvement of family planning services in Peru. If the MOH were to consider the private sector projects as tests

of different methods of providing services, they could evaluate them and pass the information on in their own planning. The failure to implement some sort of comparable record systems within the projects has probably been no great loss to date since the programs have been small and very tentative. As these programs grow and become more entrenched, however, it will become even more difficult to implement useful record and accounting systems and there will be greater need for the information that might be obtained.

Government officials may fear becoming too openly involved in these projects, however, because it might invite closer scrutiny of their own activities as well. The lack of widespread government family planning activities is probably another indication of their concern for becoming deeply involved in something that they feel might be controversial.

## VI. Suggestions for the Role of CNP

Both private and public sector family planning service projects in Peru have been cited for their lack of continuity and their fragmentation. Projects have emerged and been maintained as independent entities that are largely uncoordinated and do not share information. They have not provided comparable data about their activities and the populations that they serve, data that would be useful for making informed evaluations of the strategies tried and for assessing additional service needs. This lack has until now provided little problem because most projects have been rather small in scale and tentative in approach. If, as is now anticipated, both private and public sector service activities are to be dramatically increased within the next few years, this poses a more serious problem and promises to generate considerable waste. Lack of coordination among private sector groups has also limited their capacity to obtain from the government supportive concessions such as those that would allow freer importation of supplies and the provision of sterilization services.

The fragmentation may have been a healthy characteristic of the private sector in the past in that it was not viewed as a concerted pressure group to be entirely curtailed by a pronatalist government. The political atmosphere has, however, changed and there is more support for the services they provide.

Within this context of expansion of programs, the CNP offers an opportunity to increase coordination of activities, to provide both technical and political support and to improve program and population monitoring. The Consejo is now viewed largely as an agency interested in supporting family planning services and as a technical agency. They should capitalize on this image in

giving assistance to both private and public organizations and attempting to bring about a coherent overall effort. Among the things the CNP could undertake in this role are the following:

1. Provide assistance to projects in the development of monitoring procedures that will generate uniform information regarding service output, new acceptors and continuing users, operational costs.
2. Assist agencies in obtaining coverage and impact information from specific target populations and to provide overall monitoring of the effects of contraceptive use.
3. Generation of a fund that could be used for technical assistance for planning and evaluation.
4. Work with appropriate government agencies to create suitable mechanisms for importation, storage and distribution of contraceptive supplies, making them consistently accessible to private agencies.
5. Work as an intermediary between the MOH and private agencies that are interested in sharing government facilities.
6. Promotion of family planning, including sterilization, as health concerns.
7. Conduct studies of ability and willingness of clients to pay for family planning services and assist in developing such things as sliding payment scales.

8. Provide assistance to projects in the development of other fund-generating activities.
9. Identify lacunae of population coverage and direct programs to provide services to these populations, i.e., adolescents, nulliparous women, the more indigent.
10. Coordination of donors and identification of appropriate funding sources for projects.
11. Support training and education programs regarding pregnancy/health risk awareness through existing agencies.

## VII. Conclusions and Recommendations

There are a number of viable private sector family planning programs located largely in major urban areas in Peru. Most of them are small. Of the twenty projects observed, only three made claims of having more than 10,000 active users and fourteen reported fewer than 5,000 users. In total, they probably provide services to less than four percent of the potential user demand. In general, the projects represent a number of disparate, fragmented activities that together do not add to a coherent attempt to make family planning services available to the majority of the population in need in Peru. Because there is no one to fill the gap among women living in marginal and rural areas, we must consider this a serious fault. The fragmentation is evident in a lack of communication and sharing of experiences among the various private sector providers. Given the general lack of experience on the part of most persons who are directing and working in family planning programs, this represents a considerable fault. Although there have been some attempts to establish some sort of organization of private sector service providers, it has not been successful.

The several programs offer an opportunity to study and test different models of service provision under different conditions in Peru. This has not been exploited, although it should be of interest to private sector service providers and to government officials who are beginning to design their own implementation strategies. Lack of common reporting systems and lack of requirements that private sector projects submit reports to some central agency means that their activities and achievements have gone largely unrecognized.

Further, it means that there is little appreciation for the difficulties that they encounter and little recognition of their needs for assistance.

Agencies tend also to be reluctant to celebrate their successes and to report their problems even to one another. This timidity may have grown from real and perceived repression of attempts to provide family planning services in the past. Its result, however, is that much of what is going on remains invisible to everyone, including other private sector agencies.

The private sector approach to family planning has been to try to provide as much service as possible without regard to how much is needed or what proportion of the population is covered. Because of this, they have tended to neglect trying to obtain information from the populations in areas that they serve and they know little of needs, ability to pay, the availability of satisfactory alternative sources of methods, and their health and fertility impact on the population.

There is considerable pressure on private sector programs to generate their own support after an initial period of funding. This pressure may have already resulted in lower population penetration success than would have been the case had there been more encouragement to try to reach the poorest and most distant segments of the population. It probably means also that the women who do seek services are among those with the highest parity, women who want to limit their family size only after they have exceeded the desired number of children or their health is seriously impaired. As a result, the longer term impact will be less and needy populations will continue to go unserved.

All programs encountered have some form of administrative problems. These are evident in lack of transportation facilities for field workers, inability of programs to maintain supply inventories, failure to report useful service, population and financial information. Supervision of workers, maintaining

record systems and establishing worker selection and training procedures are among the other difficulties frequently found. These can largely be attributed to lack of experience on the parts of program administrators and designers who are managing strategies that are new in Peru. Some additional experience can be gained through mutual observation of projects and sharing of information, but one should also consider more training and experience in other neighboring countries that are trying varied approaches to family planning service provision. Experience can also be imported in the form of technical assistance.

Broad support for family planning service programs seems never to have been strong in Peru. There have been many groups who have opposed the movement at one time or another and the result has been a sometimes stymied and usually hesitant growth of programs both private and public. The groups identified as ones that have been opposed to family planning have never been uniformly so. There have always been segments of the military, leftist groups and of Catholics who favored the rights of individuals to have control over their own fertility. The most glaring example of this is the Catholics who have allowed and encouraged family planning services within parish clinics. That the private sector agencies have persisted, and new ones have emerged and grown in an atmosphere ranging from limited political support, or only tolerance, to resistance is a heroic achievement. That their collective development has not always been coherent and that their programs have not been the most stable or technically solid is, at least, understandable. If they are to develop fully now, they will need more than just financial contributions. They need technical assistance and they need to coordinate their efforts among themselves and with the government that is anticipating dramatic increases in its own service initiatives.

The capacity of any of the private sector groups to absorb large amounts of additional funds in the near future is doubtful. While almost any of them

could be doubled in capacity within a year or two, this would not require very large amounts of money. Without additional managerial experience and assistance, any one of them would be unable to handle a great amount of expansion now. If that kind of assistance is forthcoming, however, sizable increases in expansion capacity are possible. Another serious limitation is the ability of the private sector organizations to maintain their supply inventories. Until that is overcome, all of them will have difficulty maintaining their organizations and their active patients.

Recommendations:

1. The need for family planning services as a means of improving the health of women and their families should be stressed as justification for the extension of those services.
2. Private sector programs should generate uniform reporting systems that would be useful for their own management interests and in providing information about the extent of coverage, costs of services, and population impact.
3. Technical assistance needs of each private sector project should be assessed and appropriate support provided. All seem to have some weak or questionable aspects that could be improved.
4. Program administrators and coordinators have had little opportunity to observe or to work in projects other than their own. More experience could be gained through mutual observation of projects in Peru by those in the various projects and model projects in other countries should be visited as well.
5. Private sector professional and technical staff should organize themselves into a coordinated group that can share information, coordinate efforts, and act as an influential group in dealing with government agencies and donors.
6. Alternative mechanisms of obtaining government support for the private sector should be investigated. One program now uses U.S. loan funds and three others share facilities.
7. Instituto Hipolito Unanue, for one, has demonstrated that it is possible to obtain some funding for their efforts from banks and pharmaceutical companies in Peru. Other private national sources should be investigated, perhaps with the assistance of the newly formed APROPO.
8. The Ministry of Health should take greater responsibility for monitoring Projects and using them to test operational methods for effectiveness.

9. The government should also take more responsibility for assisting private sector agencies to obtain support from donors (including the GOP) and for securing appropriate technical assistance as needed.
10. The government should also take a greater interest in the coverage attained by private sector programs so that they can focus their own efforts on the gaps in that coverage.
11. The MOH should assist the private sector to insure a continuous availability of contraceptive supplies.
12. The stress on self support by the private sector should be considered with caution. This emphasis could result in failure to provide needed services to those least likely to access those services due to lack of awareness or lack of ability to pay.
13. The plurality of project designs should not be discouraged now. Instead, they should be evaluated comparatively with the expectation that different strategies may work best with different populations.
14. AID has traditionally provided only loose monitoring of PVO programs it has supported directly or through intermediaries. The potential growth of private sector population projects in Peru calls for closer watch. The difficulties of three organizations regarding questionable financial practices attests to such a need.
15. The CNP should assist private sector agencies in a number of areas as discussed in the previous chapter.
16. The possibility of coordinating service and promotional programs with commercial retail sales is not being addressed. The wide distribution of pharmacies and the existing patterns of accessing those pharmacies offer a promising possibility.
17. Most clinic and hospital family planning services are provided by physicians. There are some nurses and nurse midwives operating clinics and providing services that are acceptable to users. Their use should be expanded to take advantage of lower cost workers who are also able to work more hours each day.
18. All the projects observed seem to be lean on managerial and supervisory personnel. This will be a much more serious problem if they are to expand greatly in the near future. Technical assistance for redesign should be provided before expansion plans are implemented.

Part Two

Brief Descriptions of  
Private Sector Service Programs

MAJOR PRIVATE SECTOR FAMILY PLANNING

SERVICE PROJECTS: PERU 1983



1. Project Title: Mothers' Club Project--ALAFARPE
2. Location: Lima, Cono Sur; Jose Carlos Mariátegui, Villa Jardín, Santa Isabel de Villa, Virgen de Lourdes, Pamplona Alta
3. Date Begun: August 1981
4. Responsible Agency: Instituto Hipólito Unanue, ALAFARPE, Dr. Alfredo Brazzauro, Sra. Flor de Maria Cardozo
5. Funding:  
USAID OPG \$100,000 for two years (8/81-8/83)

6. Project Purpose:

To provide contraceptive services to women in pueblos jóvenes in the southern part of the Lima metropolitan area through a system of community-based distribution and referrals to ALAFARPE-operated health centers in the area.

To work with mothers' clubs to develop handicraft skills of women for the purpose of generating income.

7. Structure and Strategy:

The project uses the same central administrative support system as the four health center projects also operated by the Institute and family planning clients are referred to the centers for cancer detection, IUD insertion, and problems, but the clinic and CBD programs are otherwise separate and distinct.

The CBD program depends on resident distributors to motivate women to use family planning methods and to provide supplies to their neighbors. The distributors are, in turn, supervised by promoters who will be expected to manage 20 distributors each.

Both promoters and distributors visit women in their own homes in order to motivate them. Group discussions are arranged by promoters but the distributors participate also.

The program has arranged for handicraft skill training of women in mothers' clubs. These skills have included macrame, leather work, sewing, and doll-making. Women work in groups under the supervision of handicraft teachers who are contracted by the project and with project supervisors. The project also helps to find market outlets for the goods produced and manages a revolving fund with which supplies are purchased.

8. Scope of Activities:

Training of promoters and distributors.

Family planning and promotion and supply distribution at the community level. Methods distributed include oral pills, condoms and foam.

Referrals for IUD insertions and for medical problems.

Assistance with organizations of mothers' clubs and handicraft skill training.

Promotion of community responsibility and participation on the parts of women. This has included community beautification gardens, child care provision, and school improvement.

9. Project Scale:

There are now 116 community-based distributors and 20 promoters. This represents a sizable recent increase in the number of workers. In January, there were 35 distributors and 14 promoters.

In May, the project served 2800 continuing users and gained 860 new users. In January, there were 175 new acceptors and the project served about 1700 continuing users. They now estimate 3700 active users in addition to over a hundred persons referred for IUDs. The mothers' clubs have sold about \$1,000,000 worth of goods and now has 177,000 soles in its revolving fund.

10. Implementation Success:

The project had a difficult time getting started and reaching current levels of operation. Both the mothers' clubs and the CBD operation required considerably more effort than was anticipated and logistical problems of supervision have been difficult to overcome.

Goals of having 36 promoters and 360 distributors have been scaled down to 20 promoters and 200 distributors because of limitations of supervisory capacity and transportation.

New criteria and standards have been established for promotor and distributor selection so that the recently added personnel are better prepared and much more highly motivated.

11. Prognosis:

This is a promising project that got off to a slow start. It has a highly motivated staff, but insufficient administrative support from the Institute and insufficient assistance from and coordination with the clinical operations, also administered by the Institute. With added administrative support, the addition of another supervisor and some transportation support, it could probably reach its originally planned size.

Unless some means can be used to generate funds for the project through clinical fees, it will continue to require considerable outside support.

1. Project Title: Instituto Hipolito Unanue Family Planning Program

2. Location: Lima pueblos jovenes, J. C. Mariategui, Jardin, Virgen de Lourdes, Sta. Isabel de Villa

3. Date Begun: 1978

4. Responsible Agency: Instituto Hipolito Unanue, Dr. Alfredo Barzzoduro (Director), Dr. Alfredo Guzman (Medical Director)

5. Funding:

The family planning service activities are being funded by Pathfinder at this time. Pathfinder has granted \$42,000 plus supplies for the period 8/82-7/83. Fees are charged for services also.

They have also received funding from Development Associates to manage monthly meetings of family planning agency representatives.

6. Project Purpose:

To provide clinical family planning services to women in marginal neighborhoods of Lima.

7. Structure and Strategy:

The project operates in four health centers managed by the Instituto Hipolito Unanue.

The four centers operate basically with a staff of six physicians, three nurses, four nurse midwives, and nine promotors (nurse auxiliaries). The equivalent of two part-time physicians, four nurses, and four promotors are currently supported with Pathfinder funds for the purpose of promotion of family planning and the provision of method services and prenatal care.

Originally, physicians were scheduled to rotate among the clinics providing family planning services only. This has been changed so that all physicians provide these services as an integrated part of patient care.

Nurses rotate among clinic responsibilities and community promotion and follow-up. Since the creation of the CBD project in the area two years ago, the promotional efforts of the nurses have declined.

8. Scope of Activities:

Clinical family planning services offered by nurses and physicians.

Patient follow-up.

Community promotion of family planning.

The clinics also provide general MCH services which are supported through fees and contributions from other sources.

9. Project Scale:

The estimated population of the service area is 200,000.

In 1982, the project added 1686 new acceptors and expects an additional 2,500 during the current year. Continuation rates cannot be taken from the existing reporting system. (Active user rates will be confounded as patients can now obtain supplies more cheaply from community-based distributors.)

In 1982, the clinics provided 28,000 consultations for all purposes.

10. Implementation Success:

Family planning services are fully integrated within the clinical operation and are available at each location during clinic hours. The family planning services do not seem to stand out as a special effort.

Rates of acceptors are still low, although the number of IUD insertions seems to have increased by about 25% (40-45 per clinic per month) in each of the clinics. This is possibly the result of referrals from the CBD program.

Promotional efforts of the project have declined and constitute a very minor part of the effort.

11. Prognosis:

The project is now about 20% self-sufficient and receives contributions of another 20% in addition to Pathfinder support. Pathfinder support is expected to be cut in half during the 1983-84 budget year.

There is already a decline in interest for promoting family planning within the community. If funds are cut, there will probably be cuts in personnel as well and a further diminishing of interest in family planning as a special component of their clinical program.

1. Project Title: Centro Medico Carmen de la Legua
2. Location: In Lima and Callao in the barrios and pueblos jovenes of Carmen de la Legua, Sta. Rosa, Callao, Ripol, Marquez, Mirnoas and San Martin de Porras.
3. Date Begun: June 1980.
4. Responsible Person/Agency: Dr. Cesar Guzman, Director, Centro Medico Carmen de la Legua.
5. Funding:

Between July, 1981, and August, 1983, FPIA is contributing \$41,064. During the current year, the project has produced approximately 27 percent of its own funding through fees for service. Development Associates have provided training to staff members.
6. Project Purpose:

To provide clinical and CBD family planning information and method services to women residents in pueblos jovenes in the Lima metropolitan area.
7. Structure and Strategy:

The primary thrust of the project is community-based distribution and promotion of contraceptive methods. Nonsalaried resident distributors sell contraceptives at very low price and act as motivators and educators. The distributors are supervised by promoters and field supervisors. Promoters hold organized discussions with community groups throughout the area.

Initial work in communities is accompanied by contacts with community leaders and organized groups.

The project provides a range of MCH services including IUD insertions and other contraceptive methods. It also works cooperatively with private physicians practicing in the areas it serves. Users are referred to those private physicians if they are more conveniently accessed than is the Carmen de la Legua center. The physicians charge rates lower than their usual for these family planning services and obtain supplies from the project.

Distributors are responsible for follow-up of users who do not return for resupply.
8. Scope of Project:

Clinics provide MCH services, including IUD and other family planning methods.

Community-based promotion and method supply for pills, condoms and vaginal methods. Promotion is also carried out in work places.

9. Project Scale:

The project currently operates in areas populated by about 650,000 people.

The CBD staff consists of the director, a nurse supervisor, a health educator, three promoters and about 35 distributors. The clinic is staffed by contracted physicians and two nurses.

During the last full project year, there were 5555 new and 4000 continuing users served. The number is expected to reach a total of about 13,000 during the current year. During the first quarter of the current year, it served approximately 6000 new and continuing users.

10. Implementation Success:

The project has been successful in meeting goals and now constitutes the largest of all the CBD programs encountered.

The project was reorganized after a difficult first year of operation. Since that reorganization, it has succeeded in making steady increases in the number of users served.

Staff are fully committed to the continuation of the project and their involvement with it.

Earlier there was some resistance on the part of community groups, but this seems to have been overcome and the project now works closely with organized groups in the community it serves.

During 1982-83, the cost per user (undifferentiated) has been under \$3.

11. Prognosis:

FPIA is committed to funding the project for another three years. The project will expand to include ten more promoters and 80-90 additional distributors during the next year as it moves into additional areas to provide service. The target population will more than double.

This project represents the most dynamic and ambitious of the projects observed. As the service area becomes larger and the number of workers increases, the central staff may have difficulty supervising workers and monitoring activities.

12. Comment:

Our assessment of this project is very positive. It has managed to avoid problems and to maintain steady improvement in population coverage throughout its first three years of operation. It provides an opportunity for testing and expanding a simple and effective service model. Our concerns are that it may be planning to grow faster than its supervisory staff can handle and that, with expansion to additional service areas, it will neglect deeper penetration of the areas it already serves.

1. Project Title: Consultoria de Atencion Prenatal, Paternidad Responsable y Educacion (CAPPRE).
2. Location: Colegio de Obstetricas del Peru, Lima.
3. Date Begun: July 1980. Services implemented February 1981.
4. Responsible Agency: Colegio de Obstetricas del Peru, Obs. Graciela Farfan de Chavez, Dean.
5. Funding:

Partial funding is obtained through IMPPARES/IPPF. Other donations as well. The overall budget for 1982 was \$5,000,000 (soles) and in 1983 it is \$10,000,000 (soles). The project generates about 20 percent of its support through patient fees.
6. Purpose of Project:

To train student nurse midwives in family planning service provision.

To promote family planning and to provide family planning services to women attending the nurse midwife clinic.
7. Structure and Strategy:

The Colegio clinic offers training to student nurse midwives and a variety of maternal health services, including family planning promotion and method provision.
8. Scope of Activities:

The clinic offers a range of maternal services, including family planning. The family planning methods provided include oral pills and IUDs, both of which are legitimately dispensed by nurse midwives in Peru.
9. Project Scale:

Each month, the clinic inserts about 40 IUDs and distributes 200 cycles of oral pills.
10. Implementation Success:

The program has been implemented as planned, according to the director. It is, however, not very aggressive in seeking increased numbers of users.

#### 11. Prognosis:

Since nurse midwives are expected to be able to provide family planning services in Peru, this is a critical training component. While the size of this clinical activity is small, the training of nurse midwives is expected to have increasing impact on the availability of family planning services throughout the country.

To date, nurses and nurse midwives have not participated fully in the provision of services in most places. The ADIFAM clinics are an exception. In most hospitals and clinics, IUD services, at least, are the responsibility of physicians.

The training aspects of the program could be expanded to include previously trained midwives and nurses, as well as current students. This, however, seems not to be planned.

1. Project Title: Instituto Marcelino
2. Location: Barrios Altos, Lima
3. Date Begun: 1967
4. Responsible Person: Dr. Alfredo Larranaga, Director, Instituto Marcelino
5. Funding:

The Instituto's clinical service activities in Lima are supported through fees for service. It has had support from various organizations for conducting research and training and for the provision of services. These have included pharmaceutical companies (notably Wyeth and Scherring), Pathfinder, and USAID. USAID and Scherring were responsible for the initial grants to establish the clinic.

6. Project Purpose:

The Instituto Marcelino, a non-profit agency, has as its primary purposes:

- a. the provision of a full range of gynecological and family planning services to poor women of Lima, and
- b. training of health professionals in all aspects of gynecology and family planning.

7. Structure and Strategy:

The Institute operates a modern, sophisticated medical clinic serving women on an out-patient basis. It is located in a densely populated, centrally located urban residential community from which it draws the majority of its patients. It draws patients from all parts of the metropolitan area as well.

The Institute has contracted with various government agencies and with medical and nursing schools to provide training of health professionals.

8. Scope of Activities:

The Institute offers a full range of gynecological and family planning services (with the exception of endoscopy) in its Lima facility. Family planning methods include IUD, injections, pills.

Training is provided for health professionals.

The Institute operates a lending service for family planning films and has distributed books and other materials donated by USAID.

They have conducted research in association with pharmaceutical companies.

The Institute is responsible for the operation of the CBD/clinic projects in Arequipa and Chiclayo that are sketched elsewhere in this document.

9. Project Scale:

The clinic now provides some 36,000 consultations per year, about 85 percent of which are for family planning. They estimate that there are now about 10,000 active planning users being served by the Institute. Many patients begin with Marcelino and then obtain resupplies elsewhere. There are over 200 new users each month.

10. Implementation Success:

The clinic has been maintained for 16 years and continues to operate at what it considers "near capacity." It has a good reputation for clinical service provision and professional training.

The Institute has recently undergone a reorganization and has streamlined its data system to provide more efficient service. It was not possible to obtain current service service and financial reports from the Institute during the visit.

11. Prognosis:

The Institute is a strong and stable organization that is able to operate on a fee-for-service basis. It has not had positive experiences with outreach services, however, and is probably better off leaving those to other organizations unless it is willing to hire additional administrative staff.

The clinic is set up to offer sterilization services and other endoscopic treatment, but it has not been able to obtain approval from the Ministry of Health to do this.

1. Project Title: Servicio Medico San Alfonso
2. Location: Serves populations in the neighborhoods of Rimac, Independencia, Tahauntinsuyo, Comas, Progreso, San Martin de Porras, La Victoria, Villa el Salvador, and San Juan de Miraflores. The Clinica San Alfonso is in Rimac.
3. Date Begun: CBD program begun in March of 1982
4. Responsible Person: Dr. Alfonso Loli, Clinica San Alfonso
5. Funding:

Received \$140,000 per month from IMPPARES through 1982. Has received an indeterminate amount from Pathfinder. During the first three months of 1983, the project generated nearly one million soles from patient fees.
6. Project Purpose:

To provide family planning promotion and services to women in marginal neighborhoods of Lima.
7. Structure and Strategy:

The San Alfonso clinic offers MCH/family planning services and back-up for CBD clinics.

The CBD component consists of 80 promotor/distributors and ten supervisors working in nine different neighborhoods in Lima. The project promotors make systematic household visits trying to motivate people to use family planning and to distribute supplies. Users also seek promotors in their homes for resupply and consultation regarding problems.

Dr. Loli has tried to work cooperatively with ten other private physicians in the areas being served. These physicians provide IUD insertions and other clinic back-up for family planning users receiving their supplies from Loli.
8. Scope of Activities:

MCH and family planning methods offered at clinic.

Community-based distribution and promotion of family planning methods.

Training of community-based distributors and supervisors.
9. Project Scale:

Ten supervisors and 80 distributors work in the CBD system. The Clinica San Alfonso coordinates with ten other physicians operating private clinics in other areas of Lima.

From May until December, 1982, the project distributed 318,000 condoms,

18,000 cycles of pills and 220 tubes of foam and inserted 260 IUDs. It reported a total of 4,360 active users.

10. Implementation Success:

It is difficult to determine just what the program is doing now and if, indeed, it is a viable program. IMPPARES stopped its funding due to differences regarding the use of proceeds from supply sales by the project. The project has since been having considerable difficulty obtaining supplies and the director reported in May that the CBD program was not functioning at all because of lack of supplies.

11. Prognosis:

There seems to be considerable doubt about the future of this project. It seems unable to secure additional funding and unable to obtain contraceptive supplies. If community-based distributors must go for several months without supplies, there will probably be a high drop-out rate both on the part of users and the part of distributors.

1. Project Title: Centro Materno Infantil del Agustino

2. Location: Barrio El Agustino, Lima

3. Date Begun: 1979

4. Responsible Person: Dr. Jaime Nunez Parra

5. Funding:

The project began in 1979 with assistance from IMPPARES but since become independent and is self-financing. It obtains contraceptive supplies from Loayza Hospital.

6. Project Purpose:

This is a fee-for-service Ob/Gyn consulting center that offers family planning services.

7. Structure and Strategy:

The physician in charge offers family planning promotion and services as part of his Ob/Gyn practice.

8. Scope of Activities:

A range of Ob/Gyn services including family planning.

9. Project Scale:

During 1981, there were 445 new acceptors of IUDs and 176 acceptors of oral pills. In 1982, the project provided an additional 500 IUDs and served 333 pill users. The estimated number of active users is now about 1800.

10. Implementation Success:

This is a private physician who began working in El Agustino with support from IMPPARES. He has since become independent and self-financing, but continues to offer family planning services.

11. Prognosis:

This clinic demonstrates that it is possible to offer family planning services in marginal neighborhoods on a self-sustaining basis. The extent to which they are reaching populations that would not otherwise be served is not known.

1. Project Title: Program of Information and Application of Natural Methods of Fertility Regulation

2. Location: Callao, La Oroya, Ica and Huarmey (7 clinics).

3. Date Begun: About 1970.

4. Responsible Agency: Association de Trabajo Laico Familiar (ATLF), Dr. Guillermo Tagliabue.

5. Funding:

Between 1970 and 1980, funding came primarily from FPIA, with one year funding from Pathfinder.

Current funding is drawn from AID loan to MOH, PN-527-0230, 527-U-076.

Total loan money for current year about \$57,000.

6. Project Purpose:

To provide instruction in natural methods of birth control and to offer oral pills to women during a two-year postpartum period.

7. Structure and Strategy:

The organization provides family planning services in a number of Catholic parish clinics in Callao and other towns outside Lima.

Clinics are typically staffed by one part-time physician, a social assistant, and an auxiliary nurse. The Callao clinic also has a nurse midwife.

Attempts are made to follow users, but there is no direct outreach promotion or distribution.

8. Scope of Activities:

Education and promotion of natural methods of birth control.

Provision of pill for use during a two-year postpartum period.

Referrals to other agencies for continuing users and those desiring other methods.

9. Project Scale:

The project is currently operating in seven parish clinics.

Data regarding number of current users are ambiguous. Using their own 1982 year-end report, there were between 8,000 and 21,000 users of modern methods and about 1000 users of rhythm in the program during the year. The total number of new users during the year appears to be 1090, which would suggest that even the 8,000 estimate should be revised downward.

10. Implementation Success:

Given the ambiguity of the data on users, it is impossible to determine how well the program is doing regarding coverage. It did have the goal of offering educational discussions to 18,000 persons during 1982, but the meetings were attended by only 2,500.

The project does seem to be operating seven clinics.

1. Project Title: Programa de Paternidad por Action Comunitaria
2. Location: The environs of Lima.
3. Date Begun: This is a continuation of programs begun in 1968.
4. Responsible Agency: Asociation par el Desarrollo Integral de la Familia (ADIFAM), Dr. Ricardo Subiria, Director.
5. Funding:

The project was funded by FPIA from 1973 until 1982. During that period it received over one million dollars in cash and commodities from FPIA.

From April 1981 through March of 1982, the project received \$116,109. Funding was terminated in 1982 when financial irregularities were found. Since then, the program has been self-financing. It is assumed that the money generated is much less than that with which they had been working previously.

6. Project Purpose:

To provide family planning motivation and methods to women in poor neighborhoods of Lima.

7. Structure and Strategy:

The project operated as a clinic program using parish health centers until 1980, when it began a CBD program.

Community distributors receive no pay but retain 70% of the prices charged for contraceptive supplies. The distributors are supervised by persons trained in community work.

Clinic services are conducted largely by nurse-midwives who rotate among the various clinics included.

Most of the clinic facilities have been affiliated with a particular Catholic parish, but the program did purchase a clinic of its own in 1981. It did this with FPIA funds not intended for this purpose and over which there is continuing dispute.

8. Scope of Activities:

In the past three or four years, the project has offered CBD and clinic-based family planning services. Methods distributed include oral pills, condoms, diaphragms and foam.

Community promotion and education is provided through mothers clubs, church organizations, and other groups as well as to women on an individual basis. The program also targeted women who operate small stores as persons to receive special education and promotion.

9. Project Scale:

At its peak in 1982, the project operated with three nurse midwives, eight field supervisors and ninety distributors in addition to a number of auxiliary and administrative support persons. It was operating six clinics in six different neighborhoods of Lima that included about 700,000 persons.

The total number of active users reported in May of 1982 was 8,900.

Since FPIA stopped funding in 1982, the scale of the project has declined. It now operates with fewer than half the number of distributors and supervisors it had. The three nurse midwives are continuing to work and are trying to maintain the clinical operation and a portion of the CBD work as well. The current level of effort and output are not documented.

10. Implementation Success:

The project was able to reach a high level of operation under the FPIA grants. Since those grants were terminated in 1982, it has attempted to manage as a self-supporting service organization.

In order to maintain itself through self-financing, many staff people have been dropped and fees for service and for supplies have been increased. The nurse midwives (and probably others) have donated their services during this period of retrenchment.

11. Prognosis:

The project is operating at a much lower level than it was. It is not known just how viable is the possibility of self-financing for both clinic and CBD activities. Since the withdrawal of support, there have been no operational reports to indicate what success they are having.

Project personnel are reported to be dedicated and willing to forgo many benefits in order to try to sustain services.

1. Project Title: Chosica Integrated CBD and Women's Project
2. Location: Chosica and Chaclayo in the Department of Lima
3. Date Begun: September 1980
4. Responsible Agency and Persons: Obst. Mary Centeno, Irma Franco de Subiria, Asociacion par el Desarrollo Integral de la Familia (ADIFAM).
5. Funding:

Between September, 1980, and November, 1982, the project received \$76,000 plus contraceptives from Pathfinder. Since then, it has been self-sustaining.
6. Project Purpose:

To provide clinic and community-based family planning promotion and services to women in the pueblos jovenes of Chosica and Chaclayo.

To raise consciousness of women regarding their rights and obligations.
7. Structure and Strategy:

The family planning program is directed by a nurse midwife who also manages the clinic. Field supervisors manage community-level distributors.
8. Scope of Activities:

Community group and individual promotion of family planning.

Provision of clinic-based MCH services, including family planning (pill, IUD, condom, local methods).

Distribution of contraceptive supplies through community workers.

Discussion and training sessions with groups of women regarding women's rights and the role of women.
9. Project Scale:

In 1982, the project had two field supervisors working with 40 community-based distributors. It was reported to have 1700 users of IUDs and 2000 users of other modern methods at that time.

The program now has 20 active distributors and one promotor.
10. Implementation Success:

The program was fully implemented and operating at the end of the 1982 funding period. Although its external funding and source of donated supplies were curtailed, it is continuing to operate on a lesser scale with self-generated funds and the donation of services.

11. Prognosis:

This project shares a doubtful future with the other clinic and CBD activities of ADIFAM. It appears that it can manage for a short time with self-generated funds, but expansion even to its 1982 scale appears problematic. If it charges higher rates for its services, it will not be able to penetrate deeply the population that is most in need of services.

1. Project Title: Centro Obstetrico Ginecologico la Esperanza
2. Location: Av. Angamos Este 640, Surquillo, Lima
3. Date Begun: 1981
4. Responsible Agency: Asociacion de Bienestar Familiar, Dr. Rene Cervantes
5. Funding:

The project operates largely with contributions from the four physicians and a lawyer who make up the association. It has received some contributions for equipment and supplies from pharmaceutical firms and from IMPPARES. Fees for service account for a very small proportion of support.
6. Project Purpose:

To provide clinical family planning and MCH services to low-income women in the neighboring areas.
7. Structure and Strategy:

The clinic operates each afternoon with time contributed by one of the participating physicians. There are facilities for presentation of audio-visual materials and for meetings of large groups, It was expected that these would be used for promotion of family planning among the women in the neighborhood, but they are not now used.

There have been some attempts to promote the clinic through contacts with social service workers in nearby factories and businesses, but most clients are expected to be informed through word of mouth.

Low fees are charged for services.
8. Scope of Activities:

Clinical family planning and MCH services.
9. Project Scale:

The clinic is serving about 8 patients per day, an average of two of whom are family planning patients. There are no summary records or reports.

The clinic is open for four hours each afternoon.
10. Implementation Success:

The project has done little to build up its clientele and serves very few patients. The group has considered closing the clinic and in fact did close it for one month this year. They are willing to continue paying the rent and to keep trying to build up their patient load for some additional time, however.

11. Prognosis:

Unless the operators of this project obtain assistance in the organization of their clinic and the promotion of available services among the population that it wants to serve, users' rates will continue to be low and it will probably close. The number of patients served now does not justify either the time or the expense involved.

The participating physicians are among the most experienced in the provision of quality medical care, but they appear to have had little experience in operating clinics intended to serve marginal populations. As clinicians willing to contribute time, they constitute a valuable resource that is not being fully exploited.

1. Project Title: Program for Fertility Regulation

2. Location: Loayza Hospital, Lima

3. Date Begun: 1966

4. Responsible Agency: Department of Ob/Gyn, Universidad Cayetano Heredia, Dr. Carlos Munoz, Dr. Diaz Huaman.

5. Funding:

FPIA is supporting this project with \$59,096 for the year September 1982 - August 1983.

FPIA has been supporting the project since 1973. Prior to that, the project received funds from Pathfinder and directly from AID.

6. Project Purpose:

Training of students and specialists in family planning service provision, including minilaparotomy.

To establish family planning programs with rural physicians (SECIGRA).

To promote family planning among workers in Lima.

To provide a full range of family planning services to persons seeking them at Loayza Hospital.

7. Structure and Strategy:

An agreement between Cayetano Heredia University and the Loayza Hospital provides for using the hospital for training students and others. Fourth-year medical students are given practical training. Fifth-year students and interns have rotations of several weeks in Ob/Gyn, including the family planning clinic.

Clinic facilities and personnel are also used in training of other health professionals and social workers regarding family planning methods, reproductive physiology and responsible parenthood.

Clients are served in the clinic on the same basis as others seeking care at the hospital.

The program provides education and promotion among postpartum and post abortion women in the hospital.

8. Scope of Activities:

A range of family planning services is offered, including sterilization, IUD, oral pills, and barrier methods.

Family planning counselling, education and motivation is provided to women.

Health professionals and social service personnel are appropriately trained.

9. Project Scale:

Over 400 medical students, health professionals and social workers were scheduled for training during the current budget year.

Between 1978 and 1982, 650 sterilization procedures were carried out. The current year goal is 350.

For the eight-month period between September 1982 and April 1983, the clinic served 5734 continuing users and 2,983 new acceptors. These represented 71 percent and 59 percent of the annual goal. The project now estimates that it is serving 12,000 active users.

10. Implementation Success:

The project continues to operate without major difficulty and anticipates renewed funding. That the project has persisted for 15 years as a cooperative activity of the MOH (Loayza Hospital) and a private university is a singular mark of achievement, given the political difficulties encountered by the family planning movement in Peru.

11. Prognosis:

It is expected that funding for the project will be renewed at the end of the current period. Organizational support from the University, the Loayza Hospital and the MOH is solid.

1. Project Title: Consulting Centers for Family Planning/Arequipa and Chiclayo
2. Location: Chiclayo, Department of Lambayeque and Arequipa, Department of Arequipa.
3. Date Begun: September 1980 (actually delayed until April 1981)
4. Responsible Person and Agency: Dr. Alfredo Larranaga, Director, Instituto Marcelino, Lima
5. Funding:

The project has been funded through an OPG with USAID. During the first two years, AID provided \$150,000 to the project. Due to confusion in 1982, the project was not immediately extended, but they have since obtained an additional \$50,000 from USAID to continue until September 1983.

During the first two years of operation, the Institute estimated its own contribution, offset by fees for services to some extent, to be approximately \$50,000.

6. Project Purpose:

To establish professionally staffed clinics for the provision of family planning services.

To establish mechanisms for CBD in marginal areas of the two cities in which it operates. CBD services include promotion and method supply.

Centrally located clinic facilities are also used for group promotional meetings.

To provide a model for CBD systems outside of Lima.

7. Structure and Strategy:

The project offers CBD services with clinic support. Clinics are located in central locations within the cities served. Physicians provided IUD services and various other types of gynecological care including cancer detection and infertility counseling. IUDs, oral pills, injectables and condoms are offered at the clinics. The physicians who work in the clinics are contracted for these services only. They do not perform any administrative functions for the projects.

Each CBD unit is managed by a supervisor who administers promoters and distributors.

Overall program supervision is handled by Marcelino Staff in Lima and a social worker/nurse supervisor who divides her time among the various locations.

Staff training was conducted at the Instituto Marcelino in Lima.

#### 8. Scope of Activities:

Clinical services included family planning and infertility counseling, cancer detection, general medical care and the provision of family planning methods.

CBD activities include group and individual promotion of contraceptive use and the provision of method supplies to users. Referrals are made for women who indicate interest in IUDs or who otherwise show a need for physicians' services.

#### 9. Scale of Project:

**Arequipa:** Two physicians with the assistance of a receptionist and some help from the supervisors provided between 175 and 200 consultations per month, about one-third of which are for family planning.

Although 15 promotors were trained, only three seem to be participating now and these are responsible for 28 active distributors.

It was estimated that there were 800 active users in 1982. Promotor areas are widely disbursed in the marginal areas of Arequipa, making any concern for estimate of coverage rates irrelevant.

**Chiclayo:** Two physicians provided about 200 consultations per month during 1982. About one-half of these were for family planning patients. The clinic accounted for 197 new users during the year.

Program currently maintains about 2,300 active users in both the clinic and CBD components.

Four promotors are responsible for 88 distributors.

The target population is not well defined. Promotors work throughout the province of Chiclayo and are also distributed among parts of adjacent provinces.

#### 10. Implementation Success:

The project has met a number of difficulties in implementation. Much was due to lack of experience in CBD on the part of Instituto Marcelino staff and a lack of appreciation for the needs and complexity of such a program.

Continuing problems in securing motivated staff, establishing clinic facilities, obtaining contraceptive supplies and various logistical and administrative complications diminished the (never great) interest of the Institute director and other staff who should have provided force and direction for the project. A hiatus in funding between October 1982 and April 1983 further reduced any momentum the project might have built up in its first year-and-a-half of operation.

11. Prognosis:

The project is continuing to seek funding for an additional period after the current OPG expires. Without some overall project direction, it is doubtful that it can survive, however, and certainly cannot justify high rates of expenditure unless it can markedly increase coverage.

The CBD staff in both areas appear to be enthusiastic and able but are given little leadership and remain insecure. It seems improbable that such leadership will come from the Institute. The projects would be best served if they affiliated with other agencies that are more interested in dealing with CBD.

1. Project Title: Clinica Medicina Preventiva y Planificacion Familiar
2. Location: Downtown Arequipa
3. Date Begun: IMPPARES support since 1981
4. Responsible Person: Ana Maria Garcia, Clinica Medicina Preventiva y Planificacion Familiar
5. Funding:

Program operates as part of IMPPARES system but generates its own funds through fees for service and prepaid contracts for services.
6. Project Purpose:

To provide family planning and other clinical services to low-income patients in Arequipa.
7. Structure and Strategy:

The Clinic expects to be a profit-making, self-sustaining health service organization within the next year. It provides health care to walk-in patients and is attempting to work out arrangements with businesses and factories in Arequipa to care for their workers.

The director is attempting to work out pre-paid coverage and third-party payments for services through contracts with employers.

Promotion of preventive care and family planning is conducted in business establishments and with groups at the clinic.
8. Scope of Activities:

Provision of family planning services with stress on IUD, but some pill users as well.

General MCH and other medical care for out-patients.

Promotion of service utilization among groups of workers.
9. Project Scale:

The project operates with a staff of two physicians, a social worker, nurses, and auxiliaries. It is open during the afternoons and evenings.
10. Implementation Success:

The highly motivated group operating this project have been pressing hard to achieve self-support by the end of 1983. They appear to be tapping a market that has not been considered by other agencies in Arequipa.

11. Prognosis:

The project seems to be viable and ambitious. It has been steadily increasing its client load both for family planning and other services.

1. Project Title: Family Planning Project in the Pueblos Jovenes, Cuzco and Marginal Rural-Urban Area
2. Location: Cuzco urban
3. Date Begun: 1982
4. Responsible Person: Enf. Haydee Obando, Grantee
5. Funding: During the 1982-83 project year, Pathfinder contributed \$15,047 plus supplies. The 1983-84 budget calls for a Pathfinder contribution of \$14,990.
6. Project Purpose:
  - To promote the use of family planning among women in marginal areas and to provide a range of methods.
  - To promote the use of family planning among women in marginal areas.
  - To provide a range of modern family planning methods through CBD and to offer IUD services through cooperation with a physician in the Regional Hospital.
7. Structure and Strategy:
  - Two promoters working under the supervision of Enf. Obando provide discussions to groups of women and make individual household visits. These promoters distribute method supplies to the women. Women wishing to use IUDs are referred to the Regional Hospital where they are given care by a physician who is a project consultant. Sterilization services are also provided at the hospital. The project has no facilities of its own but uses a treatment room at the Regional Hospital for IUD user care and stores supplies in an MOH health post located in the community where they are working.
  - There are plans to make more use of health post staff and facilities by patients who will be referred there for care. The consulting physician and the nurse director will offer training to the health post staff. Promoters will spend more time there assisting with patients seeking services.
8. Scope of Activities:
  - Community promotion and community distribution of methods.
  - Referral for IUD and for minilap.
  - Training of cooperating health post staff.
  - Provide assistance at health posts.

9. Project Scale:

The project is currently operating in an area of 14,000 persons but this will increase during the coming year. 721 new acceptors were obtained during the first year of operation. This represents an acceptor rate in excess of 40% among the fecund female population between ages 15 and 49.

Project anticipates 500 additional users from new coverage areas during the coming year and expects to maintain about 600 previous acceptors.

10. Implementation Success:

Although not as many meeting and household contacts as planned were made during the first year of operation, the project did achieve its goal of new acceptors.

Project personnel remain dedicated and highly motivated. They have demonstrated that, through intense coverage with a very few motivated persons, high rates of coverage can be achieved. This is doubtless the simplest and least of the CBD programs encountered and, at the same time, the most effective at achieving high rates of coverage.

11. Prognosis:

Pathfinder has assured funding for the 1983-84 project year and anticipates at least one year of funding beyond that. It is not generating its own funds through charges for patient services.

This small but highly successful project offers a great deal of promise. The only question is whether it can continue to achieve high response rates if it increases in size.

The project offers a model of simplicity and for cooperation between private sector outreach services and government facility-based service provision.

1. Project Title: Proyecto Materno Infantil-Cuzco

2. Location: Cuzco urban area

3. Date Begun: January 1982

4. Responsible Person: Dr. Reinhard Plaza Bartsch

5. Funding:

The project receives some funding and supplies from IMPPARES, but expects to become self sufficient.

6. Project Purpose:

Dr. Plaza is a private physician who is interested in making family planning services widely available to the population.

7. Structure and Strategy:

The project operates with a medical director, an administrator, two promoters and a nurse midwife. All methods are provided at the center by the physician or the nurse midwife. Promoters work with community groups and with workers in business firms and factories in the area in providing education and motivation for family planning use.

8. Scope of Activities:

The clinic offers a range of MCH services, including family planning. The only methods offered are IUD and oral pills.

Field workers act only as promoters. They do not distribute contraceptives.

9. Project Scale:

During 1982, the clinic dispensed about 300 cycles of pills per month and inserted 700 IUDs during the year. The director estimates that they made 300 referrals to the regional hospital for IUD insertions as well.

10. Implementation Success:

The project began in 1982 and anticipates being largely self-financing within a year or so.

11. Prognosis:

The project director and his wife, the administrator, are committed to making family planning services widely available at low cost. They do not have plans for broader CBD or adding other service centers.

1. Project Title: MOH and Family Planning, Quillabamba

2. Location: Quillabamba, Department of Cuzco

3. Date Begun: June 1979

4. Responsible Person: Dr. Plaza, Sr.

5. Funding:

Some initial funding was received from IMPPARES. This is now a self-sustaining clinic. The clinic has been operating for some years.

The clinic was operated for several years prior to adding a serious family planning component. Between 1979 and 1981, some funding was received from IMPPARES, but it is now self-sustaining.

6. Project Purpose:

Family planning has become an integrated component of the clinical services.

7. Structure and Strategy:

The clinic owner's son, also a physician (practicing now in Cuzco) began family planning services and promotion with the help of his wife and two promoters, a secretary, and a nurse midwife.

Although the son and his wife have left, the clinic is still serving users and trying to expand coverage. They return to Quillabamba from time to time to replenish supplies and to offer supervision.

We could not determine the nature of current promotional activities except that there is continued contact with rural cooperative groups.

8. Scope of Activities:

This is a private clinic providing a range of medical care, including family planning, to residents of Quillabamba and nearby areas.

9. Project Scale:

By December of 1981, the project was reported to be serving 4000 active users, including 2000 with IUDs and 2000 using other methods. More recent data are not available.

10. Implementation Success:

The program seems to have been implemented satisfactorily and without difficulty or resistance. Services are now self-sustaining.

11. Prognosis:

Neither expansion of coverage nor continuation of family planning as a special program are anticipated. It does represent an important component of clinical services and this is not expected to change.

1. Project Title: Human Fertility Study in the City of Trujillo.

2. Location: Trujillo, Department of La Libertad.

3. Date Begun: 1980.

4. Responsible Person: Dr. Felix Guillen Araoz, Grantee, MCH Department, Ob/Gyn Section, National University of Trujillo.

5. Funding:

The project has been funded by FPIA.

The amount contributed by FPIA has been \$13,000, \$22,355, and \$25,727 for the first three years of the project, respectively. From June, 1983, until September, 1984, FPIA has granted \$46,246. In addition, the project expects to generate \$7,592 from user service fees and to receive an additional \$19,048 in other donations.

6. Project Purpose:

The project began as one what would provide training to medical and nursing students and local health professionals through in-service participation in clinic-based family planning method provision.

Current project emphasis is on service provision, both in clinics and as a CBD activity. Student continue to rotate through the clinic service component.

This is considered a pilot project that will test and demonstrate effective methods of contraceptive service provision that will later be assumed by the MOH (or will stand alone as a self-supporting system).

7. Structure and Strategy:

Project uses facilities of the Regional-Teaching Hospital and five neighborhood health posts for the provision of clinical services. Clinical services are provided by contracted physicians and fees are charged.

Promotion initially done through community meetings and at work places. With the addition of CBD, there has been more individual promotion in the areas around the health posts.

Distribution in the communities is handled by resident women who receive no salary.

8. Scope of Activities:

Medical and nursing student training.

Community promotion of contraceptive use.

Clinics and community method distribution systems.

9. Scale of Project:

Training provided to 188 medical students, 8 interns and 3 residents.

During the year 6/82 to 6/83, the clinics had 710 continuing users and 3023 new acceptors. The CBD program gathered 1000 new users.

Projected 1983-84 coverage is 2550 continuing users.

Currently operates in one treatment room of the hospital and in five health posts. It will expand to offer services in ten additional posts and to have 72 additional distributors during the coming year.

10. Implementation Success:

The project comes close to meeting goals of new acceptors at clinics, although these must be considered modest given the effort involved. Continuation rates appear very low among client patients. That may be in part due to difficulty in maintaining stock of supplies.

The CBD program has placed only half the number of distributors anticipated by this date. They have not yet hired supervisors. This may account for the low user numbers.

Project personnel have not had experience in other CBD projects and are having difficulty getting this one organized.

11. Prognosis:

FPIA funding is anticipated to continue for another three years, at which time the project indicates that it will be self-supporting or turned over to the MOH. It is not clear that either of these are real possibilities at the present time.

Arrangements to use MOH facilities have been informal to date. The Regional Health Director has requested that there be a formal agreement between Dr. Guillen and the MOH to continue the arrangement. That agreement was to have been made by June 15. It could present an obstacle to expansion if government officials are not in accord with project design.

The project does offer a promising means of introducing contraceptive services without a great deal of capital investment if agreements can be worked out with MOH.

The project director appears to be highly motivated and dedicated to making family planning services available, not only through his own program, but through other means as well.

Trujillo is in the disaster area created by the rains of 1983. As a result, the people are less able to pay for services and it is unreasonable to expect this program to raise fees in order to become self-sufficient within a short time.

1. Project Title: Limoncaro Family Planning Services
2. Location: Cooperative Arroceria de Limoncaro, Pacasmayo--Carretera a Cajamarca Km 12
3. Date Begun: 1981
4. Responsible Agency Person: Sra. Maria Reaño de Tenorio, Limoncaro; Dr. Dante Castro, Lima
5. Funding:
 

Pathfinder has committed \$20,793 to the project for the period between April 1981 through November 1983. The Cooperative is expected to provide support after November.
6. Project Purpose:
 

To promote family planning and to provide services to members of the Limoncaro Cooperative and to persons in the surrounding area.
7. Structure and Strategy:
 

Clinic staff, including two auxiliaries and a social worker, conduct promotional discussions in the Cooperative and to other groups in the surrounding area. The auxiliaries also provide methods, including IUDs, at the clinic.

A physician works at the clinic two afternoons per week attending problematic cases. The physician director is expected to visit the program for two days every two months.
8. Scope of Activities:
 

Family planning promotion and service provision.

CBD has been planned for two years, but has not yet materialized.
9. Project Scale:
 

As of April, 1983, the program reported 680 active users, including 222 IUDs, 268 pill users, and 170 using other methods.

The primary target population consists of the 2000 fecund age females of the Limoncaro Cooperative (total population 9000), although it also seeks to serve others living nearby.
10. Implementation Success:
 

The program is now covering 30 percent of its target population, although it has not implemented its planned CBD component.

11. Prognosis:

The project has been well received by the Cooperative and will be assumed as the Cooperative's responsibility after Pathfinder funding comes to an end.

The project could extend its coverage to other communities and cooperatives in the area, but this will probably not happen unless special funding is made available for this purpose.

1. Project Title: Chimbote Family Planning and Ob/Gyn Clinic
2. Location: Chimbote
3. Date Begun: February 1981
4. Responsible Agency: Dr. Alfredo Larrañaga, Instituto Marcelino, Lima  
(Transferred to the Instituto in 1982 when former director withdrew from the project.)
5. Funding:  
Funded for two years by Pathfinder for a total of \$40,773. No further funding is anticipated.
6. Project Purpose:  
To provide family planning services and Ob/Gyn consultations.  
To offer promotional and motivational talks to community groups and at work centers.  
To provide motivational home visits.
7. Project Strategy:  
This was a clinic-based program with outreach used only for promotional purposes. All methods were offered only at the clinic. Auxiliary nurses as well as physicians provided contraceptive supplies.
8. Scope of Activities:  
Provision of methods.  
Community promotion of family planning.
9. Project Scale:  
Two physicians working part-time and two auxiliary nurses working full-time provided 2367 clinical consultations during the first year of operation and 1308 during the second year.  
The project reported 1518 acceptors during the first year and 178 during the second year.
10. Implementation Success:  
The project seems to have been doing well when the director was a person who worked directly with the project and lived in the area. Attempts to maintain it without such a director were less successful.
11. Prognosis:  
The project was terminated last month and arrangements were being made to transfer equipment and records to Lima.

## APPENDIX

Persons ContactedA. Peruvian Projects and Agencies

Asociación de Bienestar Familiar/ Clínica Esperanza	Dr. René Cervantes
Asociación de Trabajo Laico Familiar (ATLF)	Dr. Guillermo Tagliabue
Asociación Multidisciplinaria de Investigación y Docencia en Población (AMIDEP)	Dr. Roger Guerra
Asociación para Desarrollo Integral de la Familia (ADIFAM)	Dr. Ricardo Subiría Sra. Irma Subiría Obst. Mary Centeno
Asociación Peruano de Facultades de Medicina (ASPEFAM)	Dr. Miguel Santillana Dr. Manuel Ramirez
Centro Materno Infantil El Agustino	Dr. Jaime Nuñez Parra
Centro Médico Carmen de la Legua	Dr. Cesar Guzmán Luz Ibarra Tania Ruiz
Clínica Medicina Preventiva y Planificación Familiar/Arequipa	Ana María García
Clínica San Alfonso	Dr. Alfonso Loli Sra. de Loli
Colegio de Obstetricas del Perú	Graciela Farfán de Chávez, Decano Consuelo Montoya del Solar Hilda de Vaca
Cooperativa Limoncarro	Dr. Dante Castro
Escuela de Salud Pública Ministerio de Salud	Dr. Federico Ugarte
Family Planning Program of Trujillo	Dr. Félix Guillén Araoz
Instituto Hipólito Unánue/ Asociación "Proyección Social de la Industria Farmacéutica del Peru (ALAFARPE)	Dr. Alfredo Brazzoduro Dr. Alfredo Guzmán Sra. Flor de María Cardozo Rubio Monica Guillén Walter Gutierrez Dr. Flores Anita

Instituto Marcelino

Lima:

Dr. Alfredo Larrañaga  
Teresa Watanabe

Arequipa:

Consuelo Montes de Oca  
Rosa Yañez  
Dr. Saenz  
Dr. Postigo

Chiclayo:

Ayme Huamán  
Dr. Carlos Cerrón  
Dra. Haydee Mejía  
Rosa Cerna  
Alva Montes

Private Clinic Cuzco and  
Quillabamba

Dr. Reinhard Plaza Bartsch  
Carlota Combe de Plaza

Proyecto Cayetano Heredia/  
Loayza Hospital

Dr. Carlos Muñoz  
Dra. Díaz Huaman  
Dra. Luz Jefferson

Pueblos Jóvenes de Cuzco

Haydee M. Obando  
Dr. Horacio Chavez  
Norma Caboa  
Adela del Castillo

Consejo Nacional de Población

Dr. Carlos Muñoz  
Dr. José Donayre  
Dr. Mario Torres  
Dr. Carlos Eduardo Aramburu

Ministry of Health Regional Office  
in Trujillo

Dr. Juan Alvitez  
Dr. Ramón Echevarría  
Dr. Salinas

B. Foreign and International Organizations

Battelle Memorial Institute

Dr. Harry Cross  
Dr. Michael Micklin

Development Associates

Dra. Victoria Jennings

Johns Hopkins University

Dr. Bruce Carlson

Pathfinder Fund/Peru

Dra. Genny Martinez

Population Council

Marcia Townsend (TDY)

United Nations Fund for Population  
Activities/Lima

George Walmsley

USAID

Arthur Danart  
Perla Alvarez

Westinghouse

Dr. John Gillespie

POPULATION FAMILY PLANNING AID SUPPORTED DONOR ASSISTANCE

TO PERU FOR CY OR FY 1983 (000s DOLLARS)

AID Bilateral Program A/	3,009
Association for Voluntary Sterilization	510
Pathfinder	500
Family Planning International Association	380
Program for Applied Research on Fert. Regulation B/	10
Development Associates, Inc.	37
Operations Research C/	200
Battelle PDD	72
World Fertility Survey & Westinghouse CPS	150
Contraceptive Retail Sales	150
Program for International Education Gyn & Obs C/	170
Population Information Program	40
International Planned Parenthood Federation D/	344
U.N. Fund for Population Activities E/	797
<b>TOTAL</b>	<b>\$6,369(000)</b>

- A. FY 1984 Request to OMB
- B. **Core** costs included
- C. Includes health account funds.
- D. IPPF 1982 Report includes all Donors' resources.
- E. UNFPA Program - Report of 9/30/82-  
Includes all Donor's resources.

Source: AID/Speidel-Denman memo March 30, 1983