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Case Study of
Rxiin Tnamet,
Guatemala

*An Organizational Transformation into an
Indigenous NGO*

A Summary

Private Initiatives for Primary Healthcare Project

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FORWARD

As populations increase and competition for shrinking public resources becomes more fierce, governments around the world are urgently seeking ways to maximize quality health care delivery while reducing costs. Ministries of Health in many developing countries are exploring how the private sector can meet health needs of their growing populations. Though the private health sector operates in most developing countries, little is known about who it serves, its efficiency and effectiveness in service delivery, and the quality of the services it provides. The Private Initiatives for Primary Health Care project (Initiatives) was designed to examine how private providers can deliver quality basic health services to low-income urban residents and remain financially viable.

Initiatives prepared case studies of five organizations in Africa and Latin America to better understand the factors influencing their success. Case studies are an appropriate approach to documenting and disseminating the organizational and development process. By recording an organization's genesis and development, case studies allow insights into how and why the private provision of basic health services is a viable approach for reaching low-income urban populations.

The subject of each case study is a social enterprise or a private organization that is dedicated to providing social services to largely disadvantaged populations that are not adequately served by public agencies or private markets. Social enterprises maintain or improve social conditions in a way that goes beyond the financial benefits created for the organizations' funders, managers, or employees. Concurrently, such enterprises must find effective ways to address financial pressures, including decreasing dependence on donors, as they develop ways to continue meeting their social objectives.

These case studies focus on the effectiveness, sustainability, and replicability of each enterprise. In looking at effectiveness, the studies place emphasis on service

delivery specifically on the enterprises' ability to remain focused on the target population, blend health needs with client demands, and merge technical quality with superior service. In examining sustainability or the capacity of the enterprise to continue to provide services, the studies explore factors including efficient enterprise management and operation, financial viability, adaptability, and community support. Replicability, determining whether or not the initiative group models can be transplanted, is both a function of effectiveness and sustainability as well as external factors that include markets, the policy environment in which the groups operate, external assistance in terms of technical and financial aid, and the presence or degree of the government support or opposition.

The case studies integrated both quantitative and qualitative data analysis and utilized multiple data collection methods such as facility studies, focus groups, medical records, participatory research, observation, interviews, market surveys, and project documents.

Initiatives is making the series of five case study summaries available. This case study on Rxinn Tnamet, Guatemala, was prepared by Ron Strohlic. A synopsis of the study was prepared by Sharon Shultz. The summary contained in this booklet was based on the report synopsis and edited by Stephanie Joyce and Raisa Scriabine.

INTRODUCTION

The Asociación de Salud y Desarrollo Rxim Tnamet (RT) was formed in late 1993 to provide affordable high-quality basic health services, particularly in the area of maternal and child health to approximately 40 000 low-income people in the highland department of Solola in western Guatemala. Of that population 33 000 reside in Santiago Atitlan and 7 000 in San Juan la Laguna, both located on the shore of Lake Atitlan. Ninety-five percent of the population in these municipalities consists of indigenous Tzutuhil-speaking individuals of Mayan descent.

RT was created as an autonomous indigenous non-government organization (NGO) providing clinical and preventive outreach services that would eventually become both self-sufficient and replicable.

COUNTRY CONTEXT

Guatemala is one of the poorest countries in the Western hemisphere. Eighty percent of the rural population lived below the poverty line in 1990 and 67 percent lived in extreme poverty. Primarily as a result of the prevailing poverty, Guatemala was in the throes of a civil war from the early 1960s until the mid 1980s.

The population of Guatemala is very young—45 percent of all Guatemalans are under 15 years of age. Over half of all Guatemalan women are of childbearing age.

The Ministry of Health (MOH) began a program in 1996 to reorganize and modernize healthcare through social participation. But it had little success in providing equitable public access to health services, particularly in rural areas. MOH outposts are generally understaffed and ill-equipped. Sixty percent of Guatemalans, or approximately 6.4 million people, have no access to formal healthcare.

Solola is the poorest department in Guatemala. Seventy-four percent of its population lives in extreme poverty and 60 percent is unemployed or underemployed. Approximately 80 percent of Atitecos (residents of Santiago Atitlan) are involved in agriculture.

Santiago faces severe public health challenges because of its high population density, lack of preventive care, lack of monetary resources to pay for curative services, limited access to latrines and household running water, inadequate municipal garbage disposal facilities, contamination of Lake Atitlan with cholera, lack of firewood for boiling water, limited supply of nutritious foods, and no municipal slaughterhouse.

Approximately 75 percent of the women in Santiago receive no prenatal care, and 92 percent give birth at home, assisted by a midwife. Ninety percent of the women use no contraception.

The MOH has health posts in Santiago and in San Juan. There are several physicians, dentists, and pharmacies in Santiago. Numerous herbalists and traditional healers also provide services in both Santiago and San Juan. About 40 percent of Atitecos have no access to formal healthcare.

When curative services are needed, Atitecos first look to traditional resources, such as home remedies, traditional healers, herbalists, midwives, or simple medicines available at most local stores. While those remedies are considered less effective than medical care, they are cheaper, more readily available, and are therefore considered more appropriate for less serious illnesses.

In cases of serious illness, people go to a pharmacy, the Ministry of Health's (MOH's) health post, or a private doctor. When an illness is extremely grave and financial resources are sufficient, the patient is taken to the nearest hospital, which is several hours away in the city of Solola.

DEVELOPING THE CONCEPT

Project Concern International (PCI) funded by the U S Agency for International Development (USAID) began to provide administrative assistance in running a hospital in Santiago in 1972. The hospital founded by U S missionaries provided inpatient services, medical consultations, and laboratory and pharmacy services to more than 30,000 people. Services and medicines were provided free or at low-fee.

In the late 1970s, PCI began to provide preventive outreach services and in 1978 expanded its services to include prenatal care, family planning services, and a child survival program. PCI also began providing advanced training for local midwives in coordination with the Ministry of Health.

Although community outreach activities declined dramatically during the civil war, the hospital remained open. When the violence ended, PCI was able to continue its outreach services.

In 1986, PCI began a USAID-funded Child Survival project which was designed to expand immunization coverage through outreach activities. However, since most parents were reluctant to immunize their children, PCI instead emphasized prevention of diarrheal disease to gain credibility among parents.

When budgetary constraints induced PCI to close the hospital in 1993, the in-country director, Deborah Bickel, in collaboration with local community leaders, decided to open an outpatient clinic which could continue to provide most of the same services. This clinic, which opened in central Santiago in late 1993 and was funded by PCI, offered streamlined curative and preventive outreach programs focused on maternal and child health.

Until late 1993 this healthcare enterprise depended primarily on child survival grants from the U S. In the face of declining child survival funding the PCI Project began its transformation into an autonomous indigenous NGO that could become self-sustaining and no longer have to depend on outside funding sources for its survival.

Whether RT should become a local autonomous indigenous healthcare NGO was the source of initial staff disagreement. Those that favored autonomous status hoped that RT would go beyond U S funding sources and seek increased support from Guatemalan and international donors. Those opposed feared that the new organization would not be financially and administratively viable without PCI support. Those favoring the formation of a local autonomous NGO won a vote on the issue and Rxiin Tnamet obtained the status of a legally incorporated NGO in early 1995.

DEVELOPMENT OF RXIIN TNAMET

The formation of a local NGO entailed radical changes for the staff which was skilled in medical treatment but not in management. Previously the staff was not involved in decision-making though PCI's in-country director had instituted a more participatory management structure when she arrived in 1993. The transition demanded that they acquire new skills and a new way of perceiving their relationship to and within the organization.

The staff saw the advantages of autonomy in greater self-management, an enhanced sense of staff and community ownership of the organization, improved teamwork and cooperation, and more control over decision making. In addition, because the staff are almost all indigenous, they have a better understanding of client needs and a greater commitment to the organization.

Conversely, the disadvantages of autonomy included the need to learn fundraising and donor management skills, the inability to rely on PCI in times of economic hardship, and more complex decision making processes brought about by a board of directors and a community advisory board.

The transition period to an independent NGO was difficult, given the many unfamiliar legal and administrative issues the staff had to face and the unclear roles between PCI and RT at this time.

RT also encountered other constraints including the low level of formal education among clients and high levels of adult, especially female, illiteracy. Low educational levels correlate with social conservatism that leads to an unwillingness to adopt new or unfamiliar ideas and practices, particularly in reproductive health and family planning. Other hindering factors include the high religious conservatism and sexist nature of local society. Many men, for example, are unwilling to let wives use birth control because of fear that the wives may become sexually promiscuous. The high rate of Mayan (Tzutuhil) monolingualism — particularly among women — posed an additional problem even for Tzutuhil-speaking staff from neighboring communities because of dialectical variations.

PARTNERSHIP DEVELOPMENT

RT's principal institutional connection remains with PCI. To help RT's staff through the difficult transition from an organization that is dependent on a donor to autonomy, PCI provided operational support, technical assistance, training, and organizational oversight through November 1996, when the PCI in-country director left the organization. PCI continues to provide limited funding, as well as assistance with RT's grant-writing and fundraising efforts. USAID provided support through child survival grants and increased RT's visibility in Guatemalan healthcare by including it in national-level discussions of healthcare policy.

The Population Council provided training in reproductive health contraceptive use volunteer supervision medical protocols and grant-writing It has also helped with external and internal evaluation and with the formulation of improved programming based on these evaluations

The USAID-funded Private Initiatives for Primary Healthcare (*Initiatives*) project managed by the JSI Research and Training Institute strengthened administration and management by helping define a strategic plan develop and manage information systems perform data analysis and use financial and technical indicators for decision-making strategic management and personnel management These efforts helped RT assume virtually all of the organization's day-to-day and long-term management functions with little outside assistance

RT's collaboration with the MOH is limited The MOH provides vaccines and both share the responsibility for providing immunizations in the community The MOH also provides oral rehydration salts (ORS) which RT distributes RT coordinates with the MOH to provide training for local midwives While relations between RT and MOH are poor at the municipal level they are much better at departmental and national levels

Other organizations that have collaborated with RT include the Asociación Pro-Familia de Guatemala (APROFAM) the Spanish NGO Médicos del Mundo and ASINDES

SERVICES

RT offers both curative and preventive outreach services. Despite the high demand for curative services and their income-generating potential, RT remains philosophically committed to preventive outreach activities.

Curative Services

RT's small clinic offers consultations with a physician, basic laboratory analyses, immunizations, contraceptives, prenatal and postnatal checkups, and dental services. There is a birthing room and two beds for overnight stays for postpartum women and children suffering from severe dehydration, malnutrition, and acute respiratory infection. The clinic does not have X-ray or ultrasound facilities. It operates from 8:00 a.m. to 4:30 p.m., Monday to Friday. A physician or nurse is available on 24-hour call, seven days a week, in case of emergencies. Staff physicians also make monthly field visits. The clinic's pharmacy stocks a wide range of medicines at reduced cost. RT also operates six mini-pharmacies through volunteers and soon plans to open five additional pharmacies in rural areas without such facilities. These mini-pharmacies will be run by female community leaders who will receive half of the profits.

RT has considered eliminating emergency services due to physician and nurse dissatisfaction with the call schedule, particularly since there are only about thirty emergency cases a month. It has, however, not eliminated the services for fear of angering the community.

Preventive Services

RT's outreach program relies on the assistance of its 326 volunteers, mostly women, based in and around Santiago and San Juan for health promotion and education among friends, family members, and neighbors. They also collect needed data and refer clients to the clinic when appropriate.

The outreach program consists of four preventive interventions: Reproductive Health (RH), Control of Diarrheal Diseases (CDD), Expanded Program of Immunizations (EPI) and Acute Respiratory Infections (ARI). These interventions were administered separately for a number of years but were re-integrated in mid-1995 as the Community Outreach Program.

Outreach services are administered by region with coordinators for Santiago Atitlan and San Juan Laguna. All coordinators, supervisors and volunteers are responsible for disseminating all outreach objectives in their respective regions.

1 Reproductive Health (RH) The RH program works to improve women's and children's health through prenatal and postnatal care and family planning. It is RT's principal intervention.

The program operates within accepted cultural and religious beliefs in promoting family planning. It stresses birth spacing not birth control. It also transmits messages in culturally appropriate terms. RT's nonthreatening approach of informing community members about family planning has resulted in a gradual decrease in the taboos.

The program introduced Depo Provera in June 1995. Contraceptives — pills, condoms, vaginal suppositories and injectables — are distributed not only from the clinic but also from the volunteers' homes. The program teaches women how to use artificial and natural birth control methods, particularly lactational amenorrhea (LAM).

2 Expanded Program of Immunization (EPI) EPI's objective is to increase immunization coverage among small children and women of childbearing age. The program's principal activities are to educate community members about the importance of immunizations and to provide immunizations in the clinic.

3 Control of Diarrheal Diseases (CDD) CDD's objective is to reduce the incidence of diarrhea and associated malnutrition and dehydration among small children by training mothers to recognize the warning signs of diarrheal dehydration and malnutrition and by encouraging the proper treatment of diarrhea with oral rehydration salts (ORS) rather than commonly used anti-diarrhetic. The oral rehydration salts are provided to community members free of charge from the volunteers' homes.

4 Acute Respiratory Infection (ARI) The ARI program trains mothers to identify acute lower respiratory tract infection in their children and to seek appropriate treatment. ARI is the third highest cause of death among children under five in RT's catchment area. Lighter cases are referred to the community-based mini-pharmacies, while more serious cases are referred to the clinic.

HUMAN RESOURCES

The clinic staff consists of nine people: the director who works as a consulting physician half-time, a full-time physician, two nurses, a pharmacy administrator, and four support staff.

There is a dearth of qualified personnel from Santiago; the physicians are subsequently all outsiders. Some do not speak Tzutuhil. Physician turnover is fairly high. Four physicians joined and left the clinic during 1996. One of the main reasons for the high turnover is that RT prefers to hire female physicians, given its focus on women's health. Since there are no female physicians in Santiago or the immediate vicinity, they are hired from outside the community. These physicians live in Santiago during the week and only see their family on weekends. This has been difficult for them.

RT also does not pay physicians competitive salaries which is exacerbated by the fact that physicians must do overnight emergency calls every three days — for which they do not receive additional compensation

Volunteers play a key role in RT's outreach services. Several factors however have limited volunteers' effectiveness. Many are illiterate and are not compensated for their work. As a result, roughly 25 percent of the volunteers are considered inactive, and many others do not work up to full potential.

DECISION MAKING

RT's organizational structure consists of an executive board, a board of directors, and a community advisory board. The executive board makes decisions on fundraising, policy, and operating decisions, and brings them to the board of directors for approval. The board of directors is responsible for decisions on strategic planning, RT's mission, vision, and objectives, programming, information systems, job descriptions, and personnel management. The community advisory board is responsible for electing the board of directors and making decisions about the quality of service in the clinic.

The executive board had consisted of the director, the sub-director, an administrative coordinator, a clinic coordinator, and an in-country coordinator. However, the PCI director and the sub-director have left. Neither position is expected to be filled in the short-term, thereby changing the composition of the executive board.

The seven-member board of directors comprises four executive board members, two staff members, and one community member. The composition of the board is unusual in that, except for one non-staff community member, it consists entirely of RT staff. It is therefore

familiar with the intricacies of the organization's day-to-day affairs. Conversely, the board does not have the kind of leverage with outside institutions that is normally associated with more influential or well-connected board members.

The board is increasingly interested in having influential outsiders, particularly because of the need to obtain funding and technical assistance. Elections for the new board of directors were to take place in March 1997.

The five-member community advisory board, consisting of three women and two men from Santiago Atitlan and San Juan Laguna, was appointed by the board of directors in 1995. Since the advisory board elects the board of directors, RT staff and board members have expressed concern that the community board's decisions may reduce the control over its program, especially if advisory board members' opinions conflict with RT's mission, particularly with regard to the reproductive program.

RT is a community-based organization inasmuch as it is receptive to the needs of those it serves. However, the staff clearly prefers to maintain control over the organization's policy and programmatic directions, as witnessed by the composition of the board of directors and concerns relating to the community advisory board.

Until the PCI director's arrival in 1993, program administration was top-down. The PCI head office in San Diego and the in-country director made almost all programming decisions. Local staff were seldom included in the process. However, when Ms. Bickel assumed the position of in-country director, she instituted a horizontal leadership style. She sought to transfer decision-making skills to the staff and to improve the organization's effectiveness by tapping into the staff's knowledge and understanding of the region, a resource that had previously been unexploited.

At the beginning, RT's decision-making process was chaotic. There were no formal mechanisms for making

decisions gathering and analyzing data or informing people about decisions that had been made. These shortcomings often caused confusion and diminished organizational effectiveness. At the same time, upper-level management did not possess the management skills necessary to run the NGO in part, because of their clinical background.

Areas of authority for decision making are now clearly demarcated so that responsibilities do not 'fall through the cracks.' The staff created new job descriptions for themselves. Each staff member now has a specific title with specific responsibilities. Areas of decision-making authority are much more clearly delineated.

The staff have learned to gather, process, and analyze data in terms of strategic objectives and are better able to make informed decisions based on complete information. The technical and financial information systems are now in place to provide the necessary data for informed decision making. In addition, all decisions are now communicated to the appropriate parties.

The director and subdirector have become increasingly adept at delegating authority. Strategic planning is now done on a formal basis at several levels, and overall objectives are formulated by the entire staff—a significant departure from the past when objectives and strategies were formulated by outsiders. After setting general objectives, specific strategies are formulated for each intervention. *Initiatives* consultants have worked closely with the staff to train them in using strategic planning tools and have helped them to formulate a five-year strategic plan concerning goals, strategies, and priorities.

RT's staff had not anticipated acquiring these skills until mid-1997 to late 1997 when PCI was expected to fully withdraw from the organization. By November 1996, however, the staff felt confident that they had acquired most of the necessary skills in organizational management, strategic planning, decision making, and information

systems. They did not want PCI to send another in-country director to work on-site with the organization, preferring to practice and improve those skills. However, they did request PCI's continued assistance with operational support and fundraising efforts.

RT staff remain concerned about the practical application of their newly acquired fund raising and donor management skills, particularly without assistance from an experienced adviser and without English language skills, which are needed in order to communicate with non-Spanish-speaking donors.

MARKETING

RT has expanded its client base mainly by addressing major local health problems through culturally appropriate approaches. It has engaged in little overt marketing, such as advertising for its affordable pharmaceutical products. It is very likely that RT is missing an important opportunity to expand revenues by informing a wider base of clients of its many services. Focus groups show that few people in Santiago know about RT's preventive services.

PROCUREMENT/INVENTORY

RT aims to sell pharmaceuticals more cheaply than the local privately owned pharmacies, while ensuring that the sale of medicines generates revenue for the clinic. The mark-up range for pharmaceuticals dispensed by RT is 10 to 50 percent. The mark-up is, for the most part, as high as possible without going over the official government sanctioned price. Some pharmaceuticals have a lower mark-up, particularly those associated with family planning, prenatal care and acute respiratory infection. Antibiotics generally have a lower mark-up so that patients can afford the entire course of treatment.

RT with assistance from *Initiatives* introduced a number of innovations to improve clinic services and lower costs. A computerized pharmacy inventory system was introduced in October 1996. The inventory system allows RT to track the supply of medicines, reducing problems of running out of stock — a common problem in the past. Information on sale patterns for each pharmaceutical will make it easier to purchase in larger quantities, reducing costs as well as the need to travel to Guatemala City to purchase supplies, from every two months currently to two to four times a year. The system tracks revenues from each product and provides information on high and low selling products. It can reduce if not eliminate losses — an estimated \$3 000 in pharmaceuticals is unaccounted for each year between the clinic and the mini-pharmacies.

The computerized inventory system now provides all clients with an itemized bill for the cost of all services and products. This may reduce complaints about the high cost of clinic services as clients will realize that the bulk of the cost is for medications; the itemized bill will allow clients to compare the clinic's pharmaceutical prices with the official price to realize how much they are saving. The bill, however, does not currently itemize the amount of the discount, so that the amount of the savings, which is generally substantial, is not clear to clients.

The clinic now sells pharmaceuticals in their original packaging. Previously medicines were purchased in bulk and repackaged to reduce costs. This made clients suspicious, thinking that they were being cheated since there was no price sticker and they did not know the official price of the product. When the clinic began to sell pharmaceuticals in their original packaging with the official price sticker in March 1996, client concerns about being cheated were eliminated.

Unfortunately, the pharmacy has not tapped into the larger market in Santiago. Most residents still buy

pharmaceuticals from private pharmacies in Guatemala which sell almost all pharmaceuticals without a prescription. Although the clinic also can supply clients with many medications without a prescription, it has failed to advertise that fact. Thus, not only does the clinic deprive itself of additional revenue, but it also deprives the community of greater availability of low-cost medicines.

PERFORMANCE

FINANCIAL DATA

RT serves its clients through a clinic providing curative services, a pharmacy, and a mostly volunteer-based outreach program focused on preventive intervention. The clinic and pharmacy generate revenue, which amounted to 15 percent of expenses in 1994 and has risen since. The outreach program recovers virtually no costs, as people are unwilling to pay for preventive service.

Internal Finances

RT has greatly increased its financial planning capabilities through training and technical assistance. The program now performs routine financial management, such as comparisons of monthly income and expenses, expense breakdowns by programmatic area, and cost recovery analyses for the clinic.

In 1995, the clinic almost tripled the amount of revenues generated between 1991 and 1993 by changing its location, selling medicines in mini-pharmacies in the community, revising the prices for consultations, increasing advertising, incorporating traditional birth attendants into the clinic, and hiring indigenous Tzutuhil-speaking doctors. Clinic cost recovery rates have been rising steadily over the past three years. Clinic revenues in 1996 came from the sale of pharmaceuticals (68% of clinic income), medical services and consultations (14%), dental services (14%), laboratory analyses (2%), and emergencies (1%).

Clinic revenues increased sharply from 1994 to 1995, while less dramatic increases are projected for 1996 and 1997 (see Table 1). However, actual revenues through mid-October 1996 revealed a drop in clinic revenues. That drop is a result of a decline in the number of patients seen at the clinic during 1996. However, the number of patients at the clinic had risen to its normal level by November 1996. It is

impossible to determine whether there will be similar fluctuations in the number of patients in the future

Table 1 ACTUAL AND PROJECTED REVENUES AND EXPENSES 1994-1997

	1994	1995	1996	1997
CLINIC INCOME				
Consultations	2930	3491	4050	4984
Laboratory	1115	1084	1258	1548
Emergencies	388	489	598	699
Other Medical	4129	3850	4504	5585
Services				
Pharmacy	20236	30000	37800	43848
Dental Clinic	3234	3485	4077	5056
TOTAL	32032	42399	52257	61720
INCOME				
EXPENSE				
Pharmacy	20041	25420	30000	34800
Curative	33276	36754	38811	41915
Preventive	39765	39194	37102	41554
Administrative	120125	104265	123437	83311
TOTAL	213207	205633	229350	201580
EXPENSE				
NET INCOME	-181175	163234	-177093	139860

RT's principal expenses proposed for FY 1997 are local salaries and benefits (48%) medical supplies (13%) foreign personnel salaries (7%) travel expenses and per diem (6%) and office rental (5%)

Financial Self-Sufficiency

PCI's projected share of the FY 1997 budget rose to 38 percent a substantial increase from 12 percent in 1996 reflecting RT's insecure funding base for 1997. The clinic is the second largest projected source of revenue for 1997 accounting for 23 percent of the FY 1997 budget as in 1996.

While the strategic plan calls for the clinic to become 100 percent self-sufficient by 1997, RT does not have a cost-per-service mentality. RT's financial resources presently consist of a mix of outside funding and program-generated revenues, mostly from the clinic. While the clinic has been able to cover up to eighty percent of its cost, the outreach program covers virtually none of its cost. The outreach program is highly unlikely to increase its community-based revenues in the near future since most residents are unwilling to pay for preventive health services. RT therefore is likely to remain dependent on donors to continue providing for outreach services since the clinic does not generate sufficient revenues to cover the cost of outreach services and because RT seeks to keep the prices of clinic services low. Even though raising the price of clinic services and pharmaceuticals could generate sufficient income for the clinic and the outreach programs, RT remains committed, as is typical of a social enterprise, to providing low-cost healthcare for the area's low-income population. RT also initially feared that it would violate its nonprofit status by recovering costs. While prioritizing cost recovery over the provision of services would defeat the purpose of RT's work, it is realizing that cost recovery and providing services to low-income people are not necessarily contradictory concepts.

Fundraising

RT's initial resources consisted entirely of USAID funding channeled through PCI. With declining USAID funding, PCI began to seek grants from other sources and later encouraged RT to do the same. The funding base was considerably diversified as a result of that process, and unrestricted PCI funding represented only 12 percent of total RT revenues for FY 1996. Other donor sources of funding for that year include the Hewlett Foundation, ASINDES, the Campbell Foundation, Coffee Kids, the Population Council, and the Guatemalan Government's Social Investment Fund.

RT has not been very successful fundraising for FY 1997 and only managed to raise the equivalent of one-third of the 1996 budget as of early November 1996. PCI funding has subsequently risen from twelve to almost forty percent of the budget for 1997.

Although RT had hoped not to rely on any individual funder for more than 50 percent of the operating budget by 1998, RT is still experiencing difficulties in securing its own funding, mainly because the staff do not have much experience in fund raising. RT remains committed to fund raising. The staff is concerned, however, that most funders are unwilling to cover salaries, which constitute the largest expense in outreach services. They are also concerned about losing funding because of donors' desires for fast results, which contradict the slow, gradual nature of change associated with preventive health services.

SERVICE DELIVERY

The clinic averages 300 to 400 patients per month — 35 percent are women of childbearing age and 15 percent are children under the age of five. About 10 percent of the remaining patients are men. RT is currently studying ways to extend its hours to make its services more accessible to men.

Focus group discussions and exit surveys of the clinic's clients showed that they were most satisfied with the high quality of the medical services provided the effectiveness of the prescribed medicines the fact that the physicians are trained and licensed the availability of Tzutuhil-speaking staff the clinic's central location ease of access as well as its full service nature including on-site laboratory and pharmacy The low cost relative to private physicians and pharmacies was also a source of client satisfaction

Areas of dissatisfaction included rude treatment by some of the support staff the small size of the clinic the cramped waiting area and the limited range of equipment such as X-rays and ultrasounds in the clinic

Preventive Services

The outreach program has been considerably successful to date particularly in promoting reproductive health and family planning Between January and September 1996 volunteers gave 2 978 talks on reproductive health referred 1 151 pregnant women to the clinic (and 136 high-risk cases) and detected 979 cases of diarrheal diseases

Reproductive Health

The RH program is clearly the most sensitive of RT's interventions There are numerous cultural and religious beliefs surrounding issues of women's health and family planning and the process of change is a slow one With increased exposure to the issues RT has noted a gradual decrease in the taboos surrounding family planning and an increased willingness on the part of both men and women to discuss those issues openly The RH program's success to date has largely been due to its approach of creating a non-threatening awareness of the benefits of family planning and the different options among community members without actively promoting or pushing the use of those methods The program adheres to the philosophy that if community

members are well-informed regarding family planning they will make the choice to avail themselves of those services when they are ready

The RH Program has been in a constant process of innovation to increase user demand for reproductive health services and correct missed opportunities. The program raised the couple year protection (CYP) during 1996 from 55 to 269 by July of that year largely by introducing Depo Provera which affords privacy, secrecy, ease of use, and efficacy.

Two male reproductive health educators were added in early 1995 to raise men's awareness of reproductive health activities, particularly since women are reluctant to use contraceptives without their husbands' permission. The male educators discuss family planning with both men and couples to make men more amenable to their role in family planning and to facilitate discussion of those issues among couples. Most men and couples are receptive to those talks. Educators estimate that only two percent of those approached are unwilling to discuss these issues.

The RH program works with 23 local midwives who are encouraged to bring pregnant women to the RT clinic for prenatal care and high-risk pregnant women to come to the clinic to give birth. Between 1995 and the first half of 1996, the program sought to raise the number of high-risk births attended by midwives in the RT clinic from zero to twenty-five. Only twelve high risk births were attended at the clinic during that time. The objective was not met for several reasons including: women prefer to give birth at home; the clinic charges for deliveries in addition to what the midwives charge; and many women fear they will be sent to the hospital in Solola if they go to the clinic—a large investment of time, money and energy.

In late 1995 RT asked midwives to call RT staff to assist with high-risk births in women's homes. This strategy has had moderate success, especially among the younger midwives. RT now estimates that the staff assists with twelve to fifteen high-risk home births annually.

The clinic has recently begun to provide family planning talks for female patients. There are three measurable objectives: to discuss family planning with eighty percent of the pregnant and post-partum women that come to the clinic; to discuss family planning with 2,500 women with children spaced too closely together; and to give 120 talks on family planning to organized groups of women.

The clinic surpassed its goal of discussing family planning with eighty percent of the pregnant and post-partum women coming to the clinic. However, it has not done as well regarding other objectives. As of July 1996, the staff had given family planning talks to 554 non-pregnant or post-partum women and provided 24 group talks to a total of 472 women. The last two goals appear very—perhaps unrealistically—high. Reasons given for not meeting those goals include time constraints in seeing patients and difficulties associated with organizing groups of women to receive family planning talks in the clinic.

Expanded Program of Immunization

The Expanded Program of Immunization keeps statistics on immunization rates and tracks immunizations provided to each client. The clinic immunizes an average of ninety children against polio, measles, BCG, and DPT each month, and approximately fifty pregnant and child-bearing age women against tetanus each month. The clinic maintains immunization records for all users, unlike the MOH, which requires users to keep their own vaccination records, which are often lost.

Control of Diarrheal Diseases

The Control of Diarrheal Diseases Program supplies oral rehydration salts from the homes of 135 community-based volunteers free of charge and distributes approximately 400 ORS units each month. The continued use of anti-diarrhetics to treat diarrhea remains an obstacle.

Acute Respiratory Infection

The availability of funding from ASINDES, an umbrella organization of Guatemalan NGOs, has led to an accelerated timetable for activities related to training mothers to identify acute lower respiratory tract infection in their children and seek appropriate treatment. The intervention will also strengthen the program's community-based income-generation component by expanding the range of stock in mini-pharmacies.

INFORMATION SYSTEMS AND QUALITY CONTROL

The introduction of an automated health and financial information system in 1995 has greatly facilitated the decision-making process. Building on technical assistance provided by *Initiatives*, the board of directors now reviews key financial and programmatic indicators quarterly, tracking the organization's financial status and programmatic objectives. They now observe trends and make necessary adjustments based on timely, accurate information.

This computerization process is, however, far from complete. Currently, only the reproductive health indicators and the pharmacy inventory control system are computerized. Lack of tracking in the other interventions has been paralleled by lack of outside funding and of organizational goals in these areas. Nevertheless, the board of directors plans to start tracking the other interventions in the near future.

A log is kept with data on each patient's visit and the clinic produces monthly summary reports. The clinic also provides monthly summaries of the type and number of laboratory analyses performed and a breakdown of patients by sex. Although no summary data are kept on diagnoses, it is speculated that most patients come because of reproductive health issues or gastrointestinal and respiratory tract complaints. Despite the existence of monthly reports, the data are not aggregated on a yearly basis nor are they analyzed in terms of trends over time.

EFFECTIVENESS

A number of factors have contributed to overall RT effectiveness

1 Providing culturally appropriate, high-quality services—RT's central location and professional indigenous Tzutuhil-speaking staff and the fact that most medical consultations take place in Tzutuhil or in Spanish with translation have increased client confidence decreased clinic turnover and boosted RT's client base and revenues. In-depth research to determine the most culturally appropriate means of transmitting written spoken and pictographic messages has increased the success of outreach interventions

RT has been careful to operate within accepted cultural and religious norms in promoting family planning. RT emphasizes that it does not want to limit the number of children people have. It wants them to have their children better spaced to ensure improved health for mothers and children.

RT has been able to mobilize and train a large volunteer base which has been instrumental in promoting interventions and in tracking large amounts of data. It has also been able to educate a largely illiterate population in preventive health measures through the formulation of training materials designed for illiterate and poorly educated users.

RT's two-tier approach which supplements curative services with preventive volunteer-based outreach has enabled the NGO to provide effective preventive services despite pressures for more curative services which recover costs more effectively.

Though demand for curative services remains high community requests for preventive services are growing especially in family planning.

2 Fostering a sense of employee ownership and building organizational management skills RT's staff and managers have created and implemented their own organizational roles. They have increased their decision-making as well as planning and management. Meetings and decision making are more participatory. The staff feel more actively involved and better informed.

3 Responsiveness and innovation By locating mini-pharmacies within the community, assisting midwives with high-risk births, and adding male RH educators, the NGO has increased its services to the community and helped meet its own healthcare goals. The program is in the constant process of innovation to improve service delivery.

SUSTAINABILITY

RT's staff have been able to successfully acquire essential organizational management and administrative tools. Nonetheless, several issues continue to detract from organizational effectiveness and sustainability. RT's lack of fund-raising and donor management skills, its unwillingness to seriously investigate clinic-based cost-recovery mechanisms, particularly improved marketing and revising the price structure of pharmaceuticals, RT's lack of evaluations of its interventions, except for the reproductive health intervention, problems in the clinic, including cramped quarters, high physician turnover, and rude staff, which adversely affect perceptions of the clinic, and some inactivity and passivity in the performance of the volunteers' duties, caused in part by the lack of monetary or material incentives for their activities.

Additional barriers to increased organizational effectiveness and sustainability will be difficult to change. These barriers include the inherent conservatism of the local population, cultural and religious beliefs that contradict RT's messages, low educational levels, high rates of illiteracy, Mayan monolingualism, poverty, sexism, poor

communication and transportation infrastructures and an unwillingness or inability of the local population to pay for preventive health services. If financial viability and sustainability are defined in terms of self-sufficiency from organization-generated revenues, then the target population's poverty is clearly a constraint. While there are mechanisms to increase clinic and especially pharmacy revenues, it is unlikely that these revenues will ever be able to cover the costs of the outreach program. Financial viability in that regard would most likely entail the elimination of the outreach work.

However, if RT can obtain a mix of funding sources including both program-generated revenues and outside donations, the target population's poverty is not necessarily a constraint to the program's long-term viability. More critical constraints would then be the lack of fund-raising skills and fluctuations in funding preferences, given RT's donor-driven nature.

REPLICABILITY

In light of its overall success in delivering healthcare services, RT now advises governmental, nongovernmental, and multilateral organizations in health policy and programs. RT also recently started providing direct technical assistance to other organizations and began replicating its model in several neighboring communities. PCI is considering replicating the RT model in other parts of Guatemala. Several factors should, however, be considered concerning the future replicability of this model.

1 Appropriate administrative, managerial, and fund-raising skills. These skills are crucial to organizational success. If personnel with those skills cannot be found, technical assistance and training should be provided from the beginning of implementation. If the organization is managed by RT or PCI, local staff should be given as much

autonomy as possible from the start. RT or PCI should therefore act in an advisorial rather than managerial capacity.

2 Culturally appropriate interventions Vital to RT's success in outreach activities, particularly in the area of reproductive health, has been the use of a non-threatening approach to create an awareness of outreach services and their benefits, allowing the population to take advantage of those services when they are ready to accept them. Aggressively pushing those services on an uneducated and unreceptive population can backfire with irreversible results.

An awareness of and sensitivity to local culture have been an essential component of RT's organizational success. RT has gained acceptance in the community by respecting community members' belief systems and transmitting messages in a culturally appropriate manner.

3 A strong volunteer base The use of community-based volunteers is an important element in organizational success. Volunteers are a low-cost and effective means of delivering information, dispensing medications and contraception, and tracking program data. More importantly, community members often trust the volunteers more than program staff and may then be more likely to adopt their outreach recommendations.

4 Need for external funding RT's experience indicates that low-income populations in Guatemala are unwilling or unable to pay for preventive health services. Cost recovery does not therefore seem to be an appropriate means of funding those activities. Rather, external funding is required to support outreach activities.

5 Appropriate price structures for curative services Curative services, particularly the sale of pharmaceuticals, have the potential to be self-supporting activities and to generate surplus revenues that could cover part of the cost of

outreach activities. Ample attention should be devoted to price structures and marketing mechanisms for curative services in order to ensure effective cost recovery.

Since its inception in 1993, RT's staff members have developed essential skills in operational management, financial management, and the use of data tracking to focus the delivery of services. It has expanded its client base and has become known nationally for its expertise in community healthcare.

RT remains at a crossroads in its organizational development. It could continue to seek complete autonomy from PCI. It could revert back to being a wholly PCI-funded and managed project, or it could continue in its present state of semi-autonomy. The most likely near-term scenario would be for a continuation of RT's present state of semi-autonomy. As such, PCI may remain as one of RT's principal funders concurrently allowing RT to enjoy the best of both worlds — secure funding coupled with a great deal of programmatic autonomy. That will allow RT to continue improving and refining its fundraising skills, conceivably becoming completely autonomous of PCI at some point in the future.

ABOUT INITIATIVES

Private Initiatives for Primary Healthcare (*Initiatives*) is a project funded by the U S Agency for International Development (USAID) and managed through a cooperative agreement with JSI Research & Training Institute. The project promotes access to quality basic health services in developing countries by strengthening local private groups' abilities to provide basic health services. The project specifically targets low-income residents of urban and peri-urban areas.

Working in Ecuador, Guatemala, Nigeria and Ghana, *Initiatives* strengthens the financial and institutional capabilities of local provider groups. In these countries, the local groups encompass a range of service models, including independent physicians and nurses, networks of providers, and traditional and non-traditional insurance schemes. *Initiatives* provides technical assistance through business development workshops and individual consulting in the areas of strategic, business and financial planning, marketing assistance and capital acquisition.