PD-ABD-396
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UNCLASSIFIED

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
Washington, D. C. 20523

PERU

PROJECT PAPER

PRIVATE COMMERCIAL FAMILY PLANNING

AID/LAC/P-661

PROJECT NUMBER: 527-0326

UNCLASSIFIED

PD-ABD-396

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number

DOCUMENT CODE: 3

2. COUNTRY/ENTITY: PERU/USAID

3. PROJECT NUMBER: 527-0326

4. BUREAU/OFFICE: LAC — 05

5. PROJECT TITLE (maximum 40 characters): PRIVATE COMMERCIAL FAMILY PLANNING

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 08 DD 30 YY 96

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY 91 B. Quarter 4 C. Final FY 93

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY 91 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total		604	604	559	4,441	5,000
(Grant)	( )	(604)	(604)	(559)	(4,441)	(5,000)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country APROPO					943	943
Other Donor(s)						
TOTALS		604	604	559	5,384	5,943

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. ACTIVITY CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) PN	PNSD					5,000		5,000	
(2)									
(3)									
(4)									
TOTALS						5,000		5,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY ACTIV. CO
PNCN - PNPD

12. SPECIAL INTEREST CODES (maximum 7 codes of 4 positions each)

A. Code	CIT	PVL	TWN	COP			
B. Amount	4,500	5,000	500	500			

13. PROJECT PURPOSE (maximum 480 characters)

To increase the provision of modern contraceptive methods through commercial channels. The target group consists of those moderate and lower-income couples not currently using a modern contraceptive method but wishing to limit or space the number of their children. The project will contribute to reach the GOP overall target of 42% prevalence in 1995.

14. SCHEDULED EVALUATIONS
Interim MM 01 YY 93 MM YY Final MM 01 YY 96

15. SOURCE/ORIGIN OF GOODS AND SERVICES
[X] 000 [ ] 941 [X] Local [ ] Other (Specify) Peru

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ____ page PP Amendment.)

Mission Controller has reviewed and concurs with the methods of implementation and financing included herein.

Paul Kramer, Controller

17. APPROVED BY
Signature
Title: Craig G. Buck, Director
Date Signed: MM 01 DD 29 YY 91

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTIO
MM DD YY

PROJECT AUTHORIZATION

Name of Country: **Peru**

Name of Project: **Private Commercial Family Planning**

Number of Project: **527-0326**

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Private Commercial Family Planning Project for APROPO involving planned obligations of not to exceed Five Million United States Dollars (US$5,000,000) in grant funds over a three year period from date of the initial obligation subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the project. The planned life of the project is five years from the date of initial obligation.

2. The project purpose is to increase the provision of modern contraceptive methods through commercial sector channels. The project consists of three components: Contraceptive Social Marketing (CSM), Commercial Services Delivery (CSD), and National Family Planning Communication.

   The target group consists of those moderate and lower-income Peruvians not currently using a modern family planning method but wishing to limit or space the number of their children, and who possess sufficient resources to pay moderately-priced commercial contraceptives products.

3. The Cooperative Agreement which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. Regulations and Delegations of Authority shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

   a. Source and Origin of Commodities and Nationality of Services

   Commodities financed by A.I.D. under the Cooperative Agreement shall have their source and origin in Peru for local cost financing and set forth in paragraph 4 below or in the United States, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services financed under the Cooperative Agreement shall have Peru as set forth in paragraph 4 or the United States as their place

a

of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Cooperative Agreement shall be financed only on flag vessels of the United States, except as A.I.D. may otherwise agree in writing.

b. Condition

Prior to the hiring of key personnel under the Project, A.I.D. shall approve, in writing, such personnel. Key personnel include the CSM Manager, CSD Manager, IEC Specialist, and Contracts Administrator.

c. Covenant

The Implementing Agency agrees that none of the funds made available under the Cooperative Agreement for family planning activities will be used to finance any costs relating to:

i. the performance of abortion or involuntary sterilization as a method of family planning;

ii. the motivation or coercion of any person to undergo abortion or involuntary sterilization;

iii. biomedical research which related, in whole or in part, to methods of, or the performance of, abortion or involuntary sterilization as a method of family planning;

iv. the active promotion of abortion or involuntary sterilization as a method of family planning; or

v. the procurement of any equipment or materials for the purpose of abortion or involuntary sterilization.

d. The following waivers to A.I.D. regulations are hereby attached:
- Waiver for non-competitive award
- Waiver of 25 percent PVO contribution

4. Authorization of Local Cost Financing

Based on the financial plan, the description of Project activities and implementation arrangements with APROPO, local cost financing with appropriated funds is hereby

authorized for the Project, as necessary to fulfill program objectives and to best promote the objectives of the Foreign Assistance Program. Per 90 STATE 410442, the Buy America Policy Guidance cable, paragraph 12, the source, origin and nationality requirements of the Standard Provisions of the Cooperative Agreement will apply. Additionally, per HB 1, Supplement B, Chapter 18A, 1c, all locally financed procurement under the project are listed under the exceptions and consequently do not need to be covered by source/origin and nationality waivers.

August 29, 1991

Craig G. Buck
Mission Director

Drafted by:HPN:MABorneck:lv
Cleared by:A/HPN:ENecochea
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C

PROJECT PAPER

COMMERCIAL FAMILY PLANNING PROJECT PAPER

(527-0326)

August, 1991

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LIST OF ABBREVIATIONS AND ACRONYMS

A.I.D	Agency for International Development
AID/W	AID Headquarters Office in Washington, DC
APRA	American Popular Revolutionary Alliance
APROPO	Apoyo a Programas en Poblacion
CA	Cooperating Agency (Grantee in AID/W centrally funded projects)
CBD	Community Based Distribution of Contraceptives
CDSS	Country Development Strategy Statement
CSD	Commercial Services Delivery
CFP	Commercial Family Planning ("The Project")
CNP	National Population Council (Consejo Nacional de Poblacion)
COSAPI	Private Construction Company
CSA	Child Survival Action Project (527-0285)
CSM	Contraceptive Social Marketing
CYP	Couple Years of Protection: Quantity of Contraceptive Supplies or Services Needed to Protect One Couple for One Year
DHS	Demographic and Health Survey
ELECTROLIMA	Electricity Company of Lima (Empresas Electricas de Lima)
ENSSA	National Health and Nutrition Survey (1984)
EOP	End of Project
FAO	Food and Agriculture Organization
FENDECAAP	National Federation of Sugar-Cane Cooperatives of Producers (Federacion Nacional de Cooperativas Agrarias Azucareras)
FPIA	Family Planning International Assistance
FP/MCH	Family Planning/Mother - Child Health
FY	Fiscal Year
GDP	Gross Domestic Product
GOP	Government of Peru
IEC	Information, Education, and Communication
IMC	Integrated Marketing Communication Plan
IMF	International Monetary Fund
INEI	National Institute of Statistics
INOPAL	Operations Research in Family Planning for Latin America Project, (AID/W centrally funded project implemented by the Population Council)
INPPARES	Instituto Peruano de Paternidad Responsable (Lima-based family planning PVO)
IPPF	International Planned Parenthood Federation
IPSS	Peruvian Social Security Institute (Instituto Peruano de Seguridad Social)
IUD	Intrauterine Device
GTZ	German Technical Assistance Agency
JHPIEGO	Johns Hopkins University/Population Communication Service
MCH	Mother and Child Health
MEDIC S.A.	Private Medical Center
MEXFAM	Mexican Family Planning Association (Asociacion Mexicana de Planificacion Familiar)
MOH	Ministry of Health
MWFA	Married Woman of Fertility Age
NGO	Non-Governmental Organization
NPP	National Population Program
OC	Oral Contraceptive
OPS	Panamerican Health Organization
OPTIONS	Centrally Funded Project Administered by The Futures Group
PACD	Project Assistance Completion Date
PID	Project Identification Document
PP	Project Paper
PRISMA	Proyectos en Informatica, Salud, Medicina y Agricultura, (Lima-based development PVO)
PRSP	Private Risk-Sharing Providers
PVO	Private Voluntary Organization

PY	Project Year
RFP	Request for Proposals
SOMARC	Social Marketing of Contraceptives (AID/W project)
S&T/POP	Bureau of Science and Technology/Population Division (AID/W))
TA	Technical Assistance
TIPPS	Technical Information on Population in the Private Sector
UNFPA	United Nations Fund for Population Activities
VSC	Voluntary Surgical Contraception
WFS	World Fertility Study

COMMERCIAL FAMILY PLANNING PROJECT PAPER

(527-0326)

I. PROJECT SUMMARY AND RECOMMENDATIONS

A. Recommendation

USAID/Peru recommends authorization of a US$5.0 million Project, to be obligated in a Cooperative Agreement with APROPO (Apoyo a Programas de Poblacion), to meet the objectives of the Commercial Family Planning (CFP) Project. Counterpart contributions from APROPO and third parties will bring the total project funding level to US$5.9 million. The Project will have a life of five (5) years and is expected to be incrementally grant funded over the next three (3) years.

B. Grantee

The Grantee for this Project will be APROPO, a Peruvian private voluntary organization (PVO) dedicated to the promotion of population policy and family planning activities. A portion of the grant resources under the Cooperative Agreement will be provided in the form of buy-ins to A.I.D. centrally-funded projects and PIO/Ts with technical assistance providers.

C. Summary Project Description and Financial Plan

1. Project Description

The goal of the Commercial Family Planning Project is to contribute to improve the health status of Peruvian families through increased access to modern family planning methods. The Project is designed to further this goal by increasing the provision of modern contraceptive methods through commercial sector channels. The Project's target group consists of those moderate and lower-income Peruvian women and men not currently using a modern family planning method but wishing to limit or space the number of their children, and who possess sufficient resources to pay for moderately-priced commercial contraceptive products. It also includes those couples using subsidized public and PVO sources when they could afford commercial outlets.

The CFP Project consists of three components: Contraceptive Social Marketing (CSM), Commercial Services Delivery (CSD) and National Family Planning Communication.

The objective of the CSM component is to increase the availability of accessibly-priced contraceptives to the Project's target group through commercial retail outlets. APROPO and the project personnel to be employed for this component will pursue the following strategy to achieve these objectives: refine the definition of the target group, select CSM brands for promotion, assess optimal CSM prices based on maximum affordability to the target group and minimally-acceptable profit margins for APROPO, carry out a national communication and promotion campaign, and analyze and propose reforms for policies that negatively affect family planning prevalence. The activities required to carry out this strategy are market research, target group analysis (focus groups, etc.), pricing analyses, development of a marketing strategy, training of project personnel and retailers, CSM brand advertising, distribution of contraceptives, and policy analysis/reform. A substantial amount of technical

assistance from the centrally-funded SOMARC (Social Marketing of Contraceptives) Project will be required to assist APROPO in carrying out these activities.

The objective of the CSD component is to broaden the financial base for family planning services by restructuring the family planning market to supplement public sector channels with more active private sector channels. This will require that private health plans expand their coverage, currently limited to curative care, to include provision of preventive health services, including family planning. The CSD component strategy will be to demonstrate to employers and insurers the cost-benefit and other positive returns of including family planning and maternal child health care services in their employees' social benefits packages/health insurance policies. Once firms are convinced, APROPO will assist them to implement family services. APROPO will cover the administrative costs of this component by collecting fees for brokerage services to put companies together with service providers and/or technical assistance, depending on the delivery modality selected. Some of the activities required to carry out this strategy are target group analysis (identifying potential client firms and service providers), development of a database containing information on prospective clients and service providers, cost-benefit analyses for presentation to firms, training of health care providers, and provision of services. Other activities such as organizing workshops will be sponsored by this component. Technical assistance from specialists in private provision of family planning services and employer-based family planning programs will be required to assist APROPO in carrying out these activities.

The National Family Planning Communication Component was included in the Project on the premise that a massive education and communication campaign was necessary to better inform Peruvians about modern contraceptive methods. A limited supply of family planning products at affordable prices is not the only barrier the Project must overcome; a lack of information and misinformation about the health effects and use of family planning methods also prevents the achievement of a higher contraceptive prevalence rate in Peru. One of the objectives of this component will be to coordinate the communication programs of all organizations working in family planning in Peru, both public and private, for profit and non-profit, in order to make a greater impact on the Peruvian populace. Some of the activities to be carried out under this component are: a communication needs assessment study, a national communication conference and workshop, and a National Family Planning Communication Campaign. These activities will be conducted in coordination with the CNP (Consejo Nacional de Poblacion). A substantial amount of technical assistance from family planning communication specialists (Johns Hopkins University/Population Communication Service Project) will be required to assist APROPO in carrying out these activities.

All three project components will be implemented by APROPO with the assistance of specialists in the field and project personnel to be hired exclusively to work on the Project. The first year of the Project will consist mainly of pre-implementation activities such as gathering demographic and market data and setting quantitative targets. Actual implementation of project activities will begin toward the end of the first project year.

During the project period, APROPO will generate revenues of US$678,668. In addition, its in-kind contribution will be approximately US$263,840.

The life-of-project (LOP) is five (5) years, and implementation is scheduled to begin in September, 1991.

2. Financial Plan

(Summary Budget in the next page)

FINANCIAL PLAN

Table 1

SUMMARY FINANCIAL PLAN

Element	PROJECT YEAR One		Two		Three		Four		Five		Total	
	AID	APPOPO	AID	APPOPO	AID	APPOPO	AID	APPOPO	AID	APPOPO	AID	APPOPO
Contraceptive Soc Mktg	163,000		154,100		69,305		71,620		66,301		526,326	0
Commercial Serv. Deliv.	85,000		71,600		57,605		60,120		62,051		337,576	0
Nat'l.-Family Communicat.	555,000		837,500		734,500		523,000		417,250		3,077,250	0
Other Direct Prj. Support	222,526		145,215		203,663		115,146		215,665		902,215	0
Administrative	165,183	50,820	51,450	109,812		166,784		172,582		178,670	156,333	678,668
Total	1,141,709	50,820	1,259,865	109,812	1,065,273	166,784	769,886	172,582	763,267	178,670	5,000,000	678,668

D. Project Issues

1. Appropriateness of Buy-ins Under a Handbook 13 Grant

When Handbook 13 policies were written, the drafters did not foresee substantial outside assistance as being required for grantee-initiated projects. The level of buy-ins being proposed for the Project, therefore, may be an issue. On the other hand, Handbook 13 does not explicitly forbid such assistance either, and the proposed buy-ins and other technical assistance will be critical to attainment of the Project's objectives. Authorization will be requested to AID/W, according to STATE 143529.

2. Project Sustainability/Capacity of APROPO to Adopt Commercial Practices

Through this Project, APROPO will be encouraged to borrow practices from the commercial sector like commissioning employees and promoting its services as a "product." The purpose of doing so will be to enable APROPO to cover a progressively greater amount of recurrent costs with self-generated revenues. Ideally, APROPO will be able to cover all recurrent costs related to Project activities, as well as their own core costs, once the Project ends in order that these activities may continue (see recurrent costs section in PP). As the adoption of a "commercial mentality" will require behavioral change on the part of APROPO, it is not yet clear how well this will work. The sustainability issue will be monitored as project implementation progresses.

3. Unquantified Target Group

The Project design team was unable to describe the project target group in specific, quantifiable terms for two reasons: the 1986 Demographic Health Study (DHS), which provides the last reliable information on contraceptive prevalence in Peru, is already outdated; and the economic situation in Peru has changed so significantly since 1986, that it is no longer safe to say that the users identified as belonging to specific socio-economic groups then, are still in those groups. A main factor has been the tremendous growth of the informal sector, and insufficient information is currently available about the purchasing power of this group.
A quantifiable target group would have been useful for projecting a target for the Project measured in terms of Couple-Years of Contraceptive Protection (CYPs). Nevertheless, the Project still has measurable targets (see the E.O.P.S. in the logframe) which are proxies for CYPs provided. In addition, during the first year of the Project, research will be carried out to further define the target group, clarifying some of the uncertainties about numbers of people in the various socio-economic groups and their respective purchasing power. A new DHS is scheduled to be carried out in 1991, and will provide updated information on contraceptive prevalence. If possible, the project targets will be amended at the end of the first year of the Project to include the number of CYPs to be provided.

4. Selection of a Non-Profit Organization to Carry Out Commercial Activities

During the project review, questions were raised about why a non-profit organization was selected to carry out commercial activities. The comment was made that a commercial entity like one of the contraceptive manufacturing firms might be a better choice, given their expertise at marketing. The design team responded that a commercial entity would be less likely to have the kind of social commitment required to maintain prices at "social marketing" levels where the greatest impact on contraceptive prevalence could be made. In addition, as the contraceptive firms that manufacture in Peru have several other lines of business, they are not likely to place much emphasis on a line that is not very profitable -- a line for which profitability is of secondary importance.

II. BACKGROUND

A. Country Setting

1. Social and Economic Conditions

Background

Peru's size, topography, and tropical location endow it with a great variety of environments and natural resources. It comprises three broad natural regions: the Coast, the Andean highlands (the Sierra), and the Amazon jungle (the Selva). Nearly one half of its total 22 million population lives in the coastal region, 40 percent in the Sierra and the remainder in the Selva, an area which comprises 67 percent of Peru's total territory. These physical divisions are reflected in marked social contrasts which have slowed Peru's integration as a society, and in recent years have contributed to violence that threatens the country's fragile democracy.

Economic Crisis

Peru is currently attempting to lift itself out of a state of economic crisis brought on by nearly two decades of statist-oriented economic policies, climatic disturbances and downturns in the world prices for the goods Peru exports. Exacerbating this crisis is the high cost, both materially and in terms of human lives, of an active and growing terrorist movement and drug trafficking. (For a more complete discussion of the political and economic situation in Peru, see the recent CDSS and PAAD).

While the current crisis had its roots in the policies of the military regimes of the 1970s which modified the structure and ownership of productive resources and greatly increased the role of the state in the economy, it deepened in 1985 with the misguided policies of the Garcia administration. The American Popular Revolutionary Alliance (APRA) Government, elected in 1985, was the first democratically elected government to succeed another in forty years. It instituted a heterodox program to control inflation and stimulate demand by freezing prices, declaring sharp wage increases, reducing interest rates, restricting imports, controlling exchange rates, and limiting external debt payments. This stimulated domestic demand and achieved an impressive, but temporary, supply response, while sharply reducing the inflation rate. An almost unprecedented 8.5 percent real gross domestic product (GDP) growth rate was achieved in 1986, inflation was cut in half and real wages rose 18 percent. GDP rose again by 9.3 percent and 7.3 percent, respectively, in 1986 and 1987.

The impact of this growth strategy was short-lived, however. Net international reserves fell, exports and capital flows declined, and the central government deficit rose. Beginning with an abortive attempt to nationalize the private banks and finance companies in July 1987, the economic gains of 1985-1986 suffered a complete reversal. Inflation rates rose to 114 percent in 1987 and 1,722 percent in 1988, and the GDP declined by 8.5 percent in 1988.

From August 1988 to August 1989, the country experienced an unprecedented hyperinflation of 5,950 percent; by 1989 it was running at an annualized rate of 7,000 percent. Real wages had dropped by about 50 percent since the beginning of the Garcia regime.

By 1990, the public sector was operating at a deficit with barely enough resources to pay for salaries. Public sector salaries are currently below the minimum wage, and per capita GDP levels are even lower than levels reached at the end of the 1950s. Mistaken economic policies fomented large-scale corruption, and generalized subsidies and price controls severely distorted relative prices. A unilateral moratorium on most external debt service announced early in the Garcia term isolated Peru from its traditional creditors as arrears amounted to

about US$12 billion, or 65% of total external debt. As a consequence, economic and social infrastructure deteriorated to unprecedented levels.

The election of Alberto Fujimori in 1990 ushered in dramatic policy reforms which have already begun to bring about significant changes. Among the necessary, but politically painful and controversial policy reforms which were aimed at reducing price distortions, improving tax collection, narrowing the fiscal deficit and stopping hyperinflation, were: (1) unification and floating of the exchange rate; (2) substantial foreign trade liberalization; (3) large overnight increases in a number of previously subsidized prices, including fuels, foodstuffs, and public utilities; and (4) the liberalization of interest rates.

While Fujimori's economic restructuring of the Peruvian economy along free market lines has gained widespread approval by the IMF and donor economists who predict improvement over the long term, the immediate effect of the austerity measures has been a severe recession that has adversely affected social indicators for all groups.

In March 1991, the GOP supplemented the adjustment program with an impressive series of measures aimed at strengthening stabilization and laying the basis for sustained growth through structural reforms. These measures are having a profound impact on the structure of the economy by reducing the extent of government participation and control. With less government intervention and newly deregulated markets, private sector firms are being offering unprecedented opportunities for growth and expansion.

The GOP program is beginning to produce solid results. Inflation has been reduced to relatively low levels, the enormous distortions in relative prices have been eliminated, and fiscal accounts are roughly balanced.

High Fertility Rates

Despite Peru's dramatic progress in reducing fertility rates by 23 percent during the decade between 1977-1986, the national total fertility rate is still 4.1 births per woman (1986 Demographic and Health Survey (DHS)) and the annual population growth rate stands at about 2.1 percent according to the last estimates. This implies that Peru adds nearly 500,000 people to its population each year. The current population of nearly 22 million has doubled in the years since the 1961 census. As another consequence of high fertility rates, a disproportionately large portion of the population is under 15 years of age and, therefore, dependent on the relatively small numbers of economically productive adults.

Augmenting the impact of high population growth rates on urban centers like Lima and other major cities, is a concurrent process of urbanization. Peruvians from the Sierra, in particular, are migrating to urban areas where social services and economic opportunities cannot keep pace with the needs. In recent years, urban areas have been growing at a rate twice as fast as that for rural areas. The Lima metropolitan area, where nearly one third of all Peruvians live, has grown by almost 1,000 percent since 1940 and now contains some 7 million people. At present, almost two of every three Peruvians live in cities of 20,000 or more inhabitants. By the year 2000, three cut of every four Peruvians will live in large cities, giving Peru a population distribution pattern similar to developed, industrialized countries.

This trend toward a greater concentration of the population in urban areas has major implications for development work in Peru. On the one hand, concentrating efforts in the cities has the potential of reaching the greatest number of people with a relatively lower expenditure of resources. On the other hand, if efforts are not made to promote agricultural and rural development, the countryside will become increasingly impoverished and susceptible to politically destabilizing

influences, the rush to the cities will continue unabated, and the current urban crisis will intensify.

The combined forces of high population growth and declining GDP result in a declining per capita income for Peruvians and severely strains the ability of most to meet their most basic sustenance needs. Peru is one of only three Latin American countries whose average food consumption per person is less than 90 percent of the Food and Agricultural Organization (FAO) standard; it was estimated in 1984 that 38 percent of all children under five are chronically malnourished and the situation has deteriorated significantly since then. Housing is insufficient and inadequate, less than half of the urban population has access to potable water, and only 30 percent of the population has access to electricity. Over 70 percent of Peru's population is unemployed or underemployed. The lack of employment and government restrictions under previous governments have contributed to the generation of an underground economy as an alternative to the formal sector. In 1989, it was estimated that of those Peruvians employed, approximately 61 percent are working in the informal sector.

High population growth and a declining GDP put strains on already limited public resources for investments in social services. Already weak public facilities face increasing numbers of new clients each year. In particular, rapid population growth affects health systems because obstetrics (mainly deliveries, pregnancy problems, and abortion complications) account for half of all hospital admissions. The recent cholera epidemic is further taxing the scarce resources of Peru's health system. The school systems also suffer from the combination of static or declining budgets and rapidly increasing numbers of school age children.

Health Impact of High Fertility

In addition to contributing to a general decline in the standard of living and the availability of public resources for social infrastructure investments, high fertility rates lead to high maternal and child morbidity and mortality rates. Infant mortality rates have declined from 97 deaths per 1,000 live births in 1972-1977 (1977 World Fertility Study (WFS)) to 76 deaths in 1981-1986 (1986 DHS). Nevertheless, Peru still has one of the highest infant mortality rates in Latin America, almost twice as high as Colombia and almost four times higher than Chile. Infant mortality rates vary widely by geographic region and socio-economic status: from 34 per 1,000 in metropolitan Lima to 110 in the Sierra, and from 22 among women with post-high school education to 124 among women with no formal education.

2. Government of Peru Population Policy

Efforts to develop a national population policy began under the military government with the formulation of "population policy guidelines" in the mid-1970s. These guidelines had no specific demographic, health, or programmatic targets and offered only a broad orientation for the population sector. As such, their effectiveness was limited. The preceding government of President Belaunde created the National Population Council (CNP) in 1980 to assist the public and private sectors to follow the guidelines.

In July 1985, the Government of Peru (GOP) took a major step in population policy with the passage of the National Population Law, Legislative Decree No. 346. Among other things, this law guarantees couples the basic human right to freely determine the number and spacing of their children, and establishes that the State shall promote responsible parenthood as a development and health priority. The Law recognizes all voluntary contraceptive methods with the express and explicit exception of sterilization.

Under the Government of President Alan Garcia, and largely as a result of his personal commitment and leadership, population matters took center stage in many

aspects of development planning and services delivery. In late 1986, President Garcia called for a national development strategy which would include the establishment of operational policies and demographic goals specifically aimed at reducing the population growth rate.

A Presidential Population Commission, charged with developing a national population strategy, was formed in early 1987. The Commission completed its work in mid-1987 and recommended a comprehensive approach to solving Peru's population problem. Their recommendations included intensified work in education, service delivery, research, and public information. The Council of Ministers and the President approved the Commission's action plan, entitled "National Population Program 1987-1990".

In 1990, Peruvians elected a new President, Alberto Fujimori, who very soon after taking office made clear his active support of population programs and of family planning in particular. President Fujimori strengthened the National Population Council (CNP) by offering his support and calling for a new National Population Program Plan to be drawn up for 1991-1995. This was recently completed, and was made public in March 1991. The new President has added important symbolic support by declaring 1991 the "Year of Austerity and Family Planning."

The broad demographic target in the National Population Program calls for a reduction of the total fertility rate from 4.1 births per woman in 1986 to 2.5 births per woman in the year 2000. To accomplish this fertility reduction, it will be necessary to increase the total prevalence of family planning and to increase the relative use of more effective, modern contraceptive methods.

Specifically, the Government plan calls for increasing contraceptive prevalence from 28 percent of women of reproductive age in 1986 to 42 percent in the year 2000. For women in union, this would mean a prevalence rate of 60-70 percent by the year 2000.

The recent National Population Program document for 1991-1995 creates a Reproductive Health and Family Planning Program (PNPF) under the direction of the Ministry of Health (MOH), supported by the CNP, which is responsible for coordinating the efforts of both the public (the MOH, the Peruvian Social Security Institute (IPSS), and the armed forces) and private (commercial, and voluntary) sectors. The PNFP is an integrated strategy to be implemented in four key areas including: 1) family planning; 2) prenatal health; 3) gynecological cancer; and, 4) comprehensive adolescent care. These programs will be realized in the twelve newly demarcated regions of Peru according to the respective levels of need and development in each region.

Originally, the National Population Program called for the public sector to cover 90 percent of all contraceptive users by the year 2000. These targets have been scaled back considerably due to diminishing public resources and to reflect the general market segmentation revealed in the 1986 DHS. The new targets of the National Population Program are as follows:

- 53 percent of modern method users should be served by the public sector,
- 20 percent by the private voluntary (PVO) sector, and
- 27 percent by the private commercial sector.

The Government targets also reflect the expectations that changes in the contraceptive method mix will include larger proportions of modern methods such as pills, IUDs, and VSC.

3. Family Planning Availability

Family planning services are available in Peru at the same types of centers where general health care is provided. This includes a number of different public,

quasi-public and private sector organizations (see Annex IX for a complete discussion of health care provision and financing in Peru). The following are estimates for health coverage in Peru, available resources, and expenditures by sub-sector (Health Sector Analysis of Peru Summary Report, Dieter K. Zshock, Stony Brook, New York, November 1986):

- The Ministry of Health (MOH) covers approximately 26% of the health care needs of the population, administers 59% of the hospitals beds, and accounts for 27% of the country's total health care expenditures;

- IPSS provides services to about 18% of the population, operates 15% of the hospital beds, and is responsible for 33% of all health care expenditures;

- The private sector provides coverage to 21% of the population, administers only 18% of the hospitals beds, yet accounts for 34% of total health care expenditures;

- An estimated 32% of the population, including one out of every six residents of Lima/Callao, have no modern health service coverage.

The following section describes the availability of family planning services in each these different sectors of the Peruvian health care system.

a. Public Sector

Ministry of Health

According to GOP planning figures, the percentage of the total population that should be receiving health care through the MOH is 58 percent. However, only 26 percent of the total population actually receives such services, leaving 32 percent of the population without access to modern medical care (this 32 percent of the population are persons without sufficient resources to seek health care services from the private sector). MOH services are delivered through a network of 2,700 health posts, 700 health centers, 125 hospitals, and 10 national institutes.

At the lowest level of the MOH system, the health posts are responsible for health promotion and preventive community-based health care activities, as well as some curative and emergency care. Health posts are generally staffed by a health auxiliary and (in some cases) a nurse or midwife. They serve a population within a ten kilometer radius, approximately 3,000 inhabitants in rural areas and 5,000 in urban areas. Under the MOH norms, health post personnel are authorized to distribute barrier method contraceptives (condoms and spermicides), may prescribe hormonal contraceptives (orals and injectables) if staffed with a nurse or midwife, and may even insert IUDs if staffed by more than a paramedic.

Health centers are located in the district or provincial capitals and offer both preventive and curative health care. They are usually staffed with nurses, health auxiliaries, technicians and/or a physician where available. There are also two levels of health centers: level one health centers usually contain six to eight beds, whereas level two health centers have no beds at all. Health centers generally serve the population within a ten kilometer radius, as well as referrals from the health posts in their jurisdictions. The size of the population covered is approximately 35,000. Under the MOH norms, health centers are authorized to apply all reversible contraceptive methods and to refer patients with high reproductive risk to hospitals for surgical procedures.

Hospitals exist at the provincial, departmental, and national levels and provide preventive, curative, and rehabilitative services, with emphasis on curative care. Hospitals have seven departments, including surgery and

obstetrics/gynecology, and also refer patients to the national institutes. Under the MOH norms, hospitals are authorized to apply all contraceptive methods, including voluntary surgical contraception for cases of high reproductive health risk.

The MOH Reproductive Health Director serves as the Director of the National Family Planning Program. He is assisted by expatriate and Peruvian advisors and by departmental family planning coordinators. The MOH prepares a yearly action plan for family planning, including departmental targets for new and continuing users by contraceptive method, commodities, and budget support needed. A service statistics system is being implemented to track program performance and feed into operational planning goals.

Peruvian Institute of Social Security (IPSS)

The IPSS is legally mandated to cover a portion of the health care costs of all private and public (including parastatal) sector salaried workers as well as cooperative members. The self-employed may join voluntarily. In 1984, a new law expanded dependent coverage to include not only maternity care and children under the age of one, but also some services for children aged one to 14. More recently, IPSS has been mandated to extend coverage to farmers' groups, mothers' clubs, rural cooperatives, housewives, and children up to age 18. The IPSS target population now includes 720,000 women of reproductive age. The percentage of the total population considered to be covered by IPSS now totals more than 28 percent, or some 6 million beneficiaries, although actual coverage is probably considerably lower.

The IPSS delivers medical services via a six-tiered system that, as of 1987, included 26 hospitals (at national, regional, and zonal levels), 48 polyclinics, 212 medical posts, and 100 factory posts. Family planning services are provided at hospital outpatient clinics and polyclinics. The IPSS National Family Planning Program Director is assisted by a small central level staff and regional family planning coordinators. Yearly operational family planning targets, commodities, and budgetary requirements have been projected since 1987, and a service statistics system has been in operation since that year.

A new law, passed in April 1991 to take effect in July, will give employees the option of participating in the national social security system (which includes some health benefits at IPSS) or providing their own social security plan through the private sector. Health insurance programs or health services can be provided, under the new law, through private sector programs. This will have a profound effect on the diversity of health insurance packages and health service providers available, and on the finances of the IPSS system. The component manager for the Commercial Services Delivery component of the Project will keep abreast of any additional legislative changes, and will target new private insurance companies that move into provision of health benefits.

b. The Private Voluntary Sector

PVO family planning activities in Peru date back to the mid-1960s. Some of the earliest PVOs included the Christian Family Movement, the Peruvian Association for Family Protection (the first Peruvian affiliate of the International Planned Parenthood Federation (IPPF), and the Instituto Marcelino. In 1973, the pro-natalist military government closed all family planning PVOs, except the Instituto Marcelino and those supported by Catholic authorities.

The family planning PVO sector was reactivated in the late 1970s and early 1980s. An institutional analysis conducted in 1985 for the Private Sector Family Planning Project (527-0269) identified 17 agencies in the sector, and others have emerged since then.

Family planning service delivery PVOs offer contraceptive services and commodities through a variety of outlets, including community-based distribution (CBD) outlets, fixed and rotating location clinics and medical posts, and commercial marketing outlets. Most receive donated commodities, usually from A.I.D. sources, and distribute them free of charge or at nominal prices. Some also pass on contraceptive commodities to other outlets, including community centers and private physicians, for subsequent distribution, although this practice has declined in recent years.

c. Private Commercial Sector

The private commercial health/family planning sector in Peru consists of direct health care providers (private physicians, clinics, hospitals), manufacturers of contraceptive products, retail outlets, health insurers and employer-provided health programs.

(1) Private Clinics, Physicians and Hospitals

There are several thousand private practice physicians, and several hundred private medical centers and hospitals in Peru. The private commercial health sector is oriented predominantly to curative outpatient care, accounting for only 18 percent of all hospital beds and four percent of primary health care facilities. The 1984 Health and Nutrition Survey (ENNSA) found that as many as two-thirds of the residents of major urban areas routinely consult private physicians for their outpatient health care needs.

There is little data on the prices charged by private physicians for clinical contraceptive methods, but evidence suggests that the prices may be quite high and unaffordable to many users. The prices in Peru vary from US$15 for IUD insertion in MEDIC, S.A. (a private medical center) to approximately US$40 for a private physician.

Marketing of clinical contraceptive methods is sensitive to availability of infrastructure, including trained providers and clinical facilities. Physicians tend to be the primary commercial sector providers of IUDs and sterilization; although many countries permit trained midwives to insert IUDs, few of these midwives are in private practice.

Health norms, codes and health plans restrict sterilization, but as in other countries, the patient can pay for an "informal sterilization" which often takes the form of a cesarean section delivery accompanied by an un-reported tubal ligation.

(2) Manufacturers

Some contraceptive products are manufactured in Peru by both local and international companies. Oral contraceptives, vaginal tablets, and injectables (hormonal contraceptive administered by injection) are manufactured and distributed in Peru. IUDs and condoms are imported and then distributed locally. The local manufacture of oral contraceptives and injectables is an advantage to the Contraceptive Social Marketing (CSM) component of the Project because it offers flexibility in manufacture levels, greater assurance and control of supply, and may have lower product costs.

The following describes current availability of contraceptive products in Peru:

<u>Oral Contraceptives and Injectables</u>: Pharmaceutical companies have fared variously in Peru in the past two years. Several have discontinued production of ethical products (products that require a physician's prescription) but maintain a limited distribution. Others have made a corporate commitment to remain in Peru and weather the economic crisis. Those that are staying have maintained and guaranteed the manufacture, packaging and regular distribution of

their pharmaceutical products. This corporate decision has been reflected in increasing market shares of these firm's brands which are filling the gap left by the products of those firms that have curtailed or decreased previous levels of manufacture and distribution.

One of the key CSM participating agencies, Schering Peruana, is one of the companies that has continued operations in Peru and is committed to adjusting their prices as required to remain viable in the commercial market. Schering manufactures locally and distributes several brands of OCs (oral contraceptives) and an injectable contraceptive. Other OC brands belonging to other pharmaceutical houses such as Wyeth and Organon are distributed in Peru, but are no longer produced locally. A second brand of injectable, Soluna, is being produced as well as distributed locally and the third, DepoProvera, is distributed by a local firm, although it is not manufactured in Peru.

Vaginal Products: Another key participating agency, Medifarma, which was manufacturing and distributing Lorophyn, the CSM brand of vaginal tablets, has not fared as well as other local companies. Their production and distribution levels have been irregular, making it a less attractive product to promote than those with dependable distribution. For this reason, Lorophyn may be discontinued as a CSM brand in the future.

Condoms: Quimica Suiza, the commercial distribution firm that worked with the previous CSM Project on a plan for the import and introduction of a CSM condom brand, has also maintained its strong presence in Peru's commercial sector. The firm has kept its wide range of consumer products intact, only eliminating those that have not been profitable in the context of the economic crisis of the past few years. Quimica Suiza's distribution is reportedly expanding to include the burgeoning number and varying type of informal sector retail outlets.

The firm's product line includes four brands of condoms purchased from Ansell, Inc., which are currently sold in packages of three units each. Sales for the first quarter of 1991 alone are reported to have surpassed annual totals for both 1989 and 1990. This substantial increase is believed to be due to a variety of inter-related factors, including the tighter control of the leakage of donated condoms in the commercial market, adjustments of the commercial market after severe dislocation due to sharp increases in prices, and consumers' increased concern with general health given the well-publicized AIDS epidemic.

(3) The Retail Sector

The commercial retail sector is responsible for fully three fourths of all pharmaceutical sales in Peru. There are currently approximately 3,500 pharmacies operating nationwide where consumers can purchase contraceptives. More will be opening soon due to the recent relaxation of GOP regulations which strictly controlled the definition of drugstores and pharmacies, as well as what products could be sold in each. For example, one important grocery store chain is adding a pharmacy section to its existing stores which will increase consumers' access to contraceptive products.

Contraceptive products are also available for purchase from the informal sector, which is growing in response to very high levels of under- and unemployment, as well as to hyperinflation-level retail prices in traditional retail outlets. The informal sector is growing in all areas of the country, from urban to semi-urban and rural. Wholesalers are reported to be reaching rural markets in the provinces with effective distribution of consumer products, more than they did in the past due to the growth in the number of informal sector outlets.

(4) Employer-Subsidized Health Plans

By law, all employers except exempted cooperatives and parastatals must pay into the national social security system (IPPS), and all installations above a certain

size must offer an on-site medical dispensary. The dispensary is basically a first-aid station and usually attends only employees, and not their dependents.

Certain employers are required to maintain full medical centers for workers and their dependents. Many are located in isolated rural areas, such as mines and oil camps. These companies constitute the "own service" market. In addition to maintaining medical centers for workers and their dependents, the mining and petroleum industries are contractually required to provide housing, education, water and electricity, school uniforms and supplies, and other social welfare benefits for workers' families. Expenditures for dependents' health care are often a major expense. Therefore, these industries should be especially receptive to cost-benefit arguments for offering preventive health care and family planning services.

Annex XIV provides a brief overview of the Peruvian private sector in order to give some idea of the potential number and types of firms that could be encouraged to maintain on-site family planning services or otherwise cover the costs of their employees family planning needs.

(5) Health Insurance

Most companies wishing to supplement the obligatory social security coverage have found it cheaper to purchase health insurance or set up self-insurance funds than to install their own medical services.

The health insurance industry in Peru underwrites services for approximately 700,000 persons throughout the country. It includes a diverse set of organizations and financing arrangements such as insurance companies, self-insurance funds and brokerage firms. The majority of the health-benefit plans on the market are purchased by private employers on behalf of their employees and dependents. The sector can be roughly categorized into four groups (see Annex IX for a more complete discussion):

- Diversified insurance companies offering health insurance policies;
- Company-sponsored self-insurance funds;
- "Brokers-as co-insurers" scheme; and
- Provider-sponsored health plans.

Self-insurance funds and brokers as co-insurers schemes developed largely in response to rapidly rising premiums charged by traditional insurance companies, although all have had problems recently due to escalating medical costs. Consumers frequently change insurance companies/brokers in attempt to find affordable group policies.

Most private health plans are intended as protection against catastrophic illness and as such, are more oriented to curative services than preventive care, such as prenatal check-ups, PAP smears, and family planning, which could avert or greatly reduce medical costs. Because the majority of these plans are purchased by employers who also pay into social security, the majority of their beneficiaries also have social security coverage and access to social security outlets for preventive care. In a recent survey of clients attending a private health center, it was found that 95 percent of those with a private health plan were also covered by social security.

Coverage is virtually identical across the industry. In interviews with the 10 largest insurance companies in Peru and 2 large brokers in Lima, it was found that all of the standard health risk plans covered outpatient care for illness, hospitalization, pharmaceuticals, laboratory tests, childbirth, and treatment for spontaneous abortion complications. None covered prenatal care, cancer prevention (Pap smear), well-baby care or family planning. Payment systems varied slightly: most of the insurance companies paid directly for hospitalization (including childbirth and treatment of abortion complications)

and outpatient care in certified clinics, and reimbursed clients for outpatient care, pharmaceuticals and laboratory examinations received in non-certified centers. All plans included deductibles or client co-payments, which varied by individual policy.

The consumers of private health plans are generally medium- to large-sized corporations. However, not all employees may be covered, and extent of coverage usually varies with employee rank. In interviews conducted with 16 companies, including 12 companies represented among APROPO's membership and four pharmaceutical laboratories, it was found that roughly half of the companies (7 of 12) offered supplementary health care: coverage was always provided to white collar employees; blue collar employees were usually covered; and temporary contract workers were seldom covered.

Most health plans also cover employees' wives and dependent children. Benefits are fairly standard across plans: all cover curative care and most covered hospitalization and childbirth. Preventive care is seldom covered, and only two plans included pre-natal care. Company managers felt that offering curative care to employees benefitted the company because it enabled workers to return quickly to their jobs. Opinions were mixed concerning the necessity of offering childbirth attention and prenatal care. Most were neutral or negative regarding potential benefits to the company of offering preventive services such as well-baby care and family planning.

At least one brokerage firm (Riesgos y Seguros, the largest insurance brokerage firm in Peru, with 126,000 beneficiaries and 25 years of market experience) would consider including family planning services in its policies if inflation stays under control and the additional cost of these services could be negotiated into the price of the policies. However, the results of the interviews conducted with employers suggest that the CSD component will have to convince them of the utility of providing preventive health care. The newly-passed banking and finance law, which is supposed to allow employees to opt out of national social security in favor of private health insurance, will give an added stimulus for incorporating preventive care as private groups compete for the enormous client pool. If, as expected, these alternative insurance plans are required to replicate the entire benefit package currently offered by social security, insurance companies and providers alike will need extensive assistance in gearing up for the new services.

B. Status of Family Planning Utilization in Peru

1. Contraceptive Prevalence and Method Mix

Contraceptive prevalence was minimal in the 1960s; as late as 1969, only 36 percent of women in union of reproductive age had knowledge of any form of modern contraception. By 1986, nearly 90 percent of all women of reproductive age knew of at least one modern method. Increasing contraceptive knowledge has been accompanied by increasing contraceptive use.

Overall, contraceptive prevalence has risen considerably over the past ten years, although total prevalence and use of modern methods still lag behind other countries in Latin America such as Brazil and Colombia. However, Peru compares favorably with other countries in the Andean region (Ecuador and Bolivia) in terms of total contraceptive prevalence.

In 1986, contraceptive prevalence was measured at 46 percent of all women in union of reproductive age, and it appears to be rising by about 2 percent per year. Current contraceptive use is equally divided between modern, effective methods and less effective, traditional methods. Traditional methods provide only about half the contraceptive protection of the most efficient methods (IUDs,

pills, and sterilization). Half of all contraceptive prevalence in Peru, therefore, is of limited effectiveness and has limited impact on fertility. Among modern methods, the pill, IUD, and female sterilization are the most popular. Each accounts for about one third of total modern use, while barrier methods (spermicides and condoms) comprise the remaining portion.

Peruvian contraceptive practice is remarkable in several regards. First, it shows one of the highest rates of IUD use anywhere in the world. Second, the use of female sterilization is almost as high as pills or IUDs, despite the legal limitation on access to that procedure. (By law, sterilization is permitted only to avert high-risk pregnancies.) These figures demonstrate the demand for long-lasting contraceptive methods.

The high use of less effective, traditional methods coupled with the strong demand for IUDs and female sterilization suggests that more women would like to use modern methods, but are forced to use traditional ones because they do not know where to obtain modern methods or because these methods are not available. Many women have also received disinformation or have unfounded health fears about the safety of modern methods, indicating the need for better information and education about contraceptives in addition to improved accessibility.

2. Contraceptive Market Segmentation

Available data suggest that the public sector serves approximately half of all modern method users, followed by the private commercial sector, and then the private voluntary sector. The 1986 DHS included questions on source of current method, but interpretation of the results is confounded by lack of precision in the questionnaire and in the response categories used.

The DHS found that 53 percent of modern method users were served by the public sector, 39 percent by the private commercial sector, and 8 percent by the private voluntary sector. (These results are based on recording of ambiguous responses; in the original publication, the PVO sector was credited with only 2 percent of total modern method users.) Sector coverage varies markedly by method: the public sector, which accounts for 80 percent of the hospital beds in the country, also accounted for 78 percent of female sterilizations, while pill users, who have a greater choice of outlets for their method, were more evenly divided between the public (46%) and private commercial (36%) sectors.

A survey of marginal areas of Arequipa, Chiclayo, Cuzco, Piura, and Trujillo conducted by the Private Sector Family Planning (SPF) Project in 1988 produced similar results. The relative contributions of the public and private sectors were basically unchanged (52 percent public sector and 48 percent private sector for all modern methods; 67 percent public sector and 33 private sector for IUDs). Better information on use of pharmacies was obtained than in the 1986 DHS; the pharmacy contribution of non-IUD modern methods was 55 percent and of all modern methods was 27 percent (versus approximately 7 percent of all modern methods in the DHS).

A thorough market analysis is planned for Project Year I (PY 1), to determine the size, location, and characteristics of the potential markets for the CSM and CSD components of the Project. Preliminary evidence suggests that current retail prices of oral contraceptives are too high for many potential consumers, given the deterioration of the Peruvian economy. Wholesale sales of oral contraceptives to pharmacies in February, 1991, averaged only 60 percent of the levels observed immediately prior to the government's de-control of prices in August, 1990, and the resultant price increases.

Many beneficiaries of private health plans are excluded from commercial family planning outlets because their policies do not cover family planning or do not cover the prices charged by private providers. A survey conducted in the largest social security hospital in Lima during April-May, 1991, found that 11 percent

of maternity patients also had private health insurance, but had come to IPSS because their policies would not cover the costs of a private hospital. Similarly, 25 percent of the last births to insured clients being seen at a private clinic had been attended in the public sector, because of low coverage ceilings.

The inability of large segments of the population to pay high commercial sector prices and the inability of the PVO and public sector to serve all of the economically needy underscores the importance of A.I.D. assistance in establishing low-priced, self-sustaining family planning programs in the commercial sector.

3. Unmet Demand for Contraceptives

Unmet demand for contraceptives in Peru is among the highest in the world. For more than a decade, Peruvian women have had, and continue to have, more children than they wanted. As early as 1981, average ideal family size was already fewer than three children, or about 1.5 fewer children than 1986 total fertility levels. Over one-third of all births occurring in the last three years before the 1986 DHS were reported to be "unwanted," because the woman did not wish to have any more children.

The rate of unwanted pregnancies is even higher, as many are terminated by clandestine abortions. Recent studies estimate that in urban areas, as many as half of all pregnancies are terminated by abortion; government statistics demonstrate that abortion complications are the fourth leading cause of hospital admissions in Peru.

There are many operational definitions of unmet demand for contraception. At a minimum, it would include all sexually active, fecund women who do not wish to become pregnant and are not using any contraceptive method. To these could be added pregnant and post-partum women who do/did not wish the pregnancy and were not using contraception when it occurred.

C. Factors Affecting Family Planning in Peru

1. Political and Economic Considerations

Viability of the Commercial Sector in a Time of Economic Crisis

The current economic situation in Peru poses a difficult constraint to the successful implementation of any project, but commercial family planning is particularly vulnerable to market place variations. Experience has shown, for example, that oral contraceptive use dropped in other countries in Latin America during recessions.

While the IMF, most donor economists, and Peruvian analysts such as Richard Webb, feel that the economic measures being taken by the Fujimori government may ultimately reverse the decades of government mismanagement, the immediate impact of these policies on Peru is extreme economic recession. Over 70 percent of Peru's working age population is unemployed or underemployed, and consumers at all levels of society are having great difficulty securing basic foodstuffs and shelter. This situation potentially constrains consumer demand for commercial family planning goods and services, particularly among first-time users who may not be as committed to continuous contraceptive use.

In addition, with trade liberalization, many previously protected enterprises may reduce operations or, in fact, disappear altogether. Their budget constraints might limit openness to proposals that they expand their employees' social benefits to include family planning services -- even if such services are demonstrated to be cost-beneficial.

On the positive side, both the formal and informal sectors are adjusting to new opportunities. Attitudes among specialists in the commercial sector that deal with contraceptives are generally positive, even about the short-term market potential of existing products and for introduction of new products. Moreover, migration to cities has important implications for commercial family planning. Since private commercial sector delivery is concentrated in urban areas, the increasingly larger urban population will enhance the economies of scale and market opportunities, which could further attract private commercial sector involvement.

The Commercial Family Planning (CFP) Project has the potential to continue to provide accessibly-priced contraceptive methods and reproductive health services for the moderate and low-income populations which have been hard hit by recent economic events. Pharmaceutical manufacturers and local distributors will benefit from the continuation of this profit-making activity which increases their interest in, and commitment to future social marketing endeavors. Private health providers and insurance companies, which hope to attract new clients from the privatization of the national security system, will benefit from assistance in implementing family planning services, which will not only be required under new legislation, but will produce financial returns in other, more expensive, services averted.

Major entities in the commercial and industrial sectors have made corporate commitments to continue business in Peru and have weathered the last years of serious crisis and uncertainty. Others have not been able to maintain operations and have reduced their presence in the domestic market or exited completely. Schering Peruana and Quimica Suiza, which have collaborated with APROPO on the CSM Project in the past, have successfully maintained business ventures in Peru and plan to continue in the future. They are interested in being considered as participating agencies and have expressed their commitment to CSM. Likewise, a few but highly visible employers and health care providers, such as Milpo Mining Company and MEDIC, SA medical group, have already implemented self-financed family planning services. They are prepared to expand their activities and can serve as persuasive role models for the CSD component.

Manufacturers have maintained the necessary levels of production of contraceptive products in Peru so that pharmaceutical companies can continue to cover retailer and consumer demand. Distributors have not only maintained their product lines, but are apparently expanding distribution coverage to include the burgeoning informal sector outlets which now increasingly include market stalls in provincial areas.

The reduction in import duties since August, 1990, for both raw materials and finished products has made it possible for contraceptives to be imported at a much lower entry cost. This allows a wider range of retail prices to be considered when establishing prices, as well as potential for higher profit margins for the Project within each brand's price structure. Marketing of this product, thus, becomes much more attractive and viable for both the CSM component and its commercial partners.

Government price de-regulation, which replaced price controls with suggested price ceilings, has allowed marketers, particularly those in the pharmaceutical sector who previously had artificially low prices set by the GOP, to substantially increase retail prices. The implication for CSM activities is that, as commercial prices rise, there will be an even greater need for accessibly priced contraceptives. It also means that the CSM component can improve the quality of product selection by marketing a range of brands within each product category (i.e., OCs, condoms and injectables) at different prices.

Relatively less effective public sector

Decreasing budgets in the public sector underscore the importance of the Commercial Family Planning Project. The public family planning service delivery infrastructure suffers from lack of trained medical personnel, management capability, and staff continuity. As public sector services diminish further and the PVO sector is utilized more fully, the role of the commercial private sector will be increasingly important.

The inefficiencies in the public sector have already led increasing numbers of Peruvians to depend on the commercial sector and the private voluntary sector for family planning services and supplies. The market research to be carried out in PY 1 will determine the number of current and potential users who have enough disposable income to afford reasonably-priced commercial sector goods, or whose private health plans do not cover family planning services.

The proportionately large urban population and widespread network of existing pharmacies and other retail and service outlets make Peru an excellent environment for such commercial provision. As the number of women entering reproductive age increases due to rapid population growth in the past, demand for modern family planning methods will increase, and the role of CSM and commercial service delivery activities will be even greater.

Legal and regulatory constraints

Overall, the legal and regulatory environment for commercial family planning activities has improved under the Fujimori government. Import tariffs and restrictions have been reduced, lowering costs for imports and local manufacture of commodities using imported materials. This improved environment has fostered a greater willingness among pharmaceutical companies and distributors to invest in new ventures, such as the introduction of new commodities and brands.

The deregulation of pharmacies has resulted in an immediate increase in the number of drug store outlets (including new pharmacies in a supermarket chain in Lima) which will continue to grow throughout the country. This will mean a greater number of outlets for social marketing products and increased marketing vigor in the long-established drug stores aware of new competition.

The restriction on dispensing oral contraceptives outside pharmacies needs to be changed so that Community Based Delivery (CBD) workers can sell social market brands. APROPO should approach the government with examples of social marketing programs, including the recently concluded operations research study sponsored by SOMARC, INOPAL, and the Pathfinder Fund, which introduced CSM products into CBD systems. Outreach into the informal sector and pueblos jovenes would be facilitated by this regulatory change.

A potential constraint to the commercial service delivery component of the Project is the prohibition on voluntary sterilization for contraceptive purposes. MOH norms permit voluntary sterilization only for high reproductive risk, which is specified by such health criteria as maternal age, parity, poor obstetric history, and acute and chronic health conditions. Most of the men and women wishing to opt for this method satisfy the MOH criteria for high reproductive risk. Nevertheless, APROPO should take advantage of the "Family Planning Year" by lobbying to have this regulation changed. While it may not limit the actual number of sterilizations, it is a relic of old attitudes inconsistent with the new atmosphere of open support for family planning. Also, sterilization, particularly vasectomy, requires promotion. Elimination of this regulation would facilitate all types of educational and promotional activities.

Continuing leadership commitment

Peru's new President, Alberto Fujimori, has been in office since July 1990. He has expressed his commitment to the National Population Program, recognizing the need for a strong family planning services delivery element. This environment will facilitate the success of the CFP Project. The National Population Council (CNP) has developed a plan for the next five years of the program. The Minister of Health indicated his intention to support the President by aggressively implementing family planning services and promoting public - private sector cooperation.

2. Socio-Cultural Considerations

The vast social, cultural, and geographic differences that exist in Peru constitute a constraint for commercial family planning. Conservative medical professionals and influential community leaders often side with the Catholic Church hierarchy in opposing modern methods of family planning. It is unusual to find half of the couples practicing family planning in a Latin American country to be still using traditional methods, as is the case in Peru. Deeply ingrained misconceptions about specific methods make the transition from traditional methods to modern ones difficult. For this reason, a social marketing component and a national family planning communication strategy and program have potential for changing attitudes and behaviors which currently present barriers to use of family planning services and products.

An advantage for carrying out successful CSM promotion is that Peru is one of the few countries in the world that allows brand specific advertising of contraceptives on television and other mass media. It is important for APROPO and the pharmaceutical companies to maintain this right by continuously exercising it. The theme used in Phase II of the previous CSM program that the individual has a right to decide when and how many children to have, will be continued under this Project.

3. Gender Considerations

Lack of Gender Disaggregated Data

Information on men's knowledge, attitudes, and practice of family planning is limited; contraceptive prevalence surveys typically have used only female respondents. In order to raise contraceptive prevalence and to increase the use of under-utilized methods, especially condoms and vasectomy, the male perspective should be investigated.

Male Opposition to Family Planning

It has been suggested that the man's consent may be necessary for the woman to adopt family planning. In Peru, spousal opposition to contraception does not appear to be an important explicit factor in a woman's non-use of family planning. In the 1986 DHS, only 1.2 percent of the women who had discontinued family planning and 8.7 percent of the women exposed to unwanted pregnancy and not using contraception cited the opposition of their spouse as the principal reason for not using family planning. However, men report the same health fears about contraceptive methods as women.

Male's Refusal to Cooperate; Lack of Male-oriented Family Planning Programs

Of the various contraceptive methods available, one (natural family planning) requires the man's cooperation and three (withdrawal, condom, vasectomy) are used by the man rather than by the woman. The two modern male methods show the lowest prevalence rates: condoms (0.7 percent) and vasectomy (less than 0.01 percent). Condoms appear to be used more in pre- and extra-marital relationships, and usage rates are under-estimated in the standard prevalence survey. Vasectomy, on the

other hand, has never been promoted, is generally unavailable except for a few private sector outlets, and is virtually unused in Peru; only one case was reported in the 1986 DHS survey.

Socio-cultural stereotypes as well as legal constraints may lead potential vasectomy providers to conclude that the method is unacceptable to Peruvian men and therefore not worth promoting; the resulting lack of information and availability prevents potential users from learning about and adopting vasectomy. Countries such as Brazil and Colombia, where vasectomy has been strongly promoted by clinical programs oriented to men, now show significant acceptance of the method. Peru has the potential to follow suit.

Women's Participation in Management and Training Opportunities

It appears that among the professional service providers (physicians) and program managers, the proportion of women is less than their proportion of the population. Gender-disaggregated data on program managers, physicians, distributors, service receivers, participants, and beneficiaries will be collected during the implementation of this Project. Gender-disaggregated training targets have been developed on the basis of these findings.

D. USAID/Peru and A.I.D. Policies and Strategies

1. A.I.D. Population Policy

The underlying principles of U.S. assistance for family planning are voluntarism and informed choice. A.I.D. seeks to (1) enhance the freedom of individuals in developing countries to choose voluntarily the number and spacing of their children, and (2) offer a range of family planning methods and information about those methods. As one component of A.I.D.'s family planning program in Peru, this Project will increase information about the safety, efficacy, and availability of both temporary, and long-lasting methods. In addition, this Project will mobilize the resources of the for-profit sector to support the expansion of family planning services in Peru.

2. USAID/Peru Population Sector Strategy

USAID/Peru's strategy for the population sector is outlined in the USAID/Peru Population Sector Strategy approved in August 1990, the 1991-1992 Action Plan and the new CDSS. Rapid population growth is a serious impediment to Peru's long-term economic development, and high fertility has detrimental health consequences for women and children. The USAID strategy responds to existing unmet demand for family planning by increasing service delivery capabilities throughout the health sector. The Mission's overall approach is to assist the public sector through the MOH and the IPSS, PVOs, and the private commercial providers by increasing the promotion and availability of family planning products and services. This Project addresses the last approach.

The Project contributes to the following USAID Population Strategy objectives:

Providing or Extending Access to Family Planning Services and Products by:

- guaranteeing contraceptive supplies
- expanding the commercial sector's role in providing non-clinical temporary supply methods
- widening the financial base for family planning services
- improving coordination between public and private sectors

Providing Services for Peruvians Seeking Long-term Family Planning Services and Products by:

- encouraging private health plans to underwrite long-lasting family planning methods
- supporting GOP policy changes

Data from the 1986 DHS indicate that 64 percent of women in union of reproductive age do not wish to have any more children. This finding has been corroborated by other surveys. The demand for longer lasting methods cannot be entirely met by the public sector, whose facilities are already over-loaded with maternity cases and medical emergencies. Extending private health plan coverage to include family planning can relieve the demand on the public sector from private sector beneficiaries who currently use public outlets, and encourage other beneficiaries who prefer not to use public outlets but cannot afford commercial prices to adopt clinical methods.

The demand for temporary methods of family planning will be handled largely by the private sector, including both commercial providers and PVOs. Approximately 280,000 women a year enter the age of child-bearing and need to space pregnancies, in addition to those women already in their child-bearing years whose demand for family planning methods still goes unmet.

E. Lessons Learned from Past and On-going A.I.D. Projects

1. Integrated Health and Family Planning Project (CSM Component, Phases I and II) (527-0230)

With the encouragement of USAID/Peru, APROPO became involved in social marketing of contraceptives. USAID/Peru and APROPO signed a five-year contract in June 1984 that proposed increasing contraceptive usage by supplying information and affordable contraceptives to Peruvians through commercial channels. Under the program, OCs, condoms and vaginal tablets were to be procured through AID/Washington and then packaged, distributed and advertised in Peru.

The CSM II Project achieved several important accomplishments, among them were:

- Building a CSM organization with the cooperation of local commercial product suppliers, distributors, advertising and market research agencies;

- Obtaining the MOH authorization allowing brand-specific advertising;

- Launching a national mass media brand-specific advertising campaign;

- Collaborating on pilot project with local PVOs to merge CBD and CSM activities.

The principal lessons learned from this experience are the following:

- Insure that the project has strong marketing management. As the implementing agency, APROPO gained experience in initiating and developing some of the key marketing activities (advertising and market research) and in coordinating inputs and participation of the commercial sector participating agencies. In the future, the implementing agency must take a closer, more active role in the product management of the CSM brands so as to achieve increased sales in the most cost-efficient manner possible.

- Manage according to long-term marketing strategy and annual marketing plans with clear, measurable objectives and a self-sufficiency plan. Objectives should include, but not be limited to, sales levels, distribution expansion, price maintenance, new and continuing users, increases in correct use and introduction of new brands.

- Eventually cover the cost of management and administration by CSM product sales. This should be figured into the plan for self-sufficiency.

- Use local sources where possible. This enhances levels of project self-sufficiency by decreasing dependence on A.I.D. for commodities and distribution and builds public/private ventures.

- Control and monitor illegitimate competition from the commercialization of donated condoms which, in the past, sabotaged the commercial market and diminished potential for CSM brand introduction.

- Base an integrated marketing communication strategy on strong reliable research and clear definition of target audiences and focus on meeting consumer need. This strategy should fit with a National Communication Plan designed and implemented by all organizations involved in family planning activities.

- Use non-traditional media as a major part of advertising and promotion due to high cost of TV and questionable impact of brand-specific promotional campaign on countering myths and rumors about modern methods, which are the greatest barriers to use in Peru.

- Distribute CSM products to an expanding number of non-pharmacy outlets to improve the level and quality of care delivered by increasing the availability of contraceptives in urban and rural areas of Peru.

- Continue the careful formulation of research methodologies and their implementation by capable and well-selected firms.

- Concentrate on improving the interpretation and application of research results to program planning and strategy adjustment.

2. TIPPS (1986-1990)

The centrally-funded TIPPS Project was designed to encourage private employers and health care providers to offer family planning services for their employees and beneficiaries, by demonstrating the cost-savings realized from maternity-related services averted.

TIPPS conducted three cost-benefit studies in Peru. and carried out two pilot service-delivery projects. The three study sites selected were ELECTROLIMA (a parastatal electric company), Milpo (a private mining company), and the IPSS. All three studies concluded that it would be cost-beneficial to offer family planning services to employees and beneficiaries.

Below are some important lessons learned from the TIPPS experience in Peru which can serve to inform the implementation of the Project's CSD component:

- Even in times of economic crisis, there are private employers who can achieve significant cost savings with family planning and are willing to invest in family planning services.

- Most urban employers do not think that their workers need family planning assistance. Statistical information is needed to convince them otherwise.

- Implementing family planning is a lengthy process and requires continuous one-to-one contact and follow-up.

- Most companies require some degree of technical assistance to establish services or to develop linkages with organizations that provide such services.

- Employers are not in the family planning business. While managers are genuinely concerned with employee welfare, implementation and supervision of family planning will always be a low priority for the company.

Annex XVI includes a detailed description of lessons learned in past and on-going A.I.D. related projects.

F. Relationship of this Project to New and Ongoing USAID Projects

1. Private Voluntary Family Planning Services Expansion Project (527-0335)

The Private Sector Family Planning Project supports the family planning PVOs in Peru. All three components of the CFP Project will coordinate closely with PVOs and the Private Sector Family Planning Project. The PVOs will expand their marketing of 6 (six) CSM products, and the CSM component of the Project will coordinate closely with CBD workers on the introduction of new CSM products. The CSD component will use PVO services wherever feasible. The National Family Planning Communication component will involve joint activities with PVOs and assist them with IEC activities.

2. Child Survival Action Project (527-0285)

USAID/Peru family planning activities in the public sector (MOH and IPSS) are financed through the Child Survival Action (CSA) Project. The CFP Project will coordinate with the IPSS in the CSD component, and the National Family Planning Communication component will coordinate with the public sector IEC programs.

3. Strengthening Health Institutions Project (527-0319)

This new project, currently under design, will incorporate innovative child survival activities and focus on institutional sustainability. The CFP Project will coordinate closely with this effort, exploring opportunities to market CSM brands and to collaborate on communication projects.

4. AID/W Centrally-Funded Population Activities

Throughout the years, various Cooperating Agencies (CAs) have provided funds to PVOs to carry out such family planning activities as training, research, and service delivery, in accordance with the mandates of their respective AID/W centrally-funded projects. Mission involvement with these activities has been limited primarily to approving project design. Since early 1988, however, the Mission has taken a more active role in targeting and coordinating CA assistance to conform with USAID's family planning strategy.

The USAID Population Division maintains a listing of all CA projects and updates it every six months. Current levels of total CA funding are approximately US$1.5 to US$2.0 million per year (from 1985-1988, 17 CAs funded 45 projects).

The CFP Project will coordinate with centrally-funded projects. The CSD component would be particularly interested in assistance from JHPIEGO for training in the family planning service centers which are contracted to work with enterprises. APROPO and Johns Hopkins University/Population Communication Services (JHU/PCS) will examine all on-going activities to coordinate with existing or potential communication activities. The CSM component will receive Technical Assistance of The Futures Group/SOMARC II. A study of other AID/W CAs working in Peru will be made to determine areas of possible collaboration like research, training, and promotion of social marketing products.

G. Other Donor Activities

As mentioned, A.I.D. provides approximately US$2.5 million in bilateral population assistance to Peru annually, plus another US$1 to US$2 million each year in central population funds. Combined, this figure has represented some 75 percent of all international donor population assistance in Peru. With the approval in late 1988 of a US$5 million project by the United Nations Fund for Population Activities (UNFPA) to the MOH, however, that percentage has declined. Recently, the German Technical Assistance Agency (GTZ) funded a project to expand delivery of IUDs in the province of Cuzco.

A.I.D. continues to be the only large-scale donor for the private sector. None of the other international donors have mounted family planning projects in the commercial sector.

H. Project Rationale and Strategy

1. Problem to be Addressed

The problem the Project will address is that due to low levels of use of modern contraceptives, Peruvian women and men continue to have more children than they want. Two "sub-problems" it will address, that serve to create this situation, are 1) inadequate supply of accessibly-priced and located family planning services and products, and 2) myths, rumors and other misinformation, or a general lack of information among Peruvians about family planning methods and usage. The individual project components will address these sub-problems directly, and in so doing, will make an impact on the overall problem the Project is designed to address. For example, the communication efforts under CSM and the coordinated National Communication Campaign will educate Peruvians about contraceptives in an effort to dispel false notions. Given the constraints of the public sector and the worsening economic situation, this Project is needed to increase availability and accessibility of family planning services to moderate and lower-income women and men.

2. Strategy to Address Problem

The Project will address the problem by mobilizing private commercial sector resources to increase the quality and level of family planning services available to the Project's target group and to communicate to them about different types of family planning methods. The Project will target its efforts to moderate and lower-income Peruvian women and men who wish to limit or space their number of children and who possess sufficient resources to pay for reasonably-priced commercial contraceptive products or who are beneficiaries of private health plans which do not cover family planning.

The separate components will employ the following strategies:

CSM Strategy

Establish strong liaisons with the commercial sector;

- Plan for eventual self-sufficiency of CSM activities by preparing the implementing agency to provide the services on a commercial basis;
- Maintain accessible pricing of contraceptive products;
- Attain ample coverage of the target market;
- Expand distribution to new user groups;
- Develop and disseminate information about family planning;
- Offer a minimum of three "social market-priced" family planning products;
- Enhance APROPO's public image as a health and family planning promotion institute.

CSD Strategy

- Identify the universe of potential participants in the CSD program, including private employers, health insurers and private health care providers;
- Demonstrate through cost-benefit analyses and other studies, the returns of including family planning services in company health programs/policies in financial terms, and in terms of increased employee productivity;
- Promote among opinion leaders the concept of family planning as a cost-effective social benefit;
- Identify private health care providers to work as partners with APROPO;
- Train APROPO to be a broker for the provision of family planning/reproductive health services;
- Offer adequate information and services for all client groups.

National Communication Strategy

- Work with public and other private family planning organizations in coordinated communication efforts;
- Involve as many PVOs as possible;
- Help individual organizations link their IEC programs to the national strategy.

3. Rationale for Strategy Selected

There is clearly a need in Peru for further family planning assistance, and many factors argue that now is a good time to begin a private commercial sector program. Some of the factors demonstrating need, and providing an encouraging environment for a commercial sector family planning project, are:

The Demographic Context

The rationale for the CFP Project in terms of demographic importance is clear. The 1986 DHS documents the high unmet need for family planning services among women in union. A major reason for non-use was the fear of damage that contraceptives would do to their health. This reason was followed in importance by a lack of knowledge of sources of products and services. A well-planned and executed Project can address these two deficits and decrease the unmet need for family planning in Peru.

Economic, Social and Political Context for CSM

In a time of economic crisis and uncertainty replete with hyperinflation and high levels of unemployment, it is all the more critical to have contraceptive information and products physically and economically accessible to people at all levels of society. Given the social and economic displacement caused by the crisis, Peruvians' purchasing power and priorities have undergone major shifts. Active promotion of a range of CSM products sold at affordable prices via convenient outlets, and family planning services offered through employer-subsidized health plans will ensure that the majority of Peruvians have access to safe and effective contraceptives. It will also relieve potential pressure

on the public, NGO and PVO sector organizations which are not in a position to increase their services and product delivery.

The current political climate is ideal for family planning programs in Peru, particularly those based in the commercial sector. The new administration supports privatization efforts and development of the commercial sector. President Fujimori has declared 1991 the "Year of Austerity and Family Planning" which is being publicized nationally via mass media. The CNP has drawn up the National Population Plan for 1991-1995 which includes specific objectives and prevalence targets for contraceptive use. Brand-advertising of ethical products is legal in Peru and sales via non-pharmacy outlets have been authorized on a pilot basis.

The Commercial Infrastructure in Peru

The commercial infrastructure in Peru is ideal for this venture. For the CSM component, there are very capable and experienced advertising agencies, market research firms and local distribution firms from which to select participating agencies. Distribution channels are well-developed in urban, semi-urban and semi-rural areas and are being expanded daily to include greater percentages of the informal sector outlets. In addition, there are pharmaceutical companies which have committed their corporate resources to continuing the manufacture and distribution of contraceptives, namely OCs and injectables, despite the economic crisis. Import regulations and tariffs have been relaxed making the introduction of condoms by a CSM program feasible. The regulations on establishing pharmacies and drugstores have recently been amended and an increase in number of outlets has already been noted. The informal sector has been recognized by the administration as a viable and legal distribution channel for consumer goods.

For the CSD component, there are a reasonable number of health service providers, health insurance firms, self-insurance funds and insurance brokers. Most of these organizations are located in Lima and Callao, or have company headquarters located in the capital. Some of these organizations have contracts with private providers in other principal cities of Peru. The commercial health sector has no formal involvement in family planning services, except in the case of the pilot project carried out with MEDIC, S.A., but are important providers of contraceptive methods, through private physicians, clinics and medical centers.

Rationale for Selection of APROPO

APROPO is an appropriate implementing agency for the three components of the Commercial Family Planning Project based on its not-for-profit status, its previous experience with a range of family planning organizations in Peru as well as its experience and success in building public/private ventures. In the past, APROPO management has played an active role in achieving important policy changes at presidential and ministerial levels, in coordinating family planning activities among local organizations, and in participating in the work of the CNP.

APROPO founders, and Board of Directors are individuals drawn from leadership positions in the business community. Their contacts with government authorities facilitate policy dialogue, which is an important element of this project.

APROPO, has had over five years of experience in CSM and is committed to continuing these activities based on lessons learned from the past. APROPO staff has worked closely in the last few years with a local advertising agency and several market research firms in Peru which have gained experience in working with the concept of marketing contraceptives and family planning services. APROPO has also had experience in CSD-type activities during the pilot project PERU 22 in 1984-85, and recently with the TIPPS Project which worked with MILPO and other mining and industrial companies.

The purpose of selecting APROPO as implementing agency is to base the CFP Project in a local agency which has the respect of all related agencies, the public stature and the relevant experience necessary to support and enhance project activities by maintaining a policy change dialogue, by its active involvement in the CNP's National Population Plan and by coordinating with other organizations working in reproductive health projects for improved coverage and quality of services and products.

III. DETAILED PROJECT DESCRIPTION

A. Project Goal and Purpose

The Project goal is to contribute to improve the health status of Peruvian families through increased access to modern family planning methods. The Project purpose is to increase the provision of modern contraceptive methods through commercial sector channels.

B. End-of-Project Status Indicators

The objectives of the Project are (1) to firmly establish a range of self-supporting CSM brands of oral contraceptive within the commercial sector to give consumers a wider choice of products and prices; (2) to establish a range of self-supporting CSM brands of condoms within the commercial sector; (3) to pilot test other self-sustaining CSM products; (4) to increase the number of employers and health insurance companies that provide family planning benefits to their employees and policy-holders; (5) to develop a national family planning communication strategy and participate in a national communication program; and (6) to establish a strong institution to carry out commercial family planning and other social marketing projects. At the end of PY 1, once the market research and target group analysis has been carried out, more specific, quantifiable objectives will be established for the Project, in terms of additional family planning outlets and contraceptive protection to be provided.

In more detail, these objectives are as follows:

1. Self-Supporting CSM brand of Oral Contraceptives within the Commercial Sector

A "self-supporting" CSM brand means that the retail sale price pays for the manufacturing and marketing costs of the product, plus on-going promotion at levels that increase sales. In addition, within five years product sales should cover the administrative costs of management of the CSM line at APROPO. While there is obviously a tension between these goals and maintaining prices that are affordable by target consumers, initial discussions with pharmaceutical and marketing companies indicate that both sustainability and affordability objectives can be achieved.

APROPO will need technical assistance in negotiating contracts with its commercial partners. Ultimately, the APROPO share of product sales profits established in the contract must cover the salary of the CSM component manager plus other administrative costs. Given the uncertainties of the Peruvian economy, it may be necessary for APROPO to accept a phased cost-recovery scheme, but the five-year goal of full sustainability will be made clear to all participants. An incentive system will be instituted at APROPO, and the CSM component manager will receive a sales commission in accordance with product performance.

2. Addition of Other CSM Brands of Oral Contraceptives

Expanding the number of CSM brands of oral contraceptives, including some higher-priced options, is a worthwhile objective of this Project. While only the lowest priced CSM brand will be promoted directly by this Project, that promotion could result in a general increase in sales of oral contraceptives, and sales of other brands will contribute to overall product category sales. More brands, and a range of prices, will improve the image of oral contraceptives and address quality of care issues. Preliminary discussions with local pharmaceutical and marketing companies indicate support for the idea. The marketing strategy to be developed in PY 1 will explore this possibility further and outline APROPO's role.

3. A Self-Supporting CSM Brand of Condoms

As with oral contraceptives, the condom brand will be self-supporting by EOP. Preliminary discussions with Quimica Suiza, a likely importer and distributor of condoms, indicate that the sales price could support the promotion of the product. The CSM component manager could handle this product as well as the oral contraceptive. Addition of condoms is important for sustainability of CSM brands. Single product and brand lines are harder to sustain than multiple product and brand lines.

A preliminary analysis of the market indicates that the business environment for commercial sale of condoms has improved in recent years. It appears that inflow of donated condoms into the commercial sector has been reduced. Additional measures recently taken by USAID should reduce the problem further. One distributor's condom sales in the last three months have amounted to more than its total sales for last year.

4. Other Products Pilot-tested on a Commercial Basis

Other potential CSM products include IUDs, spermicides, injectables, and non-family planning health products. A marketing study in PY 1 will examine the feasibility of social marketing effort of IUDs. It is recommended that APROPO continue to handle (but not spend A.I.D. funds to promote) Lorophyn, a vaginal foaming tablet. APROPO should explore introduction of a faster-acting foaming tablet, as well as social marketing of injectables financed with non-A.I.D. funds. Ultimately, APROPO should seek funding to social market other health products such as Oral Rehydration Salts (ORS). To achieve sustainability, APROPO needs to position itself squarely in the commercial sector as the institution with comparative advantage in marketing health products.

5. The Number of Employers and Health Insurance Companies that offer Family Planning Services Increased

In the first year of the Project, APROPO will determine priority targets and develop a detailed strategy to convince companies to provide family planning benefits to their employees and policyholders, using lessons learned from Milpo Mining and other companies. As with all projects involving the commercial and industrial sector, the state of the economy is a very important factor. Incentives or assistance with start-up costs may be offered in the initial years of the project.

Experience has shown that the success of industrial promotion of family planning depends on delivery of services and contraceptive supplies. APROPO will identify reliable sources and providers of the full range of services needed by both spacers and limiters to ensure that once companies have agreed to provide services, their needs are met. Part of APROPO's challenge will be to broker supplies and services and to arrange training for the medical staff of participating companies.

As different employers use different arrangements to finance health services for their employees, the project will work also work with insurance companies, brokers, and third party service providers. In addition, APROPO will explore possibilities of marketing supplies, training, information, or other services to independent physicians and medical groups.

6. A National Family Planning Communication Strategy Developed and a National Communication Program Coordinated

Comparing the large number of Peruvian women (64 percent) who do not want any more children to those using modern contraception (23 percent), it is clear that a massive communication effort is needed. Rumors and negative publicity about modern methods must be counteracted for method- and brand-specific messages to have optimal impact. Communication research has shown that use of multiple channels increases the impact of messages. Non-traditional advertising methods such as folk singers, theater groups, and interpersonal communication could have a powerful impact with different target groups.

An effective communication program could reverse prevailing attitudes and achieve behavioral change, ultimately converting the demand for fewer children into greater use of modern contraceptive methods. APROPO will support Peru's National Family Planning Communication Program. At the beginning of PY 2, a national family planning communication conference and workshop will be held to divide responsibilities between the IEC programs of the most active agencies and to train specialists in modern targeting and evaluation methods. The conference could be a major publicity event itself. Materials for the press could be prepared beforehand and President Fujimori should be invited to give the opening address.

The Johns Hopkins University Population Communication Services (JHU/PCS) project will provide technical assistance to APROPO to plan the conference, conduct training, and assist in implementation and evaluation of communication campaigns, using a base of in-country specialists previously trained in communication planning.

7. A Strong Institution able To Carry Out Commercial Family Planning Established

APROPO has had some significant successes in carrying out commercial family planning. At this stage, it needs to establish itself more solidly in the commercial sector. The Project will help APROPO to adopt management techniques from the private sector such as incentives for employees, and performance evaluations based on the level of sales achieved by the products they handle.

Technical assistance is needed in both social marketing and commercial service delivery. Each of these areas should be self-sustaining, technically and financially, after five years. To continue the promotion of commercial family planning activities after the project completion, it will not be necessary to maintain the same funding levels. Therefore, APROPO will adjust its operation according to the level of income generated.

C. Project Components

The CFP Project consists of three separate components: Contraceptive Social Marketing, Commercial Services Delivery and National Family Planning Communication. All three components will be implemented by APROPO with assistance from experts in the fields of social marketing, commercial services delivery and communication strategies. The Project has a life-of-project of five years and will be funded at a level of approximately US$5.7 million over the five year period, of which amount US$5 million will be provided directly by A.I.D. The first year of the Project will consist of pre-implementation activities such

as gathering demographic and market data and setting targets for the Project. Actual implementation of project activities will begin toward the end of PY 1, based on the results obtained from these preliminary studies.

In more detail, the project components are as follows:

1. Contraceptive Social Marketing Component

a. Participating Agencies

(1) APROPO

(2) Local pharmaceutical companies that manufacture OCs and injectables, will be competitively selected to supply the Project's CSM brands. These companies will be required to provide in-kind and/or financial contributions to project activities such as medical detailing, retailer training, communication materials and brand advertising.

(3) A local commercial distributor of OCs and injectables will be competitively selected. It will also import and distribute condoms and other CSM products and brands. Other commercial distributors may be invited to participate in project activities as needed.

(4) Local advertising agencies will be competitively selected and contracted to develop an advertising campaign for the CSM products.

(5) Local market research firms will be competitively selected and contracted to implement studies required to design, track and evaluate the CSM component's impact. Studies will be contracted for on an as needed basis.

b. Market Coverage - Target Audience

The CSM target audience includes those moderate and lower-income Peruvian couples willing and able to pay for contraceptive methods who are not contracepting or are using traditional methods and who do not want more children or want to delay the next birth, and those who are using public family planning sources when they could afford commercial outlets.

Concrete socio-economic categories have not been specified at this time, in light of the current economic situation in Peru which makes it very difficult to determine the proportion of the population falling into the various socio-economic categories usually used to quantify CSM target audiences, or to determine the purchasing power of the minimum wage. This qualitative definition will be quantified more clearly in the CSM Marketing Strategy to be prepared in PY 1 once the appropriate economic analysis of consumers' purchasing power has been completed.

c. Objectives of CSM component

The principal objective of the CSM component is expanded access to commercial family planning products. This requires careful consideration of all aspects of marketing, including program management, product/brand selection, price setting, distribution and integrated communications.

The specific objectives of the CSM component are listed below. These objectives will be quantified in the Marketing Strategy which will be developed during PY 1:

(1) Expand the CSM product line to include different products (i.e., condoms, IUDs and/or injectables) as well as the number of brands within each product category.

(2) Expand distribution by increasing the number and type of retail outlets so as to be able to reach all target groups with CSM brands, including those in the provinces and the informal sector.

(3) Increase annual sales of the CSM brands and the overall product categories (condom, pill, injectable).

(4) Achieve increased levels of cost recovery each year of the Project.

d. Promotion of CSM Products/Brands

CSM products and brands will be promoted according to an Integrated Marketing Communication (IMC) Plan developed jointly by the CSM component manager and the advertising agency in PY 1. The IMC plan will coordinate all communication messages and materials for all target groups and all media. This will support and amplify the effect of each distinct activity and more effectively reach consumers with information and promotion appropriate to their needs. The Plan will include promotion for both consumers and retailers, and include a variety of approaches, such as mass media, print materials, hotlines, public relations activities, medical detailing, retailer training program and non-traditional media. Maximizing impact at the lowest possible cost will be a critical concern.

The IMC Plan will be coordinated with the National Communication Plan to achieve the maximum impact of each effort.

The CSM Component will take full advantage of the legality of brand-specific advertising in Peru. The marketing advantage of brand-specific advertising is that it captures consumers' interest and gives them something to focus on instead of diluting that curiosity and attention by emphasizing various brand alternatives of the same product.

Brand specific advertising will be paid by the producer. The brands selected for mass media promotion will be the lowest priced alternative within each product category (i.e., the lowest-priced OC, condom, etc.). Brand-specific, informational materials for the other CSM brands will be available at the point of purchase, although not all brands may be promoted at all outlets (for example, pharmacies in pueblos jovenes may choose not to carry the most expensive brand). In this way, the brand that is economically accessible to the majority of the target audience becomes the popular brand of choice, with an attractive quality image, and retailers will maintain adequate stocks to fulfill consumer demand.

Brand-specific promotion of the lowest-price CSM brand within each product category, with promotion of the remaining CSM brands at the retail site, encourages consumers with greater purchasing power to feel they are "buying up" when they purchase the higher-priced, but still affordable CSM alternative brands. This is a natural consumer tendency and helps motivate the retailer to stock the entire CSM brand line.

Consumer acceptance of, and familiarity with, modern contraceptive methods promoted by the CSM component may be enhanced by using APROPO's name as an "umbrella" under which to promote all its products and brands of quality health and family planning care. This umbrella concept opens possibilities for future promotion of other reproductive health services and products under the name of a familiar and respected organization.

The umbrella concept may be made more concrete by designing and using a common logo, tag line and/or packaging colors for all the products APROPO promotes. Careful consideration should be given to placing the manufacturer's and APROPO's names together on the package so as to tie into the promotional and communication activities. This is particularly important in Peru where the CSM component will be working with brands that are produced, packaged and distributed by local

participating agencies. These issues will be defined more specifically when the marketing strategy is developed during the course of PY 1.

e. Pricing Structures

The end retail price for each brand of CSM product should be established so as to make it accessible to target groups with varying levels of purchasing power, as established by the pricing studies carried out in PY 1. The retail price structure must cover the CIF (cost, insurance and freight) price of the product and provide the distributor(s), retailers and the project account with sufficient margins of profit.

There should be a range of prices established for the brand alternatives in each CSM product category, with high and low versions, but all within the guidelines of economic accessibility to the CSM target groups.

f. Distribution

Local commercial distribution firms will be competitively selected according to their current level of coverage of both traditional and non-traditional retail outlets as well as their flexibility in expanding to new outlets. This is a particularly key issue in Peru where the informal sector is growing rapidly in both urban and rural areas and where distribution to market stalls in the provinces is also increasing. At a minimum, the firm or firms selected must provide coverage to the 3,500 pharmacies registered in Peru and be capable of reaching the informal sectors.

Retailers will be encouraged to place CSM products in fixed display cases provided by the distributor. The use of such point of purchase cases enhances the brand image, reminds consumers as they enter the outlet, to purchase or query about contraceptives, and enables them to request a brand without embarrassment. The display cases also provide space for informational and promotional materials.

g. Retailer Training

Retailer training is a crucial element in contraceptive marketing. Training increases the retailer's interest in, and commitment to selling products he/she formerly knew little about and had not been known to counsel clients on. The national retailer training program will include contraceptive technology as well as interpersonal relations skills. This has been demonstrated to be effective in increasing product sales and correct use in other Latin American countries.

The training program strategy and agenda will be amended annually according to participating retailers' evaluation and suggestions, and to their attendance patterns during the first year.

h. Policy Support

APROPO will identify any remaining legal or regulatory barriers to project activities, and will pursue policy change. Such areas may include:

- Requirement for sales/consumption tax
- Limitation on sales of ethical contraceptives to pharmacies

i. Market Research

Qualitative and quantitative market research will be conducted to develop marketing strategies, define target group(s) and their purchasing power, prepare communication messages and materials and monitor and evaluate project progress. Techniques typically used by CSM programs include consumer baseline and tracking studies; consumer profiles of users and non-users; message and materials design;

advertising concept testing; materials pre-testing; market retail audits; and "mystery shopper" and training evaluation studies.

The CSM component manager will receive regular sales information for each product category and for each CSM brand, preferably on a monthly basis, to track component performance and adjust marketing activities accordingly. These sales data will also form the basis for commissions paid to APROPO by participating pharmaceutical firms.

2. Commercial Service Delivery

a. Participating Agencies

(1) APROPO

(2) Five medical centers and one clinic (private hospital) will be identified, selected and trained in FP/MCH, and will provide family planning services under the Project.

(3) Two PVOs with expertise in FP/MCH training and promotion will be selected and contracted on a fee-for-service basis to support the participating family planning services providers.

(4) One or two brokers or insurance companies will be contracted to review previous cost-benefit analyses for including family planning services in insurance company health plans, and prepare new ones as needed for presentation to the insurance industry.

(5) Local advertising agencies will be competitively selected and contracted as needed to support the component's communication plan.

(6) Local market research will be conducted or selected and contracted to help design the CSD component's "product" and later track and evaluate its performance.

(7) A local software firm or individual computer service providers will be selected and contracted to develop and maintain a database of potential clients for CSD.

b. Market Coverage - Target Audiences

The target audience of the CSD component will be divided into three groups:

1) The Primary Target Audience will consist of enterprises with 200 employees or more, and the workers/dependents of these companies.

2) The Secondary Target Audience will consist of private health care providers, insurance companies, and brokers. It will also include employers with fewer than 200 employees who offer employee health plans or who would be interested in underwriting family planning services.

3) The Tertiary Target Audience will be health policy makers who can establish legal and regulatory incentives to increasing commercial sector FP/MCH services provision.

In establishing the primary target audience, it is important to distinguish between permanent employees ("planilla") and non-permanent workers ("contrata"). Peruvian labor laws confer considerable guarantees and financial benefits for permanent employees. As a result, many large companies, especially those with seasonal labor requirements such as the construction industry, maintain the bulk of their labor force under fixed-term contracts, which are exempt from the labor laws. This practice poses two obstacles for the CSD component: (1) Fixed-term

workers usually receive no supplemental benefits and therefore incur fewer costs to the employer. Providing family planning to this group is less attractive from the employer's point of view and presents greater administrative requirements than providing family planning for permanent employees. (2) Only permanent employees are listed in company registers for such organization as the Society of Industries, the Society of Mines, etc. This makes it difficult to ascertain the number and identity of those companies which maintain a large and stable work force.

The size of the Peruvian labor force in 1990 was estimated at 7.57 million people, of whom 34 percent (2.02 million) were employed in services, 16 percent (1.18 million) in commerce, 10 percent (795,000) in manufacturing, and the remainder (40%) in agriculture and other sectors (Cuanto, Peru en Numeros, 1991). The Society of Industries represents 13,712 member organizations drawn primarily from the formal manufacturing sector, as well as a few members from other sectors. Their data base includes fewer than 304,000 permanent employees, less than half of the number estimated to be employed in the manufacturing sector. Only 204 companies report 200 or more employees; they represent a total of 92,000 workers.

During PY 1, APROPO will contact other commercial organizations, such as the Society of Mines, to complete the classification of the primary target audience. Members of APROPO's board of directors will be enlisted to provide estimates of the non-permanent labor force and the companies for whom they work. The primary target audience will be the first focus of the CSD component: to market services to enable them to offer family planning benefits for their employees. Among the desired behavior changes in this group include an increased awareness on the part of managers of private firms of the demand among their workers for MCH and reproductive health services. Workers and their families should also learn more about modern contraceptive methods, and freely choose those appropriate to their lifestyle and health conditions.

The secondary target audience is responsible for influencing the utilization of FP/MCH services. It includes private physicians, clinics and medical centers, and heath insurance companies and independent brokers. Figures for 1988 list 135 private hospitals and 41 medical groups for the entire country (Cuanto, 1991), over 70 percent of which are located in Lima-Callao. The major providers are limited to approximately 10-15 large clinics and medical groups and 10 insurance companies. By the end of the Project, members of the secondary target group will be actively involved in promoting and providing reproductive health care services to private industry clients.

Key among the tertiary target audience are government policy makers who can authorize tax breaks or other incentives to companies that offer family planning services to their employees. This group also include such opinion leaders as politicians, journalists and artists. By the end of the Project, it is hoped that this group will clearly recognize the role of the private commercial sector as suppliers and financiers of preventive health care services including FP/MCH, and will encourage their active participation in expanding the family planning market.

c. Objectives of CSD

The key objective of the CSD component is to broaden the base to finance family planning services in Peru by increasing the participation of the commercial sector in family planning service delivery. In essence, it seeks to increase the provision of family planning services financed directly by the private industry or through private insurance systems.

Promoting employer-financed family planning services should not only increase total family planning resources but also lead to increase the commercial sector market share relative to the subsidized sector (PVOs and MOH). It is expected

that industrial expenditures in family planning will encourage the private commercial sector to grow faster than the subdized sector. This transfer may also allow the subsidized sector to recruit new users. This general recomposition of the family planning market is the main expected outcome of the CSD component rather than producing only new users or increases in CYP.

The first step in the CSD component is to convince employers that it is in their best interests to under-write family planning services for their employees and dependents, many of whom may currently use subsidized services in the public and PVO sectors at no cost to the employer's health plan. This will require case-by-case analyses, beginning with the utilization and cost of the social benefits the employer currently offers. In many cases, employers may be paying for pregnancy-related benefits, but are unaware of the extent of these costs or the potential for cost reduction by implementing family planning. In other cases, the costs of unwanted pregnancies to the employer may be indirect, such as lowered productivity due to employee turn-over or maternity leave.

In addition, APROPO must confront many attitudinal barriers on the part of company management. It is important to note that, with the exception of Milpo Mining Company, none of the other companies represented on APROPO's board of directors offers family planning for employees or dependents. Among the attitudinal barriers encountered in the preparatory research for this Project are:

- Perception that FP/MCH services are responsibility of MOH and IPPS only
- Managers who do not think social benefits should cover preventive health care services or who place low priority on FP/MCH services
- Managers who think that urban or skilled employees do not need assistance in obtaining family planning services

Once company management has been convinced to include family planning in employee health plans, the CSD component must make resources available to serve them. Depending on the nature of the health plan, APROPO will work with the company's own health services, health fund administrator, health insurance policy, and/or third party service providers to ensure that employees or dependents who want to utilize the family planning benefit have a reliable source of services. In so doing, it will be necessary to confront other obstacles.

Own Services:

This segment is the most predisposed to see the benefits of including preventive health services and family planning in their programs. Barriers to implementation include uncertain economic conditions, personnel policies, strikes, and lack of knowledge about what these services cost and how to offer them.

Insurance companies and brokers:

The Peruvian insurance industry has no experience with preventive care. In order to keep premiums low, it imposes restrictions on the kinds of services that will be covered and on coverage ceilings, to the extent that many policy-holders are forced to use public sector outlets for maternity care and hospitalization for major illnesses. Private insurers do not urge clients to pay for preventive health coverage for their employees, even those linked to covered benefits such as prenatal check-ups prior to hospital delivery and Pap smears to detect early uterine cancer.

Private Health Care Providers:

Most health care providers see themselves in a reactive role, providing services covered by insurance policies but not taking an advocacy position. Most are physician-run and lack sophisticated management and marketing strategies.

Attending physicians enjoy considerable autonomy, and the medical groups themselves are under minimal external supervision or control. The Project will assist private providers to gear up for the increase in demand for family planning services generated by health insurance companies and self-insurance funds. In addition, APROPO will be prepared to certify that the providers who collaborate with the Project are trained to offer a full range of high-quality family planning services.

d. CSD Product Design

The "products" of the CSD component are two sets of services that APROPO will market to private sector employers. The first consists of diagnostic services to assess the potential demand for family planning among employees and dependents and the most cost-effective way of meeting that demand. The second includes assistance in implementing family planning services under the employer's social benefits plan and promoting the new services among employees and dependents. For the first product, diagnostic services, APROPO will rely primarily on its own staff, including those contracted especially for the Project. For the second product, family planning services implementation, APROPO will rely on third party providers for clinical training and supervision and clinical services; training of educators and IEC services will be performed by APROPO staff.

Clients (employers) will be able to purchase any combination of services that best suits their needs. Some will need only assistance negotiating with their insurance company or broker to include family planning. Others will need to train and supervise medical staff in company clinics, and others will need to be put in touch with clinical service providers. When required, APROPO will handle billing arrangements or offer pre-paid arrangements with selected providers. Careful design of the product package and development of a client database will enable the implementing agency to adopt a modern, "business-to-business" approach to marketing its product.

(1) Market research

At the outset of the Project, the CSD component manager will review sectoral studies in health care financing and other formal and informal research to refine the product design, avoid past mistakes, and prevent duplication of research efforts. APROPO will conduct or commission research for each target group listed above to further clarify their needs for preventive and family planning services. At this initial stage, qualitative, as opposed to quantitative studies produce more insights into why people think and behave as they do.

APROPO will carry out two research studies in PY 1 to further define and identify the three target groups and to guide the product design and development of the marketing strategy. The first study will focus on employees and dependents as potential users of FP/MCH services and products. The research objective is to identify health care and FP/MCH demands of this potential user group, and other characteristics, such as purchasing power, consumer profile of users and non-users (employee and dependent), usual point of acquisition of services and products.

The second study will focus on employers as purchasers of social benefits, including FP/MCH services. The objective is to define the role of social benefits, especially family planning and preventive health care, in increasing the productivity and loyalty of employees. The results of this research will be disseminated through a workshop with entrepreneurs, professionals and teachers in human resources and social sciences.

The workshop will serve to:

- position APROPO as a consulting organization in preventive and reproductive health care;

- provide data to refine the APROPO database;
- promote APROPO's products and services;
- obtain consensus about benefits and the attractiveness to firms offering FP/MCH services as a social benefit;
- obtain more data about messages and components to help the communication effort.

In PY 2, APROPO will study private physicians to identify their needs for FP/MCH products and training, especially in long-lasting methods such as IUDs, tubal ligation, and vasectomy. The results will be used to develop a specific strategy to work with these professionals. In PY 3 and 5, research will focus on evaluation of component impact and lessons learned.

(2) Product Concept

Clients buy a product to solve a problem or fulfill a need. The product concept of the CSD component will be refined by the CSD component team and will be a key factor in the performance evaluation of the CSD component manager. The initial task will be to create a "product" focused on preventive health care.

The principal components of this product may include, but not be limited to:

Clinical Services
- Consultations in gynecology/family planning
- Consultations in prenatal and child care
- Screening (Pap-smear)
- Other exams, to be negotiated with the health care providers.

Consultant Services
- Situational diagnostic plans
- Cost/benefit analyses
- Implementation and monitoring of FP/MCH and other preventive programs.

IEC Services
- Lectures
- Focus group studies
- Scientific fora
- Folders, books, materials development

Training
- Service providers
- Community

e. Promotion and Pricing of the CSD Product/Brands

APROPO and its advertising agency will develop a list of possible brand names and pre-test them to determine which brand name and logo APROPO should use for the CSD component. With the assistance of an external commercial sector consultant, APROPO will conduct a study to determine the pricing strategy for this product and establish a mark-up strategy. A key objective in price-setting is to include an adequate profit margin for APROPO.

f. Production/Distribution

To assure production/distribution of the product, APROPO will identify, select and establish agreements with five medical centers and one clinic in Lima/Callao. An ideal geographical balance would include one center each in the north, south, east, west, and downtown Lima, to provide conveniently-located clinical services for APROPO's clients. One medical centers might be MEDIC, S.A. which has experience in providing FP/MCH services.

Depending on demand, APROPO may also establish agreements with PVO service providers to offer family planning to non-permanent workers and other employees who are not covered by private health plans. In return for preferential treatment, employers would pay a higher price than the subsidized price charged by PVOs to the general public, but lower than the price charged by commercial providers. Uniform prices would be established for all participating PVOs, but separate billing arrangements would be negotiated for each PVO-industrial contract.

For employers who provide their own medical services, APROPO will broker contracts for training and supervision of clinical staff and procurement of contraceptives and other commodities. For activities such as lectures, training, and development of IEC materials, APROPO will use its own personnel.

The key to production and distribution of APROPO product is establishing formal agreements for services. Agreements must be clear about prices, period of services and other conditions normally included in this type of document. Prices will be set according to health insurance tables, private provider clinic service costs, and through cost-comparison of profit margins added to PVOs' services. (See Annex XII for a "model contract" used by brokers in Peru for similar types of agreements).

When selecting health care providers to work as partners in the CSD program, APROPO will carefully analyze the organization's capacity to provide high quality preventive health and family planning services. Once found acceptable, the implementing agency will arrange for training for their medical staff, develop a promotion plan to promote their services to the client companies, share costs of commodities (e.g., IUDs and minilap kits) with them and provide them with IEC materials.

g. Communication mix

(1) Database

One of the first tasks under the CSD component will be to develop a database of potential clients to support promotion and sales. The information contained in the database will be used to segment the market and tailor promotional strategies. APROPO will identify and contract a software firm or similar organization to design and develop the database program. The data base itself will be housed at APROPO.

(2) Advertising agency

APROPO will identify and contract an advertising agency with experience in direct marketing and materials development. Together they will develop an Integrated Marketing Communications (IMC) Plan in PY 1 to promote the CSD product. Advertising activities will be carried out in five steps:

- Development of the IMC Plan
- Preparation of draft prototype materials
- Testing of materials
- Final production
- Implementation

The IMC will contain a detailed description of all the product's components and a media plan for each target audience. Experience in CSD projects proves that the best media to reach the target audience are the following:

- Direct mail/newsletters

- Telemarketing
- Workshops
- Company presentations
- Folders and other sales support materials
- Newspapers (articles, press releases, product advertising)
- Magazines (industry trade journals)
- Radio (interviews, product advertising)

In PY 2, APROPO will arrange a workshop on social benefits as described above, and will study other approaches for reaching the Project's target audience.

(3) Sales

The CSD component manager will be responsible for developing APROPO's commercial structure. He/she will be supported by the CSD Educator who will make contacts with potential clients.
One possible sales approach may be to develop a "preventive maternal and child health care policy" through collaborative agreements with an insurance broker. The CSD component team will study the feasibility of this idea.

h. Policy Support

APROPO will develop a plan for persuading the public sector (MOH/IPSS) to offer incentives to private enterprises that provide FP/MCH services. Providing incentives could enhance the transfer of users from overburdened MOH/IPSS programs to private providers, enabling the public sector to serve the kinds of users who can only afford public programs, and would further the Project objective of increasing the relative participation of the private sector in preventive health care and family planning.

3. National Family Planning Communications

a. Participating agencies

(1) APROPO

(2) PRISMA

(3) The National Population Council

(4) Advertising agencies

b. Component Description

APROPO will work in collaboration with PRISMA, the implementing agency for USAID/Peru's PVO family planning project, and the CNP to carry out this component. APROPO can play an important coordinating role in the development and implementation of a national family planning communication strategy, based on its commercial sector and experience with advertising, marketing, and media firms.

Project funds will be provided to contract a director of the communications component. While each major family planning organization will continue to have its own institutional IEC strategy and retain complete autonomy in allocating its communication budget, APROPO will work with PRISMA to coordinate the IEC programs of these various organizations.

Sharing print materials among organizations is one area of possible collaboration. Some organizations have a comparative advantage in communication with a particular audience; others in a particular medium or particular family planning method. Collective purchases of media time can result in a savings for all. Experience shows that a powerful multi-media family planning communication program can emerge from modest beginnings in collaboration.

The Johns Hopkins University Population Communication Services (JHU/PCS) Project will provide support to APROPO and its collaborators in developing institutional communication strategies and a national communication strategy. At the end of PY 1, APROPO and JHU/PCS will collaborate with the CNP to organize a national family planning communication conference and workshop to develop the national strategy. JHU/PCS will call upon a previously-trained cadre of Peruvian communication specialists to assist with the conference and provide technical assistance to individual family planning organizations. The conference will be a media event in itself. President Fujimori, who has demonstrated a keen interest in family planning, should be invited to speak. Materials and expert spokesperson will be available to the news media. In addition to transmitting useful information about family planning to the public, the workshop during the conference will produce detailed plans for a sustained family planning communication effort.

JHU/PCS will also provide technical assistance to APROPO in the CSM project component. Specifically, they will be asked to assist with the use of non-traditional advertising media -- folk singing, theater groups, etc. -- for promoting CSM products.

IV. IMPLEMENTATION PLAN

A. Overview

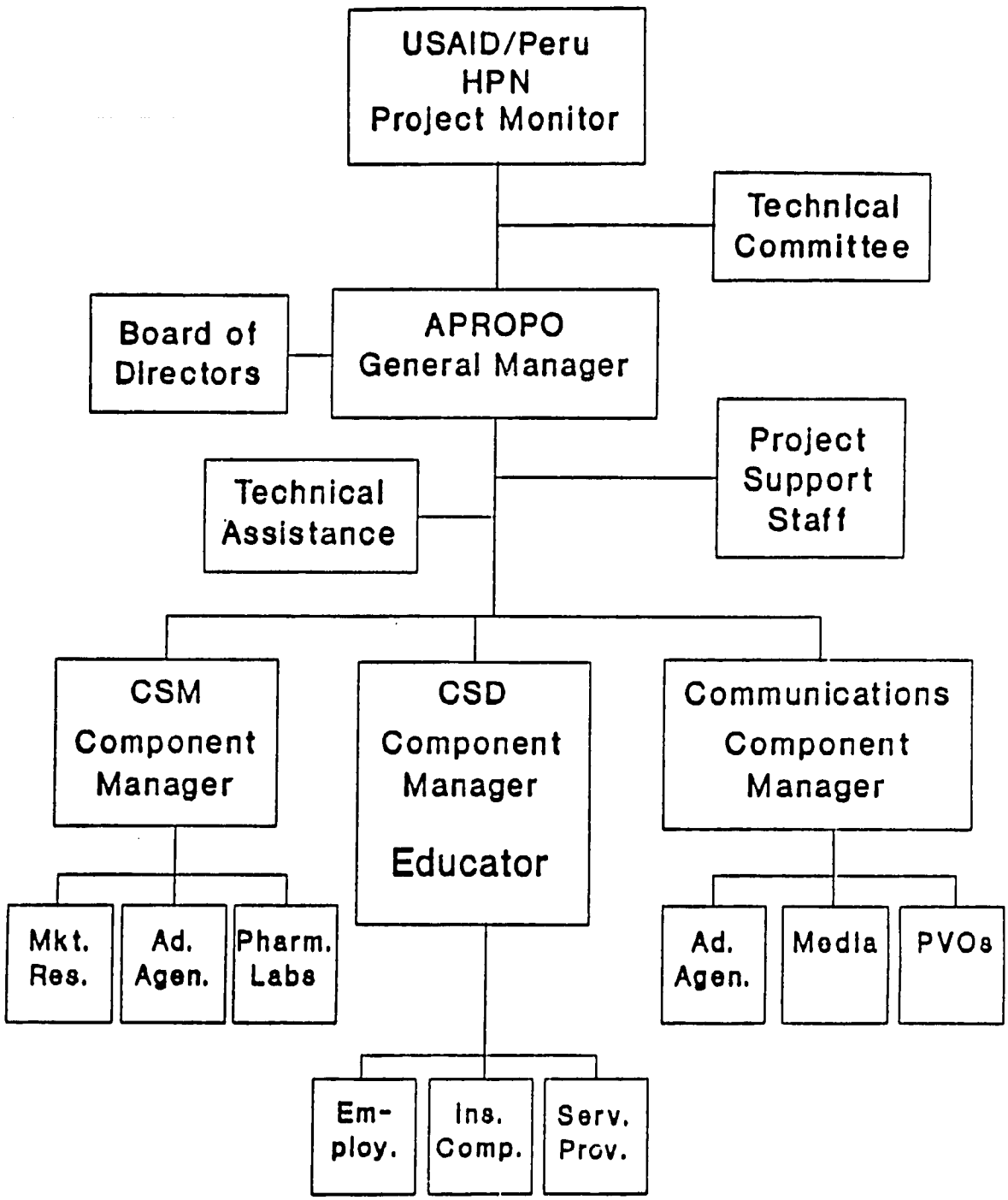
The anticipated organizational structure for overall project implementation is depicted in Figure 1 below, which illustrates the basic lines of communication and responsibility for PY 1.

FIGURE 1.
PROJECT ORGANIZATIONAL STRUCTURE: PY 1

(See next page)

FIGURE 1

PROJECT ORGANIZATIONAL STRUCTURE: PY 1



As can be seen from the diagram, APROPO will be the main implementing agency for the Project but will be assisted in this effort by various technical assistance consultants, contracted service firms (advertisers and market researchers), other participating agencies and the guidance of the USAID Project Officer. To enable APROPO to implement this Project effectively, several new project personnel will be added to its staff. The employment of these persons will begin with the Project, and will continue after it terminates only if APROPO can generate sufficient non-A.I.D. income to maintain these positions or, as in the case of the Component Manager, they generate sufficient income themselves through sales commissions. The new project staff will include the CSM and CSD Managers, a CSD Educator, a CSM Trainer, a IEC specialist, a Contracts Administrator, an Accounting Assistant and a Secretary. Some existing APROPO staff, such as the Executive Director and the Promoter who may take on the responsibilities of the CSD Educator, will have significant roles in the Project as well. All other APROPO personnel will dedicate a certain percentage of their time to support of project activities. Additional personnel will be hired with the approval of the USAID Project Manager.

APROPO's General Manager will devote the majority of her time to strengthening the agency's financial and technical status, to building coalitions with public, NGO and PVO organizations and to adopting a leadership role in family planning in Peru, beginning with the National Family Planning Communication Campaign. In addition, the Executive Director will pursue other projects in related areas for APROPO and raise funds both locally and internationally. The General Manager will also maintain relations with the APROPO Board of Directors. The General Manager will be ultimately responsible for the successful implementation of the Project, and as such, reports to the USAID/Peru Project Officer.

B. Contraceptive Social Marketing Component

1. Implementing Mechanism

The CSM project component will be managed on a daily basis by the CSM Manager. The CSM Manager will be a person with extensive experience in commercial sector marketing. He/she will operate fairly independently but will report, ultimately, to APROPO's General Manager. The CSM Manager will be responsible for monitoring the component's progress, at a minimum on a quarterly basis, to determine if project objectives are being met. The CSM Manager will submit quarterly and annual reports to the Executive Director for review and approval, and the reports will then be submitted to the USAID/Peru Project Officer.

The CSM Manager will receive administrative support from the APROPO staff, including the administrative assistant, the accountant and the secretary. A qualified person (the CSM Trainer) will be trained in contraceptive technology and interpersonal relations skills and will implement the national retailer training program.

The General Manager of APROPO will be responsible for ensuring that the CSM component is being managed smoothly, efficiently and according to the Marketing Strategy and annual Marketing Plans, and will do so by conducting regular staff meetings and briefings on the component's progress and reviewing quantitative indicators such as sales data on a quarterly basis.

2. Implementation Strategy for CSM Component

Successful implementation of the CSM program will require careful planning and preparation before products and communication efforts are launched. Full advantage should be taken of the experience and lessons learned during Phases I and Phase II of the CSM Project. Careful planning will be particularly critical in light of the significant changes in the economic and political climate in Peru

over the last two years, as well as the emergence of new opportunities for product line expansion which did not exist in past years.

The planning process is scheduled to take place over the course of the first project year and will include: conducting market research to clearly define the new target audience(s), their purchasing power, and provide input into the Integrated Marketing Communication Plan; carrying out a pricing analysis; establishing a long-term Marketing Strategy; determining whether it is advisable to do pilot projects in key socio-economic and geographic areas before "rolling out" the CSM effort nationwide (the decision will be based on market research results regarding target audience and purchasing power); negotiating subcontracts with participating agencies; initiating a series of maintenance-level communication activities to maintain the momentum of CSM efforts over the past four years; and identifying and hiring a qualified CSM Manager.

Implementation of the CSM component also requires technical assistance in CSM from SOMARC for the implementing agency. This should be provided on an ongoing and regular basis during the first three years of the Project with intensive assistance in the first one and a half years. The type and level of assistance required for PY 3, 4 and 5 will be evaluated at the end of PY 2 by APROPO and the USAID/Peru Project Officer.

Once the Marketing Strategy has been established and is approved by APROPO and USAID/Peru, it will be implemented by the CSM Manager with technical assistance from experts in CSM and family planning communication, beginning approximately in PY 2. Implementation will commence with new product and brand introductions, launching of the Integrated Marketing Communications campaign and expanded distribution to informal and non-traditional sector outlets.

3. Annual Implementation Schedule

The following year-by-year CSM component strategy will be adjusted quarterly and refined in accordance with the results of the marketing strategy. A month-to-month schedule of activities for the first year of implementation is detailed in IV. B. 4 below:

<u>Year I</u>:

Select and contract CSM Manager

Conduct market research to:
- Define target audience
- Develop messages and materials for Integrated Marketing Communication Plan
- Determine purchasing power of target groups

Define marketing strategy with plan for economic and technical self-sufficiency

Receive TA in non-traditional media

Evaluate policies affecting CSM and work for change where appropriate

Contract with local pharmaceutical and distribution firms as participating agencies

Develop Market Plan for PY2

Source and import CSM brands (pill and condom)

Consider introduction of injectables to product line

Contract advertising companies for the communication campaign

Start generic promotion of modern methods including:
- Interactive radio informational campaign
- Informational brochures at retail outlets
- Participation in SOMARC "Training of Trainers in Contraceptive Technology" for retailer training program development

Build APROPO's public image as a health and family planning promotion institute.

Year II:

Implement Marketing Strategy and Marketing Plan for PY2 (may be a series of pilot project tests, see Section III.3.D.)

Launch Integrated Marketing Communication Plan

Introduce CSM condom brands

Possibly introduce injectable brand(s)

Track sales and monitor component progress

Prepare Marketing Plan for PY3

Year III:

Continue implementation of Marketing Strategy

Implement Marketing Plan for PY3

Monitor progress toward achievement of component objectives

Conduct necessary market research for project tracking and evaluation as well as strategy adjustment

Prepare Marketing Plan for PY4

Collect documentation of project progress for mid-cycle evaluation process

Evaluate component and recommend continuation or adjustment of long-term strategy

Year IV:

Implement Marketing Plan for PY4

Develop Marketing Plan for PY5

Conduct market research necessary for project tracking

Adjust IMC Plan, if necessary, based on market research results from PY3

Year V:

Implement Marketing Plan for PY5

Conduct final evaluation of CSM component, as input to overall project evaluation, with recommendations for future continuation

4. Schedule of Activities for Year One

The first project year will test the abilities of the implementing agency to coordinate the Marketing Strategy development process and the import of

contraceptive products for commercial distribution and sale. The Marketing Strategy will validate the viability of the proposed approach.

Generally, the implementing agency will continue a low-level maintenance information communication campaign during PY I, so as to build as base of interest and awareness of contraceptive methods as well as to make APROPO known as a source of quality products and information.

Overall objectives for PY 1 include the following: *

- key market research and market analyses completed;
- Communication activities coordinated with other PVOs and pursue policy reform to permit contraceptive sales via CBD retail outlets achieved;
- Source for low-priced, quality condom brands identified and negotiated with participating agencies to ensure that they are imported into Peru;
- Long-term Marketing Strategy developed with assistance of consulting team;
- Sub-contract agreements with new pharmaceutical companies and commercial distributor signed to ensure product supply and distribution; and
- Sub-contract signed with ad agency for communications campaigns.

Monthly Schedule of Activities for PY1: *

<u>Months 1 through 4</u>

- Organize extensive series of focus groups to clearly define target group characteristics for communication strategy, messages and materials development.
- Conduct focus groups among users and non-users to collect information on consumers' KAP regarding injectables.
- Carry out a demand analysis to determine a range of prices for CSM products that will be affordable to target groups according to their levels of purchasing power.
- Determine target audience in qualitative and quantitative terms (using results of focus groups and analysis of shifts and new characteristics of socio-economic levels in Peru).*
- Conduct retail audit for (condoms) and collect sales and distribution data to determine sales volumes in commercial sector of those products CSM will promote.

* If it is not possible to do this in PY1 with a reasonable degree of certainty due to changing economic and/or political factors, it is advisable to set up several (minimum 3) pilot areas to test the marketability of CSM brands at their various prices before launching distribution and communication nation-wide. This pilot testing would be done in PY2 and should be very closely monitored and analyzed before rolling out marketing efforts nationwide. Note: if this option is pursued in the Marketing Strategy, the activities laid out by project year will change for PY2 and PY3.

- Select a minimum of three (3) excellent candidates for the Account Executive position from a pool of qualified people for final interview and contracting. (Potential candidates may be named by participating agencies and their key representatives should assist APROPO and USAID/Lima in the final selection as they are more experienced in commercial sector marketing than is APROPO.) (See Annex VI for list of qualifications and job description.)

- Consult with technical assistance team to regarding the final selection of the CSM Manager.

- Contract CSM Manager in month 3-4.

- Pursue sourcing of CSM condom brands and identify viable source.

- Receive TA to identify types of non-traditional media available in Peru.

- With local PVOs, pharmaceutical companies, commercial distributors and the National Population Council (CNP), identify areas for policy change that will benefit the CSM approach in Peru.

- Conduct PR/Promotion of APROPO as leader of family planning activities in Peru.

- Implement maintenance communication campaign. Update informational radio campaign and contract for media time for national airing. Arrange for hotline support to radio campaign. May be coordinated with local PVOs and/or CNP staff.

- Produce generic informational brochures on FP, lowdose OCs and condoms.

<u>Months 5 and 6</u>

- APROPO will work with a team of experts in family planning communication and in CSM in the first three (3) weeks of month 5 to develop a long-term Marketing Strategy for CSM in Peru. (At this point, depending on market research results, it will be decided if full country roll out is advisable for PY2 or a series of pilots should occur first and the full roll out in PY3.)**

- Finalize the Strategy in the following month and submit to APROPO and USAID/Peru at the end of the sixth month of PY 1.

- During month 5 the consultant team will assist APROPO in the preliminary negotiation of sub-contracts with participating agencies.

** A TA team to develop the marketing strategy should include a CSM strategy development expert (must have strong background working with pharmaceutical companies and negotiating agreements with participating agencies), a financial analyst, and a non-traditional media/communication expert.

- Finalize terms of sub-contracts and prepare documents for signature by end of month 6. APROPO should receive TA from a CSM expert with extensive experience with the pharmaceutical and distribution business in the final approval of these contracts, before they are signed.

- Make arrangements for import of condoms in month 6, based on the Marketing Strategy.

- Select an advertising company for national communication campaign.

Month 7

- Sign sub-contracts for products supply, distribution, and advertising/promotion.
- CSM Manager to develop the PY2 annual Marketing Plan for approval by APROPO and submission to USAID/Peru, with appropriate technical assistance where needed.

- USAID/Peru to review and approve Marketing Strategy. Technical assistance from CSM expert should be made available.

- Import and package condoms, as needed.

- Develop and present creative brief to ad agencies so they may begin the design of the Integrated Marketing Communication campaign.

Months 8 and 9

- Provide technical assistance to APROPO in review and approval of Integrated Marketing Communication campaign.

- Ad agencies to develop communication messages and materials for presentation to, and review by APROPO.

Month 10

- Pre-test all communication materials.

- Finalize Marketing Plan for PY2.

Months 11 and 12

- Prepare national retailer training program, to be launched along with marketing interventions.

- Provide orientation on CSM products and brands to commercial distributor sales representative.

- Produce and distribute materials.

- Distribute condom brands.

C. Commercial Service Delivery Component

1. Implementing Mechanism

a. Overview

The CSD component will be managed on a daily basis by the CSD Manager. This Manager will operate fairly independently but will report, ultimately, to APROPO's General Manager. The CSD Manager will be responsible for monitoring the component's progress, at a minimum on a quarterly basis, to determine if project objectives are being met.

The candidate chosen for the CSD Manager position will not necessarily have previous experience in family planning, but must have experience in marketing of insurance, health plans and private voluntary organizations. The candidate should have extensive private sector marketing expertise in Peru and experience in development and implementation of market plans. (See Annex VII for candidate profile and job description). Once on board, The CSD Manager will be trained in all technical and operational aspects of FP/MCH services and will develop a specific program in the first month of the Project. The CSD Manager will receive administrative support from the APROPO staff, including the administrative assistant, the accountant and the secretary.

The CSD Educator will have an extensive background in technical aspects in family planning and some experience in contacts with private firms and health providers. He/she will receive training from the CSD Manager in product marketing, and additional training will be provided in sales through a short-term course in a business school in Lima, at the expense of the Project.

The General Manager of APROPO will be responsible for ensuring that the CSD component is being managed smoothly, efficiently and according to the Marketing Strategy and annual Marketing Plans, and will do so by conducting regular staff meetings and briefings on the component's progress and reviewing quantitative indicators such as sales data on a quarterly basis.

The CSD Manager will submit quarterly and annual reports to the Executive Director for review and approval, and they will then be submitted to the USAID/Peru Project Officer.

b. Responsibilities of Implementing Agency

During Project Year One, the major responsibilities of the Implementing Agency will include the following:

Human Resources
- Recruit and hire the CSD Manager
- Recruit, hire, and train a CSD Educator (or re-train current staff member)

Implementing resources
- Contact private sector firms and private risk-sharing providers who may be interested in being MCH/FP services providers or clients under the program, and begin negotiations with them.
- Provide consultant services, training, and communication materials to each firm that buys the APROPO product.

Operational Resources
- Develop a workplan for the first year, including start-up activities.
- Develop a client database.
- Identify the CSD component costs
- Select, negotiate and sign sub-agreements with private health providers and PVOs to assure that the APROPO products has the required operational support.

- Identify market research firms, negotiate and supervise two market research studies related to social benefits and users profile.
- Establish the flow of information, forms and people.

General
- Monitor the CSD component activities.
- Arrange for short-term training and TA by local and international consultants.
- Identify specialized technical assistance needs and procure them.
- Submit quarterly and annual reports.

The Responsibilities of the CSD Manager will Include:

- Developing, implementing, and monitoring all aspects of the market plan.
- Assisting in the development, supervision and analysis of market research.
- Preparation of the database.
- Submitting quarterly and annual reports to the Executive Director.

The Responsibilities of the CSD Educator will Include:

- Supporting the development and updating of the database.
- Contacting prospective clients and selling the product.
- Maintaining regular follow-up with clients and prospective clients.
- Providing consultant services (situational diagnoses, cost/benefit analyses, program design, lectures/talks).
- Submitting monthly activity reports, outlining any problems and recommending solutions, to the CSD Manager.
- Submitting quarterly reports to the CSD Manager.

2. Implementation Strategy

Successful implementation of the CSD component requires careful development of all aspects of the marketing mix, including product design, price, promotion, distribution plan and communication program.

Product design will be carried out during the first six months of the Project. The lessons learned in previous and on-going projects in the private sector should be taken into account in the product's design and commercialization. A general strategy will be developed and adapted for each market segment identified, and will include a review of data and market research to clearly define the profile of the decision-makers in the primary target audience and the users of the services they provide. All this information will be entered into the database which will provide the basis for the communication and sales strategy.

A key component of the start-up phase will be the identification of private health providers and PVOs who may be interested in being FP/MCH services providers or clients under the program, and to begin negotiations with them. After this initial phase, the implementing team will initiate contact with other private risk-sharing providers, self-service firms and corporate members of APROPO to begin launching a trial phase for the product.

Implementation of the CSD component will require technical assistance to the implementing agency. This should be provided on an ongoing and regular basis during the first three years of the Project with intensive assistance in the first one and a half years. The type and level of assistance required for PY3, PY4, and PY5 will be evaluated at the end of PY2 by APROPO and the USAID/Peru Project Officer.

Once the marketing strategy has been approved by APROPO and USAID/Peru, it will be implemented by the CSD Manager with technical assistance from experts in CSD

and family planning communication, beginning approximately in end of the PY1 or beginning of PY2.

3. Schedule of Activities for Year One

Overall component objectives for PY1 include the following:

- Conduct key market research
- Establish agreements with Private Health Care providers, including five medical centers, one clinic (small hospital) and two PVOs to assure services and training in the CSD component.
- Develop a long-term Market Strategy.
- Identify and sub-contract advertising agencies.
- Develop a database.
- Establish the organizational and operational resources to implement the CSD Component.

A month-to-month schedule of activities for the first year of implementation is detailed below:

Months 1 through 4

- Select a minimum of three (3) candidates from a pool of qualified people for final interview and selection for the CSD Manager position. APROPO should enlist the services of a professional "head-hunter" firm to recruit and select this candidate. APROPO and USAID/Peru will make the final selection.

- Hire a CSD Manager in Month 3-4.

- Develop a training program for the CSD Account Executive in FP/MCH services and begin review of existing CSD-related studies.

- Hire a CSD Educator in Month 4 (could be an existing APROPO employee).

- Provide sales training to the CSD Educator.

- Develop the database.

- Determine primary, secondary, and tertiary target group characteristics (classification, number, profile, etc.).

- Submit a quarterly progress and financial report.

- Establish a list of potential private health care providers and PVOs that may be able to provide product support and determine the criteria (geographical, experience, image, etc.) for choosing partners.

Months 5 through 8

- Select, initiate, and sign a sub-agreement with private health care providers and PVOs to assure operational support to the product.

- Give training in FP/MCH services to medical centers/clinic.

- Develop a detailed research project to determine appropriate characteristics of primary targets, according to the description in the project component.

- Initiate market research in Month 6.

- Establish the flow of information, forms and people for product production and delivery.

- Establish the primary contacts with enterprises, enter client classification and other data into the database.

- Initiate negotiations with health plans that pay for family planning services to obtain cost/benefit data and subjective information like image of such services with consumers and users.

- Determine, with the help of technical assistance providers, the product cost, an optimal pricing strategy, and a plan for product promotion.

- Initiate negotiations with APROPO corporate members to encourage them to purchase the product for their own organizations, and focus on implementation in five firms from different sectors.

- Identify and contract an advertising agencies,

- Submit the first semi-annual progress and financial report.

Months 9 through 12

- Analyze the research data and refine the database accordingly.

- Develop, with the help of technical assistance providers, a long-term marketing plan for PY2, PY3, PY4, and PY5.

- Prepare the prototype materials (with messages appropriate to each target audience and medium) in project month 9.

- Pretest promotional materials.

- Define the brand and choose a logo for the product.

- Launch the official product campaign.

- Begin sales effort.

- Review the elements of the marketing mix and refine the market plan for PY2.

D. National Family Planning Communication Component

APROPO, with technical assistance from JHU/PCS, will be the implementing agency for this project component. An IEC specialist will be hired to manage this component.

1. Responsibilities of the Implementing Agency

The major responsibilities of the Implementing Agency will be to:

a. Conduct a complete communication needs assessments, establishing objectives and creating a complete inventory of organizations and programs active in family planning communication in Peru.

b. Carry out all preliminary work necessary for organizing a national family planning communication conference and workshop, in coordination

with the CNP, Ministry of Health, PRISMA and PVOs. Preparatory activities will include:

- Identification of participants
- Contracting with resource professionals
- Securing participation of President Fujimori and other top officials
- Preparing materials for news media and ensuring press coverage
- Contracting for complete logistics support

c. Oversee the Conference, facilitate the workshop, develop the National Communication Strategy and publish a plan identifying each organization's role in carrying out the strategy.

d. Provide assistance to collaborating organizations in development of family planning communication strategies and implementation of communication programs.

e. Develop a strong family planning communication program that is complementary to those of the collaborating organizations and the CSM program.

f. Facilitate and broker purchases of services, materials, and media time on behalf of the collaborating organizations.

g. Oversee implementation of the National Communication Strategy with a view toward increasing levels of participation by all collaborators.

h. Conduct periodic evaluations to make mid-course corrections to institutional and national strategies.

i. Pursue news and public interest coverage opportunities with all media. Arrange family planning coverage at scientific, business, and civic fora.

j. Generally take responsibility for bringing the benefits of family planning into the public view at all levels of society.

The types of media employed, program content, and target audience (5) for the National Strategy will be decided only after careful research and pre-testing. Important message elements will include contraceptive image, safety and reliability of modern methods, and health benefits of family planning. For service delivery organizations, operating hours, location and quality of service will be important themes. For the CSM component, quality, convenience, and economy of the products might be stressed as well as brand identification. Research may point to radio as an effective medium for the national program, and the possibility of using grassroots channels such as folk singers and theater groups will be explored. While the entire population will be targeted at some level, the informal sector, pueblos jovenes, slums, and other hard-to-reach groups should receive special attention.

An effective communication program focuses on process as much, or more, than products. An end-of-project output should be that all the participating organizations know how to design and carry out an institutional communication strategy and are skilled collaborators and enthusiastic participants in the National Family Planning Communication Strategy. Throughout the five years of this Project and beyond, specific messages and targets will change in accord with the needs of the program and attitude and behavior changes of the beneficiaries. If the appropriate process has been put into place, those changes will occur automatically. Effective IEC is an essential part of family planning programs

in all stages of development. This project component will attempt to institutionalize the capacity to develop and maintain communication programs in Peru's most important family planning organizations. This effort will be made in coordination with other USAID Peru Projects.

APROPO will have a dual role in implementation of this component. It will be responsible for developing the National Family Planning Communication Strategy in agreement with the CNP and/or Ministry of Health and will assist collaborating organizations in IEC strategy and implementation. It will also be a major player in carrying out key elements of the National Strategy. In the first three months of the Project, APROPO will develop a complete schedule of activities for the remaining 57 months of project implementation.

2. Technical Assistance

JHU/PCS will provide technical assistance to APROPO and collaborating organizations. In the first year, they will concentrate on assisting APROPO with the National Family Planning Communication Conference and Workshop and with development of the National Family Planning Communication Strategy. In the second year assistance will also include monitoring and evaluation of communication activities.

E. LOP Project Implementation Schedule

Obligation of project funds is expected to take place in August, 1991 with the signing of a cooperative agreement between USAID/Peru and APROPO. Selection of key personnel by APROPO (in particular, the two Managers) and U.S. technical assistance contractors is scheduled to take place during the first three to four months of the Project. The key implementation events to take place during the first year of the Project have been outlined above. Local market research and advertising sub-contracts are expected to be solicited and awarded by January 1992 (the sixth month of Project Year 1).

A preliminary schedule for key project events is as follows:

Event	Date
Project authorization	7/91
Project obligation/signing of CA	8/91
Contract with TA provider for CSD component	8/91
TA providers (SOMARC, JHU/PCS, and CSD Specialist in-country to begin pre-implementation activities (target group analyses)	9/91
Buy-ins to SOMARC and JHU/PCS completed (FY 92)	9/91
Recruitment for Managers begins	9/91
Recruitment for all other Project personnel begins	9/91
Managers hired and on board	10/91
All other new Project personnel selected and on board	10/91
Contract negotiation with advertising companies	11/91
Contract negotiations with participating agencies begin	1/91
National Communication Conference and Workshop held	5/92
USAID/Peru strategic review of project targets (quantifiable)	7/92
Project audit No. 1 completed	7/92
First project evaluation completed	7/94
Project audit No. 2 completed	7/94
Final project evaluation completed	7/96
Project audit No. 3 completed	7/96
Project Completion Date	7/96

F. USAID Project Monitoring

The Chief of the Health, Population and Nutrition Division, USAID/Peru, will have overall responsibility for Project management and the FSN Population Specialist) will serve as the Project Monitor. The Project Monitor will: serve as the point of day-to-day contact between USAID and the implementing agency and between USAID and the subgrant recipients; ensure that APROPO General Manager submit required documents such as quarterly status reports, annual work plans and activities requiring USAID approval; and help USAID analyze the technical aspects of project implementation.

The management burden on USAID staff will be lessened by funding the Project under a single management unit, i.e., through a cooperative agreement with APROPO.

A review of project management will be conducted semi-annually, during one of the Semi-Annual Reviews (SAR). One of the first tasks for the Project Officer will be to develop a system for monitoring project progress.

G. Procurement Plan

1. Commodities and Services

The Project will procure a significant quantity of services, including technical assistance, advertising, market research and training, to assist the Managers in carrying out their responsibilities and to increase the training/knowledge of the personnel in participating retail outlets, distribution firms, insurance companies and private industries. Some commodities will be procured by the Project, including materials for workshops, presentations to firms, and training; a small quantity of contraceptives for the CSD component (to be funded under "incentive fund for firms" line item) office supplies and equipment. These materials will be procured directly by APROPO.

2. Roles and Responsibilities

While USAID will handle the procurement actions related to buy-ins to centrally-funded A.I.D. projects, and will assist APROPO in developing the scopes of work for the two Managers, APROPO will carry out all other procurements actions directly. APROPO will be responsible for drafting sub-contracts with service providers such as advertising firms and market researchers.

H. Financial Plan and Cost Estimate

1. Financial Plan

The total cost of this five year CFP Project is estimated to be US$5,942,508. Of this amount USAID/Peru will contribute US$5,000,000 in grant funds. It is anticipated that APROPO will provide approximately US$942,508 in financial and in-kind contributions. Tables I through III provide information on sources and applications of funds, foreign exchange and local currency requirements, and expected annual disbursements. Table I (a) provides a detailed breakdown of project costs including the provision for contingencies and Table I (b) details the contingency allowance included in the project. These tables are shown in Annex XVII.

USAID/Peru resources will provide for the majority of project costs including the cost of any buy-ins, local technical assistance and services, the salaries of project personnel, audits, and evaluations. The budget items to be funded by A.I.D. are described below. APROPO's in-kind contribution include: a) the cost of office equipment and furniture that will be used during the project period;

b) the value of APROPO's stock of educational material produced in previous years and available to be used in the project IEC component; and c) the valuation of volunteer professional services.

Financial contributions of APROPO include the projection of income to be generated during the project period. One of the project objectives is to increase sustainability of the implementing agency. To meet this objective APROPO will develop their main sources of income: expanding its membership base, increasing its capacity to offer "brokerage" services to firms, and negotiating with pharmaceutical companies to get a commission on value of sales of CSM products. New sources of income will also explored. Technical assistance to the project components will contribute to strengthen APROPO's capabilities to generate income.

Detailed APROPO's contributions appear in annexes XVIII A and B.

2. Total Project Resources

TABLE I
SUMMARY FINANCIAL PLAN (By Component)
(US Dollars)

(See next page)

TABLE I

SUMMARY FINANCIAL PLAN
(US Dollars)

Table 1

SUMMARY FINANCIAL PLAN

Element	PROJECT YEAR One AID	One APPOPO	Two AID	Two APPOPO	Three AID	Three APPOPO	Four AID	Four APPOPO	Five AID	Five APPOPO	Total AID	Total APPOPO
Contraceptive Soc Mkg	163,000		154,100		69,305		71,620		66,301		526,326	0
Commercial Serv. Deliv.	85,300		71,600		57,805		60,120		62,051		337,576	0
Nat'l. Family Communicat.	555,000		837,500		734,500		523,000		417,250		3,077,250	0
Other Direct Prj. Support	222,526		145,215		203,633		115,146		215,665		902,215	0
Administrative	165,183	50,820	51,450	109,812		166,784		172,592		178,670	155,233	678,658
Total	1,141,709	50,820	1,259,865	109,812	1,065,273	166,784	763,866	172,592	793,267	178,670	5,000,000	678,658

Table III

FINANCING AND EXPENDITURES BY PROJECT YEAR

	PROJECT YEAR									
	One		Two		Three		Four		Five	
	AID	APPROPO	AID	APPROPO	AID	APPROPO	AID	APPROPO	AID	APPROPO
Beginning Funds Balance	0	0	1,383,291	13,180	2,599,426	15,568	1,533,153	6,184	763,267	35,302
REVENUE:										
APPROPO		64,000		112,200		157,400		201,700		243,000
AID	2,505,000		2,495,000							
EXPENSES/COSTS										
Contraceptive Soc Mktg	163,309		154,100		63,305		71,523		68,301	
Commercial Serv. Deliv.	86,000		71,600		57,805		60,120		62,051	
Matl. Family Communicat.	555,000		837,500		734,500		523,000		417,250	
Other Direct Prj. Support	222,526		145,215		203,663		115,145	-	215,665	
Administrative	105,183	50,820	52,450	109,912		166,784		172,592		178,670
Total	1,141,709	50,820	1,255,865	109,912	1,065,273	166,784	769,835	172,592	763,267	178,670
Ending Funds Balance	1,363,291	13,180	2,599,426	15,568	1,533,153	6,184	763,267	35,302	0	105,632

Schedule of Obligations:

September 1991	505,000
1992	1,500,000
1993	2,495,000
	5,000,000

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Table 1 (a)
Schedule of Costs

	PROJECT YEAR					
	One	Two	Three	Four	Five	Total
CONTRACEPTIVE SOCIAL MARKETING, (CSM)						
Personnel						
CSM Manager	28,000	29,400	30,870	32,414	34,035	154,719
CSM Trainer	14,000	14,700	15,435	16,206	17,016	77,357
	42,000	44,100	46,305	48,620	51,051	232,076
Technical Assistance						
SOMARC	121,000	110,000	23,000	23,000	17,250	294,250
TOTAL CSM ELEMENT	163,000	total csm	69,305	71,620	68,301	526,326
	==========	==========	==========	==========	==========	==========
COMMERCIAL SERVICES DELIVERY, (CSD)						
Personnel						
CSD Manager	28,000	29,400	30,870	32,414	34,035	154,719
CSD Educator	14,000	14,700	15,435	16,206	17,016	77,357
	42,000	44,100	46,305	48,620	51,051	232,076
Technical Assistance						
Consulting/Experts	44,000	27,500	11,500	11,500	11,000	105,500
TTOTAL CSD ELEMENT	86,000	71,600	57,805	60,120	62,051	337,576
	==========	==========	==========	==========	==========	==========
NATIONAL FAMILY PLANNING COMMUNICATION						
IEC specialist	28,000	29,400	30,870	32,414	34,035	154,719
Advertising	232,000	370,630	369,130	337,586	185,955	1,495,291
Promotion	110,000	270,000	270,000	100,000	150,000	900,000
Trainning	30,000	30,000	30,000	30,000	30,000	150,000
	400,000	700,000	700,000	500,000	400,000	2,700,000
Technical Assistance						
John Hopkins University	165,000	137,500	34,500	23,000	17,250	377,250
TOTAL PROJECT ELEMENT	565,000	837,500	734,500	523,000	417,250	3,077,250

Other Direct Project Cost						
Personnel						
Contracts Administrator	25,000	25,250				51,250
Accounting Assistant	4,900	5,145	5,402	5,672	5,955	27,074
Project Secretary	8,400	8,820	9,261	9,724	10,210	46,415
	38,300	40,215	14,663	15,396	16,165	124,739
Research/Evaluation	90,000	84,000	84,000	78,750	94,500	431,250
Travel and Transportation	20,000	21,000	21,000	21,000	21,000	104,000
External Evaluation			42,000		42,000	84,000
External Audit	40,000		42,000		42,000	124,000
Equipment	34,226					34,226
TOTAL PROJECT EXPENSE	222,526	145,215	203,663	115,146	215,655	902,215
GENERAL ADMINISTRATIVE EXPENSES						
Personnel						
General Manager	35,000 *	36,750 *	38,588	40,517	42,543	193,358
Family Planning Promoter	14,000 *	14,700 *	15,435	16,207	17,017	77,359
Researcher	16,380 *	17,199	18,059	18,962	19,910	90,510
Accountant	16,380 *	17,199	18,059	18,962	19,910	90,510
Administrative Assistant	16,380 *	17,199	18,059	18,962	19,910	90,510
Messenger	2,129 *	2,235	2,346	2,463	2,586	11,759
Secretary	4,914 *	5,160	5,418	5,689	5,974	27,155
Subtotal	105,183	110,442	115,954	121,762	127,850	581,291
Rent & Utilities	13,600	13,600	13,600	13,600	13,600	68,000
Office Supplies	6,600	6,600	6,600	6,600	6,600	33,000
Insurance	9,900	9,900	9,900	9,900	9,900	49,500
Telephone/Fax	7,920	7,920	7,920	7,920	7,920	39,600
Maintenance	6,600	6,600	6,600	6,600	6,600	33,000
Subtotal	50,820	53,820	50,820	50,820	53,820	254,100
TOTAL PROJECT EXPENSE	156,003	164,262	166,774	172,582	178,670	838,391
APSOPO	53,820	109,812	166,794	172,582	175,670	678,668
AID	105,183	54,450				159,633
TOTAL ALL EXPENSES	1,132,529	1,363,677	1,032,057	942,468	941,937	5,372,668
APSOPO	53,820	103,812	166,794	172,582	178,670	678,668
AID	1,141,709	1,259,865	1,065,273	763,886	763,267	5,000,000

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Schedule of Costs and Contingency Detail

PROJECT YEAR

	One	Two	Three	Four	Five	Total
CONTRACEPTIVE SOCIAL MARKETING, (CSM)						
Personnel						
CSM Manager	28,000	28,000	28,000	28,000	28,000	140,000
CSM Trainer	14,000	14,000	14,000	14,000	14,000	70,000
	42,000	42,000	42,000	42,000	42,000	210,000
Technical Assistance						
SOMARC	110,000	100,000	20,000	20,000	15,000	265,000
Total	152,000	142,000	62,000	62,000	57,000	475,000
Cost contingency						
On personnel, 5% increa. cost		2,100	4,305	6,620	9,051	22,076
On technical assistance, 10%	11,000	10,000				21,000
On technical assistance, 15%			3,000	3,000	2,250	8,250
Total Contingency	11,000	12,100	7,305	9,620	11,301	51,326
TOTAL CSM ELEMENT	163,000	154,100	69,305	71,620	68,301	526,326
COMMERCIAL SERVICES DELIVERY, (CSD)						
Personnel						
CSD Manager	28,000	28,000	28,000	28,000	28,000	140,000
CSD Educator	14,000	14,000	14,000	14,000	14,000	70,000
	42,000	42,000	42,000	42,000	42,000	210,000
Technical Assistance						
Consulting/Experts	40,000	25,000	10,000	10,000	10,000	95,000
Total	82,000	67,000	52,000	52,000	52,000	305,000
Cost contingency						
On personnel, 5% increa. cost		2,100	4,305	6,620	9,051	22,076
On technical assistance, 10%	4,000	2,500				6,500
On technical assistance, 15%			1,500	1,500	1,000	4,000
Total Contingency	4,000	4,600	5,805	8,120	10,051	32,576
TOTAL CSD ELEMENT	86,000	71,600	[illegible]	60,120	[illegible]	[illegible]

NATIONAL FAMILY PLANNING COMMUNICATION

IEC Specialist	28,000	28,000	28,000	28,000	28,000	140,000
Advertising	232,000	370,600	369,130	337,586	185,965	1,495,281
Promotion	110,000	270,000	270,000	100,000	150,000	900,000
Trainning	30,000	30,000	30,000	30,000	30,000	150,000
	400,000	698,600	697,130	495,586	393,965	2,685,281
Technical Assistance						
John Hopkins University	150,000	125,000	30,000	20,000	15,000	340,000
	550,000	823,600	727,130	515,586	408,965	3,025,281
Cost contingency						
On personnel 5 %		1,400	2,870	4,414	6,035	14,719
Total Contingengy	15,000	12,500	4,500	3,000	2,250	37,250
	15,000	13,900	7,370	7,414	8,285	51,969
TOTAL PROJECT ELEMENT	565,000	837,500	734,500	523,000	417,250	3,077,250

OTHER DIRECT PROJECT COST

Personnel						
Contracts Administrator	25.000	25,000				50.000
Accounting Assistant	4,900	4,900	4,900	4,900	4,900	24,500
Project Secretary	8,400	8,400	8,400	8,400	8,400	42,000
	38,300	38,300	13,300	13,300	13,300	116,500
Research/Evaluation	90,000	80,000	80,000	75,000	90,000	415,000
Travel and Transportation	20,000	20,000	20,000	20,000	20,000	100,000
External Evaluation			40,000		40,000	80,000
External Audit	40,000		40,000		40,000	120,000
Equipment	30,000					30,000
	218,300	138,300	193,300	108,300	203,300	861,500
Cost contingency						
On personnel, 5%		1,915	1,363	2,096	2.865	8,239
On other than personnel	4,226	5,000	9,000	4,750	9,500	32,476
Total Contingency	4,226	6,915	10,363	6,846	12,365	40,715
TOTAL PROJECT ELEMENT	222,526	145,215	203,663	115,146	215,665	902,215

GENERAL ADMINISTRATIVE EXPENSES

Personnel						
General Manager	35,000	35,000	35,000	35,000	35,000	175,000
Family Planning Promoter	14,000	14,000	14,000	14,000	14,000	70,000
Researcher	16,380	16,380	16,380	16,380	16,380	81,900
Accountant	16,380	16,380	16,380	16,380	16,380	81,900
Administrative Assistant	16,380	16,380	16,380	16,380	16,380	81,900
Messenger	2,129	2,129	2,129	2,129	2,129	10,645
Secretary	4,914	4,914	4,914	4,914	4,914	24,570
Subtotal	105,183	105,183	105,183	105,183	105,183	525,915
Rent & Utilities	18,000	18,000	18,000	18,000	18,000	90,000
Office Supplies	6,000	6,000	6,000	6,000	6,000	30,000
Insurance	9,000	9,000	9,000	9,000	9,000	45,000
Telephone/Fax	7,200	7,200	7,200	7,200	7,200	36,000
Maintenance	6,000	6,000	6,000	6,000	6,000	30,000
Subtotal	46,200	46,200	46,200	46,200	46,200	231,000
Total	151,383	151,383	151,383	151,383	151,383	756,915
Cost Contingency						
On Personnel Costs		5,259	10,781	16,579	22,667	55,286
APROPO		2,809	10,781	16,579	22,667	52,836
AID		2,450				2,450
On Other than personnel	4,620	4,620	4,620	4,620	4,620	23,100
Total Contingency	4,620	9,879	15,401	21,199	27,287	78,386
APROPO	4,620	7,429	15,401	21,199	27,287	75,936
AID		2,450				2,450
TOTAL PROJECT ELEMENT	156,003	161,262	166,784	172,582	178,670	835,301
APROPO	50,820	109,812	166,784	172,582	178,670	678,668
AID	105,183	51,450				156,633
TOTAL ALL ELEMENTS	1,192,529	1,369,677	1,232,057	942,468	941,937	5,678,658
APROPO	50,820	109,812	166,784	172,582	178,670	678,668
AID	1,141,709	1,259,865	1,065,273	769,886	763,267	5,000,000

TABLE II

SUMMARY OF TOTAL PROJECT COSTS BY FUNDING SOURCE AND FOREIGN EXCHANGE (FX) AND LOCAL CURRENCY COSTS (LC)

Funding Source	FX	LC	TOTAL	Percent
USAID	558,750	4,441,250	5,000,000	84.0
APROPO	0	942,508	942,508	16.0
- Financial Contrib.	0	(678,668)	(678,668)	(11.5)
- In-kind Contrib.	0	(263,840)	(263,840)	(4.5)
TOTAL	558,750	5,383,758	5,942,508	100.0

Table III shows project financing and expenditures by project year and the obligation plan for A.I.D. funds by U.S. fiscal year.

3. Budget Elements

Technical Assistance

Technical Assistance will be procured for each of the three project components through two different mechanisms: most technical assistance will be procured through buy-ins to AID/W centrally-funded projects (e.g., SOMARC and PCS/JHU), and a small amount may be procured directly from individual consultants through PIO/Ts prepared by USAID/Peru.

Training

In-country training will be provided to retailers, family planning service providers and selected project staff. The "training" line item under the National Communication Component provides for travel, training materials, and training-of-trainer costs.

Local Services and Materials

Advertising and market research services, as well as other types of services available from local sources, will be procured under the three project components. Office equipment, materials for training, workshops and presentations to firms will also be purchased locally.

Project Personnel

Salaries will be paid to Project personnel. They include: the CSM Manager, the CSM Trainer, the CSD Manager, the CSD Educator, an IEC specialist, a Contracts Administrator, an Accounting Assistant, and a full-time Project Secretary. Additional personnel will be determined as needed with the approval of USAID.

Administrative Costs

Among the administrative costs to be financed by the Project will be the salaries of APROPO's already existing administrative and support staff, pro-rated for the amount of time they dedicate to the Project; travel costs for Project personnel; severance pay contingency for personnel hired solely to work on the Project; and other administrative costs incurred by the Project such as personnel recruitment and professional services (lawyers and auditors) costs among others. These costs will be covered gradually by income generated by APROPO through project activities. The goal is that by the end of the Project, administrative costs will not require A.I.D. funding.

Evaluation

Two project external evaluations will be contracted during the life of the Project, most likely through an IQC. The evaluations will take place at the end of the third and fifth years of the Project.

Audits and Financial Review

Funds are provided to contract independent auditors, through RIG/A/T, to carry out three project audits: one each at the end of project years one, three and five. Financial reviews will be carried out as recommended by the auditors. The audits and financial reviews will be conducted in accordance with A.I.D. policies.

4. Financial Implementation Arrangements

During the design phase of this PP, the design team met with the implementing agency to discuss the financing arrangements for project implementation. Table IV shows the different methods of financing that will be used for each item to be procured under the Project. These methods are A.I.D. Direct Payment (PIO/T) and Advance/Liquidation. These methods are in conformity with A.I.D. policy statements on financial and administrative management and will be implemented in accordance with agency policy.

5. Recurrent Costs and Other Financial Issues

Recurrent costs are incremental expenditures associated with activities that must be made on a regular basis during the Project to achieve objectives, and after the Project has terminated to sustain accomplishments and continue activities. During the life of the Project, USAID and APROPO will be financing recurrent costs. It is expected that APROPO will assume a greater proportion of these costs as the Project progresses. After the end of the Grant, APROPO and other third parties will be financing all recurrent costs.

The primary recurrent costs are those related to payment of salaries of project personnel, and financing of the family planning promotion and communication campaign (i.e., advertising and market research costs). To the extent that additional technical assistance is required after five years, this will also be a recurrent cost. At the end of the Project, APROPO should be covering most of these costs with revenues generated from the services it provides (the APROPO "product") and negotiated contributions from contraceptive manufacturers.

I. Monitoring and Evaluation Plan

Two evaluations will focus on the impact of the Project. As mentioned, the first will be carried out at the end of the third year of implementation and the second during the fifth and final year. The first evaluation will serve to demonstrate whether the Project will provide a cost-effective means of attaining its objectives and will provide the basis for a "go/no-go" decision regarding continued project implementation. The end-of-project evaluation will demonstrate the overall impact of the Project in terms of Couple-Years of Contraceptive Protection (CYPs) provided. The information obtained in the first year studies regarding project targets will provide the basis against which to assess the Project's performance.

J. Financial Reviews and Audits

As required by A.I.D. regulations, project financial and compliance audits will be requested from RIG/A/T as per their established procedures concerning non-federal audits, at the close of project years one, three and five. Financial

reviews will be carried out as recommended by the audits, and may include an examination of the Project's internal controls and APROPO's compliance with the terms of the Cooperative Agreement.

K. Disbursement Procedures

Table IV shows the different methods of financing that will be used for each item to be procured under the project. These methods are A.I.D. Direct Payment (PIO/T) and Advance/Liquidation. These methods are in conformity with A.I.D. policy statements on financial and administrative management and will be implemented in accordance with agency policy.

TABLE IV

METHODS OF IMPLEMENTATION AND FINANCING
(by executing entity)

INPUTS	METHODS OF IMPLEMENTATION	METHODS OF FINANCING	FX LC	AMOUNT US$
Program Costs - APROPO				
- CSM	Cooperative Agreement Letter	Periodic Advance	LC	232,076
- CSD	Cooperative Agreement Letter	Periodic Advance	LC	232,076
- NFPC	Cooperative Agreement Letter	Periodic Advance	LC	2'927,250
- Other Direct Costs	Cooperative Agreement Letter	Periodic Advance	LC	769,215
- Administration	Cooperative Agreement Letter	Periodic Advance	LC	156,633
				4'317,250
Technical Assistance - AID				
- SOMARC (Buy-in)	Contract (PIO/T)	Direct Payment (AID/W)	FX	294,250
- Consultants (off-shore)	Contract (PIO/T)	Direct Payment	FX	30,500
- John Hopkins Univ. (Buy-in)	Contract (PIO/T)	Direct Payment (AID/W)	FX	150,000
				474,750
Audit and Evaluation - AID				
- Audit	Contract (PIO/T)	Direct Payment	LC	124,000
- Evaluation	Contract (PIO/T)	Direct Payment	FX	84,000
				208,000
	Local currency	4'441,250		
	Foreign Exchange	558,750		
TOTAL				5'000,000

1. Method of Financing Foreign Exchange Costs

USAID/Peru and AID/W will assume responsibility for disbursing funds for some of the foreign exchange costs of the Project. These include technical assistance procured through buy-ins, and audits and financial reviews. Technical assistance will be provided through AID/W in the form of buy-ins with SOMARC and the Population Communication Service Project/Johns Hopkins University. In other cases, technical assistance will be contracted directly with individual consultants through the PIO/T process, at the request of APROPO. Disbursements by AID/W will be charged to the Project by Advances-of-Charge (AOC). The audits will be contracted through the non-federal audit mechanism established by the RIG/A/T. Payment terms will be negotiated by the EXO or RCO, as appropriate in their contracting negotiations. Financial management reviews will be confirmed and contracted through co-signed PIO/Ts and contracts executed directly by USAID/Peru.

2. Method of Financing Local Currency Costs

Local currency Project costs will be approved by USAID in the form of a Cooperative Agreement Letter (CAL) as follows: an annual cash flow projection of costs will be developed presenting monthly cash requirements; quarterly requirements will be presented to USAID as the basis for monthly advances of cash requirements. Advances will be liquidated by monthly billings from APROPO. Monthly advance liquidations presented to USAID will be made after the bank statements have been received and accounts reconciled by APROPO. These advance clearances will be made on or before the fifteenth day following the end of the reporting month.

Technical assistance and technical studies will be approved by the CAL procedure for APROPO contracting and monitoring. USAID will provide advances as needed. The process will be the same as explained above.

The Mission will perform or, if appropriate, contract accounting firms to perform on USAID's behalf (from the financial review line item) periodical post review of vouchers at the implementing office. If during the audit or financial review it is determined that the systems are no longer adequate, USAID will require all supporting documents until action is taken to resolve the problem areas.

V. PROJECT ANALYSES

A. Technical

The technical analysis for this project addresses the feasibility of the technologies to be used to increase commercial sales of moderately-priced contraceptive products (CSM), expand family planning coverage in employer-subsidized health plans (CSD), and achieve greater familiarity with modern contraceptive methods and address rumors and dis-information through communications campaigns. The approaches and techniques described in this project have all been tested in social marketing, private health care, and/or communications programs, either in Peru or other countries in Latin America.

1. Contraceptive Technology

All of the contraceptives to be included in this project are already in use in Peru at this time. The oral contraceptives to be included in the CSM component are registered in Peru and have been marketed for many years. The brand of condoms has not yet been selected, but the probable distributor, Quimica Suiza, is the authorized Peruvian distributor for Ansell, the U.S. manufacturer which provides condoms to A.I.D. Lorophyn, the spermicide promoted under the previous CSM project, is registered, manufactured, and marketed locally. Should another spermicide be added to the CSM line, preference will be given to a brand already registered in Peru. IUDs are not manufactured locally and would have to be imported. Two effective copper-bearing devices are registered in Peru, Multi-load (Schering) and the TCu-380 (licensed by The Population Council). The latter is the device donated by A.I.D. and can be purchased from a number of authorized manufacturers. Injectable hormonal contraceptives, although not approved by the U.S.F.D.A., are registered and marketed in Peru. Any promotion and distribution of injectables under the CSM component will be financed with non-A.I.D. funds.

2. Contraceptive Social Marketing (CSM)

The principles of CSM are well understood and have been successfully applied for many years and in many socio-cultural contexts. The CSM component will employ well-tested marketing tools and state-of-the-art scientific measures to identify target audiences, pretest messages and media, and evaluate the impact of Project interventions in attaining the specified objectives. Findings from the previous

CSM project and national surveys clearly demonstrate the acceptability of family planning promotion among Peruvian women and men and the impact of brand name advertising on commercial retail sales. Peru possesses the necessary infrastructure, including pharmaceutical laboratories and distributors, market research firms, and advertising agencies to mount effective product promotion and guarantee reliable supply of product throughout the commercial system.

3. Commercial Services Delivery (CSD)

The commercial sector is already the second largest supplier of family planning services in Peru after the public sector. Expanding commercial sector coverage is more a question of stimulating demand than increasing supply. Cost-benefit models to demonstrate the financial returns of family planning to employers, health care providers, and insurance companies have been developed by previous A.I.D.-funded projects such as TIPPS and successfully applied in Peru. Contraceptive technologies used in the commercial sector are the same as those used by the private sector and PVOs. Although Peru is relatively new to the area of commercial marketing of preventive health care and family planning, the techniques contained in the Project have been successfully applied in other countries in South America and on a pilot basis in Peru itself.

4. Family Planning Communication

The techniques described in the National Family Planning Communication component have been successfully applied by the JHU/PCS project throughout the developing world. As discussed above, Peru possesses the necessary infrastructure to design and implement a national communication effort. What has been lacking to date is an overall strategy that pulls all the necessary components together into a cohesive, systematic application of sound communication principles.

B. Financial

The CFP project has three financial objectives: (1) to increase commercial sales of CSM products; (2) to increase purchase of family planning services from commercial outlets by employer-subsidized health plans; and (3) to improve the financial self-sufficiency of APROPO as an institution. The financial analysis will examine each of these objectives in turn.

1. Increase commercial sales of CSM products

Schering is the industry leader in oral contraceptives in Peru, and Microgynon is its best-selling product. However, sales of all pharmaceuticals, including OCs, have declined significantly since the price increases of August, 1990. Given that the population of women in union of reproductive age continues to grow, this means that prevalence of commercial brands has declined by more than the drop in sales.

From a purely financial perspective, increasing commercial sales depends heavily on price and distribution outlets.

a. Price

The previous CSM project adopted standard SOMARC guidelines that the price of one cycle of pills should not exceed 2 percent of the minimum wage. This price ceiling was maintained up until abolition of price controls. Since August, 1990, the price of Microgynon has been higher than the ceiling (currently 2.2% of the minimum wage), and it appears that due to current economic conditions, the 2 percent price ceiling may be too high.

According to an independent economic analysis firm, Cuanto, the purchasing power of the average salary paid to blue collar workers in the private sector in Lima

fell 56 percent between 1980 and 1990. (In comparison, workers in Argentina lost 32% of their purchasing power, and Mexican workers lost 24% of theirs). By May, 1991, it cost 3 minimum salaries to adequately feed a family of six in Peru with 2,170 calories and 63 grams of protein per person per day. Between 1985-1990, per-capita consumption in Metropolitan Lima among middle and lower-income families fell by 64 percent; one third of the decline occurred in the first 4 months following the price increases of August, 1990.

Peruvian families adapted to the "shock" of August, 1990, by drastic reductions in non-essential and deferable spending: expenditures for clothing fell by 71 percent and for health care by 77 percent. Lower-income families curtailed their spending somewhat more than middle-income families. Expenditures for food fell by only 9 percent, although the quantity of foodstuffs purchased showed a greater proportional impact (19% decline in calories and 29% decline in protein. Cuanto, Ajuste y Economia Familiar 1985-1990, 1991).

Patterns of health care spending showed enormous changes following the shock. Use of private sector outlets fell by more than half, from 17 to 8 percent of consultations for illness among lower-income families and from 25 to 11 percent among middle-income families (Cuanto, ibid). Spending on medical services for illness fell by 66 and 22 percent among lower- and middle-income families, respectively, and spending on pharmaceuticals fell by 90 and 62 percent.

Peruvian and international experts believe that average family income will not improve appreciably over the next 3-4 years. Since families will not be able to postpone expenditures on clothing, housing, etc. indefinitely, it is likely that their pattern of spending will show further readjustments in the coming year, with food showing relatively greater reductions than other items. It is too soon to predict whether spending on health care will decline further (like foodstuffs) or recover slightly (as is predicted for clothing, transportation, etc).

The current price of Microgynon represents 1.6 percent of the mean family income of middle-income families in Lima and 2.3 percent of the mean family income of the lower-income group. Outside Lima, it varies between 2.6 percent (other urban areas) and 5.1 percent (Sierra) of mean family income. Economists at Cuanto believe that the price of the lowest-priced CSM brand of OCs should be reduced to 1 percent of the minimum wage. At this level, they would represent 1.5 percent of the mean family income among lower-income families in Lima, 2 percent among the majority of families in other urban areas and upper-income rural families on the coast and in the selva, and 2.5 percent of the mean family income in the rural Sierra. These groups include 85-90 percent of the population which still does not use modern contraceptives.

b. Accessibility

The formal distribution network of pharmacies and boticas provides good coverage of Peru's urban areas, but coverage in peri-urban and rural areas is less extensive. Increasing the formal distribution network alone will not solve the problem of accessibility in these areas.

The CSM/CBD operations research project recently conducted by APROPO demonstrated the potential of alternative networks to increase the distribution of CSM products, provided that the price is accessible to their client populations. CBD workers in Lima and Ica offered Microgynon at retail pharmacy prices in addition to lower-priced (donated) Lo-Femenal, During the 4 months prior to the price increase, Microgynon showed significant market penetration in both Lima and Ica and significantly increased CBD worker sales in Lima relative to a control group which sold only Lo-Femenal. After the price increase in August, 1990, sales of Microgynon in both cities fell to near zero and never recovered. The significant finding of the study was the CBD network reached a large number of women who were willing and able to pay a moderate retail price but who did not frequent pharmacies, despite the fact that the product had the same price in both outlets.

The August price increase effectively destroyed the incipient CBD market for Microgynon, but program supervisors feel that sales would resume if prices were lowered.

c. Facilitating factors

Despite the generally gloomy economic picture, once an appropriate price is established, the prospects for successful social marketing appear favorable. Factors favoring implementation of the CSM component include the following:

1. The CSM brands have held their own for over six years of extremely difficult economic conditions.

2. The collaborating organizations, Schering Peruana and Quimica Suiza, are willing and eager to expand the social marketing program.

3. In general, the Fujimori government has created a positive business atmosphere, reducing import tariffs, lifting price controls, and controlling inflation.

4. Licensing of pharmacies has been liberalized allowing the creation of more pharmacies; one supermarket chain has already opened retail drugstores in their Lima stores.

5. The leakage of donated condoms into the private commercial sector has been reduced and will be reduced further allowing the introduction of a CSM brand.

6. The informal sector has expanded, creating more outlets for products in pueblos jovenes and other hard-to-reach areas.

Social marketing of contraceptives has worked all over the world and has made good start with established brands in Peru despite the economic crisis. Achieving self-sustainability within at least two product lines (oral contraceptives and condoms) is a reachable goal by the end of the Project, providing that the economy does not deteriorate further.

2. Increased purchase of family planning services by employer-subsidized health plans

Experience to date demonstrates that even under favorable economic conditions, the process of convincing employers to add family planning benefits and implementing service delivery or payment mechanisms is time-consuming. The current economic slump and prospects for slow recovery will make it difficult for companies to invest in new services for employees or expanded benefits for policy-holders. At the same time, the economic squeeze on the middle class and privatization of social security will increase the pressure on private health plans to widen their coverage to include preventive care. This will favor the CSD component.

To compensate for short term economic limitations, the Project will include limited funds to assist selected companies to gear up for family planning services (included under the "Incentive Fund for Firms" line item in the budget). Priority will be given to one-time start-up costs. In exceptional cases, short-term cost-reimbursement for clinical services provided by third-party providers may be offered to employers, as long as it does not cover more than 50 percent of the price charged to the employer or extend for more than 6 months.

Priority will be given to companies with in-house medical services or self-insurance funds. Incorporating family planning in this context will be cheaper and administratively simpler than for companies which purchase health insurance policies.

3. Improve APROPO's financial self-sufficiency

At present, APROPO is almost completely dependent on USAID/Peru funding for its core institutional support, although progress has been made to increase financial support from membership fees and corporate donations. The activities included in the CSM and CSD components are expected to generate income for APROPO above and beyond their respective operating costs by EOP. The APROPO Board of Directors will be informed at the beginning of this cooperative agreement that any follow-on Commercial Family Planning activities are expected to be self-sustained after the project period.

APROPO will develop, with technical assistance, their capabilities to generate income. Besides expanding its membership base, APROPO will increase its capacity to offer 'brokerage services' to firms, it will be also strengthened through technical assistance, and will be offered to private companies and PVOs on a commercial basis. New sources of income will be also explored, such as Enter-Educate products including the production of songs with messages about family planning, which has been a successful experience for JHU/PCS projects.

APROPO project income will increase progressively during the project period. It will start with US$50,820 in the first year, 4% of total PY1 costs, and will reach to US$249,000 in the PY5, 27% of total annual costs. The estimated generated income during the 5-year period will be US$678,668. It is expected that general administration expenses will be entirely covered by project generated income in year five.

It is not expected that the CSM and CSD components will generate enough profit to maintain activities at the funding levels provided by the Project, nor should such levels be necessary to maintain support for family planning in the commercial sector once the Project has terminated. Depending on volume of business or profit margins, after PY 5 APROPO may decide to scale back operations in each component.

C. Economic

The goal of the Project is to improve the health status of Peruvian families through increased access to modern family planning methods. The Project will contribute to this goal by increasing the availability of modern methods through the commercial sector. In general terms, Peru will benefit from the savings to society of the "cost" of individuals not born as a result of this Project (measured in terms of public expenditures foregone, or pressure relieved on the country's health, education, and nutrition infrastructures by a reduced population), and the increased productivity of women who, with fewer children, have more time to dedicate to productive economic activities.

A cost-benefit analysis was performed for the earlier USAID/Peru PVO Strengthening Project (527-0335), based on estimates of the economic value of one averted birth ($411) compared to the "break-even" cost of averting such a birth ($46) (See Annex III, Exhibit D of that Project for the complete analysis). The projected cost of averting births for that project compared very favorably to the break-even figure and thus suggested that the project was a good economic investment.

The CFP project is expected to broaden the financial base for family planning in Peru and to restructure the family planning market, moving current users who have purchasing power out of subsidized public and PVO sources. This will allow the subsidized sector to expand its coverage, by increasing outreach to previously unserved and/or under-served populations (i.e. the rural areas), provided that it does not decrease its family planning funding. If previous subsidized sector users who passed to the commercial sector are replaced by new contraceptive acceptors, increased coverage will result in increased contraceptive prevalence.

Like any development effort, the CFP project has an opportunity cost in addition to its direct financial outlays. Project activities are designed primarily to stimulate demand for commercial family planning products and services, so it is reasonable to ask whether or not Project funds might be better invested directly in services provision, as in USAID/Peru activities with the public and PVO sectors.

Unlike USAID/Peru bilateral assistance to the subsidized service sector, which largely supports recurrent costs (commodities for the public sector; commodities and salaries for the PVOs), CFP expenses are for investment. The largest single Project line-item is for promotion. While pharmaceutical companies and private providers do set aside a budget for promotion, the relatively short-term, massive effort needed to substantially increase demand for commercial goods and services far exceeds the capabilities of any single commercial enterprise.

The appropriate time-horizon for measuring economic returns of the CFP project is long-term. Proxy impact indicators will be developed during the first year. Direct impacts on contraceptive prevalence will be limited to marginal gains - that is, additional CYP or points of prevalence achieved over and above that which would have been expected without the Project. (For example, calculation of cost/CYP for the CSM component would be based on sales increases rather than total sales). Indirect impacts on contraceptive prevalence will be assessed by measuring source substitution, that is, the extent to which the commercial sector captures users from the subsidized sector.

Family planning is cost-beneficial. The Peruvian National Family Planning Program depends on all three sectors - public, PVO, and commercial. An expanded self-financed commercial sector, the objective of the CFP project, will enhance the sustainability of the entire national program.

D. Social Soundness

This project will broaden the financial base for family planning by increasing retail sales of commercial contraceptive products and the purchase of family planning services from commercial outlets. This section examines the socio-cultural context in which the project will operate and the socio-cultural feasibility of proposed interventions, project beneficiaries, and the anticipated impact of the project.

1. Socio-Cultural Context

The Peruvian population is relatively young and predominantly urban. Forty percent of the population is less than 15 years old, and after four decades of high population growth, the age structure of the population will change only slowly. One third of the total population now lives in the Lima-Callao metropolitan area, and by the year 2000, three out of four Peruvians will live in large cities.

It is safe to say that all regions of Peru have begun the demographic transition from higher to lower fertility rates, driven by a steady increase in use of contraception to postpone or limit future births. Knowledge of contraception in nearly universal throughout the country, although rumors and dis-information about the safety and efficacy of modern methods remain. Modern methods, primarily pills, IUD, and female sterilization, account for only half of all contraceptive use.

2. Socio-Cultural Feasibility

Family planning is widely accepted, despite some anti-family planning influences in the country, chiefly among the far right and far left of the political spectrum. The 1986 DHS found that the majority of women of reproductive age

favored public promotion of family planning. A public opinion survey held in metropolitan Lima in January, 1989, found that

- 81 percent of the respondents were in favor of reducing the population growth rate,
- 95 percent supported "responsible parenthood",
- 87 percent supported the use of mass media to promote family planning, and
- 77 percent supported the distribution of contraceptives.

Political support for family planning has grown significantly under the last two governments. President Fujimori has been extraordinarily outspoken in favor of "scientific methods" of family planning and declared 1991 "The Year of Austerity and Family Planning". Several privatization projects are underway, including the sale of state-own enterprises and permitting private health plans to compete directly with social security. The Ministry of Health permits brand-name advertising of ethical contraceptive products.

Generic and brand-specific IEC campaigns have been conducted using mass media, such as television, radio, and billboards, as well as printed matter such as pamphlets and posters. Radio and television stations have been willing to sell space at reduced rates and have even donated free air time for family planning educational programs. A large proportion of the target population lives in urban areas served by the mass media; television ownership is wide-spread and radio ownership near universal. Over 90 percent of Microgynon users interviewed in a pharmacy client intercept survey reported having heard or seen advertisements for the brand, and the majority of first-time purchasers said that the advertisements were important in their choice of Microgynon.

As many as one in four beneficiaries of private health plans are forced to use public outlets for maternity care and family planning because their plans do not include family planning or because they do not pay the full price of commercial outlets. Surveys conducted in both Lima and the Sierra indicate that these women would use their plans for family planning if it were available, and the majority who currently use a traditional contraceptive method would switch to a modern method if their plan covered the cost.

The interventions contemplated under the CFP project respond to the needs and preferences of the target population. Communication efforts will address specific fears about modern methods and promote specific methods for specific populations. Social marketing will ensure that moderately priced quality methods are available in formal and informal commercial outlets. The CSD component will introduce and increase family planning coverage among employer-subsidized health plans.

3. Project Beneficiaries and Impact

The primary beneficiaries of the CFP Project will be moderate to lower-income Peruvians who desire family planning services and can afford to pay moderate commercial prices for contraceptives, or who are covered by private health plans which currently do not include family planning. The fulfillment of the Project's objectives will further the GOP goal of increasing contraceptive prevalence and reducing the population growth rate. This in turn will contribute to Peru's social and economic development.

Expanded family planning practice and the correct use of effective contraceptive methods will have economic, social, and health impacts. Women who use effective contraception will experience health benefits through:

- reduction of unwanted pregnancies and induced abortions;
- reduction of high-risk pregnancies and their ensuing complications; and

- reduction of side effects and complications caused by the use of inappropriate contraceptives.

Children of family planning users will enjoy improved health through:

- better birth spacing and decreased high-risk pregnancies; and
- improved family nutrition in general, brought about through the birth of fewer children.

4. Summary

There is a clearly-documented unmet demand for family planning among Peruvian women and men. The GOP population policy emphasizes the need for effective family planning service delivery and relies on the commercial sector to support the National Population Program. The contraceptive services and methods supported under this project are socio-culturally acceptable and recognized under the Population Law and MOH norms. Government policy and popular opinion support the use of IEC campaigns to dispel fears about modern contraception and to encourage its wider use.

E. Institutional

APROPO will serve as the implementing organization for the CFP Project. Financial, managerial and planning functions, as well as ultimate program accountability, will be the responsibility of APROPO. Its institutional capacity to successfully undertake these tasks is discussed below. Project activities such as advertising and market research will be mainly executed by APROPO through sub-contracts with local firms. Experience under the previous CSM project indicates that capability exists within the private commercial sector in Peru to effectively undertake these activities. Criteria for selection of these local sub-contractors is also described below.

1. APROPO

a. Nature of Organization and History of Foundation

APROPO (Apoyo a Programas de Poblacion) is an incorporated, non-profit Peruvian institution founded in 1983 by a group of persons conscious of the negative impact of Peru's high population growth rate on the country's economic and social development. APROPO's purpose is to educate Peruvians about the need for family planning and the availability and use of different family planning methods.

APROPO's first General Assembly convened on April 13, 1983 to approve the corporate statutes. These statutes have subsequently been modified four times to bring them more closely in line with the organization's objectives. APROPO is governed by a General Assembly of its voting members, and by a 6-8 member Board of Directors composed of individuals drawn from leadership positions in the business community. Although APROPO is a relatively new organization, the business expertise of the Board of Directors lends it extensive experience, and their close contacts with government official facilitates policy dialogue.

APROPO's General Manager, Dra. Carola Luque, reports directly to the Board of Directors and supervises four salaried staff, a messenger and a small number of local consultants. She is a dedicated visionary who has worked tirelessly for the cause of family planning and an honest administrator who is extremely conscientious about maintaining tight fiscal control. This Project will attempt to complement those skills with commercial business experience. In addition to the Executive Director, APROPO's salaried staff consists of a family planning promoter, a researcher, an accountant, and an administrative assistant.

APROPO has a membership of approximately 80 associates, drawn largely from the private sector. One of the recent amendments to the statutes allowed a special category of non-dues paying members who will instead contribute their time to the institution. This change is intended to widen the base of potentially-interested members and further a "culture" of family planning throughout the various socio-economic strata of Peru.

As a non-profit institution, APROPO has the authority to accept grants and donations as well as to contract for sponsorship and implementation of projects such as the CFP Project. At the time the original CSM project was designed, local legal counsel (Dr. Fernando de Trazegnies, Dean, Faculty of Law, Universidad Catolica, Lima) advised that APROPO's legal status allows it to conduct all activities necessary to implement commercial social marketing activities. APROPO has the independent authority to commit and disburse its funds without approval of other agencies.

APROPO has survived in difficult circumstances for many years. For the last few months, for example, the organization has been without any significant funding, and the staff has continued to work at much reduced (and sometimes no) salaries.

Due to APROPO's prominence as a family planning promoter, its achievements under the earlier project, the energy and commitment of its General Manager and the stature of its Board of Directors, USAID has determined that a sole source waiver of competition for the services of APROPO as implementing agency is justified on the basis of predominant capability. A copy of the action memorandum seeking this waiver and signed by the Mission Director is presented in Annex V.

The Board needs to be more supportive of APROPO, however, both institutionally and programmatically. This Project will pressure the Board to embrace the goals of the organization through adopting family planning services in their own companies and participating in the sustainability goals of the Project by gradually assuming support of the cost of the General Manager's salary and other administrative costs.

b. Sources of Income

APROPO has four sources of funding for its activities and administration: dues collected from its associate members ($60/year per associate with additional requested donation of $200 -- 12 of the 80 members have complied with this request so far), donations from individuals and institutions, income from sales of promotional and educational materials and diagnostic/consultative services (only one paying consultation has been carried out to date, but more are planned for the future. See discussion below under future plans), and international donor (mostly A.I.D.) project financing. Over the past year, private donations fell off dramatically as a result of the extremely difficult economic situation in Peru. APROPO hopes to compensate for this loss by increasing membership and dues collections, branching into new forms of direct income generation, and renewing funding from A.I.D. under this Project. Financial self-sustainability is a goal of APROPO as it is well aware of its importance to its donors. Plans to achieve sustainability are discussed below.

c. Accounting and Administrative Capability

APROPO's accounting "division" consists of one person, an accountant, responsible for preparing vouchers, writing checks, processing data, preparing the payroll, reconciling bank accounts, and all other activities involved in keeping APROPO's finances in order and up to date. The accountant reports directly to the General Manager. Only on exceptional occasions has temporary help in the form of data processors been employed to assist the accountant.

In addition to its regular annual audits, APROPO has been audited at the request of A.I.D. on two occasions: in 1989 by an outside auditing firm contracted by

USAID/Peru (Ramirez Enrique and Co.), and in March 1991 by a non-federal audit (Price Waterhouse) contracted by RIG/Tegucigalpa. With the exception of a few minor inconsistencies, both reviews found APROPO in compliance with generally accepted accounting practices in Peru. Some of the recommendations for improving accounting procedures made by the audits are described below:

Accounting and Administrative Evaluation and Audit performed by Ramirez Enrique and Co. (1989)

One of the primary recommendations of this audit and administrative review was that APROPO should hire a data processor to assist the accountant, who they believed was overworked. One consequence of the accountant's excessive workload was the fact that neither the journals entries nor the balance statements had been brought up to date in several months. APROPO's tight financial situation at the time prevented it from implementing this recommendation, and subsequently the workload diminished due to reduced outside funding and assistance was no longer required. With the initiation of the new Project, provisions are being made again to increase the size of the accounting and administrative staff.

The evaluators also noted a lack of written policies and procedures for financial accounting which they believed created vulnerabilities in the internal controls system, especially as the system consists of only one person. It was also noted that, for the same reason, the organization and functions manuals had not been updated to reflect the current reality. These problems have since been corrected.

A final recommendation made by the auditors was that APROPO could benefit from the installation of a different type of software package that would allow them to prepare reports in formats more appropriate for A.I.D. and GOP reporting requirements.

Project Audit performed by Price Waterhouse (1990)

The precursor CSM project, which ended in February 1990, was audited by Price Waterhouse in December, 1990. The project received a clean report on its financial accounting and management practices. The only minor recommendations that have not yet been acted upon were that: 1) files should be maintained on all personnel, including copies of their authorization of employment, C.V.s, authorization for salary increases, etc.; and 2) that APROPO management should be reviewing and signing off on payroll calculations and preparation. The General Manager agreed that both practices would be instituted immediately.

No problems are anticipated with APROPO's ability to manage funds under the new Project.

Administrative Capacity

APROPO has a small but experienced staff composed by the General Manager, who is Ph.D. in Social Sciences, a Psychologist, a Sociologist, an Accountant, an Administrator, and an Economist. To implement this project, APROPO need trained professionals in communications, marketing, and commercial health care management. For this reason, the project includes funding for three component managers for the CSM, CSD, and communications components. Project success in these areas depends on identifying and hiring trained and experienced individuals in each of the three substantive areas and granting them sufficient autonomy to develop strategic plans and carry out day-to-day activities. USAID/Peru concurrence will be required prior to filling these key positions, and technical assistance from outside sources (SOMARC, JHU/PCS, etc.) may be requested during the selection process.

d. Projects Implemented with A.I.D.-Financing

APROPO first received funding for project activities in April 1984, from Family Planning International Assistance (FPIA) to carry out a program of Information, Education and Communication on Responsible Parenthood and Family Planning ("Peru 22"). Through this project, APROPO contracted a team of professionals to give talks on family planning in 192 labor centers around Lima.

On June, 1984 APROPO was registered as a PVO with A.I.D. APROPO has complied with annual submission of documentation required to maintain its registration status and was so advised to PVC in LIMA 07567 dated 6/31/91.

APROPO has received A.I.D. funding from the Contraceptive Social Marketing project 527-0230 from June 28 1984 through February 28, 1990 by means of a Cooperative Agreement. The purpose of the project was to increase contraceptive usage by approximately 60% from the 400,000 to 650,000 Peruvian couples using a modern method of contraception through making family planning information and affordable contraceptive products available to unserved couples using existing commercial channels, described as the Contraceptive Social Marketing program (CSM). The project consisted of four major commercial activities: (1) market research, (2) product packaging, (3) distribution and sales and (4) advertising/promotion.

Since then APROPO has been continuously receiving assistance for its contraceptive social marketing activities from A.I.D. through:

<u>Maternal-Child Health and Family Planning ($31,000)</u>

This activity ran from May 1989 to March 1990 and was funded under the TIPPS Project (an A.I.D.-financed project implemented by John Short & Associates). The purpose of this activity was to extend the model of maternal and child health care provision developed in the Milpo Mining Company to other mining companies in the Cerro de Pasco region.

<u>Commercial Social Marketing/Community Based Distribution ($31,000)</u>

With financing from The Pathfinder Fund, SOMARC/The Futures Group, and the Population Council/INOPAL, APROPO conducted a pilot project to explore new avenues for CSM distribution. This Project began in February 1990 and terminated in May 1991.

<u>PRISMA - Private Voluntary Sector Family Planning Project (527-0335)</u>

From April 1991 through March 1992

<u>USAID/APROPO Contract ($88,948)</u>

USAID contracted APROPO to prepare a series of nine studies to assess the lessons learned from previous CSM activities in preparation for the design of the Commercial Sector Family Planning Project. The nine studies were as follows:

1) Evaluation of the Results of the CSM Project
2) Evaluation of the Impact of Brand Advertising on Microgynon Sales
3) Perspectives on the Local Manufacture of Contraceptives
4) Communication Strategies for the Promotion of Maternal and Child Health/Family Planning (MCH/FP)
5) Perspectives on Extending the Milpo Model within the Mining Sector
6) Promotion of MCH/FP Services in the Fishing Sector
7) Promotion of MCH/FP Services in COSAPI
8) Basic Information and Activities Required to Promote MCH/FP in the Commercial Sector

9) **Evaluation of the Introduction of MCH/FP in the Insurance Sector**

e. **Future Strategic Planning**

APROPO's strategic planning for the future continues along the three lines first established in 1987: "Institutional strengthening of APROPO, identification and initiation of one project per year, and strengthening of relations with donors and other organizations collaborating in the family planning effort in Peru."

Under the institutional strengthening focus, APROPO plans to work toward eventual financial self-sustainability by developing new sources of income including new donors. The first priority will be to expand its membership base and revenues from dues collections. In addition, APROPO will strengthen its capacity to offer "brokerage" services to firms of family planning service packages for their employees. One such paid consultancy has already been begun with Textil del Valle, S.A. in Chincha. APROPO provided a diagnostic of the family planning services needs of the company's employees, design of a services plan, and is now assisting with implementation of the program. An objective of the CFP Project is to strengthen APROPO's capacity to offer such a "product" to private sector firms.

2. Criteria for Selection of Local Sub-Contractors

As for the previous CSM project, the local sub-contractors will have to fulfill the following criteria:

a. A local market research firm or firms will be selected on the basis of their ability to meet as many of the following criteria as possible:

- Has operated in Peru for more than five years and employs a competent permanent staff;
- Has experience in qualitative as well as quantitative research methodologies and has previously conducted surveys involving national coverage, taking into consideration differences between urban and rural populations in Peru and socio-cultural characteristics of the large Quechua-speaking population;
- Has experience with focus-group and consumer panel research;
- Has access to interviewers who are natives of the region in which they work;
- Has the ability to construct an adequate sampling frame;
- Has designed satisfactory questionnaires; and
- Has a record of on-time service delivery.

b. Local advertising agency (or agencies) selection to participate in the CFP Project will be based on the following:

- Subjective evaluation of the agency's understanding of the CFP Project and of the agency's creative department presentation;
- Is a full-service agency, i.e., having all of the capabilities necessary for the production and placement of advertising campaigns in all available media;
- Capacity to offer coverage in all regions and languages;

- Demonstrated capability in producing and placing advertising in all media available in the market; and

- Experience in the advertising of mass marketed consumer products.

Criteria for the contracting of the services of other local firms will be developed by the component managers during the first year. These other potential local contractors will be pharmaceutical companies, commercial distribution firms, and family planning services providers.

F. Women in Development

While Peruvians in general will be beneficiaries of the Project, as with most family planning projects, women will enjoy the greatest benefits of the Project. Most of the purchases of oral contraceptives are made by women; by assuring the availability of moderately-priced commercial products, women's access to that method will be enhanced. Similarly, the expansion of the CSM product line to include condoms will benefit both women and men. Finally, expanding the coverage of private health plans to include preventive health and family planning will benefit both working women and the wives of male workers.

G. Environmental

The Initial Environmental Examination (IEE) prepared for the PID recommended a categorical exclusion from the requirement to carry out an environmental assessment. This determination was made based on the absence of any activities in the Project that would have a direct impact on the environment. The IEE makes reference to Section 216.2, Paragraphs c(2)(i) and (viii) which allow a waiver of the requirement for further environmental review for projects that do not have an impact on the natural or physical environment, and for programs involving nutrition, health care and population and family planning services -- to the extent that they do not include activities like construction of water supply systems, waste water treatment facilities, etc. The IEE was reviewed and approved by the Environmental Officer LAC Bureau's Chief Environmental Advisor and a copy is included in Annex IV.

VI. CONDITIONS, COVENANTS, AND NEGOTIATING STATUS

The Cooperative Agreement will be subject to the following essential terms, covenants, and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

A. Source and Origin of Commodities and Nationality of Services

Commodities financed by A.I.D. under the Cooperative Agreement shall have their source and origin in Peru or in the United States, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services financed under the Cooperative Agreement shall have Peru or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Cooperative Agreement shall be financed only on flag vessels of the United States, except as A.I.D. may otherwise agree in writing.

B. Condition

Prior to the hiring of key personnel under the Project, A.I.D. shall approve, in writing, such personnel, including CSM Manager, CSD Manager, Communication Manager, IEC Specialist, Contracts Administrator, Assistant-Accountant. Any other personnel will be determined with A.I.D. project manager approval.

C. Covenant

The Implementing Agency agrees that none of the funds made available under the Cooperative Agreement for family planning activities will be used to finance any costs relating to:

1. the performance of abortion or involuntary sterilization as a method of family planning;
2. the motivation or coercion of any person to undergo abortion or involuntary sterilization;
3. biomedical research which relates, in whole or in part, to methods of, or the performance of, abortion or involuntary sterilization as a method of family planning;
4. the active promotion of abortion or involuntary sterilization as a method of family planning; or
5. the procurement of any equipment or materials for the purpose of abortion or involuntary sterilization.

D. Contributions from Non-A.I.D. Sources

The A.I.D. requirement for Operational Program Cooperative Agreements ("OPCAs"), that a minimum of at least twenty-five percent of total project costs be contributed from non-U.S. government sources. According to the projections presented in the financial plan, the total contribution of APROPO amounts to US$942,508 (in-kind and cash), which is equivalent to 16% of total project costs. The waiver of the 25% contribution requirement is attached.

E. Standard Mandatory and Required as Needed Conditions

The Cooperative Agreement that will be negotiated with the Implementing Agency will include the standard conditions required of non-U.S. nongovernmental organizations and required as needed conditions for non-U.S. NGOs.

F. Substantive Involvement of USAID/Peru

Participation of and/or prior approval from USAID/Peru will be required in the design and/or execution of the following Project activities:

(1) Buy-ins to AID/W centrally-funded projects. USAID may recommend and will review and approve all requests for buy-ins to A.I.D./W centrally-funded projects under the Cooperative Agreement.

After such approval, the Implementing Agency will request USAID to issue the necessary PIO/Ts.

(2) Project personnel. USAID approval will required prior to selection and contracting of Project key personnel by the Implementing Agency. These include the CSM Manager, CSD Manager, IEC Specialist, and Contracts Administrators. Any

deviation from the number of support personnel as specified in the Project Paper will require the prior approval of USAID.

(3) Local contracts for technical services and consultants. USAID will participate in the preparation of scopes of work for all subcontracts issued by the Implementing Agency under the Cooperative Agreement for local technical services and consultants. This will include, but not be limited to institutional financial audits of the Implementing Agency. Prior approval from USAID will be required for all Requests for Proposal (RFPs), and selection of subcontractors and consultants.

(4) External Evaluation and Audits. Using funds under this Cooperative Agreement, USAID will conduct a project evaluation during PY 3 and PY 5 as described in the Implementation Plan. USAID will use the results of this evaluation to make adjustments in the project objectives and implementation plan. APROPO will authorize USAID to issue the necessary PIO/Ts and other documentation to carry out this evaluation. Three project audits will be conducted by independent auditors, through RIG/A/T: one each at the end of project years one, three, and five.

Annexes

I.	Logical Framework
II.	PID Approval
III.	Statutory Checklist
IV.	Environmental Determination
V.	Waiver of Competition for APROPO as Implementing Agency
VI.	CSM Project Component Manager: Candidate Profile and Job Description
VII.	CSD Project Component Manager: Candidate Profile and Job Description
VIII.	CSD Project Component Educator: Candidate Profile and Job Description
IX.	Communication Specialist
X.	Summary of General Health Service Provision in Peru
XI.	Case Study on Private Provision of Health Service (MEDIC S.A.)
XII.	Model Contract for Medical "Broker"
XIII.	Description of Private Sector in Peru
XIV.	Demand Analysis by CUANTO S.A.
XV.	Analysis of Overlapping of Social Security and Private Insurance Benefits
XVI	Lessons Learned
XVII	Detailed Project Costs
XVIII	APROPO's Contribution
XIX	Justification for Waiver of 25% Contribution Requirement

LOP $5,000,000
FY 91 - 95
Commercial Family Planning
(527- 0326)

LOGICAL FRAMEWORK

Narrative	Objective Verifiable Indicators	Means of Verification	Important Assumptions
Goal To improve the quality of life for Peruvian families through increased access to modern family planning methods.	Increased prevalence of modern methods to 42% of WRA in 1995 *. Reduced unmet demand for contraception (target to be determined in PY 1)	Possibility of national survey in 1996	**Measures of Goal Achievement** - Continued economic viability of commercial sector - Continued GOP commitment to family planning - Continued funding of public and PVO f.p. programs
Purpose: To increase the provision of modern methods by commercial retail outlets and employer-subsidized health plans.	**End of Project Status** Increased CYP of pills/injectables through commercial retails sales over baseline Increased CYP of condoms through retail sales Enrollment of eligible MWRA in employer-subsidized family planning programs	IMS reports Pharmaceutical laboratory sales reports Service statistics from commercial providers Project mini-surveys	a) Laboratories set accessible prices b) Locally produced CSM products available c) Economy permits consumers to pay for contraceptives d) Import tariffs for contraceptives remain low e) Companies continue to subsidize employee health plans f) Clients will use family planning services

* Objective of the Peruvian Population Program

LOGICAL FRAMEWORK

LOP $5,000,000
FY 91 - 95
Commercial Family Planning (527- 0320)

Narrative	Objective Verifiable Indicators	Means of Verification	Important Assumptions
Outputs	**Magnitude of Outputs**		
1. Expanded CSM product line	1.a. 1 pill brand added b. 2 condom brands added c. Other products added	Project reports	
2. Continued participation by pharmacies in CSM product sales	2.a. 100% of pharmacies carry some CSM products b. 75% of pharmacies carry full CSM line (including higher-priced brands)	2.a. Spot checks b. Distributor Reports	
3. Expanded distribution system for CSM products	3. Number of alternative retail sites carrying CSM products	3.a. Spot checks b. Distributor Reports	
4. Increase in employers and insurance companies offering family planning benefits and employees/dependents covered	4. Comparison of numbers of plans including family planning and employees/dependents covered in 1991 and 1996	4.a. Project technical reports to USAID/Peru b. Project mini market surveys	4.a. Employers continue to subsidize health plans b. Progress in privatization of IPSS continues
5. Continuing improvement in policy climate for commercial family planning	5.a. Continued low import duties of contraceptives b. MOH approval for laboratories to sell to non-pharmacy outlets	5. Official GOP publications (El Comercio)	5.a. GOP continues publications policies b. Liberalization of pharmacy registration continues
6. Implementation of national family planning communications campaign	6.a. Number of participating agencies b. Messages/materials produced and aired	6. Project technical reports to USAID/Peru	
7. Increased knowledge about contraceptives and sources among women and men	7. Increased percent of women and men with accurate knowledge of methods and sources	7.a. Periodic KAP mini-surveys b. Possible national survey in 1996	

LOGICAL FRAMEWORK

LOP $5,000,000
FY 91 - 95
Commercial Family Planning
(527- 0326)

Narrative	Objective Verifiable Indicators	Means of Verification	Important Assumptions
Inputs (Budget in 000's)			
A.I.D.:	Project Agreement PIO/Ts.	Vouchers	- Funds available and USAID can make obligations
- Commercial Social Marketing 526			- Availability of qualified/ appropriate TA
- Commercial Service Delivery 338			- Maintenance of adequate USAID/Peru staff to plan, manage, and evaluate project inputs
- Communications 3,077			project inputs
- Other Direct Project Support 902			
- Administrative 157			
5,000			
- Non-A.I.D. contribution: APROPO * 679			

ANNEX II (a)

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT IDENTIFICATION DOCUMENT FACESHEET (PID)

1. TRANSACTION CODE: [X] A = Add, C = Change, D = Delete — Revision No. ____

DOCUMENT CODE: 1

COUNTRY/ENTITY: PERU/USAID

3. PROJECT NUMBER: 527-0326

BUREAU/OFFICE: A. Symbol: LAC; B. Code: 05

4. PROJECT TITLE (maximum 40 characters): COMMERCIAL FAMILY PLANNING

ESTIMATED FY OF AUTHORIZATION/OBLIGATION/COMPLETION

A. Initial FY: 91

B. Final FY: 92

C. PACD: 95

7. ESTIMATED COSTS ($000 OR EQUIVALENT, $1 =)

FUNDING SOURCE	LIFE OF PROJECT
A. AID	5,000
B. Other U.S. 1.	
B. Other U.S. 2.	
C. Host Country	
D. Other Donor(s)	1,250
TOTAL	6,250

8. PROPOSED BUDGET AID FUNDS ($000)

APPROPRIATION	B. ACTIVITY CODE	1. Grant	2. Loan	D. 1ST FY 1. Grant	D. 1ST FY 2. Loan	E. LIFE OF PROJECT 1. Grant	E. LIFE OF PROJECT 2. Loan
PN	PNSD			500		5,000	
TOTALS				500		5,000	

10. SECONDARY ACTIVITY C: PNCN - PNPD

SPECIAL INTEREST CODES (maximum 7 codes of 4 positions each)

A. Code	CIT	PVL	TWN	COP			
B. Amount	4,500	5,000	500	500			

PROJECT PURPOSE (maximum 450 characters)

To increase the provision of modern methods by Commercial Family Planning Programs. The Commercial Sector will help reach GOP overall target of 38% prevalence by 1994, by providing contraceptives to the unprotected portion of couples with incomes higher than the minimum legal wage.

RESOURCES REQUIRED FOR PROJECT DEVELOPMENT

Staff: Five person team during three weeks: a Population Specialist, a Contraceptive Social Marketing Specialist, an expert in Private Commercial F.P. Services assisted by 2 local consultants and Mission staff.

Funds: PD&S Funds (Population Account) for consultant services 3,000
Operating expenses for TDYs from AID/W and local 12,000
US$ 15,000

ORIGINATING OFFICE CLEARANCE: Signature: Edgar Necochea; Title: Acting Chief HR/HPN; Date Signed: MM 05 DD 28 YY 91

16. DATE DOCUMENT RECEIVED AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

PROJECT DOCUMENT ACTION TAKEN: B = Suspended, A = Approved, D = Disapproved, CA = Conditionally Approved, DD = Decision Deferred

17. COMMENTS

APPROVED: Signature: Craig G. Buck; Title:

19. ACTION REFERENCE

20. ACTION DATE: MM DD YY

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ANNEX II (b)

ACTION MEMORANDUM FOR THE MISSION DIRECTOR

DATE: June 10, 1991

FROM: Maria Angelica Borneck, Population Specialist, HPN
THRU: Edgar Necochea, A/Chief HR/HPN

SUBJECT: PID 527-0326: Commercial Family Planning

PROBLEM: The attached Project Identification Document for the Commercial Family Planning Project in the amount of US$5.0 million for FY 91 - FY 95 requires your Approval.

DISCUSSION: The attached PID was prepared by the staff of Health, Population, and Nutrition Division of the USAID/Peru Mission, LAC/DR/HPN and by Peter LaPera of LAC/DR/SA. This PID was reviewed by the Project Committee and Senior Mission Management on April 3, 1991 and recommended for approval.

RECOMMENDATION: Based on the authorization granted by AID/W to the Action Plan 1989 - 90, which included CFP project development, we recommend that you approve the Commercial Family Planning PID by signing the attached facesheet.

Clearances:

PDP:CKassebaum
CONT:PKramer
DD:BKennedy

Agency for International Development
Washington, D.C. 20523

LAC-IEE-91-78

ENVIRONMENTAL THRESHOLD DECISION

Project Location	:	Peru
Project Title	:	Private Commercial Family Planning
Project Number	:	527-0326
Funding	:	$5 million
Life of Project	:	5 Years (FY 91-95)
IEE Prepared by	:	Maria Angelica Borneck, HPN USAID/Peru
Recommended Threshold Decision	:	Categorical Exclusion
Bureau Threshold Decision	:	Concur with Recommendation
Comments	:	None
Copy to	:	Barbara Kennedy, Acting Director USAID/Peru
Copy to	:	Heather Goldman, USAID/Peru
Copy to	:	Dewey Cardenas, USAID/Peru
Copy to	:	Howard Clark, REA/SA
Copy to	:	LAC/DR/SAM, Lewis Lucke
Copy to	:	IEE File

John O Wilson Date AUG 15 1991

John O. Wilson
Deputy Chief Environmental Officer
Bureau for Latin America
and the Caribbean

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ANNEX IV

ENVIRONMENTAL DETERMINATION

Project Country: Peru

Project Title : Private Commercial Family Planning Project

Project Number : 527-0326

Funding : FY 1991 - FY 1995
Grant: $5,000,000

A. Project Description

The Private Commercial Family Planning Project (PCFP) addresses the needs of couples who wish to postpone a first or subsequent birth and rely on the private commercial sector health delivery system. The Private Commercial Family Planning Project will use private commercial channels to increase access to high-quality family planning information and supplies. Contraceptives for this project will be produced and sold at prices accessible to low income families by local Peruvian pharmaceuticals firms under Government of Peru regulations. (During the first two years, A.I.D. may provide condoms to test the commercial market.) These pharmaceutical firms will become increasingly responsible for providing the information and training necessary to inform family planning providers and users of the safety, efficacy, and availability of temporary contraceptive methods. The project will also seek to interest companies in integrating family planning services into on-going company-financed health insurance company (or employees cooperative) funded medical programs, or group medical practices.

A.I.D. funding for the PCFP Project is $5,000,000; it will finance local PVO project staff, advertising/promotion, market research, contraceptive commodities, technical assistance, evaluations and audits, and USAID project administration. It is estimated that another $1,250,000 --mostly in in-kind contributions of contraceptives and training-- will be provided by the private sector: pharmaceutical firms, distributors, company-supported health insurance plans and medical programs, and a Peruvian PVO (APROPO). The assistance will be obligated to APROPO via a cooperative agreement; most implementation will be undertaken through buy-ins to centrally-funded projects, such as SOMARC, and PCS/JHU.

B. Project Goal and Purpose

The goal of the PCFP project is to improve the quality of life for Peruvian families through increased access to modern family planning methods.

The project purpose is to increase the provision of modern methods through the commercial sector in order to increase prevalence of use of modern contraceptive methods in Peru. Specifically, the project will provide access of family planning information and commodities to young, low-income couples

not currently using a family planning method, motivate commercial health care providers to offer family planning services, and promote the financial sustainability of private sector contraceptive producers and distributors.

C. Identification and Evaluation of Potential Environmental Effects

The project will have no significant environmental effects. The activities will have no direct effect on the physical environment. The assistance to be provided will be used for technical assistance, training of private sector personnel in social marketing, in-country market research, data management equipment, travel, advertising and promotion of contraceptives, and evaluations. The project is for population and family planning services. No construction is included in this project.

D. Statement for Categorical Exclusion

On the basis of the discussion above, it is the opinion of USAID/Peru that the project does not require an initial environmental examination, because its activities are within the classes of actions described in Section 216.2, Paragraphs c(2)(i) -- relating to technical assistance and training -- and (viii) -- relating to population and family planning services. The project is categorically excluded from further environmental review pursuant to 22 CFR 216, as indicated below:

> Section 216.2 c (2)(i) -
> The action does not have an effect on the natural or physical environment.
>
> Section 216.2 c (2)(viii) -
> Programs involving nutrition, health care or population and family planning services except to the extent designed to include activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment).

Concurrence of the Mission Environmental Officer and the Director:

I have reviewed the above statement and concur in the determination that the "Private Commercial Family Planning Project" qualifies for Categorical Exclusion (A.I.D. 216.2 (c)) and does not require an Initial Environmental Examination.

Dewey Cárdenas
Mission Environmental Officer

Barbara Kennedy
Acting Director, USAID/Peru

UNCLASSIFIED STATE 272436

ACTION: AID-2 INFO: AMB DCM ECON

USAID / LIMA
MAIL ROOM
19 AGO. 1991
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VZCZCPE0158
RR RUEHPE
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INFO RUEHQT/AMEMBASSY QUITO 7451
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UNCLAS STATE 272436

17-AUG-91

TOR: 12:55
CN: 57128
CHRG: AID
DIST: AID
ADD:

AIDAC LIMA FOR H. GOLDMAN, D. CARDENAS, QUITO FOR

E.O. 12356: N/A
TAGS:
SUBJECT: ENVIRONMENTAL THRESHOLD DECISION FOR USAID/PERU PRIVATE COMMERCIAL FAMILY PLANNING PROJECT (527-0326)

H. CLARK, REA/SA

1. LAC DEPUTY CHIEF ENVIRONMENTAL OFFICER, J. WILSON, HAS REVIEWED AND HEREBY APPROVES MISSION REQUEST FOR CATEGORICAL EXCLUSION FOR SUBJECT PROJECT.

2. IEE NUMBER IS LACIEE-91-78. COPY OF ENVIRONMENTAL THRESHOLD DECISION IS BEING POUCHED TO MISSION FOR INCLUSION IN PROJECT FILES. EAGLEBURGER
BT
#2436

NNNN

ACTION:HPN(FILES)
INFO:HR
AGR
D

UNCLASSIFIED STATE 272436

ANNEX V

UNITED STATES GOVERNMENT

memorandum

DATE: July 18, 1991
RCO-91-167

REPLY TO ATTN OF: Clement Buchner, RCO

SUBJECT: Approval of justification for exception to competition - APROPO Commercial Family Planning Project

TO: María Angelica Borneck, HPN
USAID/Lima

Ref your fax dated July 16, 1991 setting forth justification as required by HB 13 Ch 2 3(b) for non-competitive award of grant to PVO APROPO.

Justification is considered appropriate to support the proposed Cooperative Agreement under Commercial Family Planning Project. Please cite specific reference under Ch 2 para 3(b) and indicate total estimated value of Cooperative Agreement.

You are welcome to consult on any other issues during the development of this C.A.

OPTIONAL FORM NO. 10
(REV. 1-80)
GSA FPMR (41 CFR) 101-11.6
5010-114

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TELEPHONE 333200
TELEX 20335 PE USAIDPR
FAX 337034

AGENCY FOR INTERNATIONAL DEVELOPMENT

UNITED STATES AID MISSION TO PERU
C/O AMERICAN EMBASSY
LIMA, 1 PERU

UNCLASSIFIED

FAX MESSAGE COVER SHEET

TO: Mr. Clement Bucher, RCO

Date: July 26, 1991

FAX No.: 56-1228

CITY AND COUNTRY: Quito, Ecuador

FROM: Maria Angélica Borneck, HPN

CHARGE TO:

DIVISION CHIEF APPROVAL: A/HPN:ENecochea

CLEARANCE:

SUBJECT: Justification for non-competitive award for project 527-0326

No. of Pages: THREE (including Cover Sheet)

Attached please find subject document for your approval. It incorporates your suggestions.

Thank you for your assistance.

JUSTIFICATION FOR SELECTION OF APROPO AS RECIPIENT

According to Handbook 13, Chapter 2, para 2. 3(b), Competition is not required for:

> Assistance awards for which one recipient is considered to have exclusive or predominant capability, based on experience, specialized facilities or technical competence, or based on an existing relationship with the cooperating country or beneficiaries.

The grantee under this Cooperative Agreement will receive a US$ 5'000,000 grant to implement the Commercial Family Planning Project (CFP 527-0326), which consists of three components: Social Marketing of Contraceptives, Commercial Service Delivery and National Family Planning Communication.

The Mission has identified APROPO as the 123(e)-eligible Private Voluntary Organization to undertake this Cooperative Agreement. It should receive the award non-competitively, based on its predominant capability, experience, and existing relationship with the host country government.

APROPO (Asociación de Apoyo a Programas de Población) is an incorporated, non-profit Peruvian institution founded in 1983 with the purpose to educate Peruvians about the need for family planning and the availability and use of different family planning methods. APROPO is governed by a General Assembly of its voting members (approximately 80 associates), and by a board of 8 members composed of individuals drawn from leadership positions in the business community. Their close contacts with government officials facilitates policy dialogue, which is a crucial element in the Commercial Family Planning Project.

APROPO has a small but highly qualified technical staff composed of a General Manager, who is a Ph.D. in Social Sciences and Communications, a Sociologist specialized in research and evaluation, a Psychologist specialized in promotion of Commercial Services, a Certified Public Accountant, and an Administrator. They have an Economic Advisor specialized in Finance. The APROPO staff will be strengthened through the incorporation of professionals in Marketing and Communications to implement the proposed project.

APROPO has become the only PVO in PERU with experience in management of Commercial Sector programs. From June 1983 to February 1990, APROPO implemented the first Social Marketing project in Perú with USAID funding and technical assistance from SOMARC (centrally-funded project). That project had four basic elements: Policy dialogue, promotion of family planning methods, coordination with pharmaceutical companies, and the training of drugstore employees. Due to the policy dialogue established with different levels of government authorities, the legal barriers to full project implementation were removed. Also, APROPO made agreements with pharmaceutical companies to assure contraceptive supplies at affordable prices, with the approval of the Ministry of Health (MOH).

Through the implementation of a mass media campaign to promote the Social Marketing products, APROPO participated with the contracting agency the in design and implementation of the campaign, using radio, and T.V. Print and audio visual material were also prepared to complement these efforts. The Communication component is essential for the success of the proposed project.

As a follow-on activity, APROPO developed with SOMARC, Population Council and Pathfinder a pilot project to combine efforts of social marketing with community-based distribution programs. This project obtained important results to be used as inputs for the planning process and management of PVOs who wish to initiate social marketing operations, and therefore improving conditions for the operational success.

APROPO also has experience in the activities required for the development of the Commercial Services Component, through a project with TIPPS (centrally-funded project) to introduce family planning services in health plans of the mining sector companies. Other types of industries have also been contacted by APROPO to extend this benefit to their workers.

In the implementation of the different project activities and accomplishment of their objectives, APROPO has demonstrated high level standards of technical capability, learning capacity to absorb cooperating agencies' technical assistance, flexibility to adapt and react to adverse circumstances and to take advantage of opportunities. In the administrative aspect it has also shown good capabilities as reported by the Controller's Office and External Auditors.

APROPO has survived as an organization in difficult circumstances. For the last six months it has worked without significant outside funding, and the core staff has continued to work at much reduced or without salaries due to their commitment to the family planning cause.

APROPO is highly respected by international and local institutions working in the population and family planning activities and has recently been performing a role as promoter and coordinator of IEC activities developed by service provider PVOs as a group. As a result of its good reputation, APROPO been selected by the PVOs as one of the two representatives of the private sector in the National Population Council for the period 1990-91.

For these reasons the USAID Mission recommend that APROPO receive the award for the Commercial Family Planning Project on a non-competitive basis.

_____

Clement Bucher
Regional Contracting Officer

_____

Date

14013

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ACTION: AID-2 INFO: AMB DCM

USAID / LIMA
MAIL ROOM
20 AGO. 1991
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UNCLAS LA PAZ 12145

20-AUG-91 TOR: 14:53
CN: 57592
CHRG: AID
DIST: AID
ADD:

due date 08/27

ACTION COPY
ACTION TAKEN:
DATE:
INITIALS:

AIDAC

E.O. 12356: N/A
SUBJ: PRIVATE COMMERCIAL FAMILY PLANNING PROJECT
- (527-0326)

REF: BORNECK TO ALLEN FAX AUGUST 9, 1991

1. RECIPIENT SELECTION
-

ACTION:HPN(FILE)S
INFO:HR
CONT
PDP
D
PRC

- RLA ALLEN APPROVES SELECTION OF APROPO AS RECIPIENT OF A COOPERATIVE AGREEMENT UNDER SUBJECT PROJECT, UNDER THE AUTHORITY OF HB 13, CHAPTER 2, SECTION 2B3B. SUGGEST YOU CALL THIS A "JUSTIFICATION FOR SELECTION OF APROPO AS RECIPIENT," AS JUSTIFICATIONS FOR "LESS THAN FULL AND OPEN COMPETITION" ARE REQUIRED FOR DIRECT CONTRACTS, NOT GRANTS.

2. TWENTY-FIVE PERCENT CONTRIBUTION REQUIREMENT
-

- SEE HB 3, APP 2G FOR THE APPLICATION OF THIS REQUIREMENT TO OPGS, I.E. PROJECTS CARRIED OUT WHOLLY THROUGH HB 13 GRANTS TO PVOS. AS YOU STATE IN YOUR DRAFT MEMO, THE 25 PERCENT CONTRIBUTION REQUIREMENT OF FAA 110 DOES NOT APPLY AS A MATTER OF LAW TO OPGS TO PVOS, BUT AID APPLIES THE REQUIREMENT TO OPGS AS A MATTER OF POLICY. HB13, APP 2G PERMITS THE USAID DIRECTOR (AS THE "AUTHORIZING OFFICER") TO WAIVE THE 25 PERCENT CONTRIBUTION POLICY FOR OPGS. RLA ALLEN HEREBY CLEARS SUCH A WAIVER BASED ON THE JUSTIFICATION IN REF FAX. BOWERS

BT
#2145

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ANNEX VI

CSM PROJECT COMPONENT MANAGER

CANDIDATE PROFILE

1. Minimum five (5) years experience in consumer products and/or ethical products marketing in Peru.
2. Spoken and written Spanish and English.
3. Team player. Strong interpersonal relations skills.
4. Organizational skills.
5. Computer literacy in wordprocessing and spreadsheet programs.
6. Interest in/and commitment to social issues. Favorable position on family planning.

JOB DESCRIPTION

The position of Account Executive will report to the APROPO Executive Director and have primary responsibility for the preparation of the annual marketing plans and the execution and tracking the various elements contained in the long-term Marketing Strategy. Specific responsibilities will include, but not be limited to:

1. Monitor sales performance on a national and regional basis and prepare a monthly report for APROPO and USAID/Peru. This will include explanations and implications related to planned marketing activities as well as identification of problems and possible solutions.
2. Monitor, evaluate and report on results from management information systems on a monthly basis to APROPO Executive Director and to USAID/Lima Project Monitor.
3. Preparation of the Annual Marketing Plan, including the coordination of the responsibilities of the participating agency partners.
4. Preparation of the Creative and Media Plan briefs for the advertising agency.
5. Coordinate all functions performed by the advertising and market research firms.
6. Monitor and approve in advance of transmission the specific radio and television media plans.
7. Provide primary coordination between participating agencies.
8. Facilitate quarterly working sessions with key representatives of participating agencies.
9. Monitor all marketing expenditures against programmed sales performance.
10. Coordinate product import, supply and distribution as required for each CSM product.
11. Conduct periodic checks (quarterly) of the trade in urban, semi-urban and semi-rural areas.

ANNEX VII

CSD PROJECT COMPONENT MANAGER

CANDIDATE PROFILE

1. Minimum of five years experience in marketing management, and developing/implementing/monitoring marketing plans.
2. Previous experience in the health sector with private risk-sharing providers or private health care providers, is a must.
3. Previous experience in business-to-business sales and direct marketing.
4. Spoken and written Spanish and English.
5. Strong interpersonal relations and leadership skills.
6. Computer literacy in wordprocessing and spreadsheet programs.
7. Favorable position on preventive health care and FP/MCH.
8. Training: Business Administration, Economics, Communication.
9. Post-graduate degree in Marketing.

POSITION DESCRIPTION

The position of Account Executive will report to the APROPO Executive Director and have primary responsibility for the preparation of the annual CSD product marketing plans and the execution and tracking of the various elements contained in the long-term Marketing Strategy. Specific responsibilities will include, but not be limited to:

1. Develop, implement and monitor all aspects of the marketing strategy for the CSD component.
2. Structure the CSD program and coordinate activities.
3. Execute and monitor the CSD project component budget.
4. Design and improve the "product".
5. Establish the pricing policy.
6. Negotiate with health-care providers, private risk-sharing providers and own services providers.
7. Prepare the Annual Marketing Plan, including the coordination of the responsibilities of the participating agency partners.
8. Develop a Database Program including contracting software, designing files configuration, and establishing the flow of information.
9. Prepare the Creative and Media Plan briefs for the advertising agency.
10. Coordinate all functions performed by the advertising and marketing research firms.
11. Monitor activities and performance and prepare a monthly report for APROPO and AID/Peru. This will include planned marketing activities and performance as well as identification of problems and recommendations for solutions.
12. Prepare quarterly and annual reports.

ANNEX VIII

CSD PROJECT COMPONENT
CSD EDUCATOR

CANDIDATE PROFILE

1. Minimum of five years experience in family planning services.
2. Previous experience in CSD programs.
3. Fluent spanish; English desirable.
4. Strong interpersonal relations.
5. Previous experience or favorable disposition toward sales services.
6. Computer literacy in wordprocessing and spreadsheet programs.
7. Training: Social Services, Psychology, Nursing.

POSITION DESCRIPTION

The position of CSD Educator will report directly to the CSD Account Executive and have primary responsibility for contact with prospective clients and clients. Specific responsibilities will include, but not be limited to:

1. Support the development and updating of the database program.
2. Contact prospective clients and sell the "Product".
3. Maintain regular follow-up with clients and prospective clients.
4. Provide consultant services, such as cost/benefit analyses, FP/MCH services, program design, talks, and charlas.
5. Submit monthly activities report, describing performance and problems and recommended solutions, to the CSD Account Executive.
6. Submit quarterly reports to CSD Account Executive.

ANNEX IX

COMMUNICATIONS SPECIALIST

General description of the job:

Design, conduction and implementation of communication programs, and mass and interpersonal communication campaigns in the family planning and HCH fields.

Requirements:

- University title in Mass Communication (preferably or in Social/Human Sciences)
- Previous working experience in the fields of communication, information, and education
- Great leadership with mass media communication
- Experience in the relationship with mass media communication
- Experience in the design and production of audio-visual and printed materials
- Knowledge of qualitative and quantitative research techniques

ANNEX X

SUMMARY OF GENERAL HEALTH SERVICE PROVISION IN PERU

Health care services in Peru is available from both the public sector and the private sector. Within these sectors, the major health care providers are the following:

PUBLIC SECTOR

- Ministry of Health (MOH)
- Peruvian Institute of Social Security (IPSS)

PRIVATE SECTOR

- Providers of Health Services:
  - Clinics
  - Medical centers
  - Private physicians
  - Laboratories and diagnostic centers
  - PVOs

- Financiers and Purchasers of Services:
  - "Own services" available in mining companies and cooperatives
  - Insurance companies
  - Company-managed health funds
  - Broker-managed health funds
  - Provider-managed prepaid plans
    - a) plan and hospital share risk
    - b) plan, hospital and medical group share risk
    - c) plan assumes risk alone

- Suppliers to Health Care Providers
  - Pharmaceutical industry
  - Medical equipment
  - Industrial materials
  - Importers/distributors
  - Pharmacies
  - Other commercial distribution points
  - Community-based distributors (CBD)

In 1980, the Social Security system's dual benefit structure was abolished, and standard benefits were established for all beneficiaries. To emphasize the complete integration of the two organizations, the Social Security Administration was reorganized and given a new name: the Peruvian Institute of Social Security, or IPSS. The major problem of social security during this period was its deteriorating financial solvency. Declining employer contributions due to the increasingly difficult economic climate, a dwindling tax base resulting from a drastic fall in salaries measured in constant terms, a relaxation of controls and mismanagement of facilities, all contributed to increasing IPSS deficits. Services rapidly deteriorated and social security health services lost their former reputation for sound administration and effective delivery.

As a result, pre-payment for private care by those who were dissatisfied with the public health system and aware of the benefits of pooling their health risks grew rapidly in this period.

The inflation of the early 1980s and the recession of 1982-1983 forced health insurance buyers -- particularly the health funds of industrial, service and commercial firms -- to look for the most cost-effective way of obtaining coverage. The market became very competitive, with several factors contributing to the development of alternative health care financing and delivery system.

A large portion of the patients who pay for their health care on a fee-for-services basis, feel the cost of private health services has risen even more quickly than the general consumer price index. In response, there has been significant growth in recent years in private health insurance sales. Major employers have also begun to show interest in private health benefits programs, both as way of increasing employee benefits without raising salaries and as a supplement to, or replacement for, the inadequate services provided to their employees by IPSS.

PRIVATE HEALTH CARE RESOURCES

Health care facilities are primarily concentrated in Peru's major urban areas and the chart below shows the different types of facilities available:

Health Care Facilities

Type of Facility	Total	MOH	IPSS	Private
Hospitals	332	123	18	191
Health Centers	712	586	76	50
Health outposts	1,821	1,728	86	7
Hospital Beds	31,824	19,722	4,966	7,136

Source: OPS, 1986

Since 1986, a substantial number of primary health service centers have developed. Under the MOH, there has been a 27% increase in health centers and 66% increase in health outposts. This increase in investment was mostly in primary health care, although some facilities are not adequately equipped and staffed.

In general the ratio between physicians and nurses, and the population served between 1985 and 1990 has improved from 1,089 per physician to 995, and from 1,505 per nurse to 1,294. Medical professionals are largely concentrated in Lima and other larger cities. In Lima, there is a physician for every 436 inhabitants, while in some places in Peru, there is only one physician for every 47,500 inhabitants. The statistics are similar for nurses.

Distribution of Physicians by Region (Percent), 1984

REGION	IPSS	MOH	Private
Selva	0.1	3.4	4.0
Sierra Norte	8.4	6.2	3.5
Sierra Sur	10.1	9.1	9.6
Costa Norte	13.7	7.0	13.3
Lima Costa	66.0	70.2	66.0
Costa Sur	1.7	4.0	3.6
TOTAL	100.0	100.0	100.0

Source: Zschock and others.

Hospital occupation data prior to 1986 demonstrate an excess capacity in the private sector which created lower prices for private risk-sharing providers.

Private Providers:

Ambulatory care centers (usually called "medical centers" in Peru) form another important component in the private sector in Lima/Callao. These are recent arrivals; most have been in operation only since the early 1980s. Although their emphasis is in medical and surgical specialities, a few offer other types of care (such as dental services) as well. Their emergence is due two factors: an increasing number of physicians, and the activities of insurance companies.

The number of physicians in Lima/Callao has been growing faster than the general population, increasing the relative supply. In the face of diminishing average patient/doctor ration, some doctors have formed group practices in order to economize on capital and operating costs, while others have organized themselves into corporations, working jointly out of a single facility that provides a full range of ambulatory services.

The five largest medical centers, in terms of plant, physicians, human resources and volume of services are: MEDEX, MEDIC, S.A., Los Pinos, Juan Pablo I, and, Marconi.

According to information supplied by the commercial director of MEDIC, S.A., insurance companies represent 80% to 90% of the business of the centers, which varies from approximately 5,000 consultations per month in the case of MEDIC, S.A., to 18,000 consultations for the remainder. The price charged by MEDIC, S.A. for services varies from $7.90 for insurance companies, to $8.50 for brokered patients, to $17.00 for private patients.

The number of monthly visits to medical centers for 4,700 consultations were distributed as follows:

Client	No. Consultations
Condor	900
Positiva	650
Riesgos y Seguros	650
Central Mortgage Bank	480
El Pacifico	300
Private	250
Others	1,470
TOTAL	4,700

Private Risk-Sharing Providers:

Another important sector is private risk-sharers. They include a variety of pre-payment schemes and delivery systems that can be categorizated in four basic configurations:

a) Diversified insurance companies offering health insurance policies. Policies are sold, either directly or through brokers, to large groups of employees and to individual families.

b) Company-sponsored health fund (HF), typically associated with large companies with over 3,000 employees. Most HFs serve as administrative tools by which employee and employers contributions are collected and administered. They are, in effect, self-insurance schemes. If the total cost of claims exceeds the pool of the contributions, the fund must ask the contributing parties for additional funds. The HF's are administered either by the company or for a fee by an administrator (generally an insurance broker).

c) Broker-as-co-insurer scheme. Here, the administrator of a health fund agrees to assume a minimum amount of the insured group's risk. His/her risk is limited to the sum total of the fund's pool of contributions. If total claims surpass this amount, the fund agrees to raise the necessary amount to pay the debt. However, if total claims are less than the fund's revenues for a given period, the broker retains the difference as his profit.

d) Provider-sponsored prepaid health plan. These plans are sponsored by private hospitals and offer comprehensive coverage. They consist of a package of different insurance mechanisms offered directly by the health care provider. Although a patient's choice of provider is limited to the physicians affiliated with the plan, the coverage and benefits are competitive in the risk-sharing market.

NON-GOVERNAMENTAL ORGANIZATIONS

Approximately 21 Peruvian NGOs are involved in providing health services in Peru plus another 36 international NGOs supported by the United States, Canada, Europe and Japan.

The NGOs concentrate their activities in the provision of maternal and child health, including family planning, immunizations, and nutritional services.

ANNEX XI

CASE STUDY ON PRIVATE PROVISION OF HEALTH SERVICE IN PERU (MEDIC, S.A.)

An interesting project that was carried out with MEDIC, S.A., a private health provider working principally with the private risk-sharing providers, demonstrated the possibility of working with private health providers in a family planning program.

MEDIC, S.A. hired a family planning educator and two family planning physicians. The educator worked both in the clinic and with insurance companies and their clients. During the first year of family planning services delivery, MEDIC, S.A. offered consultations to insurance companies and private patients at a subsidized price, and commodities (IUDs, pills, and barrier methods) at slightly higher than cost but lower than commercial pharmacies.

The Project Director visited insurance companies and brokers to convince the companies to include family planning in their health plans. Once the services were accepted by the insurance companies, the educator visited their clients to promote the new services directly to workers covered by the company policies.

A baseline survey conducted in the medical center waiting room revealed that although contraceptive prevalence was already high (54 percent of married women covered by insurance between the ages of 20 and 44 already used modern contraception) and fertility low (average fertility of 3.0 births per women), there was still an unmet need for additional contraceptive services. One quarter of all married women covered by insurance admitted to having had at least one fetal loss, and the estimated total abortion rate exceeded the birth rate. Eleven percent of the women interviewed had been sterilized; two thirds of these tubal ligations had been carried out after a cesarean section delivery.

In spite of the country's economic conditions and uncertain legal status of the insurance industry, MEDIC, S.A. was able to enroll two insurance companies and one self-insurance fund in the family planning program. This represented the first time that the health insurance industry had recognized true preventive care.

This pilot project demonstrates the potential for the use of private health providers to increase the commercial health sector participation in family planning programs.

ANNEX XII

LOS RUISEÑORES OESTE · 277
CORPAC · SAN ISIDRO
LIMA · PERU
☎ 41-8764 / 41-8773
TELEX 21331 PE

CONTRATO DE ATENCION MEDICA HOSPITALARIA

Conste por el presente documento privado que se extiende en duplicado, el Contrato de Atención Médica Hospitalaria que celebran de una parte la CLINICA SAN FERNANDO, con L.T. No. 90G3329, inscrito en el Libro 49543 del Registro Mercantil de Lima, con domicilio legal en Pasaje Miguel de los Ríos # 199 La Victoria, debidamente representada por su Director DR. PEDRO CENTURION PIMENTEL, con L.E. No. 07851679 y L.T. No. 2224968, a quien en adelante se le denominará LA CLINICA y, de otra parte, SEGMEDICAL S.A., con L.T. 90L1855 y domicilio legal en Los Ruiseñores Oeste No. 277 - San Isidro, debidamente representada por su Director Gerente General, SR. GEORGE MAZULIS SEGOND, con C.E. No. 08194341 y L.T. No. 0496804 y su Presidente Ejecutivo EDUARDO F. CORREA BERNINZON, con L.E. No. 07277663 y L.T. No. 3622088, a quien en adelante se le denominará LA COMPAÑIA, en los términos y condiciones siguientes:

PRIMERO: FINALIDAD DEL CONTRATO

LA CLINICA asume la obligación de atender a los titulares y a sus dependientes afiliados a los Programas de Asistencia Médica Familiar, brindándoles atención médica hospitalaria integral al crédito a la sola presentación de su CREDENCIAL "SEGMEDICAL" y el Reporte e Informe Médico que acredite el derecho de atención al usuario, debidamente firmado por la Empresa Contratante del Programa.
En caso de Emergencia Accidental o Atenciones de Urgencia que requieran de internamiento se presentarán provisionalmente, sujeto a regularización posterior, los documentos personales del paciente. Tratándose de un menor, los documentos a retener serán los de un familiar.

SEGUNDO: ATENCION MEDICA CUBIERTA

Este Contrato cubre:

a) La atención médica quirúrgica, gineco-obstétrica y pediátrica, farmacia, exámenes auxiliares y todos los servicios médicos que sean necesarios para el adecuado tratamiento de los asegurados hospitalizados, siempre que dichas atenciones no estén contempladas en la Claúsula Tercera del presente Contrato.

b) La atención brindada en Emergencia de LA CLINICA por accidentes, cuyo tratamiento se inicie dentro de las 48 horas de producido el acontecimiento.
No incluye la atención médica ambulatoria, ni la atención brindada en Emergencia por enfermedades que no sean resultados de accidentes. Dicha atención deberá ser pagada por el paciente a LA CLINICA.

TERCERO: ATENCION MEDICA NO CUBIERTA

El programa no cubre gastos derivados de enfermedades o accidentes originados o relacionados con:

a) Curas de reposo, surmenage, intento de suicidio, desórdenes funcionales de la mente y cuidados psiquiátricos en general, con excepción de Cefalea Tensional y Distonía Neurovegativa.

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b) Exámenes periódicos de salud de una persona sana. Chequeos.
c) Cirugía plástica para condiciones pre-existentes.
d) Cirugía estética para fines de embellecimiento y/o condiciones pre-existentes al momento de la afiliación, a excepción de los casos necesarios como consecuencia de un accidente, cuyos gastos fueron cubiertos por el Programa.
e) Aparatos ortopédicos, prótesis u otros similares.
f) Tratamiento dental incluyendo prótesis, ortodoncias y calzas.
g) La optometría y adquisición de anteojos y cristales.
h) Enfermedades resultantes del uso o afición a las drogas, estupefacientes o alcoholismo, así como las lesiones por accidentes que se produzcan en situaciones de embriaguez o bajo la influencia de drogas o que se hubieren ocasionado voluntariamente.
i) Lesiones o enfermedades que resulten de la participación activa en actos delictivos, huelgas, motines, revoluciones y conmoción civil.
j) Gastos por concepto de sangre y plasma.
k) Controles pre y post natales, aborto provocado.
l) Prescripciones de farmacos en general, vitaminas, tónicos o equivalentes y la medicación que no sea coherente con los diagnósticos.
m) Suministro o uso de bragueros, aparatos o equipos ortopédicos, con excepción de la prótesis que reconoce el IPSS, en cuyo caso se pagará a las tarifas vigentes de dicho Instituto.
n) Cuidados de enfermeras especiales, salvo autorización expresa, recomendada por el médico tratante.
o) Lesiones o enfermedades a consecuencia de actos de guerra, revolución, energía atómica y fenómenos catastróficos.
p) Lesiones ocasionadas por la participación en competencias oficiales y/o prácticas de deportes riesgosos como : automovilismo, motociclismo, pesca submarina, etc.
q) Enfermedades y/o defectos congénitos y/o pre-existentes y gastos derivados por causas relacionadas.
r) Lesiones resultantes de la terapia de rayos X, radioterapia, radium o isópotos, aplicada sin la disposición médica correspondiente.
s) Diálisis peritoneal u órgano artificial para transplante.
t) Toda clase de audífonos.
u) Los gastos de operaciones de fimosis o circunsición. Estos serán cubiertos bajo el Beneficio de Maternidad (Parto).
v) Gastos incurridos por los acompañantes del paciente.

En los casos señalados y en el supuesto que LA CLINICA prestara estos servicios, informará al paciente que estos gastos deberán ser pagados por él al momento del alta.

CUARTO: LUGAR DE PRESTACION DE LOS SERVICIOS Y PERSONAS QUE LOS PRESTEN

Toda la atención médica será proporcionada en las instalaciones de LA CLINICA, con el plantel médico que se especifica en el Anexo No. 1 que forma parte de este Contrato.

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QUINTO: PROCEDIMIENTO PARA RECIBIR LA ATENCION MEDICA

El afiliado titular o dependiente que desee hospitalizarse en **LA CLINICA** debe presentarse acompañado de la **CREDENCIAL "SEGMEDICAL"** de **LA COMPAÑIA** y el Reporte e Informe Médico y la Orden de Atención debidamente llenados, los cuales deberán estar firmados y sellados por la Empresa Contratante.

El Reporte Médico y la Orden de Atención tendrá para **LA CLINICA** una vigencia de treinta (30) días, contados desde su presentación. El afiliado titular y/o sus dependientes deberán hacer uso de las mismas sólo dentro de los quince (15) días de su emisión.

En los casos de urgencia, en los que se compruebe que no es posible obtener el Reporte e Informe Médico y la Orden de Atención, **LA CLINICA** brindará la atención médica requerida, reteniendo la **CREDENCIAL "SEGMEDICAL"** y documentos personales, hasta que se cumpla con presentar dichos documentos firmados por EL Empleador. Si el paciente no cumple con entregar a **LA CLINICA** la documentación antes mencionada en las siguientes 72 horas, **LA CLINICA** se comunicará con los representantes de **LA COMPAÑIA**, informando de la situación anormal creada por el paciente y/o familiar.

SEXTO: RECUPEROS DE GASTOS ANTE EL I.P.S.S.

En los casos de pacientes que requieran gozar de los beneficios que les reconoce el Instituto Peruano de Seguridad Social, **LA CLINICA** se compromete a proporcionar al paciente toda la documentación necesaria para que pueda efectuar el recupero de los beneficios otorgados por el IPSS, sin responsabilidad para **LA CLINICA** en cuanto a los montos de aquel reembolso, para lo cual remitirá a **LA COMPAÑIA** el expediente con copia sellada, junto con un texto que precise que los originales han sido entregados al interesado para que efectúe dicho trámite ante el IPSS. La firma del afiliado deberá constar en ese documento que será entregado a su Empleador.

SEPTIMO: FACTURACION DE LA CLINICA

Por las prestaciones médicas que brinden a los afiliados dentro de las claúsulas de este Contrato, **LA CLINICA** emitirá facturas individualizadas para cada caso e incluirá los montos de los honorarios médicos correspondientes, facturas que deberán guardar relación con las tarifas pactadas, según Claúsula Novena.

- Todos los servicios de **LA CLINICA** y honorarios de los médicos se facturarán en un solo documento en original y dos copias debiendo ser confeccionado de acuerdo a Ley. Al mismo, se anexarán los detalles de análisis, radiografías, recetas, medicinas y otros exámenes auxiliares proporcionadas al paciente, con los resultados pertinentes.

- El monto total de los gastos incurridos deberá ser aceptado, bajo firma, por el paciente, al momento del alta y con las facturas se acompañará el Reporte e Informe Médico y la Orden de Atención debidamente llenados por el médico tratante y por **LA CLINICA**. Las facturas sin la firma del paciente serán devueltas a **LA CLINICA**, según la Claúsula Octava.

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- Adicionalmente, cuando así lo solicite **LA COMPAÑIA** y/o el afiliado y/o su Empleador, **LA CLINICA** adjuntará el Historial Médico del paciente que permitirá a la Compañía aprobar el gasto de su afiliado y procesar el expediente para su pronto pago, según claúsula Octava.

OCTAVO: RESPONSABILIDAD POR EL PAGO Y EL PLAZO DEL MISMO

Las facturas de **LA CLINICA** serán expedidas a nombre del paciente, con cargo a **LA COMPAÑIA** y remitidas directamente a sus oficinas, quien las abonará en un plazo de 14 (catorce) días calendarios, contados desde su recepción, en la Cuenta Corriente Bancaria que **LA CLINICA** le indique a **LA COMPAÑIA** por otro conducto. El Banco con el que trabaja **LA CLINICA** podrá ser reportado y modificado a su sola solicitud escrita.

En el caso de que **LA COMPAÑIA** no encontrará conforme alguna factura o requiérese Historial Médico adicional, podrá devolver a **LA CLINICA** dicha factura, indicando el motivo de su devolución, en un plazo máximo de 05 (cinco) días calendarios, contados desde la fecha de recepción.

Una vez enmendada la factura o presentado el Historial Médico solicitado, **LA COMPAÑIA** se obliga a pagarla dentro de los 14 (catorce) días calendarios siguientes a la nueva recepción, efectuada siempre bajo cargo. Queda establecido que las facturas podrán ser revisadas por **LA COMPAÑIA**, aún cuando estuvieren canceladas a **LA CLINICA**, comprometiéndose esta última a otorgar Notas de Abono por las rectificaciones efectuadas de común acuerdo.

NOVENO: TARIFAS

LA CLINICA se compromete a sujetar su facturación a las tarifas convenidas, según tarifario que se adjunta como Anexo No. 2, y que forma parte integrante de este Contrato. Su actualización periódica queda convenida entre las partes.

Estas tarifas podrán modificarse por acuerdo previo entre las partes. Los medicamentos serán proporcionados por las farmacias de **LA CLINICA**, a tarifas oficiales autorizadas por el Ministerio de Salud y sus Organismos correspondientes.

DECIMO : AUDITORIA

LA CLINICA dará a la Dirección Ejecutiva de **LA COMPAÑIA** y Médicos Auditores, las facilidades necesarias para la revisión de toda documentación, incluyendo la historia clínica del paciente, quienes tendrán a su vez la facultad de inspeccionar, verificar y controlar la atención médica que se estuviere brindando, sin afectar por cierto los Reglamentos de **LA CLINICA** en su relación con el paciente.

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DECIMO PRIMERO: DURACION DEL CONTRATO

El presente Contrato tendrá un plazo de vigencia de un año a partir del 01-ENERO-1989 y se entenderá que queda automáticamente prorrogado si ninguna de las partes comunica por escrito su voluntad de rescindirlo con 30 (treinta) días calendarios de anticipación al vencimiento.

No obstante lo anterior, este Contrato podrá ser rescindido por cualquiera de las partes siempre que se haga por escrito y con una anticipación de 30 (treinta) días calendarios, sin que aquello origine responsabilidad alguna para ninguna de las partes contratantes.

En este caso, LA COMPAÑIA reconocerá todas las facturas que se originen por servicios prestados hasta la fecha efectiva de rescisión y obligará a LA CLINICA a brindar sus servicios normales y acostumbrados, salvo que se trate de un evento por fuerza mayor o situaciones fuera de su control.

El presente Contrato se firma en la ciudad de Lima, el día del mes de de 1991.

p. LA CLINICA
SAN FERNANDO

p. LA COMPAÑIA
SEGMEDICAL S. A.

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Contratante _____

Titular _____

Segmedical N° _____

Fecha _____/_____/_____

INFORMACIÓN MÉDICA PREVIA AL INTERNAMIENTO DEL PACIENTE

A) DEL PACIENTE

1. Nombres y Apellidos _____
2. Sexo _____ Edad _____ Documento de identidad _____
3. Dirección domiciliaria _____

B) DEL CUADRO PATOLOGICO A TRATAR

1. Diagnóstico presuntivo _____

   Definitivo _____
2. Tratamiento médico ☐ Quirúrgico ☐ _____
3. El cuadro a tratar es de origen congénito Si ☐ No ☐
4. Hace cuánto tiempo se inició la causa básica del cuadro _____

C) DE LA CLINICA, TRATAMIENTO, HONORARIOS

1. En qué clínica internará a su paciente _____ Fecha ____/____/____
2. Es Ud. miembro del cuerpo médico de esa clínica SI ☐ No ☐
3. Cuántos días permanecerá internado el paciente _____
4. Utilizará los servicios de ayudante SI ☐ No ☐ Cuántos _____
5. Utilizará los servicios de Anestesiología SI ☐ No ☐ Tipo de Anestesia _____
6. A cúanto ascenderán sus honorarios $. _____

D) DEL MEDICO TRATANTE

1. Nombre y Apellidos _____
2. Dirección del consultorio _____ 3. Teléfono _____
4. Horario de atención en consultorio _____
5. Fecha _____/_____/_____

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ANNEX XIII

Description of Private Sector in Peru

Prior to the 1960s, business activities in Peru were concentrated in agriculture, agrobusiness, and mining. Some development of the industrial sector was made with an eye to import substitution. Similarly, the fishing industry had a substantial increase, due largely to the production of fish meal.

In the 1970s, the commercial business sector suffered great dislocations due to changes in the agreements established under the Andean Pact. Employee profit-sharing mechanisms were implemented, and limits were placed on the repatriation of earnings by foreign investors. Agriculture was reformed, limiting private property ownership and distributing private property to local rural sector workers. This gave rise to large-scale and often inefficient agricultural cooperatives.

During the 1970s, several state business were established by expropriating private business that had been providing public services and those dedicated production of to primary products such as mining, paper production, oil drilling, and fishing. Thus the number of bureaucratic entities in Peru grew with their characteristic systems of controls and centralized authorities.

The overall level of business activities diminished during this time, resulting in great imigrations from rural areas to cities where people found limited possibilities for self-employment in the informal sector markets.

The 1980s were characterized by an intensification of economic and social problems reflected in weakening state-run businesses and a commercial sector which first suffered the effects of hyperinflation and then recession.

Currently, the Peruvian commercial sector is composed largely of small and medium-sized businesses, the majority of which are located in urban zones, mostly in Lima. The principal sectors are manufacturing, construction, transportation, finance, insurance, commerce, tourism, fishing and textiles. In the rural areas, business is concentrated in two basic areas: mining and agricultural.

An analysis of the distribution of the private commercial sector work force by type of activity in 1989 is outlined below:

ECONOMIC ACTIVITY	PERSONS EMPLOYED IN SECTOR	PERCENTAGE OF TOTAL
Agriculture	2,555,900	34.0
Services	1,987,500	26.8
Business	1,136,800	15.3
Manufacturing	772,700	10.4
Transportation	326,900	4.5
Mining	178,300	2.4
Financial	182,000	2.5
Construction	267,500	3.6
Electricity	22,300	0.4
TOTAL	7,429,900	100.0

Source: INE, Statistical Compendium
Preparation: IEES/SNI

PWA*/ Level of Employment
Percentage Structure

Level of Employment	1989	1990
Employed	18.3%	
Unemployment	7.9%	
Subemployment	73.8%	

* People of Working Age

Recent Economic and Business Climate

Short-term economic conditions remain unstable. A positive signal was the reduction in the inflation rate to 5.8% in March, 1991. However, with exception of the agricultural sector, GDP decreased by 9.5% from March 1990 (INEI). Agriculture and cattle-raising showed some growth.

The contribution of the fisheries sector declined 34% from the previous year, mostly due to the cholera epidemic (poorly-prepared fish products are suspected of transmitting the disease, and many of Peru's traditional trading partners suspended imports of fish products). The mining sector registered a a reduction of 5.3%; however, the metals sector registered an increase of 6% due to reduction in union conflicts. The production of copper, zinc and lead increased. Oil extraction decreased by 17%. Construction output was down by 30%, mainly due to cutbacks in the public works budget.

Commercial activity in March registered a contraction of 9.9% due to lower volume of fish products and manufactured products. The main contributing factors were the low levels of production of consumer goods (-13%), food (-17%), plastics (-35%), chemicals (-23%), among others.

In the short-run, the deep recession of the economy is a serious constraint to increased participation of the commercial sector in family planning services. In the medium- and long-run, if GOP policies to reduce inflation, renegotiate the external debt and reinsert the country in the international financial system succeed in reactivating the economy, conditions will be more favorable to develop project activities, especially in the CSD component.

ANNEX XIV

HPN

ESTIMACION DE LA DEMANDA DE ANTICONCEPTIVOS MODERNOS ENTRE POBLACION DE MUJERES EN EDAD FERTIL DEL PERU

(4 DE MAYO DE 1991)

1. A continuación se presentan estimados del uso actual y demanda potencial de productos contraceptivos modernos por la población de mujeres en edad fertil del Perú. Los estimados y comentarios se refieren tanto a los precios como al número de demandantes.

2. Cabe señalar que estos cálculos han sido efectuados por Cuánto S.A. dentro de un plazo de tiempo muy corto (aproximadamente una semana), y sin trabajo de campo de suficiente escala y detalle para lograr datos representativos sobre las características de la demanda actual y potencial. Las bases de los estimados que se presentan a continuación han sido las siguientes:

(a) La información disponible en nuestros archivos sobre la distribución del ingreso, los patrones de gasto, y el tamaño y estructura de la población. Las fuentes principales ya existentes han sido tres Encuestas ENNIV (Encuesta Nacional de Niveles de Vida), la primera efectuada por el INEI y el Banco Mundial en 1985-86, y la segunda y tercera por Cuánto en Junio-Julio de 1990, y luego en Noviembre de 1990.

(b) Una encuesta, breve e informal, de 12 boticas y de 4 ambulantes en 12 distritos de Lima Metropolitana, efectuada durante la semana del 22 al 26 de abril.

(c) Estimados demográficos del Modelo Quipus.

3. Con relación al precio actual de las píldoras anticonceptivas Microgynon, llegamos a las siguientes conclusiones:

(a) El precio actual es de $US 1.30 según información proporcionada por la AID, y de I/m 0.8 a I/m 0.85 según nuestra encuesta de boticas.

(b) Según la AID, el criterio actual para la fijación del precio es que sea igual a un 2% del Ingreso Mínimo Legal o Vital (IML). El precio actual para el público general, en las boticas (I/m 0.8 a I/m 0.85), es sólo ligeramente superior a la cifra correspondiente a un de 2% del IML (I/m 0.76). Como porcentaje del IML, el precio actual está fijado entre 2.1% a 2.2%.

(c) Según nuestra proyección, es altamente probable que el aumento en el tipo de cambio exceda al del IML durante los próximos 12 meses, por lo que un precio de US$ 1.30 fijado en dólares resultaría en una elevación de la relación entre el precio en Intis y el monto correspondiente a 2% del IML.

(d) Si analizáramos la relación del precio, no con el IML sino con el ingreso real mensual promedio familiar de los distintos grupos sociales, concluiríamos que el precio actual excede a ese ingreso familiar para la gran mayoría de la población. En base a la estratificación social que se presenta en el Cuadro I, sólo en Lima se logra una relación entre el precio y el ingreso medio familiar de aproximadamente 2%: en el estrato (tercio) bajo de Lima la relación es de 2.3%, y en el estrato medio de 1.6%. En los demás grupos sociales, sin embargo, la proporción fluctua entre 2.6% (otras areas urbanas) y 5.1% (Sierra rural). Además, el coeficiente se acerca al 3% para los dos deciles más pobres de Lima. Debe tenerse en cuenta que, en promedio, trabajan y reciben ingresos aproximadamente 1.5 personas en cada hogar, por lo que el ingreso familiar "mínimo" o "vital" debería exceder en casi un 50% al IML.

4. Para efectuar una recomendación con relación al precio más adecuado para el Microgynon, deberíamos tener en cuenta las siguientes consideraciones adicionales:

(a) Los niveles actuales de extrema pobreza que se observan en el país son, en un grado importante, muy recientes, y resultantes de la severa recesión y colapso de los servicios públicos acaecidos, sobre todo, en los últimos tres a cinco años. De esto se concluye que la pobreza actual, especialmente entre la población urbana, representa una situación relativamente nueva para gran parte de las familias, por lo que los mecanismos de adaptación y de sobrevivencia aún no han sido plenamente desarrollados. De allí que, para cada nivel de pobreza en el Perú de hoy, el sufrimiento y los efectos negativos sociales sean algo mayor de lo que serían para una población pobre pero adaptada a esa situación, como lo es en mayor grado, por ejemplo, la población rural.

(b) Si bien se esperaría una mayor demanda de anticonceptivos ante la angustia que significa esta nueva pobreza, la demanda observada demuestra una tendencia, más bien, a la disminución, según tanto la encuesta de boticas como los datos proporcionados por la AID. La explicación más probable de este fenómeno, aparentemente contradictorio, es que el efecto de menor ingreso, o empobrecimiento, ha excedido al efecto del cambio en la prioridades hacia un mayor uso. Las familias probablemente tienen una mayor demanda, pero no han podido hacerla efectiva, debido al fuerte alza en el precio real (como porcentaje del ingreso) de los productos anticonceptivos durante los últimos años.

(c) Es muy probable que la demanda efectiva, al precio actual, siga bajando durante el próximo año, debido a un cambio gradual en la estructura del gasto familiar: lo reciente de la caída en los ingresos ha permitido que, hasta ahora, muchas familias mantengan gastos recurrentes postergando ciertos otros gastos, tales como la reparación de ropa, del hogar, y de enseres del hogar, y tales como algunos gastos médicos y de dentista. Debe esperarse que los gastos postergados recuperarán an parte su proporción anterior a expensas del presupuesto disponible para gastos más frecuentes, incluídos los productos anticonceptivos. Al mismo tiempo, la probable reducción de la demanda efectiva de productos anticonceptivos modernos se explicaría por la posibilidad de sustitución de estos por los métodos del retiro y del ritmo, sustitución que probablemente viene ocurriendo gradualmente y que aún no se ha completado.

(d) Debe tenerse en cuenta, también, que las proyecciones macroeconómicas que vienen efectuando el BCR y el MEF, así como el FMI y el Banco Mundial, todas indican que el nivel promedio de ingresos en el país experimentará muy poco cambio durante los próximos tres a cuatro años.

Nuestra recomendación con relación al precio del Microgynon es que, para un objetivo de no sólo impedir una reducción aún mayor, sino, además, lograr un aumento significativo en la demanda efectiva entre los distintos grupos sociales, en particular fuera de Lima, el precio debe reducirse sustancialmente, a un nivel de aproximadamente 1% del actual IML. En la actualidad, este criterio significaría un precio de aproximadamente I/m 0.35 a I/. 0.4.

Puede estimarse que, a este nuevo precio, la compra regular de Microgynon llegaría a representar aproximadamente 1.5% del ingreso familiar medio para los dos déciles más pobres de Lima, más de 2.0% para la mayor parte del resto de la población urbana así como para la población rural más favorecida, de la selva y de la costa, y más de 2.5% del ingreso promedio familiar para la población rural de la sierra. Como puede apreciarse en el Cuadro I, estos grupos representan, en total, aproximadamente el 85% al 90% de la población que aún no usa métodos modernos.

CUADRO L
Distribución de las mujeres en edad fértil que son demandantes potenciales de productos anticonceptivos, según grupo social-regional y según uso actual

	%Mujeres	Tienen Gratis	Compran	No Usan	Ingreso Medio
Total	100	27	27	46	I/m./mes
Lima:					
Estrato Alto	11	1	8	2	
Estrato Medio	11	4	5	2	57
Estrato Bajo	11	5	2.5	3.5	40
Otro Urbano	30	10	9	11	35
Rural:					
Costa y Selva	13	3.5	1.5	8	29
Sierra	24	3.5	1	19.5	18

Notas: 'Compran' incluye la compra de anticonceptivos parcialmente subsidiados. El 100% de las mujeres demandantes potenciales, según estimados del Modelo Quipus, es de 2.4 millones.

ANNEX XV

OVERLAP BETWEEN PRIVATE HEALTH INSURANCE AND SOCIAL SECURITY COVERAGE:

IMPLICATIONS FOR COMMERCIAL SECTOR FAMILY PLANNING

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PROPOSITO DEL ESTUDIO

El presente estudio pretende realizar una estimación de la población blanco susceptible a usar programas de planificación familiar con seguros privados de salud.

Se piensa que entre 500 y 700 mil personas están aseguradas con planes privados de salud, siendo la modalidad de financiamiento de la misma el compartir el pago entre la empresa y el beneficiario. Lo que no es conocido es la población dupla entre seguros privados de salud y el otorgado por el IPSS.

Partimos del supuesto que la mayoria de los beneficiarios de seguros privados de salud también son cubiertos por el IPPS.

El ampliar la cobertura de los planes de salud e incorporar el beneficio de planificación familiar permitirá descongestionar los servicios públicos en la medida que la población asegurada por planes privados usen seguros públicos.

Es importante señalar que no es propósito del presente estudio medir la totalidad de la población asegurada, dado que no existen cifras formales; sino mas bien interesa evaluar el comportamiento de personas aseguradas.

FUENTES DE DATOS

Se ha considerado tres fuentes de datos:

1.- Muestra de 20% de casos de siniestros registrados durante 1989 en Riesgos y Seguros.

Riesgos y Seguros es una empresa que funciona como Broker y que trabaja con gran parte de las compañias de seguros. Se consideró conveniente su elección en la medida que se tenía garantizado el acceso a sus archivos y por el interés demostrado por el Gerente General sobre el tema de la Planificación familiar.

2.- Entrevista de usuarias femeninas en MEDIC.SA.

MEDIC.SA es un centro médico privado que trabaja con compañias de seguros y que ha participado en otros estudios financiados por AID. Es el único centro médico comercial que promueve la planificación familiar; además ofrece servicios gratuitos de control prenatal y de niño sano a sus clientes asegurados (por lo general, los planes privados de salud no reconocen tales servicios preventivos).

3.- Pacientes del servicio de maternidad del Hospital Edgardo Rebagliati.

El Hospital Edgardo Rebagliati atiende el 86% de todos los partos y complicaciones de aborto cubiertos por el IPSS en Lima, siendo aproximadamente 16,000 partos y 2,000 complicaciones de aborto por año.

Se pretende responder a tres interrogantes:

1.- Cuál es la representabilidad de casos de maternidad y aborto en siniestralidad de compañías de seguros.

2.- Cuál es el uso de servicios públicos por las mujeres aseguradas con planes privados de salud y las razones para usar servicios de maternidad en sectores públicos en lugar de usar su póliza.

3.- Cuál es el porcentaje de mujeres atendidas en maternidad en el IPSS que cuentan con planes privados de salud y las razones para acudir al Hospital Rebagliati en vez de usar el seguro privado.

METODOLOGIA

I.- RIESGOS Y SEGUROS

Dentro de los planes privados de salud existen dos formas de pago para atenciones:

a) Directo: Gasto por servicio ambulatorio. No entra en el sistema de contabilidad para siniestros.

b) Reembolso: Gastos no cubiertos por crédito ambulatorio, que incluye especialistas y servicios en otros centros médicos y clínicas no conveniados con la póliza.

En Riesgos y Seguros, se tomó una muestra aleatoria de 20% de los pagos de reimbolso, siendo los reclamos cuyo número termina en 0 ó en 5 (reclamos procesados durante 1989). La muestra no cuenta con los pagos directos a centros médicos o clínicas.

La muestra equivale a 444 reclamos de siniestralidad.

Hallazgos:

Las adultas femeninas aseguradas o esposas constituyen el 33% del total de reclamos. De esta población el 5% engloban razones de hospitalización y el 95% de los reclamos por servicios ambulatorios. (cuadro)

El costo promedio para esta población en dólares al cambio del día fue de US$ 280 para servicio hospitalario y US$ 20 por reclamo por servicios ambulatorios.

Se encontró pocos casos de partos, 3 detectados y 1 caso de aborto. Si bien es cierto son pocos representan el 50 % de los casos de hospitalización de aseguradas o esposas.
(cuadro)

Conclusión:

Para la población cubierta por Riesgos y Seguros, la maternidad no es un rubro importante; pero si lo es en el caso específico de hospitalizacion.

Es probable que la clientela de Riesgos y Seguros no sea representativa del universo de clientes asegurados en el sector privado. Debido a la incertidumbre política y económica sostenida en los ultimos años se ha mantenido una clientela cautiva y la decisión de trabajar sólo con empresas grandes, lo cuál puede originar una poblacion muy selectiva de beneficiarios.

MEDIC.SA

En el mes de Mayo 1991, se realizó una encuesta en la sala de espera del servicio materno-infantil . Este servicio agrupa las especialidades de ginecología, planificación familiar, pediatría y ecografía.

Se consideró entrevistar a mujeres hasta de 45 años de edad.
Se logró entrevistar a 201 mujeres; de las cuáles la edad promedio era alrededor de 30 años. (cuadro)

De ellas el 94% eran casadas o unidas y el 6% solteras. El 60% tiene 1 año o menos como cliente de MEDIC.SA, lo que demuestra el crecimiento rápido de la clientela del centro médico.

El 88% eran aseguradas y el 12% particulares (por no tener seguro privado deben pagar el total de la consulta). En el caso de aseguradas, el 92% manifiestan que el pago de la póliza es compartida entre la empresa y el titular. Por otro lado, el 94% manifiestan que son aseguradas también por el IPSS.

El uso de servicios particulares es amplio. El 50% han usado 3 ó más especialidades en Medic.sa y en otros centros medicos particulares en el último año.

En lo que respecta al uso del IPSS, de aquellas mujeres que tienen derecho a usarlo, el 18% usaron servicios del IPSS en los ultimos

12 meses. Los más comunes son maternidad y emergencia, servicios que generalmente los planes privados no ofrecen o ponen limites estrechos de pago.

El 80% de las mujeres tienen 1 ó más hijos (cuadro). En relación a los partos atendidos desde 1985, que contaban con seguros privados; 79 fueron atendidos en esta época y fueron asegurados. El 25% (20 de estos 79) fueron atendidos en el IPSS, y si consideramos partos desde el 88. 28% fueron atendidos en el IPSS.

La razón principal para el uso del IPSS era costo, 52% de aquellas que usan servicios públicos manifestaron que la póliza de salud no alcanzaba el precio de la clínica. El 14% refirieron el querer guardar el beneficio para otra eventualidad.

En relación al uso de servicios de planificación familiar observamos que 34% de toda la muestra y 36% de las mujeres casadas si usaron algún servicio de planificación familiar en los últimos 12 meses. De las cuáles 35% usaron algún servicio público, del IPSS y en algunos casos del Ministerio de Salud y otras, el 7% usaron agencias privadas voluntarias; el resto servicios privados.

Sólo el 16% utilizan el servicio de planificación familiar de Medic.sa.
(cuadro)

Conclusiones

Una parte significativa de la población asegurada acude a servicios públicos para maternidad y para planificación familiar. El motivo principal es el económico, como se puede observar al hacer uso de servicios de maternidad.

Cabe destacar que la fecundidad en esta población es bastante baja en relación a la población asegurada por el IPSS.

La posibilidad de que los planes privados ofrezcan estos servicios puede reducir el porcentaje de los beneficiarios que acuden al sector público o sector privado voluntario.

IPSS (HOSPITAL REBAGLIATI)

El tercer componente de este estudio fue entrevistar a las mujeres en los pisos de maternidad donde se encuentra el servicio de planificación familiar en el post-parto. Esa selección fue hecha porque había un acceso preestablecido debido al proyecto piloto DIU Post Parto - Post Aborto desarrollado aquí.

Se logró entrevistar a 207 mujeres, indagando si tenian planes

privados de salud y de ser asi, la razón por la que se atienden en el IPSS y no en una clinica privada.

La paridad de las mujeres atendidas en el IPSS es más alta que la atendida en el sector privado. Un factor puede ser la selección de la muestra , que refleja que existe diferencia en el comportamiento de fecundidad de las 2 poblaciones, demostrando una relación inversa entre el poder adquisitivo y alta tasa de fecundidad.

El 12% de las mujeres manifestaron tener un plan privado. El motivo principal para usar el servicio de IPSS es el económico y el 58% de las pacientes con planes privados refirieron que su póliza no alcanzaba el precio y otro 25% no tenía derecho a maternidad por el tipo de plan o por inscripción reciente en el plan.

Debido al éxito del programa piloto de planificación familiar en el post-parto inmediato, el 70% de las pacientes de maternidad manifiestaron de haber escogido el método que querían usar y el 40% mencionaron el DIU. Cabe destacar que dichos servicios son ofrecidos únicamente en el Hospital Rebagliati y en ninguna clínica privada.

Conclusión

Existe la posibilidad de reducir el uso de servicios públicos por la inclusión de planificacion familiar en los planes privados. Los 12% de los partos atendidos en el Hospital Rebagliati que cuentan con un plan o seguro privado de salud representan aproximadamente 1,900 partos durante el año. En la medida que las compañias de seguro no se responsabilizan por una proporción significativa de los casos de maternidad supuestamente cubiertos, ellas son menos susceptibles a los argumentos de la conveniencia costo-beneficio de reconocer y promover la planificación familiar.

Bajo el sistema actual si es importante que los planes privados incluyan beneficios preventivos pero no se puede esperar que este factor por sí solo produzca un gran impacto sobre la congestión de servicios públicos.

Los resultados son importantes si el gobierno sigue con la estrategia de privatizar el IPSS; esto originaría que las compañías de seguros atiendan una mayor población y amplien su cobertura de atención.

Table 1

Riesgos y Seguros:
Reimbursement claims paid to adult women
Distribution by diagnosis and type of service

TYPE OF SERVICE

DIAGNOSIS	Hospital	Out-Pat.
Child birth	3	5
Dilation & curettage	1	2
Gynecology	2	39
Others	1	93
TOTAL	7	139

Table 2

Riesgos y Seguros:
Dollar Value of Claims Paid to Adult Women
By Type of Service

TYPE OF SERVICE	Mean	Std Dev	Cases
HOSPITALIZATION	276.72	237.69	7
OUT PATIENT	20.58	48.89	139

Table 3

Riesgos y Seguros:
Dollar Value of Hospitalization Claims Paid to Adult Women

By Diagnosis

DIAGNOSIS	Mean	Std Dev	Cases
Child birth	133.43	123.70	3
Dilation & curettage	97.70	0.0	1
Gynecology	530.70	274.89	2
Others	377.62	0.0	1

Table 4

Age Distribution of MEDIC.SA Clientele

AGE GROUP	FREQUENCY	PERCENT
20-24	25	12.4
25-29	64	31.8
30-34	53	26.4
35-39	41	20.4
40-44	18	9.0
TOTAL	201	100.0

Table 5

Characteristics of MEDIC.SA Clientele

TYPE OF CLIENT	FREQUENCY	PERCENT
INSURED	176	87.6
PRIVATE	25	12.4
TOTAL	201	100.0

Table 6

Insured Clients: Source of Financing

SOURCE OF FINANCING	FREQUENCY	PERCENT
EMPLOYER	9	5.1
EMPLOYER & EMPLOYEE	163	92.1
INDIVIDUAL	5	2.8
TOTAL	201	100.0

Table 7

Social Security (IPSS) Coverage of MEDIC.SA Clients

COVERAGE	FREQUENCY	PERCENT
WITH IPSS	188	93.5
WITHOUT IPSS	13	6.5
TOTAL	201	100.0

Table 8

Use of Social Security Services
Among MEDIC.SA Clients with IPSS Coverage

USED IPSS SERVICES	FREQUENCY	PERCENT
YES	34	18.0
NO	154	81.5
NO RESPONSE	1	.5
TOTAL	189	100.0

Table 9

Place of Last Live Birth (1985-1991)
Among MEDIC.SA Clients with Private Health Insurance

PLACE OF BIRTH	FREQUENCY	PERCENT
PRIVATE HOSPITAL	56	70.9
IPSS	20	25.3
MOH	2	2.5
OTHER	1	1.3
TOTAL	79	100.0

Table 10

Use of Family Planning Services in last 12 months
Among MEDIC.SA Clientele

USED FP SERVICES	FREQUENCY	PERCENT
YES	69	34.3
NO	132	65.7
TOTAL	201	100.0

Table 11

Family Planning Outlets Used by MEDIC.SA Clients

FAMILY PLANNING OUTLET	FREQUENCY	PERCENT
IPSS	18	26.1
MOH	6	8.7
MEDICSA	11	15.9
OTHER COMMERCIAL	28	40.6
PVO	5	7.2
OTHER	1	1.4
TOTAL	69	100.0

Table 12
Age Distribution of IPSS Maternity Patients

AGE GROUP	FREQUENCY	PERCENT
15-19	3	1.4
20-24	34	16.4
25-29	62	30.0
30-34	66	31.9
35-39	29	14.0
40-44	12	5.8
45-49	1	.5
TOTAL	207	100.0

Table 13

Coverage by Private Health Insurance
Among IPSS Maternity Patients

PRIVATE HEALTH COVERAGE	FREQUENCY	PERCENT
YES	24	11.6
NO	183	88.4
TOTAL	207	100.0

Table 14

Reason for not choosing private hospital
among IPPS maternity patients with private health insurance

REASON FOR NOT USING PRIVATE HOSPITAL	FREQUENCY	PERCENT
NO MATERNITY COVERAGE	2	8.3
WAITING PERIOD	4	16.7
PRICE OF PRIVATE HOSPITAL	14	58.3
PREFER REBAGLIATI HOSPITAL	3	12.5
OTHER	1	4.2
TOTAL	24	100.0

Table 15

Interest in Receiving Postpartum Family Planning
Among IPSS Maternity Patients

PREFERRED METHOD	FREQUENCY	PERCENT
IUD	82	39.6
PILLS	15	7.2
BARRIER	15	7.2
STERILIZATION	11	5.3
NATURAL	19	9.2
NORPLANT	2	1.0
NO METHOD	63	30.4
TOTAL	207	100.0

ANNEX XVI

Lessons Learned from Past and On-going A.I.D. Projects

A.I.D. provides approximately US$2.5 million in bilateral population assistance to Peru annually, plus another US$1 to US$2 million each year in central population funds. The following describes lessons learned from three projects, one bilateral and two centrally-funded, which included activities similar to those that will be carried out under the CFP Project.

1. Integrated Health and Family Planning Project (CSM Component, Phases I and III) (527-0230)

a. Experience

Because the contract proposed bringing in U.S.-manufactured products as a donation, and Peruvian law restricted the sale of donated contraceptives without first paying high import duties, APROPO and the technical advisor first dedicated themselves to removing these restrictions. This process took almost two years, and authorization was not secured until April 1986.

APROPO next turned to obtaining necessary local technical assistance. RFPs for market research and advertising were issued and firms selected. In May 1987, USAID/Peru requested assistance in exploring alternative CSM models for the Peru program. During the assessment visit, the consultants discovered that the minimum wage in Peru had increased substantially, enough so that the price of locally manufactured contraceptives was judged to be accessible to C and D class consumers (i.e., upper-lower and middle-lower socio-economic groups), the target markets for CSM. The high-cost strategy of selling U.S.-manufactured products was changed to a more effective and cost-efficient plan to promote and distribute high-quality, low-priced contraceptive products manufacture in-country. This change in strategy was approved by the APROPO Board of Directors and USAID/Peru.

The Peru CSM II Project officially began in October 1987 with APROPO as the implementing agency and with Futures/SOMARC providing technical assistance on an as-needed basis determined by USAID/Lima. The project objective was to increase the sales of OCs and vaginals among young consumers in the C and D socio-economic classes who were non-users. APROPO developed a marketing plan which set sales projections and targets for its two brands, planned a mass-media advertising campaign, developed and implemented market research for project design and evaluation, initiated national retailer training and pursued the sourcing and introduction of a CSM condom brand.

The CSM II Project reached its target audience; motivated consumers to use modern methods on a trial basis, particularly OCs' achieved the confidence and respect of local PVOs and government ministries; initiated activities that have increased the volume and depth of discussion of family planning and modern methods in the press, in pharmacies and among the general populace; and made a significant contribution toward maintaining sales levels of OCs while all other ethical products experienced drastic declines in volume sales between 1987 and 1989.

In addition, APROPO has initiated, developed and is implementing novel activities in CSM such as the radio information/hotline program; the Information Kit designed for retailers and CBD workers in counseling consumers; the CBD/CSM pilot project; and brand-specific mass media advertising, which is not legal in other Latin American countries.

Some of the achievements of the CSM Project have directly benefitted PVOs. For example, APROPO's securing of MOH approval to sell donated contraceptive commodities at a profit, opened the way for PVOs to charge higher prices for the supplies they provide. Several CBD programs reported anecdotally that users of the A.I.D.-donated pills were requesting the CSM brand, even if it meant paying a much higher price than for the PVO brand. By carrying the CSM brands, PVOs generate their own income through the sales of contraceptives, become more economically self-sufficient, and achieve greater freedom in selecting the products they wish to offer. The PVO programs also can take advantage of CSM mass media advertising and promotion which benefits their clients as well as the more comprehensive goal of increasing contraceptive use.

b. Lessons Learned

Commercial sector family planning projects, by definition, work within the local commercial infrastructure and have as a key objective, achieving financial and technological autonomy. In order for this to occur within a reasonable and carefully assessed time frame, a capable implementing agency must be identified and contracted. The idea is to find an agency that is financially and technically solid prior to undertaking the commercial sector project. This is rarely the case, however, so the donor must contract with a capable local agency with commercial sector experience and relevant contacts, with the mutual understanding that a minimal level of funding will be applied to institution strengthening. After a reasonable, and pre-determined amount of time, it will have been agree that the implementing agency must be fully autonomous in order to continue implementing the commercial sector family planning projects.

The following are lessons learned from APROPO's management of the CSM Project from 1984 - 1990:

Management

Monitor closely the relationship between the distribution of products and advertising/informational materials, training and other promotional activities, and sales data by region and by institution (public, PVO, and commercial sectors). Sales data analysis is critical to project monitoring and regular adjustment of marketing strategies.

- Contract with a high-level Marketing Manager with extensive experience in consumer and/or ethical product marketing who will be responsible for meeting objectives laid out in annual marketing plans.

- Negotiate long-term sub-contracts with pharmaceutical companies and a commercial distribution firm to ensure: adequate product supply, social pricing, national distribution, and contribution to the project's marketing efforts (in-kind and/or financial).

- Receive ongoing and regular TA in CSM from a continuous source for the first three years. TA is also required in communications and policy support.

- Hire a qualified staff member to be trained in contraceptive technology and interpersonal relations skills, to prepare them to implement effectively the national retailer training program.

Products and Brands

- Market a minimum of two brands in each product category so as to ensure the flexibility and survival of each product under the Project, as well as provide range to consumer in terms of an image and price.

Advertising and Promotion

- Focus all communication efforts on increasing sales in the overall categories, as well as on the CSM brands.

- Develop all materials and activities as components of the same well-orchestrated strategy rather than as discrete interventions. Each effort should support and/or reinforce others in the strategy.

- Focus activities on information rather than straight promotion, at least in the first five years of the project.

- Include interpersonal relations skills as part of the national retailer training program. The program should be ongoing and adjusted each year based on retailers evaluations and suggestions. The program should be implemented by person(s) specifically trained for that purpose.

- Promote CSM brands under national umbrella campaign to establish implementing agency as "sponsor", thus legitimizing new products and replacement brands.

Distribution

- Coordinate closely with the public, NGO, and PVo sectors to increase consumers' access to CSM brands as well as reinforce the positive image of family planning via quality CSM brands at accessible prices.

Market Research

- Use tracking data such as monthly distribution and sales information to monitor project progress and adjust marketing strategy.

2. TIPPS (1986-1990)

Experience

ELECTROLIMA did not implement family planning services because of problems encountered in negotiations with the service providers and lack of motivation among its politically-appointed board of directors.

Milpo accepted the recommendations of the study, and in April 1988, hired an additional physician and nurse and contracted for four weeks of specialized training in family planning and child survival with two PVOs in Lima. The company assumed all commodity and service delivery costs. In 1990, USAID/Peru funded an evaluation of program impact.

In the first 18 months of program operations, complete vaccination coverage among children ages one to four rose to 75 percent, up from the 5 percent level observed at baseline. Approximately 90% of children aged one, and 35 percent of the children aged one to four, have been enrolled in growth monitoring. All of the more severely malnourished children were enrolled in nutritional rehabilitation.

In the reproductive health program, virtually all of the pregnant women were enrolled in prenatal care (four or more visits) and the births attended in hospital increased from 64 percent at baseline, to 78 percent in 1989. Cancer screening received high priority. Approximately half of the eligible women received pap smears in 1989.

Family planning proved to be extremely popular, 291 women out of an eligible population of less than 1,000 received IUDs. Total contraceptive

prevalence among miners' wives of reproductive age rose from 34 percent at baseline to 48 percent, and the use of modern methods more than doubled.

Integrated FP/MCH services have been well-accepted by Milpo management, health care providers and the community. Management repeatedly expressed its decision to continue with the program as a permanent part of its benefits package, even though not required to do so under its union contract.

In March 1989, TIPSS implemented a one-year pilot project with APROPO to promote the FP/MCH concept with other mines in the Cerro de Pasco area, based on the Milpo experience. In November 1989, two additional private mines signed agreements with APROPO to initiate the new services and contracted for training and supervision. At this point in time, services and contracted for training and supervision. At this point in time, services delivery in the three mines that adopted the program can be expected to continue with minimal or no donor assistance.

The other pilot project was with MEDIC, S.A., a private medical group in Lima that primarily serves private health insurance clients. Prior to the pilot project, none of the private insurance plans they utilized included preventive care or family planning.

MEDIC, S.A. sales representatives met with employers, insurance plan officials and administrators of self-insurance funds to discuss the financial benefits of family planning. The project succeeded in convincing two insurance companies and two bank self-insurance funds to include family planning services.

The most significant achievement of the MEDIC, S.A. project was to introduce preventive health care for the first time ever in private insurance coverage in Peru.

3. The Family Planning Enterprise Program (936-3034)

An important objective of the CSD component is to support the APROPO goal of moving toward self-sustainability. Although it did not operate in Peru, lessons learned from the centrally-funded Family Planning Enterprise Program can help achieve that objective.

> To achieve sustainability, project designs must be carefully tailored, provide for technical assistance as well as financial support, and operate within a realistic time frame.

It is essential that projects be carefully designed in response to the particular characteristics of the recipient organization. Technical assistance must be incorporated into the project design and may be in management and/or technical areas, and each technical assistance plan must reflect the specific needs of each organization.

In terms of time frame, most project designs assume a "best case" scenario and on average, allow only two years to achieve sustainability objectives. Adopting the best case scenario resulted in overly-optimistic time frames as project designs did not account for the wide variety of factors that can affect project implementation. These factors included changing economic environments, changing markets, increased competition, inability to hire additional staff rapidly, delays in acquiring equipment and refurbishing, and a variety of personality factors.

Experience has shown that a three to five year time frame for project implementation is more realistic.

- Entrepreneurial behavior and business-like operations are essential if NGOs are to compete with for-profit providers

Income generation is essential for sustainability, and virtually any income generation program involves competition, or working together with for-profit providers. The most successful NGOs are those that behave like other entrepreneurs, seeking out and taking advantage of market opportunities and using the same operating systems and tools as businesses. This must include a willingness to compete with the for-profit sector in terms of salaries and prices offered for inputs needed to run NGO business operations. Attitude and professed willingness are not enough. It is behavior that counts.

- The most promising projects have verified markets
- Comprehensive, accurate and precise knowledge of the market is essential for project success.
- Top NGO management commitment to sustainability is essential.

NGO business ventures cannot work well without strong leadership and commitment from the top. Most involve some kind of risk, ranging from a financial investment to altering the image of the organization. They also invariably involve change.

Top managers must also be convinced that the long-term viability of the NGO depends on increased financial self-reliance, and they must encourage an entrepreneurial spirit within the staff.

ANNEX XVII - A

Table 1 (a)
Schedule of Costs

	PROJECT YEAR					
	One	Two	Three	Four	Five	Total
CONTRACEPTIVE SOCIAL MARKETING, (CSM)						
Personnel						
CSM Manager	28,000	29,400	30,870	32,414	34,035	154,719
CSM Trainer	14,000	14,700	15,435	16,206	17,016	77,357
	42,000	44,100	46,305	48,620	51,051	232,076
Technical Assistance						
SOMARC	121,000	110,000	23,000	23,000	17,250	294,250
TOTAL CSM ELEMENT	163,000	total csm	69,305	71,620	68,301	526,326
COMMERCIAL SERVICES DELIVERY, (CSD)						
Personnel						
CSD Manager	28,000	29,400	30,870	32,414	34,035	154,719
CSD Educator	14,000	14,700	15,435	16,206	17,016	77,357
	42,000	44,100	46,305	48,620	51,051	232,076
Technical Assistance						
Consulting/Experts	44,000	27,500	11,500	11,500	11,000	105,500
TTOTAL CSD ELEMENT	86,000	71,600	57,805	60,120	62,051	337,576
NATIONAL FAMILY PLANNING COMMUNICATION						
IEC specialist	29,000	29,400	30,870	32,414	34,035	154,719
Advertising	232,000	370,600	369,130	337,586	185,965	1,495,281
Promotion	119,000	270,000	270,000	100,000	150,000	900,000
Trainning	30,000	30,000	30,000	30,000	30,000	150,000
	400,000	700,000	700,000	500,000	400,000	2,700,000
Technical Assistance						
John Hopkins University	165,000	137,500	34,500	23,000	17,250	377,250
TOTAL PROJECT ELEMENT	565,000	837,500	734,500	523,000	417,250	3,077,250

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OTHER DIRECT PROJECT COST						
Personnel						
Contracts Administrator	25,000	26,250				51,250
Accounting Assistant	4,900	5,145	5,402	5,672	5,955	27,074
Project Secretary	8,400	8,820	9,261	9,724	10,210	46,415
	38,300	40,215	14,663	15,396	16,155	124,739
Research/Evaluation	90,000	84,000	84,000	76,750	94,500	431,250
Travel and Transportation	20,000	21,000	21,000	21,000	21,000	104,000
External Evaluation			42,000		42,000	84,000
External Audit	40,000		42,000		42,000	124,000
Equipment	34,226					34,226
TOTAL PROJECT ELEMENT	222,526	145,215	203,663	115,146	215,655	902,215
GENERAL ADMINISTRATIVE EXPENSES						
Personnel						
General Manager	35,000 *	36,750 *	38,588	40,517	42,543	193,398
Family Planning Promoter	14,000 *	14,700 *	15,435	16,207	17,017	77,359
Researcher	16,380 *	17,199	18,059	18,962	19,910	90,510
Accountant	16,380 *	17,199	18,059	18,962	19,910	90,510
Administrative Assistant	16,380 *	17,199	18,059	18,962	19,910	90,510
Messenger	2,129 *	2,235	2,346	2,463	2,586	11,759
Secretary	4,914 *	5,160	5,418	5,689	5,974	27,155
Subtotal	105,183	110,442	115,964	121,762	127,850	581,201
Rent & Utilities	19,800	19,800	19,800	19,800	19,800	99,000
Office Supplies	6,600	6,600	6,600	6,600	6,600	33,000
Insurance	9,900	9,900	9,900	9,900	9,900	49,500
Telephone/Fax	7,920	7,920	7,920	7,920	7,920	39,600
Maintenance	6,600	6,600	6,600	6,600	6,600	33,000
Subtotal	50,820	50,820	50,820	50,820	50,820	254,100
TOTAL PROJECT ELEMENT	156,003	161,262	166,784	172,582	178,670	835,301
APPROP	50,820	109,812	166,784	172,582	178,670	678,668
AID	105,183	51,450				156,633
TOTAL ALL ELEMENTS	1,192,529	1,369,677	1,232,057	942,466	941,937	5,678,663
APPROP	50,820	109,812	166,784	172,582	178,670	678,668
AID	1,141,709	1,259,865	1,065,273	769,884	763,267	5,000,000

ANNEX XVII - B

Schedule of Costs and Contingency Detail

PROJECT YEAR

	One	Two	Three	Four	Five	Total
CONTRACEPTIVE SOCIAL MARKETING, (CSM)						
Personnel						
CSM Manager	28,000	28,000	28,000	28,000	28,000	140,000
CSM Trainer	14,000	14,000	14,000	14,000	14,000	70,000
	42,000	42,000	42,000	42,000	42,000	210,000
Technical Assistance						
SOMARC	110,000	100,000	20,000	20,000	15,000	265,000
Total	152,000	142,000	62,000	62,000	57,000	475,000
Cost contingency						
On personnel, 5% increm. cost		2,100	4,305	6,620	9,051	22,076
On technical assistance, 10%	11,000	10,000				21,000
On technical assistance, 15%			3,000	3,000	2,250	8,250
Total Contingency	11,000	12,100	7,305	9,620	11,301	51,326
TOTAL CSM ELEMENT	163,000	154,100	69,305	71,620	68,301	526,326
COMMERCIAL SERVICES DELIVERY, (CSD)						
Personnel						
CSD Manager	28,000	28,000	28,000	28,000	28,000	140,000
CSD Educator	14,000	14,000	14,000	14,000	14,000	70,000
	42,000	42,000	42,000	42,000	42,000	210,000
Technical Assistance						
Consulting/Experts	40,000	25,000	10,000	10,000	10,000	95,000
Total	82,000	67,000	52,000	52,000	52,000	305,000
Cost contingency						
On personnel, 5% increm. cost		2,100	4,305	6,620	9,051	22,076
On technical assistance, 10%	4,000	2,500				6,500
On technical assistance, 15%			1,500	1,500	1,000	4,000
Total Contingency	4,000	4,600	5,805	8,120	10,051	32,576
TOTAL CSD ELEMENT	86,000	71,600	57,805	60,120	62,051	337,576

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NATIONAL FAMILY PLANNING COMMUNICATION

IEC Specialist	28,000	28,000	28,000	28,000	28,000	140,000
Advertising	232,000	370,600	369,130	337,586	185,965	1,495,281
Promotion	110,000	270,000	270,000	100,000	150,000	900,000
Trainning	30,000	30,000	30,000	30,000	30,000	150,000
	400,000	698,600	697,130	495,586	393,965	2,685,281
Technical Assistance						
John Hopkins University	150,000	125,000	30,000	20,000	15,000	340,000
	550,000	823,600	727,130	515,586	408,965	3,025,281
Cost contingency						
On personnel 5 %		1,400	2,870	4,414	6,035	14,719
Total Contingengy	15,000	12,500	4,500	3,000	2,250	37,250
	15,000	13,900	7,370	7,414	8,285	51,969
TOTAL PROJECT ELEMENT	565,000	837,500	734,500	523,000	417,250	3,077,250

OTHER DIRECT PROJECT COST

Personnel						
Contracts Administrator	25,000	25,000				50,000
Accounting Assistant	4,900	4,900	4,900	4,900	4,900	24,500
Project Secretary	8,400	8,400	8,400	8,400	8,400	42,000
	38,300	38,300	13,300	13,300	13,300	116,500
Research/Evaluation	90,000	80,000	80,000	75,000	90,000	415,000
Travel and Transportation	20,000	20,000	20,000	20,000	20,000	100,000
External Evaluation			40,000		40,000	80,000
External Audit	40,000		40,000		40,000	120,000
Equipment	30,000					30,000
	218,300	138,300	193,300	108,300	203,300	861,500
Cost contingency						
On personnel, 5%		1,915	1,363	2,096	2,865	8,239
On other than personnel	4,226	5,000	9,000	4,750	9,500	32,476
Total Contingency	4,226	6,915	10,363	6,846	12,365	40,715
TOTAL PROJECT ELEMENT	222,526	145,215	203,663	115,146	215,665	902,215

GENERAL ADMINISTRATIVE EXPENSES

Personnel						
General Manager	35,000 ‡	35,000 ‡	35,000	35,000	35,000	175,000
Family Planning Promoter	14,000 ‡	14,000 ‡	14,000	14,000	14,000	70,000
Researcher	16,380 ‡	16,380	16,380	16,380	16,380	81,900
Accountant	16,380 ‡	16,380	16,380	16,380	16,380	81,900
Administrative Assistant	16,380 ‡	16,380	16,380	16,380	16,380	81,900
Messenger	2,129 ‡	2,129	2,129	2,129	2,129	10,645
Secretary	4,914 ‡	4,914	4,914	4,914	4,914	24,570
Subtotal	105,183	105,183	105,183	105,183	105,183	525,915
Rent & Utilities	18,000	18,000	18,000	18,000	18,000	90,000
Office Supplies	6,000	6,000	6,000	6,000	6,000	30,000
Insurance	9,000	9,000	9,000	9,000	9,000	45,000
Telephone/Fax	7,200	7,200	7,200	7,200	7,200	36,000
Maintenance	6,000	6,000	6,000	6,000	6,000	30,000
Subtotal	46,200	46,200	46,200	46,200	46,200	231,000
Total	151,383	151,383	151,383	151,383	151,383	756,915
Cost Contingency						
On Personnel Costs		5,259	10,781	16,579	22,667	55,286
APROPO		2,809	10,781	16,579	22,667	52,836
AID		2,450				2,450
On Other than personnel	4,620	4,620	4,620	4,620	4,620	23,100
Total Contingency	4,620	9,879	15,401	21,199	27,287	78,386
APROPO	4,620	7,429	15,401	21,199	27,287	75,936
AID		2,450				2,450
TOTAL PROJECT ELEMENT	156,003	161,262	166,784	172,582	178,670	835,301
APROPO	50,820	109,812	166,784	172,582	178,670	678,668
AID	105,183	51,450				156,633
TOTAL ALL ELEMENTS	1,192,529	1,369,677	1,232,057	942,468	941,937	5,678,668
APROPO	50,820	109,812	166,784	172,582	178,670	678,668
AID	1,141,709	1,259,865	1,065,273	769,886	763,267	5,000,000

‡ AID funded

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ANNEX XVIII - A

COMMERCIAL FAMILY PLANNING PROJECT (527-0326)

Total Contribution of APROPO and Others

I.	In-kind Contribution	US$263,840
	Equipment and furniture	50,000
	Educational material	178,240
	Staff time	35,600
II.	Financial Contribution	678,668
	Income generated PY1	50,820
	PY2	109,812
	PY3	166,784
	PY4	172,582
	PY5	178,670
III.	Total Contribution (I + II)	US$942,508

GENERAL ADMINISTRATIVE EXPENSES

Personnel						
General Manager	35,000 *	35,000 *	35,000	35,000	35,000	175,000
Family Planning Promoter	14,000 *	14,000 *	14,000	14,000	14,000	70,000
Researcher	16,380 *	16,380	16,380	16,380	16,380	81,900
Accountant	16,380 *	16,380	16,380	16,380	16,380	81,900
Adainistrative Assistant	16,380 *	16,380	16,380	16,380	16,380	81,900
Messenger	2,129 *	2,129	2,129	2,129	2,129	10,645
Secretary	4,914 *	4,914	4,914	4,914	4,914	24,570
Subtotal	105,183	105,183	105,183	105,183	105,183	525,915
Rent & Utilities	18,000	18,000	18,000	18,000	18,000	90,000
Office Supplies	6,000	6,000	6,000	6,000	6,000	30,000
Insurance	9,000	9,000	9,000	9,000	9,000	45,000
Telephone/Fax	7,200	7,200	7,200	7,200	7,200	36,000
Maintenance	6,000	6,000	6,000	6,000	6,000	30,000
Subtotal	46,200	46,200	46,200	46,200	46,200	231,000
Total	151,383	151,383	151,383	151,383	151,383	756,915
Cost Contingency						
On Personnel Costs		5,259	10,781	16,579	22,667	55,286
APROPO		2,809	10,781	16,579	22,667	52,836
AID		2,450				2,450
On Other than personnel	4,620	4,620	4,620	4,620	4,620	23,100
Total Contingency	4,620	9,879	15,401	21,199	27,287	78,386
APROPO	4,620	7,429	15,401	21,199	27,287	75,936
AID		2,450				2,450
TOTAL PROJECT ELEMENT	156,003	161,262	166,784	172,582	178,670	835,301
APROPO	50,820	109,812	166,784	172,582	178,670	678,668
AID	105,183	51,450				156,633
TOTAL ALL ELEMENTS	1,192,529	1,369,677	1,232,057	942,468	941,937	5,678,668
APROPO	50,820	109,812	166,784	172,582	178,670	678,668
AID	1,141,709	1,259,865	1,065,273	769,886	763,267	5,000,000

* AID funded

ANNEX XVIII - B

COMMERCIAL FAMILY PLANNING PROJECT (527-0326)

APROPO In-kind Contribution

I.	Equipment and Educational Material	US$228,240
	Office Equipment and Furniture 1/	50,000
	- Desks, filing cabinets, tables, chairs audio visual equipment	41,000
	- Personal Computers (2) and printers (2)	9,000
	Educational Material 2/	178,000
	- Cassettes	48,900
	- Information Kits	51,900
	- Books	14,000
	- Newsletters	20,000
	- Leaflets	10,000
	- Audio-visuals	6,000
	- Film (CSM)	22,000
	Warehousing Services	1,440
	- 30 sq. mt. (Quimica Suiza) 12 months x $120	
II.	Staff Time	US$ 35,600
	Assistance in PP design	10,000
	- General Manager	4,000
	- Admin. Assistant	4,000
	- Researcher	4,000
	- Educator	4,000
	- Accountant	4,000
	- Consultant (2)	9,600
III.	Total In-Kind Contribution	US$263,840

1/ Insured value in "La Fenix Peruana"
2/ Cost of Production and Printing

Source: APROPO

ANNEX XIX

Private Commercial Family Planning (527-0326)

JUSTIFICATION FOR WAIVER OF 25 PERCENT CONTRIBUTION REQUIREMENT

It is A.I.D. policy that a 25 percent contribution from non-Federal funds to total project costs is required for operational program grants (OPG's) and operational program cooperative agreements (OPCA's) to PVOs. Although it is not mandated by legislation, A.I.D. has administratively determined to establish this requirement. This non-Federal contribution may include cash and in-kind contributions from PVOs, local collaborators and other non-governmental donors as well as from host governments, other governments and international organizations.

Asociacion Apoyo a Programas de Poblacion (APROPO) has been selected as the implementing agency of the Commercial Family Planning Project. The total A.I.D. contribution to this project will be US$5,000,000. The total APROPO contribution will be US$942,508, equivalent to 16 percent of total project costs.

The Mission considers that a partial waiver of the 25% contribution requirements is justified on the grounds that this is not a typical PVO project in which A.I.D. receives a proposal from the PVO requesting A.I.D. assistance in carrying out one of their programs. Rather, in this case A.I.D. has approached APROPO to implement the project, based on its experience and technical competence.

The Mission has a fundamental interest in the Commercial Family Planning Project because it is a crucial element in the Mission Population Strategy and Country Development Strategy Statement. Its purpose is to increase the provision of modern contraceptive methods through commercial channels to contribute to improve the health status of Peruvian families. Through promotion activities and a national communication campaign the project will mobilize private sector resources to contribute to meet unsatisfied demand for modern contraceptive methods, increasing the prevalence of modern contraceptive methods, increasing the prevalence of modern contraception and therefore reducing the Fertility rate, which is an objective of the National Population Program.