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PARAGUAY RESIDENT ADVISOR FINAL REPORT
Oct 26, 1996 - Aug. 29. 1997

Family Planning Management Development (FPMD)
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FAMILY PLANING MANAGEMENT DEVELOPMENT PROJECT

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I. Background

The Family Planning Management Development Project [FPMD] of Management Sciences for Health [MSH] was first invited to Paraguay by USAID in March 1996 to [a] participate in the first of a series of participatory strategic planning meetings initiated by USAID Paraguay to develop a long term plan for its Population Program and [b] to perform an initial management assessment of the principal local entities providing family planning services. FPMD was represented by the Director of its LAC Division and a senior member of the Technical Unit who had done considerable work in Paraguay with the IPPF affiliate.

As a result of the March 1996 visit, FPMD developed and submitted to USAID Paraguay a broad outline of a one year assistance package, mostly targeting [a] the Ministry of Health's family planning services and [b] the development of consumer awareness and involvement through the not-for-profit sector, for approximately \$250,000. For almost six months following the visit, the USAID population program activities came to a near standstill due to the aborted coup in the country and the subsequent visit of USAID Administrator Brian Atwood. During that period there were substantive conversations between FPMD and both USAID Paraguay and Washington concerning the possibility of doubling the FPMD allocation in order to include a Resident Advisor who, in lieu of the absence of a HPN Officer at the Mission, would manage the entire population portfolio. The Resident Advisor was to be provided office space within the USAID Paraguay office to facilitate the overall management responsibilities required. An agreement was reached and the senior FPMD Technical Unit staff person who had made the March trip was the choice of both the Mission Director and FPMD for the position. It was agreed that the FPMD staff person would return to Paraguay in September 1996 to [a] facilitate the next strategic planning meeting for the Mission [b] complete the FPMD management assessment and [c] determine personal willingness to accept the Resident Advisor position. The position was accepted and the FPMD staff person returned to Paraguay in late October 1996 as the Resident Advisor.

II. Resident Advisor Duties

Prior to the arrival of the Resident Advisor in October 1996, the FPMD LAC Director developed and submitted to USAID Paraguay a job description that reflected both the overall USAID Paraguay population portfolio management and the specific FPMD-related responsibilities of the Resident Advisor. The key responsibilities included to:

1. Provide technical and operational oversight for all Cooperating Agencies that will be working in population in Paraguay. This includes structuring and overseeing the planning processes for each CA individually and the coordination and integration of all activities into a comprehensive country program.
2. Act as primary representative of and liaison for USAID's population program with the principal local counterparts which include UNFPA, the Ministry of Health, Local Government and NGOs.
3. Design and provide technical and operational oversight for the FPMD Management

Development Plan [MDP] for Paraguay. This may include leading some specific interventions as appropriate and as time permits. Participate in country meetings as related to the design, implementation, and evaluation of FPMD project activities in Paraguay.

4. Maintain regular and frequent communication with the Regional Director/Latin America and the Caribbean Unit and the other FPMD/LAC staff as appointed, with regard to ongoing activities of the FPMD/Paraguay project, to insure progress toward project goals and compliance with FPMD/MSH operating standards.

5. Prepare and submit quarterly Progress Reports to the Regional Director/Latin America. Develop annual work plan and travel schedules for consultants and subcontractors. Assist in the development of any regional unit work plans as related to Paraguay activities.

III. Initial Activities [Nov. 1, 1996 - April 1, 1997]

[It should be noted that the period from mid-December to Feb 1 is the time of summer vacation and holiday throughout Paraguay. It is extremely hot and there is little professional activity possible. It is also the season in which home leave is often taken by Americans.]

The vast majority of the initial activities of the Resident Advisor involved the principal coordination and management role for the Mission's population program and the Cooperating Agencies responsible for its implementation. The September 1996 Strategic Planning meeting, facilitated by the [future] Resident Advisor, finalized a Results Framework for the Mission's population program, identified the outline of specific activities to be carried out by the participating CAs and identified several key issues and activities that would require immediate clarification and follow up. Principal among these were:

- Development of a monitoring and evaluation plan for the USAID Paraguay Results Framework
- The creation of detailed and integrated CA work plans that referenced the Results Framework.
- Resolution, through the acceptance and identification of Priority Regions, of the key issue of insufficient resources to impact the entire MOH family planning service delivery network simultaneously.
- Resolution of the inability of the MOH, and its principal contraceptive supplier UNFPA, to ensure a consistent and available supply of a broad range of contraceptives at its service delivery sites [especially IUDs and injectables].
- Inability of UNFPA, and other donors, to have significant impact on the MOH family planning program by attempting to vertically address/improve systems, personnel and procedures from the central level down to the service delivery level.
- Continuing the participatory planning and oversight process through the facilitation of an active and involved local Advisory Committee made up of the principal counterpart service delivery and donor organizations.

In addition to visiting service delivery and administrative sites, getting to know the principal counterparts and representing the Mission at the appropriate meetings, the Resident Advisor:

- Developed and distributed to all CAs a yearly planning document to identify, cost and reference

to the Results Framework all proposed activities.

- Facilitated a November 1996 Meeting of Advisory Committee at which the final version of the Results Framework for population was presented for discussion and approval. The idea of Priority Regions for the MOH activities was also presented for discussion. The Committee discussed this at length and agreed with the reality of limited funds and choose the Regions of Central, Cordillera and Misiones to be the focus of USAID Paraguay assistance.
- Developed a monthly newsletter to inform USAID Washington, CAs and other interested parties as to ongoing activities and issues in population in Paraguay.
- Introduced the Fully Functional Service Delivery Point concept to USAID Paraguay and the MOH as an integrated approach to service delivery improvement.

With final approval in November by the Advisory Committee of the Results Framework and the Priority Regions concept, a number of critical organizing efforts needed to be made in order to begin program implementation of the MOH work. [With the prohibition by the Mission of working with the local IPPF affiliate, and other than a social marketing program that was in the early planning stages and a small adolescent project, most of the resources at this point were being directed towards the MOH]. In the increasingly decentralized public health care model recently approved by the congress, critical decision-making power was being shifted to a number key individuals and governing bodies at the regional and local level. Representing the MOH, the Regional Health Director, along with chief nurse and/or nurse in charge of family planning, are the key decision makers. Representing local government, the Governor, his/her Secretary of Health and the recently establish Regional and Municipal Health Commissions all have important decision making responsibilities. The specific role of each of these players, and how they are to interact, is still very new and not entirely defined but all must be involved and informed to implement a successful assistance program at the regional and local level. While the Mission's Population Advisory Committee had approved the Priority Region concept and specifically chosen the regions of Central, Cordillera and Misiones, the key decision makers in these regions had not been informed or involved nor had their permission or approval to participate been secured. Much of the first two months of 1997 was spent in numerous visits to the priority regions to formally present and explain USAID's population program and Results Framework to the many important regional and local decision makers and to solicit their active participation. A formal letter of invitation was signed by the Mission Deputy Director [the Mission Director was on home level for most of December and all of January] and personally delivered to the Governor of each of the priority regions explaining the program and inviting them to participate.

To finalize the participation of the key regional representatives, and to familiarize them with the personnel and proposed activities of the respective CAs working [and for the CA representatives to get to know the regional representatives], the Resident Advisor organized an Advisory Committee meeting for February 27, 1997 and simultaneously arranged for all CA representatives to be in country and to attend. Representatives from the priority regions were formally included in the Advisory Committee membership. The meeting was organized to:

- Present the final data from the most recent Reproductive Health Study to the Advisory Committee, priority region representatives and CA staff.
- Induct priority region representatives into the Advisory Committee.

- Have regional representatives present the major issues and problems facing its family planning program in the respective priority regions to the CAs.

Given that March is the period in which local USAID Missions both mark up CA allocations for the coming year and prepare their annual reports to Washington [R4], the Resident Advisor performed a number of tasks relative to these activities:

- Provided guidance to the Mission as to the relative roles, responsibilities and activities of each CA in the coming year.
- Drafted the principal population sections of the annual report [R4].
- Negotiated the FPMD allocation for the coming year which was for \$600,000 or a \$100,00 increase over the previous year's allocation. The increase was to be directed towards providing assistance to the local IPPF affiliate [CEPEP] which was no longer to be excluded from USAID population assistance.

IV. Second Semester Activities [April 1 - Aug. 29, 1997]

At the end of March, the Mission redefined the principal role and responsibilities of the FPMD Resident Advisor. The Resident Advisor was asked to:

- Establish a separate office space outside the Mission offices.
- Focus on a technical assistance role relative to FPMD specific activities [a local hire HPN Officer would be sought].
- Submit [to the Mission Director before her April program review at USAID Washington] a comprehensive work plan that included both the initial allocation of \$500,000 and the mark up for the coming year for \$600,000 and that indicated the specific FPMD activities to be implemented with both the MOH and the IPPF affiliate CEPEP. The draft plan was prepared and submitted to the Mission Director before her departure for Washington. After submitting the first draft, FPMD received feedback from the Mission that the plan should be rewritten to:
 - Reflect that FPMD would now be responsible for all of the Intermediate Result 1.2 [Quality Services] in the population Results Framework
 - Reflect that there would be four MOH priority regions instead of three with the addition of Asuncion.

- During the period March 28 - June 19, seven draft FPMD work plans were prepared and submitted to USAID Paraguay none of which were approved.
- Resident Advisor made a series of visits to priority region to discuss and plan for initial FPMD and other CA activities.
- Two of the four Regional Health Directors in the priority regions are replaced for national political reasons related to the ongoing presidential campaign. Change in key personnel required another series of visits by Resident Advisor to priority regions to introduce and explain program.
 - Resident Advisor developed goals, objectives, scope of work and methodology for initial assessment of local IPPF affiliate.
- Resident Advisor attends FPMD LAC retreat in Boston. During this visit:

- FPMD Paraguay work planning process was suspended by the Mission pending a future Intermediate Result 1.2 program design by a USAID Washington team.. New direction was received to begin immediate preparations for collaborating with the Evaluation Project to design and oversee implementation of a baseline client satisfaction survey and facilities inventory at selected MOH sites in the priority regions.

- Mission expressed definitive preference for a new FPMD Resident Advisor. It was agreed that present Resident Advisor's position would be terminated August 29, 1997.

- Resident Advisor oversaw and participated in the CEPEP management assessment.

- Resident Advisor assisted FPMD consultant with orientation, design, implementation of survey work with the Evaluation Project.

V. FPMD Country Strategy Considerations Present and Future

FPMD has two major areas of responsibility within the USAID population Results Framework. The first area is improving the quality of Ministry of Health Services at selected sites in four priority health regions in the country. Applying the FPMD's Fully Functional Service Delivery Site concept [renamed "Quality Service Delivery Sites" by the USAID Paraguay], the strategic approach is to focus on integrated improvement of service delivery sites rather than vertical systems or procedures. It is hoped that an integrated approach to site improvement will create both working models of service delivery excellence and the regionally installed capacity to replicate those quality sites throughout the regions and the country as a whole. All of this is to happen in a rapidly decentralizing public health care model in which Departments [which closely correspond to Health Regions] take control and responsibility for public health care. At the departmental/regional level there are MOH representatives, gubernatorial and municipal individuals and commissions; all which will have ultimate decision-making power. In addition to its own technical inputs, FPMD is to coordinate the activities of the other CAS to insure an integrated and comprehensive approach to service site improvement.

The other area of responsibility for FPMD is the non-profit sector and specifically the IPPF affiliate CEPEP. It is an institution in financial and strategic crisis after a series of internal and external changes. The organization recently changed Executive Directors and while the new Director is of exception quality, she is facing both a short term financial crisis and an internal questioning of basic corporate values and priorities that comes with institutional crisis. For years it has survived on international donor support and has had [high quality] research as one of it's principal activities producing the last three national DHS/Reproductive Health Surveys. While it has a clinic service delivery structure and network, it has considerable unused capacity and has never generated a significant amount of local income. FPMD has been asked to strengthen the management of the organization in order to better position it to both be more self-sustaining and to be able to successfully use and account for renewed donor funding.

1. Quality Service Delivery Sites of the Ministry of Health

1.1 A strategic key to a successful implementation of the Intermediate Result 1.2 will be the

investment and program ownership, *at the local level*, in the concept, content, process, etc. of the Fully Functional Service Delivery Point. Bringing in outside resources to either do the substantive work or provide the technical inputs, without participation, active involvement and *leadership* at the local level will make individual site success, let alone replicability throughout the regions, highly unlikely. We know from experience throughout the developing world that caring, invested local personnel can make great things happen with limited resources but that conversely all the resources in the world will not ensure quality service delivery if the employees are not sufficiently invested and motivated.

1.2 Local investment and ownership will only come as a result of a continuous process of involvement of local officials, supervisory and key service delivery personnel in the strategy development, planning, implementation, monitoring and evaluation of all activities related to integrated site improvement. Presenting regional personnel with packages of assistance will not secure their investment. Nor will attendance at brief, highly structured and infrequently held committee meetings. Considerable time needs to be spent listening to them; to understand their needs/issues and to ensure that what is developed reflects their priorities and local conditions. This time investment needs to include USAID Paraguay [for the unique political presence they bring] as well as all the participating CAs. This is a time consuming process that needs to be built into every step of assistance. An initial, *participatory* planning process at the local level that [a] introduces the Fully Functional Service Delivery Point concept [b] inventories current sites based on that concept and [c] develops a local action plan of integrated assistance and local capacity building will be extremely important.

1.3 Given the critical importance of points 1 and 2, it should be recognized that successful implementation of Intermediate Result 1.2 [Quality] is largely an organizational development/team building effort *not* a technical one. The mistaken [almost exclusive] reliance on technical inputs to improve service delivery has been the proven, unsuccessful approach of other donors [UNFPA] both in Paraguay and elsewhere. Technical inputs will always be available and are relatively simple and straight forward in the Paraguayan MOH context. What is much more complex is creating a sustainable context/structure to absorb, use and replicate those inputs. That is the much more basic and fundamental issue and it must be addressed first and continuously.

1.4 Perhaps one example of listening to the local level, understanding their concerns and issues and putting assistance in a structure that reflects their needs and ensures their long term investment is the issue of “family planning” itself. There is nothing about the MOH service delivery structure, the preparation of its personnel or the way it understands and delivers services that reflects “family planning” per se. All services are thought of and delivered at least in a “reproductive health” context if not more likely in a “maternal and child health” context. There must be ways found to modify language and approach to accommodate this basic reality.

1.5 Replication of quality service delivery sites will only happen as a result of a consciously developed, comprehensive strategy of local capacity building that exists from the very beginning. It needs to be built into the overall planning process for Intermediate Result 1.2 and the individual plans of each participating CA. It will also operationalize the long term investment/commitment made by local officials and as such could be one of their major incentives for involvement and

ownership.

1.6 The use of a static definition [certain number of modern methods, certain services , etc.] of a Quality Service Delivery Site is a fundamental misunderstanding of the Fully Functional Service Deliver Point concept and is a mistake for two basic reasons:

- It denies the basic reality that in a given health region there are health posts, health centers and regional hospitals; all of which make up a connected *network* of health services. It is neither financially realistic nor efficient to have the same or even similar services at all sites. What is needed is accessibility and a creditable referral system within the entire network *as a whole*.

- Once again in terms of the critical issue of local investment and ownership, it denies local leadership the basic right and opportunity to define their services in ways that reflect their local realities.

1.7 The term “coordination”, as applied to FPMD’s primary responsibilities with the other participating CAs, needs to be carefully and explicitly defined by USAID Paraguay and FPMD. FPMD will want to avoid any relationship that leaves them with accountability for the actions of other CAs if there is not the commensurate authority to oversee their efforts. Clarifying communication roles and responsibilities will be another important issue.

1.8 The “80/20 rule” is very much operative at the MOH service delivery sites where more than 80% of the existing client load is served at less than 20% of the service delivery sites. This offers the possibility for both long and short term strategies impacting [increasing] overall client loads. At many sites, the client load, demand and public perception of services is relatively low for reasons that are not that numerous or complicated. While the issue of client-focused services is always a major long term problem with most MOH programs, at many sites in Paraguay the immediate problems are [a] a consistent supply of a variety of methods [specifically IUDs, and injectables] and [b] sufficient provider hours to accommodate client needs and schedules. Once again, these are not largely technical issues but rather ones of organizational development and local and national priorities [liaison and advocacy]. Successfully addressing these two issues at the selected sites in the priority regions could have a significant short/mid-term impact on client load. If they are not addressed, it will be hard to achieve the program success.

2. Sustainability of CEPEP

2.1 It’s important to recognize at the outset that CEPEP is in serious financial and organization difficulty; especially short term. This fact should necessarily define the types of inputs and the amount and specific targets of assistance. Both short and longer term, CEPEP needs an enormous infusion of capital and no amount of technical or other types of assistance will substantially mitigate that need. Capital needs include:

- Paying basic, existing salaries and benefits
- Adequately equipping headquarters and clinics with basic communications and computer equipment
- Additional medical supervisory staff

- Additional medical service delivery staff at clinics the cost of which is a fraction of the potential income those positions could generate
- Additional medical equipment for clinic services with high demand and profit margin
- Paid advertising including television, and higher quality printed materials
- Longer term, the purchase of clinic and administrative space.

2.2 The absorptive capacity for technical assistance is limited.

2.3 The changes in leadership and focus of the institution will profoundly effect the culture of the organization and everyone in it in ways that neither the institution itself or its principal donors totally realize. There is upheaval and personnel changes still to come as the organization develops new strategies and priorities.

2.4 The approach of many donors to wait until CEPEP is strong before investing in its projects and programs again, while understandable, denies the basic nature of non-profit organizational development. CEPEP desperately needs the capital, economy of scale, client and community confidence, and income generation that comes from donor programmatic investment in order to survive and grow *while* it strengthens its internal management and programmatic oversight capabilities. There is an inherent risk investing in CEPEP in the short term but to survive, donors must be willing to accept that risk. There is no waiting until it is “ready.”

2.5 Because of the financial problems facing the organization, the organization as a whole and any assistance provided by donors and CAS should focus on activities that stimulate and institutionalize income generation.

2.6 CEPEP clinics are the key to the future survival and expansion of CEPEP. A national network of clinics in an environment of increasingly privatized health care represents an invaluable resource. Presently the CEPEP clinics have a vast amount of unused capacity for which they are now paying the fixed costs. The key to their success and to the generation of considerable new local income is raising the use of existing clinic services [and therefore lower unused capacity]. This will lower unit costs and increase profit margins and total net income.

2.7 FPMD should look for ways to support CEPEP’s desire to develop more marketable skills within its very experienced Research and Evaluation Unit. The development of an ability to do quality market research would not only be very “sale-able” in Paraguay generally but would also be an invaluable resource for the sale of its own clinic services as well.