

PW-A-BX-377

12/1/95

**MANAGEMENT NEEDS AND
SUSTAINABILITY ASSESSMENT:**

**HUMAN RESOURCE
DEVELOPMENT FOUNDATION**

Final Report

**Roy Brooks
Alison Ellis**

**Draft report: July 1995
Final report: August 1995**

**Family Planning Management Development Project
Management Sciences for Health**

**Project No.: 936-3055
Contract No.: DPE-3055-C-00-0051-00
Task Order No.: A1700 TKNGO**

TABLE OF CONTENTS

I.	EXECUTIVE SUMMARY	1
II.	BACKGROUND	2
III.	OBJECTIVES	3
IV.	METHODOLOGY	3
V.	FINDINGS	5
	A. <u>PROGRAMMATIC SUSTAINABILITY</u> (5)	
	1. Strategies for service delivery	
	2. Community and collaborative involvement	
	B. <u>INSTITUTIONAL SUSTAINABILITY</u> (8)	
	1. Logistics	
	2. Organizational structure and decision-making	
	3. Planning and market research	
	4. Management information systems	
	5. Human resources development	
	6. Service delivery support: quality assurance, IEC, and evaluation	
	C. <u>FINANCIAL SUSTAINABILITY</u> (17)	
	1. Accounting and finance systems	
	2. Audits	
	3. Financial status and trends	
VI.	RECOMMENDED NEXT STEPS	22
ANNEX 1	23
	Contacts (23)	
	Meeting Schedule (23)	
ANNEX 2	25
	Table: Source and Value of Commodities, and Fees Charged (27)	
	Table: Trends in Contraceptive Acceptance (28)	
	Table: Personnel Providing Services (31)	
	Table: Source of Training for Personnel (32)	
	Table: Services Provided (33)	
ANNEX 3	35
	Table: Financial Sustainability (37)	
ANNEX 4	39
	Balance Sheet (39)	

SUMMARY OF RECOMMENDATIONS

Accounting and finance systems	18
Audits	18
Human resources development	13
Logistics	9
Management information systems	12
Organizational structure and decision-making	10
Planning and market research	11
Service delivery support	17
Strategies for service delivery	8

L EXECUTIVE SUMMARY

The Human Resource Development Foundation (HRDF) has undergone a period of growth in staffing and projects over the past two years, the most significant expansion since its founding in 1988. From 1994 to date, resources from international donors have increased by nearly 100%—from \$430,505 to \$819,304 in 1995. This is due to the organization's success in obtaining recent funding from the European Union (EU) for an AIDS Project; the International Labor Organization (ILO) for a "Working Children" project; UNFPA funding via a subcontract from the Turkish Ministry of Health (MOH) for a Safe Motherhood Project in Istanbul; funding from JHPIEGO for development of a pre-service training curriculum for medical personnel on family planning, other reproductive health (FH) services and AIDS; and funding from SOMARC for the development of a FP training curriculum and training for pharmacists. Continuation funding from PFI for HRDF's Community Based Services (CBS) Project is pending, as is EU funding for the Family Planning Unit at Istanbul University.

HRDF has strong, technically competent project staff at the Central Office and in the projects visited. Staff have the range of technical skills necessary (e.g., medicine, training, education, counseling, social work, information, education, and communication [IEC] materials development, research, CBS project management) to implement and supervise the range of project activities undertaken by the Foundation. Project staff are committed to the goals of the HRDF and to making the Foundation stronger technically and financially.

The HRDF is taking a leadership, "cutting edge" role and making an important contribution at both local and national levels to knowledge of and experience in FP, RH, AIDS, maternal/child health (MCH) policy and service delivery issues, as well as the plight of working children. Its projects are addressing felt needs in the communities served as well as gaps in knowledge of service providers, educators and gaps in national policy. Since 1989 the HRDF has pursued as a priority strategy the strengthening of knowledge and training of FP service providers for improved quality of care. The HRDF has accumulated significant experience and has made important contributions in this area.

The ironic challenge for HRDF is that the organization has grown so quickly in the past two years, it may not be able to financially sustain more than half the current operations after the next 18 months. This is due to the fact that current (1995) external donor funding of \$819,304 decreases to only \$58,875 by 1997, unless donors extend some of the projects. The funding sources are almost entirely from external donors—over 92%. This situation is compounded by the fact that none of the key management staff are supported by core, as opposed to project, funding. HRDF is certainly aware of this situation, and is continually holding discussions with current as well as potentially new donors in order to hopefully continue with their success in receiving outside funding.

Although the HRDF Board of Directors (BOD) and staff are quite concerned about the lack of any permanent funding sources, they are in a state of flux as to how to obtain local funding. Some of the options discussed include:

1. Creating a Technical Consultancy Agency for services the HRDF provides, e.g., organization of training programs, publications and training/reference materials, organization of meetings, seminars, etc.
2. renting out the first floor of the central office
3. starting an English school on first floor of the central office
4. opening a cafeteria at the central office
5. establishing private clinics
6. forming a for-profit company enabling the HRDF to collect revenues
7. obtaining a tax deduction status to receive donations

In addition, a cost recovery program for existing services provided should be put into operation. It is the opinion of the team that this is not an option, but rather a necessity for the long-term financial sustainability of the HRDF.

It is therefore imperative that the HRDF initiate strategic planning. The planning should be facilitated by an outside consultant with specific experience in business and/or health care finance. Strategic planning should be organized as soon as the new Executive Director is hired. The product should be a work plan that should begin no later than the end of 1995. Priority areas where the HRDF feels its organizational strengths may best compliment proposed strategies for income generation should be identified. Once agreement is reached on the one or two priority areas for income generation, a feasibility study should be conducted that results in a business plan outlining the technical expertise and start up costs needed to carry out at least a pilot income generation program. Ideally, at least one of two possible pilot programs could be implemented by mid-year 1996.

HRDF will need to explore the availability of donor funding to carry out the above recommendations. There are a number of other recommendations concerning programmatic and institutional sustainability which are highlighted in this report.

II. BACKGROUND

The Family Planning Management Development (FPMD) Project was requested by USAID/Ankara and USAID/Washington to undertake management needs and sustainability assessments of three NGOs: The Human Resource Development Foundation (HRDF), the Turkish Family Health and Planning Foundation (TFHPF), and the Family Planning Association of Turkey (FPAT). It should be noted that the FPAT does not currently receive funding from USAID. HRDF and TFHPF receive funding for discrete project activities through USAID-funded Cooperating Agencies (CAs) working in Turkey.

FPMD is a world-wide, USAID centrally-funded project implemented by Management Sciences for Health. FPMD works at the regional, national, and local levels throughout Europe, the Near East, Africa, Asia and Latin America. The project provides management assistance to national family planning programs and organizations, both public sector and non-governmental, to improve

institutional and managerial effectiveness for the provision of high-quality family planning services. FPMD's approach to organizational development is built on extensive experience, which includes the provision of technical assistance to family planning organizations in over 30 countries. The project's technical areas of expertise include: strategic planning; business planning; operational work planning; financial and human resource management; management information systems; coordination and collaboration between the public and private sectors; and program evaluation.

III. OBJECTIVES

The management needs and sustainability assessment undertaken in collaboration with the HRDF is the first step in addressing the program outcomes and indicators for the NGO sector identified in the USAID five-year country strategy for Turkey. The specific objectives of the assessment were to:

1. Prepare a set of findings and recommendations regarding HRDF management systems and structures;
2. Jointly identify activities for the next 2-4 years designed to build on the HRDF's strengths, contributions to the National Family Planning Program; and
3. Within these recommendations and strategic activities, address the issue of the HRDF's programmatic, institutional and financial sustainability.

IV. METHODOLOGY

The management needs and sustainability assessment was undertaken during 9-15 June 1995 by Roy Brooks, MSH Consultant in Health Finance and Management, and Alison Ellis, Regional Director, Asia/Near East, FPMD. The team undertook the following activities:

1. Prior to their arrival in Turkey, the team reviewed general background documents on the relevant economic, social and demographic indicators of development and the current status of family planning and reproductive health in Turkey. They also reviewed background documents provided by the HRDF, including its Program Highlights 1992-95 (dated March 1995), and project proposals prepared for various donors' funding (e.g., EU, PFI, JHPIEGO, etc.)
2. The team conducted a series of interviews with key HRDF personnel, including two Board members, the Executive Director, Finance Manager and project staff. Through the review of documents, including project work plans prepared by donors, and meetings with staff, the team gathered information concerning:

- an overview of the HRDF, including: history and current operations; facilities and equipment; services offered (e.g., family planning, other reproductive health, other health), information on service providers and referral systems; public education, motivation, and advocacy activities; organizational goals, policies, and strategies; organizational structure and decision-making; finances, including systems for resource allocation and costs of services; community involvement/public relations activities;
 - The team also gathered information on key program management, and management support systems in place, including: planning (both program planning and planning for financial sustainability [e.g., fundraising]), logistics, human resource development and management, financial management, management information systems, quality assurance and evaluation systems.
3. Ms. Ellis conducted field visits to two HRDF projects, and Mr. Brooks to one project based in Istanbul which included: The Safe Motherhood Project funded by UNFPA under a subcontract from the MOH, and the Family Planning Unit of the Maternal Child Health/Family Planning (MCH/FP) Training and Research Center at Istanbul University. Ms. Ellis also conducted a field visit to the Community Based Services project in Izmir, funded by PFI. She met with the Project Coordinators and project staff during all visits, as well as briefly with community workers at the Safe Motherhood project.

See Annex 1 for the list of contacts and schedule of meetings.

Mr. Brooks and Ms. Ellis used questionnaires they developed to generally guide the interviews. Data collection was also guided by HRDF's completion of forms prepared by the team.

On the basis of the team's review of documents, interviews with key HRDF personnel, and field visits to project sites, the team:

- Analyzed the strengths and weaknesses of the HRDF in terms of its management systems and structures, within the context of its own priorities and needs, the priorities and needs of the Turkish national family planning program, and the HRDF's achievements with respect to programmatic, institutional, and financial sustainability;
- Formulated recommendations to strengthen the HRDF's overall programmatic, institutional and financial sustainability; and
- Recommended appropriate actions and strategies for addressing identified needs and weaknesses in HRDF management systems and structures to the Executive Director, Finance Director and Istanbul-based project staff.

V. FINDINGS

A. PROGRAMMATIC SUSTAINABILITY

1. Strategies for service delivery

The HRDF has undergone a period of growth in staffing and projects over the past two years, the most significant expansion since its founding in 1988. Between 1994 and 1995 to date, resources from international donors have increased by nearly 100%. This is due to recent funding from the EU for an AIDS Project; the International Labor Organization (ILO) for a "Working Children" project; UNFPA funding via a subcontract from the MOH for a Safe Motherhood Project in Istanbul; funding from JHPIEGO for development of a pre-service training curriculum for medical personnel on family planning, other reproductive health (RH) services and AIDS; and funding from SOMARC for the development of a FP training curriculum and training for pharmacists. Continuation funding from PFI for HRDF's Community Based Services (CBS) Project is pending as is EU funding for the Family Planning Unit at Istanbul University. The majority of the HRDF's current projects have initiated activities in the last few months: the ILO Project in January 1995, Safe Motherhood in February, AIDS Project in April, SOMARC Project in May. Only the PFI-supported CBS Project is of long-standing, dating from 1986, prior to the establishment of the Foundation.

HRDF's Program Highlights document includes statements regarding the aims of the Foundation, and its program priorities: manpower development, reproductive health, and family planning. The family planning component is the only component with specific objectives and strategies for achieving Foundation goals in this area.

HRDF does not have an organization-wide work plan. Project specific work plans and detailed line item budgets have been prepared in conjunction with the various donors to help guide project staff's activities and spending. These work plans are quite simple, tending to identify the specific activities to be undertaken and start-end dates for each activity.

HRDF's programmatic strategies may be categorized as follows:

- Strengthening the knowledge and training of family planning service providers for improved quality of care. Activities include development of training and reference materials, organization of contraceptive technology update seminars, various publications, etc.
- Introduction and replication of the community-based FP service delivery model using community women from slums areas of major cities (e.g., Izmir, Gaziantep); a similarly designed project in Istanbul (Safe Motherhood) includes an MCH component

- Subject to EU funding and MOH approval, an accredited FP/RH training center at Istanbul University providing the full range of female contraceptive methods, vasectomy, and reproductive health services
- An AIDS Project which targets sex workers and STD/AIDS care providers
- A project targeting school inspectors designed to heighten awareness of the incidence and consequences of working children.

These latter two projects are very new and are "cutting edge" in that apparently no other organizations are focusing on these issues. These are thus contributing to increased knowledge and understanding of the issues and policy implications for the MOH and Ministry of Education, respectively. The AIDS Project in particular is a highly sensitive one in Turkey's conservative society. Finally, the HRDF is undertaking technical (medically-oriented) projects targeting medical service providers (physicians and pharmacists) through the development of specialized curricula. Through the development process, consensus will no doubt be achieved concerning standards for knowledge and quality of care among these service providers. In sum, HRDF's various service delivery and policy-related projects are wholly consistent with the general aims of the Foundation and specific strategies related to FP/RH and AIDS as they are defined in the Program Highlights. Annex 2 provides summary tables concerning the mix of services provided by HRDF.

In terms of strategies for service delivery, the CBS model—with which HRDF has had nearly 10 year's experience—as well as its new Safe Motherhood project, largely based on the CBS model, are important contributions to national program efforts. While limited in scope (geographic areas) and number of clients served annually, per se, the projects are serving poor areas not currently well served by the MOH or other facilities. The impact of the CBS model has been well documented in countries such as Bangladesh where, as in Turkey, there is a significant gap between knowledge of FP and acceptance of methods, particularly of effective methods, and barriers to access due to economic and cultural factors, as well as misinformation about methods. The Izmir Project Coordinator analyzes the impact of her CBS project in the communities served. For example, changes in contraceptive acceptance of effective and less effective methods are examined quarterly. Moreover, she conducted a complete survey of contraceptive acceptance in a project area which had not been served by the project for four years.

While the Izmir project has gained significant, and apparently lasting, achievements, the ultimate success and impact of CBS and Safe Motherhood projects as they are designed are wholly contingent upon the capacity and capabilities of MOH and SSK facilities, as well as private sector providers, to which clients are referred for the more effective methods (e.g., IUDS, Norplant® [if available], sterilization) and other RH services. The Izmir CBS project and Safe Motherhood Project are good examples: women leaders in the projects' catchment areas are generating demand for clinic-based services which the local MOH Health Units are able to satisfy with varying degrees of success. The Izmir Project Coordinator has lived and worked in the area for many years. She is well known to the Provincial MOH Directorate and MOH Health Unit staff.

Her strong, personal contacts with MOH authorities over the years have facilitated a satisfactory situation whereby women referred to MOH Health Units in project catchment areas receive services. Moreover, through her personal contacts she has arranged for sterilization to be provided at no cost at MOH and SSK facilities in Izmir. Close collaboration with the Provincial MOH Directorate has been an essential element of the CBS project since its beginning. A formalized relationship was established under a protocol signed between the MOH/Ankara and the HRDF. As part of this protocol, MOH trainers participate in training of CBS outreach workers. More recently, the Project Coordinator and the MOH provincial directorate have agreed to meet every three months.

The Istanbul Safe Motherhood Project developed linkages with the Marmara and Istanbul Universities and an SSK hospital at the beginning of the project. Through the Foundation's contacts it has arranged for free IUD and Norplant® services at some of these facilities for women referred from the project catchment area. While the Project reports good relations with the MOH and MOH Health Units serving the catchment area through liaison by the Executive Director, Medical Coordinator, and Project Coordinator, it has encountered some difficulties with the MOH Health Units being unable to satisfy the demand for referrals. For example, HRDF medical staff conducted some training of MOH Health Unit personnel as some staff were ill-informed about FP methods, e.g., indications and contraindications for pill usage.

2. Community and collaborative involvement

The degree of HRDF community and collaborative involvement is high, demonstrated by the various project activities. The CBS and Safe Motherhood Projects draw upon women leaders and field supervisors from the projects' communities. The AIDS and Working Children Projects plan to identify leaders from among the target populations addressed by these projects who will be developed into community-based resources in support of the objectives of the projects. The majority of HRDF's projects draw upon local expertise to enrich project activities; for example, the AIDS Project's Advisory and Expert Committees are composed of knowledgeable government and university-based personnel, and the Izmir CBS Project makes use of a provincial MOH Directorate staff member to serve as lead trainer for the Project's new CBS workers. Furthermore, HRDF medical staff are seen and used as technical resources to the MOH, the 13 medical schools involved in the JHPIEGO project, and midwifery and pharmacist schools in Istanbul where they are called upon to serve as lecturers in FP.

Strengths

- HRDF has strong, technically competent project staff at the Central Office and in the projects visited. Staff have the range of technical skills necessary (e.g., medicine, training, education, counseling, social work, IEC materials development, research, CBS project management) to implement and supervise the range of project activities undertaken by the Foundation.

- Project staff are committed to the goals of the HRDF and to making the Foundation stronger technically and financially.
- The HRDF is taking a leadership, "cutting edge" role and making an important contribution at both local and national levels to knowledge of and experience in FP, RH, AIDS, MCH policy and service delivery issues, as well as the plight of working children. Its projects are addressing felt needs in the communities served as well as gaps in knowledge of service providers, educators and gaps in national policy.
- Project activities are well designed.
- The HRDF is committed to community and collaborative involvement. Its projects demonstrate the degree of this commitment through use of available technical resources to enrich and help to guide project activities.

Areas for Improvement and Recommendations

- An organization-wide work plan should be developed annually to document how staff resources, particularly the medical staff as well as project-level resources, will be used and needed during the year.
- To the extent possible, HRDF should charge an honorarium or consulting fee to Istanbul area schools which request the lecturer services of its medical and other staff.
- To the extent possible, HRDF should obtain FP/MCH/RH brochures from the MOH and/or SSK and/or TFHPF to support its CBS and Safe Motherhood Projects' field-based activities.

B. INSTITUTIONAL SUSTAINABILITY

1. Logistics

The Central Office does not have a system for the management of commodities. This is because commodities distributed by the CBS Projects are shipped directly to the project sites by Pathfinder/Boston approximately once per year. The Safe Motherhood Project obtained an initial supply of commodities (pills, condoms) through HRDF personal connections with pharmaceutical companies and from the TFHPF (spermicides). Available supplies are far less than the needs projected by the program. Only after the agreement with the MOH for the Safe Motherhood Project was signed did the Foundation learn that the MOH was unable to supply contraceptives to the project, as the HRDF had assumed it would. Approximately half of the initial supply of pills and condoms have been distributed by community workers in the last two months. It is not clear from where additional supplies will be obtained, although HRDF staff seem confident that re-supply will not be problematic due to their personal contacts. Commodities are stored at these

projects' respective field offices. Storage conditions are adequate. Both projects have good computerized systems for tracking the quantity of commodities available, and quantities provided and distributed to community workers. The CBS Project conducts a physical inventory of commodities on their arrival and once every month.

The EU-funded AIDS Project includes a condom distribution component. The budget provides funds for the commercial procurement of a small quantity of condoms for distribution by leaders to their fellow sex workers. This supply will be maintained at the Project's field-based office in Istanbul. Project staff advised that they intend to develop a computerized record-keeping system for tracking the condoms distributed to the leaders. There is certainly an appropriate, simple computerized model in the Izmir CBS Project which the AIDS Project could adapt.

Strengths

- There are effective, computerized systems of record-keeping at the project level to track and control supplies held by community workers and available to the projects. These models can be easily adopted by other HRDF projects and/or other NGOs.
- There appears to be an understanding of correct storage conditions on the part of project staff.

Areas for Improvement and Recommendations

- Since distribution of commodities is an essential component of the Safe Motherhood Project, it is strongly suggested that a source(s) of supply for the total quantity of commodities needed for the balance of the project period (through December 1995) be secured now, rather than waiting until a crisis emerges. (Note: since the assessment was conducted the HRDF has secured contraceptive supplies [i.e., 70,000 condoms, 12,000 spermicides and 500 pills] from contacts with the MOH/Ankara MCHFP General Directorate, pharmaceutical companies and other institutions.)
- HRDF should consider developing a strategy for alternative, reliable free or low cost sources of supply in the event that PFI supplies are no longer available or quantities available are reduced in the future.
- If HRDF service delivery activities expand to other areas of the country, the Foundation may need to consider developing a Central Office-based commodities procurement/distribution/tracking system, particularly if current or future donors prefer to ship to the Central Office rather than multiple shipments to far-flung provincial-based projects.

2. Organizational structure and decision-making

The organizational structure of HRDF is such that decisions are made in a participatory fashion with management committee meetings held a minimum of every two weeks. The management system appears to be very decentralized. The Board of Directors (BOD) is very well represented and provides an excellent mix of expertise including the President of the Chamber of Commerce, several prominent physicians, a demographer, and a communications specialist. The Executive Board consists of seven members; it meets approximately 10 times a year. The content and format of the minutes are carried out in accordance with the Prime Ministry regulations as set forth for Foundations. An agenda is prepared prior to each meeting, and receives prior approval of the Chairman of the Executive Board. In addition, the agenda is accompanied by a status report on current activities as well as budgetary summaries.

Both the annual plan and the annual budget are approved by the BOD, and there is continual consultation between the Executive Director and Board Chairperson. The Board also approves any raises two times a year.

The HRDF mission is clearly stated, and both management and BOD are willing to expand this mission if necessary to strengthen financial sustainability. However, they stated they want to have "family planning" as the number one priority.

The lines of communication within the central office and between the central office and the projects appear to be well defined, and very efficient. The organization is of a size that it does not require too much formality in terms of official meetings. However, the key management staff meet at least every two weeks, and it appears that everyone is well informed of the organization's operations at all levels.

Strengths

- The quality and expertise of the staff has enabled the HRDF to successfully gain wide support among external donors.
- HRDF has managed to purchase their central office building, which is a considerable asset to the Foundation.

Areas for Improvement and Recommendations

- There is a desire on behalf of the BOD to focus priorities and not necessary be continually "chasing after donor funds."
- The HRDF has not been too successful in tapping Turkish money sources. There is a great deal of competition for funds, making income generation the most potentially viable mechanism for local funding.
- There is a question as to whether the HRDF should obtain tax deduction status, in addition to the not-for-profit status it currently holds. Unless the HRDF anticipates a

large amount of funding from local contributions, there is probably not much advantage to obtaining the tax deduction status.

- Sometimes there is difficulty in recruiting staff due to limited salary levels. At the moment, this can only be overcome by continued external donor funding.

3. Planning and market research

As previously mentioned, the work plans at the project levels need to be consolidated at the central level.

Market research conducted by selected projects in the form of base line data studies is the best example of the HRDF's performance in this area. This information is well used for determining priorities and monitoring individual progress on a daily basis.

HRDF is not at the level to be able to support any operations research activities which might provide information on how best to provide services in a cost-efficient manner.

Areas for Improvement and Recommendations

- The work plan needs more definition at the project level so that it is structured for both organizational and individual accountability, has specific time frames, and includes a budget projection at least on a quarterly basis.
- There is a strong need for the HRDF to develop a strategic plan to anticipate the decrease in funding during the next two years, and to enable the organization to have a plan that uses longer time horizons than just one year.

4. Management information systems

The management information system (MIS) provides some information concerning goals and objectives, but MIS is not really used to track the organization's programmatic progress at the central level in a consolidated manner. On the other hand, most of the individual projects have excellent computerized management systems installed and functioning. These local systems are used in monitoring target levels and evaluating strategies, and they are also available to all necessary personnel who need this information (not all projects are of a nature that require extensive MIS for monitoring).

For example, the Safe Motherhood Project (SMP) in Istanbul and CBS projects in Izmir and Gaziantep have local, working management information systems that assist in the development and collection of target strategies, base line data, demographic information, productivity levels of individual personnel, and potential impact of programs. In the case of SMP's MIS, which was

developed based on the system installed previously in Izmir and Gaziantep, there are currently two computers which were used to conduct an extensive 10,000 population survey for baseline data. This same data was then used to develop a priority strategy to target services for pregnant women and those using the withdrawal method. They were also able to provide information on a weekly and monthly basis concerning productivity of individual workers.

Strengths

- MIS is well developed within the field-based projects, particularly in the CBS Project which has been implemented for several years.
- The HRDF currently has access to an outside private company which developed some of the computer programs, and can be contracted for necessary changes.
- HRDF has capitalized on the experience of its CBS projects in Izmir and Gaziantep to transfer project management systems and approaches to the SMP in Istanbul. The result is that HRDF greatly expedited the start up process in Istanbul, and also has comparable data and registration systems among their three CBD-based projects.

Areas for Improvement and Recommendations

- The organization is not yet large enough to support a staff person specifically assigned to MIS. For the moment, the contracted outside service is certainly the best arrangement. The HRDF should use pre-packaged programs whenever possible.
- As the organization grows there will be a need to generate data in a more consolidated fashion and more frequently. This will not be possible unless there is a specific individual assigned to this task at least part time (possibly a volunteer).
- There is a need to use MIS for monitoring the overall work plan of the organization, preferably in a consolidated and timely (quarterly) basis.
- The question was raised by HRDF as to the need for more computers. It is suggested that a complete assessment be undertaken before making any recommendations. For example, a network arrangement might eventually be desirable.
- Data should be used to continue to expand the ways in which the project is impacting family planning and reproductive health so that the HRDF may hopefully encourage government support for the replication of its service delivery models.

5. Human resources development

There are a total of 13 personnel in the central office, five with the SMP, and approximately 40 in Gaziantep and Izmir.

HRDF uses advisory committees as needed for special projects; these are called on an *ad hoc* basis. The annual plan is prepared with participation at the staff, Executive Director, and BOD levels. However, it is generally agreed that work plans need to be more time- and person-specific, which would also enable the Finance Department to more precisely project expenditures.

The staff turnover is extremely low, therefore no specific statistics are kept on this other than personnel files maintained. There is no head of personnel due to the small size of the organization; personnel matters are currently handled by the Executive Director. There is no formal employee evaluation system. CBS/SMP Projects' community workers have established targets, but no written evaluations exist. Raises are not related to performance—the Finance Officer stated that in the last several years she was only aware of two individuals who received a raise different than the applied percentage increase for all staff which is approved by the BOD. Incentive systems appear to exist at the field worker level only. At this level it seems to be very effective. It is also not clear if there are market studies done on salary levels.

As previously mentioned, HRDF understands that there is currently an imbalance in the ratio of management to medical staff, and they are working to resolve this.

Strengths

- Given the size of the organization, the staff are highly qualified and a strong asset to the sustainability of the HRDF.

Areas for Improvement and Recommendations

- There is no formal employee evaluation system. The community workers have established targets, but no written evaluations exist at any level. There needs to be a focus on human resource development for staff since HRDF has grown significantly over the last two years. This should specifically include a formalized annual (preferably semi-annual) evaluation of all employees, and in writing, with a discussion of general responsibilities, agreement on specific tasks to be completed in specified time periods, and discussion of training, development, and supervision support needed to accomplish agreed upon tasks.
- There is no merit system for raises based on performance. It is desirable to begin to consider a more formal incentive plan.
- At the moment, the Executive Director is overseeing human resource development in addition to handling several other responsibilities. It is recommended that an individual other than Executive Director be designated specific responsibility for overseeing human

resource development, so it can have a more formalized focus and not detract from other responsibilities of the Executive Director.

- The new Executive Director will be expected to have a strong background in management versus a medical background. HRDF believes this will help to provide a better balance between management and technical needs of the organization.
- The BOD will need to have more fund raising skills in order to be able to generate more local funds.
- There is no core-funded staff; this will need to change over time so that at least a few key individuals are not completely dependent on project (donor) funding.

6. Service delivery support: quality assurance, IEC, and evaluation

HRDF's training activities are largely carried out by the two Central Office physicians (GPs). They support Project Coordinators in the training of CBS and Safe Motherhood Projects' community workers and supervisors by contributing to the training of these workers. They developed a 3-week training curriculum for the Safe Motherhood Project in January 1995 which was shared with the MOH and other NGOs. These staff are also responsible for 13 2-day training sessions with pharmacists under the new SOMARC Project; four of these sessions are currently scheduled. As noted above, the medical staff also serve as periodic FP expert lecturers at local medical institutions. HRDF also calls upon a group of outside experts to serve as lecturers. There is no overall training plan or schedule. In addition to training responsibilities, which includes curriculum development, and preparation of resource materials (contraceptive technology updates, FP reference book based on National Service Delivery Standards, articles for the HRDF's periodic newsletter), the physicians serve as technical resources to all of the HRDF's projects, particularly those which are initiating project activities, e.g., AIDS Project and Safe Motherhood.

Supervision of the medical aspects of field-based projects is also the responsibility of these two physicians. They meet with Project Coordinators (Istanbul-based) every two weeks, and make periodic site visits to the CBS Projects for training or supervision purposes. There are no written supervision guidelines for medical quality nor a supervision system such as a checklist. However, the medical staff write follow-up letters to the Project Coordinators noting project strengths and areas for improvement.

Istanbul-based project staff appear to meet and discuss project progress, problems and constraints frequently. All staff are committed to a team approach to project implementation both within projects and across the organization.

The CBS Project in Izmir and Safe Motherhood Project in Istanbul have strong, comprehensive project management, supervision, and evaluation systems. In fact, the CBS Project Coordinator helped to orient the newly employed Safe Motherhood Project Coordinator and trained her in the

systems she has developed and employs faithfully. These systems have been adapted to include adequate coverage of the project's MCH activities. The systems include:

- A standardized questionnaire for the conduct of a detailed and comprehensive baseline survey of all eligible couples living in the projects' catchment areas. The surveys yield extensive data on community conditions and needs, on socio-economic conditions, FP/RH knowledge, attitude and practice, etc. The survey questionnaire has been and will continue to be used by community-based projects initiated by the HRDF. It is administered in each household visited by community workers during the first 2-3 months of project operations in a new district.
- Work plans for community workers are prepared by their field supervisors. House-to-house visits "target" high risk couples, i.e. no method, pre-and post-partum and post-abortion, withdrawal users.
- A written supervision system exists which uses checklists and other reports, plus "spot checks" of community workers' house-to-house activities, supplemented by weekly meetings and other frequent opportunities for review and discussion of progress, problems and obstacles to the implementation of activities. These frequent supervisory meetings between field supervisors and community workers, as well as between the Project Coordinator and field personnel also allow for on-the-spot refresher training, including role playing.
- Routine collection of data on the number of house visits, users by methods, referrals, etc. and use of this data for work plan review/adjustment, program monitoring and supervision, and routine reporting to the HRDF Central Office.
- Routine maintenance of data to track the commodities provided to and distributed by women leaders.

As noted above, the CBS Project tracks changes in contraceptive acceptance on a quarterly basis and has conducted a study and prepared a report on the impact of its activities in an area which has not been served by the project in four years.

The AIDS Project also has good systems for collecting information and tracking progress. For example, the Project will conduct focus groups with sex workers to identify its women leaders and to collect information on conditions and needs of this special population. It will also use these meetings to educate the HRDF on appropriate language (slang) to include in specialized brochures the project will develop for the target population. Regrettably, the donor did not include funding for an impact study at the end of the project period. The ILO Working Children Project has also collected baseline data (contracted out to a survey company) on knowledge/attitude/practice (KAP) of targeted schools inspectors and has developed its own curriculum for training the inspectors using the survey results as a basis. An evaluation meeting with the inspectors is planned at the end of the project to gauge changes in their KAP.

Aside from books prepared for and in collaboration with the MOH, the HRDF has or is developing some IEC materials. Most are designed/targeted for specific project activities, e.g., the newsletter which will be issued under the JHPIEGO project, brochures for the AIDS Project. In addition, the HRDF prints a periodic newsletter which has a mailing list of over 8,000. Staff report that the newsletter is not being prepared as frequently as they would like, presumably due to workload. The HRDF has also developed a useful reference card summarizing indications/contraindications of contraceptive use for use by medical and non-medical personnel in HRDF projects and elsewhere. Inquiry as to any HRDF attempts to evaluate the impact of its available materials was not made.

Strengths

- Frequent review and discussion of progress and constraints in the implementation of program activities through Central Office meetings among project teams with the Executive Director and medical staff, as well as with field-based Project Coordinators.
- Strong systems at the CBS and Safe Motherhood Projects' levels, e.g., community worker recruitment criteria and supervision system, including "spot checks", regular meetings with community workers and refresher training, data collection and use of data, maintenance of computerized records on commodities available and distributed, reporting and budget monitoring.
- Written training curricula are developed by technically qualified staff.
- Medical staff conduct periodic field visits to service delivery projects and write follow-up letters. They also review service statistics data reported by field-based projects. Medical personnel are otherwise used as technical resources to all HRDF projects. In general there is good use of technical resources within the HRDF for the benefit of all projects, e.g., the ILO Working Children Project Coordinator helped recruit the AIDS Project staff; the Izmir CBS Project Coordinator contributed to the orientation of the new Safe Motherhood Project Coordinator.
- Use of baseline surveys to help guide program activities, and in some cases, to evaluate the impact of project activities.
- Formal and documented project management systems, e.g., that used by the CBS Izmir Project and Istanbul Safe Motherhood Project, which may be replicated for rapid start-up of similar projects elsewhere in the country, particularly with the technical involvement of the Izmir Project Coordinator who is highly competent and knowledgeable.
- High standards for quality of care are valued by all HRDF Central Office and project staff.

Areas for improvement and Recommendations

- The HRDF is growing. As such systems which are lacking or which are currently informal will become more critical.
 - To the extent possible the medical staff should attempt to develop an annual or semi-annual training plan. These staff are particularly overworked and over-taxed at the moment due to the myriad of specific project management responsibilities (e.g., for JHPIEGO and SOMARC projects) as well as the need to serve as technical resources to other HRDF projects, including supervision of service delivery projects.
 - If service delivery projects continue to expand in scope and geographic coverage, quality assurance activities should be further systematized, perhaps through the introduction of a checklist or at least written organization-wide standards for service delivery projects.
- If not already done, the HRDF should attempt to evaluate the impact of its materials (books, posters, slide shows), perhaps through the distribution of a questionnaire with its periodic newsletter and questionnaires or focus groups with specific audiences to which these materials have been distributed. Tangible documentation of the impact of services provided always increases the competitive edge for receiving donor funding, and this is important for their financial sustainability.
- To the extent possible, all project proposals prepared by the HRDF should include a provision for the conduct of an impact evaluation at the end of the project. End-of-project survey and other results should be written up and distributed widely to the MOH, international donors, and NGOs.

C. FINANCIAL SUSTAINABILITY

1. Accounting and finance systems

The HRDF accounting system is a pre-packaged system that provides inventory, payroll, accounts receivables, and accounts payables. The balance sheet, income and expense report, and inventory for the organization, however, are not computerized, and are not consolidated more than twice a year. The total budget of the HRDF does not make it imperative to have a computerized balance sheet, so this is not a problem at this time.

It is important, however, to at least consolidate the income and expense reports more frequently to ensure that the financial status of the organization can be better monitored in relation to budget projections. For example, the last consolidated income and expense statement was prepared in

January, and there were significant changes that had occurred during the first six months of the year that were not yet noted.

The budgets are approved at the Executive Director and the Board of Director levels. Signatory authority for expenses is at the petty cash level for projects only, and up to a determined amount for the Executive Director, after which checks must be signed jointly by both a Board member and the Executive Director.

Strengths

- The accounting system appears well organized and fully computerized at the level of payroll, and accounts payable and receivables. Inventory and balance sheet are done manually, but this is appropriate given Ministry regulations and formats that must be followed.

Areas for Improvement and Recommendations

- The income and expense sheets as well as the payroll need to be consolidated across all projects. It is currently difficult to get a timely picture of the financial condition of the organization as a whole.
- There is a notable need to be able to produce variance reports on a monthly basis for income and expenses. Even if this is a straight-line extrapolation of expense projections, it would be helpful for monitoring overall HRDF expenses and income. Two of the three projects have this capability, and HRDF will provide this information to the SMP in the next few months (at the moment, the SMP Coordinator only knows how much petty cash she has spent, and even this is done on a revolving fund basis versus a monthly designated [allowable] amount).
- It is suggested that project coordinators need to have control and responsibility over more than just petty cash, particularly if they implement any revenue generation programs.

2. Audits

The HRDF was able to share one audit report, prepared for the PFI-funded project from 1992. It is not clear if the HRDF's entire operation is audited by an outside firm, or at least, an audit report was not shared with the team. It does have an audit by the Ministry of Finance every year.

Areas for Improvement and Recommendations

- If not already done so, there needs to be an external audit by an outside private company at least once every two years.

3. Financial status and trends

The trends in financial sustainability can be seen in the following table:

TRENDS IN FINANCIAL SUSTAINABILITY

DONOR INCOME	1993	1994	1995	1996	1997
USAID					
-JHPIEGO	255,697	266,368	374,580	222,450	0
-PATHFINDER	47,021	20,223	30,000	0	0
EU	277,745	140,468	275,224	383,250	58,875
UNFPA	0	1,569	100,000	0	0
ILO	0	1,877	39,500	0	0
TOTAL DONOR	580,463	430,505	819,304	605,700	58,875
TOTAL LOCAL INCOME GENERATED	60,090	92,646	77,140	60,000	80,000
TOTAL INCOME	640,553	523,151	896,444	665,700	138,875
TOTAL EXPENSES	414,967	413,062	852,058	629,229	82,404
LOC INC/TOT INC	9%	18%	9%	9%	58%
LOC INC/TOT EXPENSES	14%	22%	9%	10%	97%

1993 \$ = 14.385 TL - 1993-1994 Actuals

1994 \$ = 38.250 TL - 1995-1997 Donor Commitments - Local income

1995, 1996, 1997 estimates

\$ = 42.500 TL

This table dramatically illustrates the success that HRDF has had in the last two years in obtaining outside funding, while simultaneously demonstrating that by 1997 external funding is expected to decrease from a high in 1995 of \$819,304 to a low just 18 months later in 1997 to \$58,875. Although HRDF is contemplating contingency plans, there are no firm contracts as yet from external donors. However, they are considering how they might increase their local funding, which is discussed in the section below on strategies for financial sustainability.

The table on Financial Sustainability provided in Annex 3 illustrates in more detail the level of diversification of funding sources. Once again it shows that HRDF has very strong support from outside donors, particularly JHPIEGO, the European Union, and UNFPA. The total income for HRDF from external donors accounts for over approximately 91% of all income. HRDF receives

other, local funding from the provision of outside consulting or training (approximately \$7500/year), bank interest, rent, and sale of technical products (books and brochures). The general guideline for NGOs throughout the world is to be no more than 70% dependent on external donor funding. This is a goal that HRDF needs to strive for during the next two years at most.

HRDF has been able to create a net worth that is significant enough to assist with its sustainability goals, as can be seen from the balance sheet in Annex 4. The primary asset is the property where the central office is located. HRDF believes that the value of the property is significantly underestimated, and could be worth several times more than the estimated \$35,000. Consideration as to how this building might assist in the collection of rental income follows in the sustainability section below.

Proposed strategies for financial sustainability:

There are specific strategies that the HRDF is considering in order to obtain a higher percentage of income from local and, hopefully, more permanent sources. These strategies basically fall into two categories: (1) cost recovery from client services; and, (2) development of other revenue generating enterprises.

Strategy 1 - Cost Recovery: At the moment there are absolutely no client fees, or means to recover costs from services delivered to clients. As a non-profit organization, the HRDF is faced with a number of legal restrictions concerning charging for services, including:

1. The fact that the UNFPA money received by the HRDF is through a subcontract from the MOH, and the MOH does not allow NGOs to charge for services;
2. There is a Ministry of Finance regulation stating that charitable organizations cannot charge for services.

The HRDF has not conducted any formal market research, but it is clear that a significant portion of the clients served by their projects could afford to pay at least something for the services and commodities they are currently receiving for free. This is demonstrated in one of the community-based projects where the HRDF is providing pills at no charge to women who were previously buying pills from local pharmacies. The reason HRDF gives for this practice is that it enables the project to better monitor the clients' use of the contraceptives.

It is recommended that the practice of providing contraceptives free to clients who are currently paying for them be reassessed. For one, the practice has the potential of merely *transferring* patients from one commodity source to another, while not truly *increasing* the number of new users. This could result in a costly zero-sum gain for the community-based projects. More importantly, it is taking a very limited source of commodities out of the hands of new users. Lastly, it is widely known that once services are provided for free, the client begins to expect this practice to continue, thereby making it all the more difficult to initiate any type of cost recovery plan.

Recommendations concerning cost recovery:

1. Need to explore how some organizations can charge for services and why the HRDF cannot. For example, the two other NGOs visited by the team in Turkey are accepting "donations" for client services. The expectation is that those clients who can afford to pay must offer a minimum donation for services received.
2. Need to do a market study to document how much current clients can pay for services and commodities provided.

3. Need to eliminate the "free service" mentality in order to be sustainable. Even a "token fee" is better than a free service in the long run.
4. If the HRDF can not charge for services, than a policy review needs to be made soon, preferably by end of this year, and a policy needs to be determined not if, but how, free services will be limited.
5. Further discussion with the HRDF needs to take place concerning the use of fees and some of the advantages including: increased client perception of the quality of service, more appropriate client demand for services, and the ability to recover costs in a more permanent manner.
6. Provide human resource development training to the Finance Officer, and provide this staff member with more responsibility and authority to make site visits and discuss with providers programmatic changes, including cost saving measures, income generating activities and fee structures, and employee incentive plans (including contractual hires).

The fact that HRDF provides FP services, yet is the only one of the three NGOs visited that does not receive at least donations for services, represents a significant additional source of income that is not currently being utilized. Although it has non-profit status, the other NGOs are able to collect donations from clients in a legal and socially acceptable manner. As mentioned, it is conceivable that HRDF is developing a counter productive strategy by making women who are currently paying for pills eligible for free pills.

Strategy #2 - Developing other enterprises or operations which generate revenues: The Executive Director and BOD are quite concerned about the need to develop local funding sources, but although a number of options have been discussed, there has been no plan to test any of the options.

Some of the options that have been discussed include:

1. Creating a Technical Consultancy Agency for services the HRDF provides, e.g., organization of training programs, publications and training/reference materials, organization of meetings, seminars, etc.
2. renting out the first floor of the central office
3. starting an English school on first floor of the central office
4. opening a cafeteria at the central office
5. establishing private clinics
6. forming a for-profit company enabling the HRDF to collect revenues
7. obtaining a tax deduction status to receive donations

The basic challenge will be to fill the Executive Director position as soon as possible and make a decision as to what options HRDF will want to implement.

VI. RECOMMENDED NEXT STEPS

First and foremost, there is a need to initiate strategic planning, facilitated by an outside professional in finance and/or business.

HRDF needs to formulate a three-year strategy, particularly in light of terminating funding which is no less than 18 months away. The Foundation needs to subsequently identify pilot programs to generate income, and then develop a business plan for priority programs to be implemented/tested (with assistance of an outside consultant, preferably).

In short, the HRDF has to narrow down the options for income generation it is considering, and begin to put some of the options into action within the next 18 months. The HRDF should explore with USAID (as well as other donors) the possibility of obtaining funding for strategic planning and seed money for pilot programs.

ANNEX 1

Contacts

Human Resource Development Foundation

Ms. Nuray Fincancioglu, Executive Director
Dr. Dogan Gunes Tomruk, Medical Coordinator
Dr. Muhtar Cokar, Assistant Medical Coordinator
Ms. Furuzan Guyer, Project Coordinator, AIDS Project
Ms. Nevhan Varol, Research Coordinator, AIDS Project
Dr. Nuray Yolsal, Medical Coordinator, AIDS Project
Ms. Gayli Gelikhan, Project Coordinator, Working Children
Ms. Muesser Alkan, Finance and Administration Coordinator
Ms. Zeynep Turkmen, Project Coordinator, Safe Motherhood
Dr. Aysen Bulut, Executive Board Member, and Director, Family Planning Unit, MCH/FP Training and Research Centre
Ms. Tulay Bayindirli, Project Coordinator, Community Based Services Project, Izmir
Ms. Hatice Alkin, Assistant Project Coordinator, Community Based Services Project, Izmir
Mr. Hasip Buldanlioglu, Executive Board member, Treasurer, and Banking Consultant in Financial Management

Meeting Schedule

- 9 June** Team meeting with Executive Director, Finance Director and project staff based at the HRDF Central Office
- 12 June** Meetings with Medical Coordinator Unit, AIDS Project staff, and Working Children Project staff (Ellis)
- Meeting with Finance Director and Executive Director (Brooks)
- 13 June** Field visits to Safe Motherhood Project (Ellis/Brooks) and Istanbul University (Ellis)
- Meeting with Executive Director (Brooks)
- Meeting with Medical Coordination Unit (Ellis)
- 14 June** Field visit to Community Based Services Project in Izmir (Ellis)
- Meeting with two Board members, and meeting with Finance Director (Brooks)
- 15 June** Meeting with Executive Director, Finance Director, and Istanbul-based project staff to discuss findings and recommendations

ANNEX 2

Previous Page Blat

Table: Source and Value of Commodities, and Fees Charged

Please complete information in the appropriate boxes for your organization.

TYPE OF SERVICE	Source and Value of Commodities (Place a ✓ in the appropriate box for the source, and indicate the value)			Fee for service charged by your organization? (Circle the appropriate answer)
	Your Organization	MOH	Private Sector	
Oral Contraceptives	✓donation			Yes No ✓
Injectibles				Yes No
Implants		✓		Yes No ✓
IUDs		✓		Yes No ✓
Sterilization: Male Female		✓ ✓		Yes No ✓ Yes No ✓
Spermicides			✓donation	Yes No ✓
Condoms	✓donation			Yes No ✓
Diaphragms, Caps				Yes No
Natural Family Planning: Counseling Education				Yes No Yes No
Infertility: Diagnosis Treatment				Yes No Yes No
STDs: Diagnosis/Treatment Screening only				Yes No Yes No
FP/Reproductive Health Counseling Education				Yes No ✓ Yes No ✓
Other Reproductive Health Services (please specify)				Yes No
•				Yes No
•				Yes No

Previous Page Blar

Table: Trends in Contraceptive Acceptance

Please provide the annual objective by method, and the total number of acceptors and total number of referrals for each method, by year.

SAFE MOTHERHOOD PROJECT, ALIBEYKÖY

TYPE OF SERVICE	1993			1994			1995 Year to Date [1 Jan - 30 April]		
	Objective	Acceptor	Referral	Objective	Acceptor	Referral	Objective	Acceptor	Referral
Oral Contraceptives							634		251
Injectibles									
Implants									
IUDs							576		813
Sterilization: Male Female									
Spermicides							131	140	
Condoms							633	430	
Diaphragms, Caps									
Natural Family Planning: Counseling Education									
Infertility: Diagnosis Treatment									
STDs: Diagnosis/Treatment Screening only									

TYPE OF SERVICE		1993				1994				1995 Year to Date [1 Jan - 30 April]		
	Objective	Acceptor	Referral	Objective	Acceptor	Referral	Objective	Acceptor	Referral			
FP/Reproductive Health Counseling Education												

*Figures in the IUDs row indicates new users

25

COMMUNITY BASED SERVICE PROJECT - İZMİR AND GAZIANTEP

TYPE OF SERVICE	1993			1994			1995 Year to Date [1 Jan - 30 April]		
	Objective	Acceptor	Referral	Objective	Acceptor	Referral	Objective	Acceptor	Referral
Oral Contraceptives	825	580		1650	2022		413	413	
Injectibles									
Implants						72			8
IUDs	325		1366	650		4925	163		1412
Sterilization:									
Male	50		19	100		55	25		17
Female	17		207	35		578	9		153
Spermicides	375	781		750	2111		188	252	
Condoms	3000	4530		6000	11549		1500	2101	
Diaphragms, Caps									
Natural Family Planning: Counseling Education									
Infertility: Diagnosis Treatment									
STDs: Diagnosis/Treatment Screening only									
FP/Reproductive Health Counseling Education									

Figures above indicate new users

Table: Personnel Providing Services

Who is authorized by your organization to provide family planning and other reproductive health services? Please place a ✓ in the appropriate column if your organization currently provides and/or funds the delivery of the service.

TYPE OF SERVICE	MEDICAL DOCTOR	NURSE	MIDWIFE	PARAMEDIC	COMMUNITY WORKER
Oral Contraceptives		✓			✓
Injectibles					
Implants					
IUDs		✓			
Sterilization: Male Female					
Spermicides		✓			✓
Condoms		✓			✓
Diaphragms, Caps		✓			
Natural Family Planning: Counseling Education					
Infertility: Diagnosis Treatment					
STDs: Diagnosis/Treatment Screening only					
FP/Reproductive Health Counseling Education		✓ ✓			✓ ✓
Other Reproductive Health Services (please specify)					
•					
•					
•					

Table: Source of Training for Personnel

Please circle **Yes** or **No**, according to whether or not your organization provides training for the personnel listed.

Medical Department

Staff Category	Initial or Refresher Training Provided by Your Organization?
Department Manager	Yes No✓
Program Manager	Yes No✓
Project Coordinator	Yes No✓
Medical Doctor	Yes No ✓
Nurse	Yes¹ No
Midwife	Yes No ✓
Paramedic	Yes No✓
Counselor	Yes² No
CBD Agent	Yes No✓
Outreach or Community Worker	Yes³ No
Community Volunteer	Yes No✓

¹Initial and refresher trainings. Kuçukköy FP Clinic.

²Initial and refresher trainings. Vasectomy counselors.

³Initial and refresher trainings. CBS workers.

- Gaziantep and İzmir CBD Project.
- Alibeyköy Safe Motherhood Project.

Table: Services Provided

Please place a ✓ in the appropriate column for service delivery if your organization currently provides and/or funds the provision of the service.

TYPE OF SERVICE	CLINIC BASED	COMMUNITY DISTRIBUTION	IEC ONLY	REFERRAL TO OTHER SERVICE
Oral Contraceptives	✓	✓		✓
Injectibles				
Implants				✓
IUDs	✓			✓
Sterilization: Male Female				✓ ✓
Spermicides	✓	✓		
Condoms	✓	✓		
Diaphragms, Caps	✓			✓
Natural Family Planning: Counseling Education				
Infertility: Diagnosis Treatment				
STDs: Diagnosis/Treatment Screening only				
FP/Reproductive Health Counseling Education				
Other Reproductive Health Services (please specify) • Ante/Post-Natal care				✓
• Infant care				✓

ANNEX 3

Previous Page Blank

Table: Financial Sustainability

Revenue Generating Activity	Annual Revenue Projected	Annual Expenses Projected	NET Revenue After Expenses	% of Total Revenue
1. Client Services a. Clinics b. Laboratories c. Other				
2. Private Sector Activities Donation Interest Celebrity cards				
3. Reduction of Expenses				
4. Reduction of Services Provided				
5. Partnerships with Other Organizations				
6. Outside Consulting or Training	\$ 7,600		\$ 7,600	4
7. Outside Donors : See following page				
8. Selling Technical Products (software, manuals, books)				
9. Commercial Marketing (sales from contraceptives, etc.)				
10. Fund Raising Donations Fellowships	\$ 9,500 \$ 1,200	— \$ 1,200	\$ 9,500 —	1
11. Other Interest Exchange gains Rent	\$ 7,000 \$17,500 \$ 9,500	— — —	\$ 7,000 \$17,500 \$ 9,500	4
TOTAL	\$ 761,788	\$ 685,853	\$ 75,935	100

Previous Page Blank

Revenue Generating Activity	Annual Revenue Projected	Annual Expenses Projected	NET Revenue After Expenses	% of Total Revenue
7. Outside Donors¹				
Name and expiration date				
Pathfinding Int'l.				
CBS (USAID), May 1996	\$ 102,413	\$ 102,413		14
Support (Private), Sept. 1995	\$ 30,000	\$ 30,000		4
JHPIEGO				
FP Training, Oct. 1996	\$ 90,240	\$ 90,240		12
EU				
AIDS, Oct. 1996	\$ 197,035	\$ 197,035		42
Training Center, July 1997	\$ 117,750	\$ 117,750		
UNFPA (MOH)				
Safe Motherhood, Dec. 1995	\$ 100,000	\$ 100,000		13
ILO				
IPEC, Dec. 1995	\$ 39,500	\$ 39,500		5

¹1995 Budget Year

ANNEX 4

Balance Sheet
Human Resource Development Foundation
1994
USD

ASSETS	AMOUNT	LIABILITIES	AMOUNT
CASH	506	CUMULATIVE DEPRECIATION	347,639
BANKS	318,790	OTHER LIABILITIES	25,684
RECEIVABLES	478	TAXES DUE	5,233
FIXED ASSETS	27,493	SOCIAL SECURITY DUE	2,847
BUILDINGS	34,384	SAVINGS PROMOTION FUND	506
		SEVERANCE PAY FUND	86
TOTAL¹	\$381,651	TOTAL	\$381,995

¹Totals do not match 100% due to exchange rates.