MIDTERM EVALUATION
OF THE
PROFAMILIA DIVERSIFICATION, SUSTAINABILITY, AND SOCIAL MARKETING GRANT

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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal care
ASHONPLAFA	Asociación Honduerna de Planificación de la Familia (Honduras)
C	Córdobas (currency of Nicaragua)
CBD	Community-based distribution
CMS	Commercial Market Strategies Project
CPR	Contraceptive prevalence rate
CYP	Couple year of protection
DHS	Demographic and Health Survey
DIMECOSA	Dirección de Mercadeo y Comunicación Social, PROFAMILIA's social marketing and communications department
FP	Family planning
FPLM	Family Planning Logistics Management Project
GDP	Gross domestic product
GNP	Gross national product
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
ICPD	International Conference on Population and Development (Cairo)
IEC	Information, education and communication
IPPF	International Planned Parenthood Federation
IR	Intermediate Result
IUD	Intrauterine device
JHU	Johns Hopkins University
JSI	John Snow, Inc.
MCH	Maternal and child health
MINSA	Ministerio de Salud (Ministry of Health, Nicaragua)
MSH	Management Sciences for Health
NGO	Nongovernmental organization
Pap test	Papanicolaou test
PASMO	Pan American Social Marketing Organization
PCS	Population Communication Services
PHC	Primary health care
POPTECH	Population Technical Assistance Project
PRIME	Program for International Training in Health
PROFAMILIA	Asociación Pro-Bienestar de la Familia Nicaragüense
PSA	Prostate-specific antigen
PSI	Population Services International
PVO	Private voluntary organization
QAP	Quality Assurance Project
RH	Reproductive health
SO	Strategic Objective
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TFR	Total fertility rate
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URC	University Research Corporation
USAID	United States Agency for International Development
VSC	Voluntary surgical contraception
WHO	World Health Organization

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EXECUTIVE SUMMARY

The United States Agency for International Development (USAID) Mission in Nicaragua arranged with POPTECH for a 4–person team to conduct an external, midterm evaluation of USAID's $10.6 million grant to the Asociación Pro-Bienestar de la Familia Nicaragüense (PROFAMILIA). The broad purpose of the grant is to support PROFAMILIA's general objectives of helping to reduce population growth and fertility rates and contributing to the development of healthier families. The purpose of the midterm evaluation was to assess performance to date in achieving grant goals and results, financial sustainability, and organizational sustainability.

CONCLUSIONS

Achievements have been modest but impressive, given the turmoil in leadership and management that has characterized the grant since its inception in 1998. Although there have been some improvements in many areas, the overall impression is of an organization that is lacking identity and direction, and is in urgent need of strong leadership.

Goal Achievement

The grant has no specific health or fertility goals and PROFAMILIA does not use indicators to measure improvements in these areas. Data are collected, however, on couple years of protection (CYPs). Although this is not a required indicator, it is often used as a proxy for contraceptive prevalence and is the only indicator available related to goal achievement. There has been a slight increase in CYPs (6 percent from 1997–2001), but this is well below PROFAMILIA's own targets, and it is unlikely that PROFAMILIA will meet its 2002 target.

Result Achievement

The grant has seven expected results (intermediate objectives) and PROFAMILIA has been active in pursuing most of them.

1. **Increased recognition of reproductive rights and positioning of PROFAMILIA as a leading institution in this field**: PROFAMILIA is very active in this area, although the effects of those efforts have not yet been assessed. To date, there have been 314 meetings with social agencies, 336 reproductive health (RH) events, and 20 agreements made with nongovernmental organizations (NGOs). However, it seems that PROFAMILIA is avoiding conflict with the Catholic Church on controversial reproductive rights issues and is positioning itself more as a family health provider than as a champion of reproductive rights.

2. **Increased use of temporary contraceptive methods**: In the 1997 evaluation (Bergthold et al., 1997), PROFAMILIA was strongly criticized for emphasizing sterilization to increase CYPs. The proportion of temporary to permanent methods was 2:8. The new policy has been excessive in emphasizing temporary methods and

limiting permanent ones. The grant target was to achieve a balance of 52 percent temporary and 48 percent permanent methods by the end of 2002. It is now at 84 percent temporary and 15 percent permanent and unlikely to be reversed anytime soon.

3. **Expansion and diversification of medical services**: PROFAMILIA clinics now provide 21 diversified services and volume has grown significantly from 160,443 visits in 1999 to a projected 214,556 in 2001. New users increased from 6,475 in 1998 to 46,638 in 2000. Laboratory examinations, gynecology, and other medical services are the most popular. Although services have expanded rapidly, the motivation has been more to increase revenues/sustainability than to address health needs.

   Quality of care has been enhanced and client satisfaction has improved significantly. A quality assurance system is under development, but much more needs to be done in developing clinical standards and guidelines. Not enough attention is being given to RH services, especially gynecology and prenatal services. Delivery, even normal delivery, is restricted by PROFAMILIA regulations that are more oriented toward avoiding liability than improving health. As a result, the volume of deliveries is too small to maintain quality, be financially viable, or contribute to a reduction in maternal mortality. No steps are being taken to improve home deliveries. The community-based distribution (CBD) network is not involved at all. Weaknesses are also evident in supervision, laboratory procedures, clinical management of Papanicolaou (Pap) tests, medical training, and physician recruitment.

4. **Increased access in rural and marginal urban areas**: Based on recommendations from the 1997 evaluation, PROFAMILIA reduced the number of CBD posts and supervisors without any significant reduction in productivity. In fact, the number of visits increased from 155,570 in 1998 to 294,711 in 2000. New users increased from 31,032 in 1998 to 40,021 in 2000. Since sterilization has been de-emphasized, the CBD program now accounts for about 60 percent of PROFAMILIA's contraceptive sales (excluding social marketing), up from 25 percent in 1997. The major problem facing CBD is that it is not sustainable; it needs to be at least partially subsidized.

5. **Increase in adolescents provided information and education**: Ten youth clubs have been formed, 701 youth promoters have been trained, and 220 mini-clubs have been established. There were 4,335 youth members as of June 2001. No data have been collected on the effectiveness of these activities but qualitative assessments indicate that they are successful in educating youth in sexuality, family planning, and human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS). The clubs raise small amounts of money for local activities, but the program overall is not sustainable. Like CBD, it needs to be subsidized to survive. One group that seems to have been overlooked so far is out-of-school youth, especially those engaged in high-risk behaviors.

6. **Improved management capacity and sustainability**: The principal indicator for this result is compliance with the strategic plan. Unfortunately, the plan has not yet been developed. **Management and organization** are significant problems. Not only has the history of leadership changes affected operations, the current structure is unsustainable. Lack of consensus on PROFAMILIA's direction, role conflicts, the top-heavy nature of central administration, overlap, duplication, and disputes about responsibilities all contribute to an inefficient and costly organizational structure. Fortunately, PROFAMILIA is about to have new leadership. There is a new executive director, and a new board of directors is expected to be elected in September or October.

   Nevertheless, **management capacity** at PROFAMILIA is quite good and improving. Most of the management staff is committed and competent. Technical assistance over the past few years has been very helpful, not only in building up essential management systems, but in strengthening the knowledge and skills of the managers. Relations with USAID remain strong.

   Financial sustainability is 46 percent at mid-year. The target for 2001 is 57.6 percent, and the grant target for 2002 is 60 percent. The regional centers average 69 percent now, and the Commercial Market Strategies Project (CMS) clinics are at 87 percent, so it is likely that the organization as a whole can reach its target if it is able to bring costs under control and if social marketing is allowed to implement its programs. The major cost categories that contribute to the deficit are central, personnel, and social programs (youth, CBD, and communications).

7. **Established social marketing program**: Social marketing was to be the focal point of the grant. Unfortunately, it was combined with communications, and that has confused much of the leadership of PROFAMILIA, which has sometimes used social marketing funds for communications activities. The social marketing staff has produced excellent materials and campaigns for both components. It has increased sales, increased demand for services, and generated revenue. The component has great potential but it has been hampered by interference from PROFAMILIA leadership and delays in contraceptive registration. As a result, it is well behind its 100 percent sustainability target by 2002.

RECOMMENDATIONS

1. **Redefine PROFAMILIA's Mission**. PROFAMILIA needs to redefine its vision, its mission, set strategic objectives for achieving them (including measurable indicators), and then develop a strategic plan for meeting those objectives (including a new organizational structure). This recommendation is the most important one as it is the starting point for providing direction and eliminating confusion. The leadership of PROFAMILIA needs to initiate the process and agree on a common goal and plan. That must be followed by teambuilding exercises to bring all employees, volunteers, and contract personnel to that same agreement. PROFAMILIA also needs to define its role as an advocate of reproductive rights.

2. **Resolve the sustainability–social obligation issue**. This issue has divided the organization, pitting those who are concerned with the survival of the organization against those who want to help the helpless. Both are laudable; a solution is to provide needed RH services that it can sustain. This implies developing service packages based on need, not just cost or income potential. It also implies providing services for which there is a demand. The proposed mechanism is to separate sustainable from unsustainable programs/activities and apply sustainability objectives only to those that are sustainable. The unsustainable programs/activities would not be undertaken unless subsidized.

    - **Sustainable:** have sustainability targets of at least 100 percent (clinics, social marketing). Surpluses over 100 percent might be used to cross-subsidize some unsustainable programs/activities.

    - **Unsustainable:** do not have sustainability targets and must be subsidized (CBD, youth, promotion). Cost recovery could reduce the needed subsidies.

3. **Improve quality of care in reproductive health**. Quality of care should be given much more emphasis than it has been given, especially in reproductive health, which is the core service area. Standards of care and procedural guidelines are needed for all subservices of gynecology and maternal care, at a minimum. The quality assurance system should be completed and installed systematically so that it permeates the entire organization, not just medical services. Steps should be taken immediately to respond to basic client concerns, such as waiting time, continuity of care, and interpersonal communications. PROFAMILIA should design and launch a campaign to promote appropriate contraceptive methods and informed choice, not just temporary methods. Long-term methods (sterilization and intrauterine devices [IUDs]) are appropriate for many women, especially those over 30 who do not want any more children. PROFAMILIA should reevaluate its maternal care services (antenatal care [ANC], delivery, postpartum) and decide what it can do to increase safe outcomes and reduce maternal mortality—not only in its clinics, but also in its catchment areas.

4. **Support and encourage social marketing**. Social marketing is an important and well-managed program within PROFAMILIA and deserves the support and respect of the leadership, which should cease interfering with the technical and financial prerogatives of the program and approve its budgeted activities. USAID should grant a one-year, no-cost extension to the social marketing component to allow it to carry out these activities, launch its remaining two contraceptive products, establish a market niche, and reach its sustainability objectives. As with other components of PROFAMILIA, separate cost centers should be set up to separate social marketing from communications. DIMECOSA (Dirección de Mercadeo y Comunicación Social) should be given complete control of its social marketing budget, including the use of revenues to establish approved revolving and support funds. Both are critical to the future sustainability of the program. PROFAMILIA should also take advantage

of DIMECOSA's expertise to commission market research on current and new products and services. Currently, PROFAMILIA has no basis for deciding what services or products to offer. Market research can help determine demand, appropriate prices, appropriate packaging, and positioning.

5. **Decide what to do with CBD and youth programs.** It is clear that PROFAMILIA is the best institution to be providing CBD services. Its networks are more productive, cost-effective, stable, and sustainable than those of private voluntary organizations (PVOs). It has a permanent presence in the country and an established, experienced, trained network of CBD workers with an 80–90 percent retention rate. However, concerns about sustainability are limiting the extension of the networks and the expansion of service packages. PROFAMILIA and USAID need to decide whether to continue this social program, and if so, how to support it financially.

   The same holds for the youth program. PROFAMILIA is recognized as a leader in the area of youth education. Its youth clubs seem to be effective, and they fill a significant gap—teenage pregnancy rates are high (41 percent in rural areas and 30 percent in Managua).

6. **Prepare and implement a financial sustainability strategy**. The clinics (without the social programs) are almost 100 percent self-sustaining. They have the potential for generating surpluses that could be used to partially subsidize social activities. To do this, they will need to reduce personnel costs and increase revenue from services. Salaried medical providers are prime targets for the former. By adopting the CMS contracting procedure, the current deficit in this category could be eliminated. A target for the latter is the expansion of safe delivery services, which is now practically nil due to fears of liability. Inefficient sites and services should be ended and new clinic sites and services that can contribute to overall sustainability should be identified.

   At the central level, cuts are needed in central administrative and support costs, personnel, and transport costs. Other priority initiatives include setting minimal caseloads for physicians, establishing sustainability targets for clinics, establishing a profit-sharing/incentive plan that covers all employees, and constructing a new Managua clinic capable of meeting client demand.

7. **Strengthen management systems**. The first priority must be the clarification of PROFAMILIA's mission and objectives. As part of this, the sustainability versus social responsibility issue must be resolved. In addition, technical assistance to fill the gaps in management systems (such as human resource management and quality assurance) should be continued. A transition plan for the absorption of the six CMS clinics needs to be developed, ideally as part of an overall strategic plan. USAID and PROFAMILIA need to work much more closely together over the next 16 months to make sure that the recommendations included in this report are discussed and, where appropriate, implemented.

SUMMARY

PROFAMILIA is a fine organization that is going through a difficult period of adjustment. The recommendations made in this report can help the association make that adjustment in a relatively short period. In fact, at the debriefing it was clear that PROFAMILIA is already undertaking some of the recommended steps and is committed to implementing others. The required restructuring, as difficult as it may be, will produce a much stronger, more focused, and more productive association. USAID support during this transition period (moral, technical, and financial) is clearly needed; it is hoped that the Agency will be willing and able to provide it.

I. INTRODUCTION

CURRENT DEMOGRAPHIC AND HEALTH SITUATION

Nicaragua is now the poorest country in the Western Hemisphere, according to a recent World Bank report. The gross national product (GNP) is $430 per capita, lower even than Haiti at $460. Nicaragua is still recovering from the effects of Hurricane Mitch, which caused an estimated $1.5 billion of damage. The poorest regions of the country were the most affected. Last year's financial crisis added to the problems, as did falling coffee prices, which led to widespread layoffs. In addition, there is a drought and creeping signs of famine and disease. Against this background, the United States Agency for International Development (USAID) Mission in Nicaragua has responded by continuing its largely successful $25 million bilateral program and adding the $103 million Hurricane Mitch Reconstruction and Recovery Program, $30 million of which was used for health.

Partly due to this and other donor assistance, health and fertility rates in Nicaragua have been improving over the past decade. The 1998 Demographic and Health Survey (DHS), for example, showed that infant mortality dropped from 58/1,000 in 1993 to 40/1,000 in 1998. Contraceptive prevalence (CPR), a proxy for the total fertility rate (TFR), increased from 56 percent in 1999 to 61.6 percent in 2000.

USAID MISSION STRATEGY AND REPRODUCTIVE HEALTH ACTIVITIES

USAID's Strategic Objective (SO 3) in health is to help increase the number of "better educated, healthier and smaller families," which is necessary for the Mission to achieve its overall goal of "sustainable economic growth and development." The SO supports the development of human capital through basic education, primary health care, nutrition, and reproductive health (RH). The objective of the RH component is to further reduce family size by enhancing private sector provision of family planning (FP) services, using social marketing to increase demand for these services, and providing contraceptives through public and private outlets. Increasing emphasis is being placed on temporary methods and birth spacing for young people and young mothers.

USAID's largest donation in RH is a grant to the Asociación Pro-Bienestar de la Familia Nicaragüense (PROFAMILIA), an International Planned Parenthood Federation (IPPF) affiliate founded in 1970 to provide FP services. USAID has been a primary supporter of PROFAMILIA since 1990. Under its previous cooperative agreement (1993–98), USAID helped PROFAMILIA expand from two modest clinics in urban Managua to a network of a dozen regional centers covering most of western and central Nicaragua. A complementary rural network of community-based distribution (CBD) volunteers and promoters also was expanded significantly. The current grant (1999–2003) focuses on the expansion of temporary method coverage, establishing a social marketing program and attaining ambitious sustainability targets.

In addition to the grant, USAID has also provided a substantial supply of contraceptives to PROFAMILIA, intended largely for the social marketing program. USAID has also channeled ample technical assistance to PROFAMILIA from a range of cooperating agencies, including the Johns Hopkins University/Population Communication Services (JHU/PCS), University Research Corporation (URC), Management Sciences for Health (MSH), and John Snow, Inc. (JSI).

It is important to remember that the PROFAMILIA grant is only one component of the Mission's $35 million Healthy Families Program. Other components include a child survival contract with PROSALUD and grants to six private voluntary organizations, as well as the aforementioned contraceptive and technical assistance components.

In 1999, as part of the Hurricane Mitch Reconstruction and Recovery Program, USAID/Nicaragua obligated $5.6 million of its $30 million to the Commercial Market Strategies (CMS) contract to build six self-financing primary health care centers in the Mitch-affected parts of the country. These centers are to be turned over to PROFAMILIA in December 2001. They will increase the size of PROFAMILIA's clinical network by at least 50 percent.

THE PROFAMILIA GRANT

A midterm evaluation conducted by the Population Technical Assistance Project (POPTECH) in March 1997 was highly critical of PROFAMILIA's performance and management as well as USAID's oversight. As a result, both parties made significant efforts to tailor the current grant to meet those criticisms. PROFAMILIA made great efforts to redefine itself, which resulted in an internal restructuring and the development of a new mission statement and strategic plan in 1998. The new mission statement is:

> **The fundamental mission of PROFAMILIA is to help improve the quality of life of the Nicaraguan family by providing health and educational services on sexual and reproductive health, with an emphasis on family planning.**

PROFAMILIA now has two general objectives:

1. Help reduce Nicaragua's population growth and fertility rates by promoting family planning activities, especially among poor, uneducated urban and rural sectors, with a special focus on early, late, frequent, and multiple pregnancy prevention and the advantages of smaller families.

2. To contribute to the development of healthier families, by providing accessible and quality reproductive health services to Nicaraguans, especially among the poor sectors, prioritizing prenatal and postpartum care, specialized child health care, counseling for adolescents, prevention of sexually transmitted diseases (STDs), including human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), and cervical and breast cancer screening.

These objectives are included in the description of the grant, as are the following key activities, also known as intermediate objectives:[1]

1. Increase recognition of the right to family planning and sexual and reproductive health care, and position PROFAMILIA as a leading institution in this field;

2. Increase use of temporary[2] contraceptive methods among people under 35 years of age;

3. Expand and diversify PROFAMILIA's sexual and reproductive health services at its regional centers;

4. Increase access to family planning methods and sexual and reproductive health services among the poor uneducated urban and rural sectors;

5. Increase the number of adolescents who receive sexual and reproductive health information and education at PROFAMILIA;

6. Improve PROFAMILIA's capacity for the technical and administrative management of the sexual and reproductive health programs, for the purposes of achieving self-sufficiency; and

7. Create the social marketing program for the sustainable distribution of contraceptives in Nicaragua.

EVALUATION SCOPE OF WORK

USAID/Nicaragua arranged with POPTECH for a 4–person team to conduct a midterm evaluation of its $10.6 million grant with PROFAMILIA in July 2001. USAID/Nicaragua sought to obtain from this evaluation a limited number of actionable recommendations (with priorities and a timeframe established), as well as the party responsible for implementing the recommendation.

Through this evaluation, USAID sought to better enable PROFAMILIA to fulfill its mission and mandate to consolidate itself as the premier nongovernmental organization (NGO) provider of family planning and maternal and child health (MCH) services in Nicaragua. USAID required constructive guidance to help PROFAMILIA focus managerial attention and responsibility on carrying out whatever actions are required to meet that organizational mission. At this midpoint in the most important grant for the USAID SO 3 team, USAID and PROFAMILIA needed to assess progress in planned activities and results, and to identify any changes that the PROFAMILIA senior

[1] "Diversification, Sustainability and Social Marketing Project," PROFAMILIA/USAID project agreement. 524-G-SS-99-00013-00, December 18, 1998.

[2] The narrative reads "modern" methods (Ibid., pp. 2 and 45) but the indicator is "temporary" methods (annex 1), which is the indicator used by PROFAMILIA.

management team and board of directors need to undertake. USAID anticipated that this evaluation would provide a clear managerial mandate for the new executive director and PROFAMILIA managers, as well as specific guidance for the new board of directors. Moreover, given the conclusion of the CMS technical assistance funded under the Hurricane Mitch Reconstruction and Recovery Program by December 31, 2001, and the transfer of responsibility to PROFAMILIA, it is particularly timely that USAID support this midterm evaluation. USAID intends to use this evaluation to contribute to decisions on the structure, nature, and emphasis of future USAID assistance beyond the life of the current grant.

The evaluation addressed the following questions:

1. **Achievement of Activity/Grant Goal and Purpose:** Is the grant on schedule to achieve its goal? Does PROFAMILIA provide quality services for its customers? How has PROFAMILIA progressed since the 1997 POPTECH evaluation?

2. **Financial Sustainability:** How can PROFAMILIA improve progress towards assuming an increasing share of its recurrent costs? How can core costs of the PROFAMILIA administration and headquarters attributed to the grant be systematically reduced without weakening the institution?

3. **Organizational Sustainability:** Are the organization, staffing, and management of PROFAMILIA adequate to achieve the activity purpose and goal? If not, what changes are required to do so? Are the strategic plan and annual operating plan adequate and utilized by key managers? Are human resources management policies and procedures articulated and put into practice? Assess the roles, responsibilities, and division of labor between the senior management team, the board of directors, and the assembly?

The full scope of work can be found in appendix A.

EVALUATION METHODOLOGY AND SCHEDULE

The evaluation team conducted its work from July 28 to August 18, 2001. The members and their assignments were:

- Jack Reynolds, Ph.D., team leader, grant achievements and organization and management;

- M. Roy Brooks, M.P.H., M.B.A., financial sustainability and cost control;

- Kelly O'Hanley, M.D., M.P.H., clinical services and quality of care; and

- Sandra Wilcox, M.P.H., communications, community-based distribution, and promotion.

The team spent much of its time reviewing documents and interviewing PROFAMILIA staff, consultants, and others in the central and regional offices. (See appendix B for a list of contacts and persons interviewed, and appendix C for documents reviewed.) The team visited PROFAMILIA regional centers and clinics in Managua, Matagalpa, Rivas, Masaya, Chinandega, and Boaco. Two of the three active CMS clinics were also visited, in Sébaco and Tipitapa. The analysis was built around the topics included in the scope of work. These were discussed internally and with PROFAMILIA and USAID staff. Debriefings were held with each organization in mid–August to present major findings, conclusions, and recommendations.

II. GRANT ACHIEVEMENTS

EVALUATION ISSUES AND FINDINGS

Three principal questions were outlined in the scope of work: whether the grant is on schedule to achieve its goals and results, whether the 1997 evaluation recommendations had been accepted and implemented, and whether the evaluation indicators were appropriate and influenced grant operations.

It is important to distinguish between PROFAMILIA and USAID achievements. Although the PROFAMILIA grant is a component of USAID's Healthy Families Program, this evaluation is only concerned with the PROFAMILIA grant. PROFAMILIA's progress toward the goals and results set forth in the grant agreement is examined. USAID's progress toward the goals and results of its SO 3 or its Healthy Families Program is not assessed.

Achievement of Goals

Goals (or Strategic Objectives or purposes) are desired improvements in health and fertility status. Although the grant has demographic and health goals, they are not being measured by PROFAMILIA. The grant agreement describes PROFAMILIA's goals (see the section on the current demographic and health situation above) but no indicators are identified, not even in annex 1: Indicators.[3] For its part, the Mission's SO 3 has only one indicator that applies to RH, the total fertility rate (TFR). It also uses the CPR as a proxy indicator in the years between Demographic and Health Surveys (DHS). The grant agreement has no quantified targets for either the TFR or the CPR. When asked why the grant did not have any health or demographic indicators, the reply from PROFAMILIA was that USAID collects this information periodically, implying that it was not PROFAMILIA's responsibility. (The PROSALUD contract was also checked; it did not have any indicators for its health goals either, indicating that USAID did not require its program components to adopt standard health and demographic performance indicators. A partial explanation is that at the time, USAID was focused on reconstruction from the effects of Hurricane Mitch and gave priority to immediate infrastructure activities.)

Achievement of Results

Results are desired improvements in health and fertility behavior, knowledge, and attitudes. The grant has seven expected results:

- Increased recognition of reproductive rights and positioning of PROFAMILIA as a leading institution in this field,
- Increased use of temporary contraceptive methods,

[3] Ibid.

- Expansion and diversification of medical services,
- Increased access in rural and marginal urban areas,
- Increase in adolescents provided information and education,
- Improved management capacity and sustainability, and
- Established social marketing program.

Unfortunately, most of the indicators are not of the effects of the grant on health knowledge, attitudes, or behavior, such as contraceptive prevalence, new acceptors, continuation, users, and so forth. Many are indicators of activities or the outputs of those activities (e.g., number of advocacy activities, number of adolescents receiving information, number of medical services provided).

USAID has one relevant result indicator for SO 3: contraceptive prevalence (CPR). As noted above, PROFAMILIA was not required to use this indicator. PROFAMILIA assumed that this was USAID's responsibility and does not measure CPR. MINSA makes annual computations of the CPR at the national level and it is not possible to disaggregate the data to determine PROFAMILIA's contribution.

Although it is not a grant requirement, PROFAMILIA computes couple year of protection (CYP) data, which are often used as a proxy for CPR. However, CYP is not included in the list of expected results and, with the exception of results 2 and 7, it has not been used to measure grant performance.[4]

Nevertheless, since the data are available, they are summarized in table 1, which shows that CYPs increased 15 percentage points from 1997 to 2000. They are projected to decline in 2001 and the overall gain for the grant is now only expected to be 6 percentage points. In addition, annual achievement has been well below PROFAMILIA's CYP targets every year. PROFAMILIA is likely to miss the grant CYP target by a significant margin. This is due in large part to the steep decline in sterilizations since 1998. The large increase in temporary method use has not made up for that decline.

PROFAMILIA's achievements on the seven results that were included in the grant agreement were mostly positive, with the exception of results 6, as table 2 shows.

[4] In result 2, CYP was selected to show the increase in use of temporary methods over permanent methods. It was not selected to show total CYP trends over time. Result 7 includes CYPs delivered by the social marketing program.

Table 1
CYP Performance, 1997–2001

	1997	1998	1999	2000	2001*	Total
Planned	155,018	99,845	85,917	89,517	98,453	528,750
Actual	105,219	68,413	68,300	74,268	74,774	390,974
Percent	68	69	79	83	76	74

* PROFAMILIA projection based on January–June data.

Table 2
Grant Results and Achievements to Date

Expected Result and Type of Indicator	Achievements
1. Rights and repositioning activities (output: events)	**Very active**: 314 meetings with social agencies, 336 RH events, 20 agreements with NGOs; effect of this activity not measured.
2. Increase use of temporary methods (chart D–1,* effect: use)	**Positive and negative results**: the proportion of temporary to permanent methods changed from 19–81 percent in 1997 to 84–16 percent in 2001. The goal for 2002 is 52.4 percent temporary and 49.6 percent permanent methods. The increase in temporary methods is positive, but the distribution is far out of balance and not likely to be reversed soon.
3. Increase RH services and users (tables D–2.1-2.2, output: services; effect: new users)	**Significant expansion**: services expanded to 21; medical services provided increased from 121,917 in 1997 to a projection of 308,418 in 2001.
4. Increase access in rural and marginal urban areas (tables D–3.1-3.2, output: visits, effect: new users)	**Steady improvement**: the number of visits increased from 155,570 in 1998 to 294,711 in 2000; new users increased from 31,032 in 1998 to 40,021 in 2000.
5. Increase in adolescents served (table D–4, output: events)	**Active and attractive:** created 10 youth clubs, trained 701 youth promoters, formed 220 mini-clubs, have 4,335 participants in June 2001; effect on behavior not measured.
6. Improve management capacity and sustainability (table D–5, input: income)	**Less progress than planned**: indicator is compliance with the strategic plan; the plan has not yet been prepared. Sustainability target for 2001 is 57.6 percent; PROFAMILIA is currently at 46 percent.[5]
7. Create social marketing program (table D–6.3, input: SM program, output: condoms)	**Program created but implementation slow**: 1.2 million condoms in 2000; 888,000 in the first 6 months of 2001. Spending well behind budget.

*All referenced charts and tables are contained in appendix D.

As noted above, the increased use of temporary methods has been dramatic. The decrease in acceptance of permanent methods (vasectomy and tubal ligation) has been equally dramatic. Table 3 summarizes the changes. The CYP graph for 1997–2001 (chart D–1) demonstrates these two trends very well. This remarkable change is due to a series of policy shifts made by PROFAMILIA in response to criticisms in the 1997 evaluation. The report stated, "The use of CYP has had a significant negative effect on program

[5] See Cuadro 1, p. 6, "Evaluación de Medio Término," document prepared for the evaluation team by PROFAMILIA in August 2001.

direction and operations. It is clear…(that) staff at all levels feels under tremendous pressure to produce CYPs… This leads to pressure in the clinics to perform as many sterilizations as possible, since each sterilization counts for 10 CYPs."[6]

Table 3
Percent CYP Distribution of Temporary and Permanent Methods, 1997–2001

Method	1997	1998	1999	2000	2001*
Temporary	30	62	75	81	84
Permanent	70	38	25	19	16

* PROFAMILIA projection based on January–June data.

PROFAMILIA changed its policies and operating procedures in a number of ways to address that criticism. The CYP was largely eliminated as a performance indicator, campaigns were undertaken to promote temporary methods, eligibility criteria were strengthened, incentives were eliminated, and only obstetric/gynecologic specialists were allowed to perform sterilizations.

Obviously, this strategy worked very well—perhaps too well. The method mix is now tilted in the opposite direction and the program has gone well beyond its goal of balancing the distribution at roughly 50 percent temporary and 50 percent long-term methods. Whether this trend can be reversed before the grant ends will depend on PROFAMILIA's policies.

Indicators 3 and 6 have also been very important to PROFAMILIA: increase in medical services and increase in sustainability. PROFAMILIA sets specific targets for each service provided by each clinic. It also sets income and sustainability targets for each regional center and program. Although the medical service indicators may appear to be indirect indicators of health improvement, they are not. They are management indicators of service volume. In fact, the primary objective of expanding and diversifying medical services seems to be to generate enough income to reach 100 percent sustainability. Table 4 summarizes the total volume of these services. It shows how rapidly medical services and revenues have grown over the past two to three years.

Table 4
Medical and Nursing Services Provided, 1997–2001

Type of Service	1997	1998	1999	2000	2001*
Medical	62,629	100,435	163,446	226,430	214,556
Nursing	59,288	49,231	65,344	92,163	93,862
Total	121,917	149,666	228,790	318,593	308,418

* PROFAMILIA projection based on January–June data.

Table 5 summarizes the sustainability data and shows that the regional centers and PROFAMILIA as a whole have increased sustainability slowly. The CMS franchise

[6] Bergthold, et al., *Midterm Evaluation of the Family Planning Expansion and Regionalization Project: A Report to PROFAMILIA and USAID/Nicaragua,* POPTECH Report No. 97–100–51, April 1997, pp. 6–7.

clinics are (potentially) the most sustainable and are expected to reach 100 percent by the end of 2002. Social marketing lags because of delays in program implementation, but it too has a good chance of becoming self-sustaining within two to three years.

Table 5
Sustainability Achievement, 1999–2001

	1999	2000	2001*	2002
Regional Centers	51%	64%	69%	
PROFAMILIA	30%	39%	46%	
Target	31%	45%	58%	60%
Social marketing		7%	14%	
CMS Franchises			87%	

*January–June

For PROFAMILIA, the lag has been due to a continued deficit as costs exceed revenues by a wide margin (10 million córdobas [C] in 2000). In the first half of 2001, the deficit is much lower (C$3.7 million). The largest cost categories are personnel (58 percent), followed by depreciation (9 percent), basic services (8 percent), and travel and transportation (7 percent). In terms of programs, the principal contributors to the deficit are the social programs, which, while important, do not generate much revenue. The most prominent of these are the youth program, the communications program, and the CBD program.

Although CBD is not completely self-sustaining, it does generate users and revenues. Table 6 shows the distribution of CYPs by clinic and CBD network. Ever since the reduction of sterilization procedures, there has been a dramatic shift in CYP production from the clinics to the CBD promoters. CBD only provided 25 percent of CYPs in 1997. That has increased to 61 percent in 2001. This trend is likely to increase in the future, unless there is a change in policy to start promoting long-term methods again.

Table 6
Source of CYPs, 1997–2001

Type of Service	1997	1998	1999	2000	2001*
Clinic	79,356	36,856	25,849	32,625	29,451
Network	25,863	31,577	42,451	41,644	45,683
Total	105,219	68,433	68,300	74,269	75,134
Percent of Network	25%	46%	62%	56%	61%

* PROFAMILIA projection based on January–June data.

Implementation of 1997 Evaluation Recommendations

Many of the recommendations made in 1997 were accepted and applied, even before the end of the last cooperative agreement. This was precipitated largely by USAID's decertification of PROFAMILIA until the changes suggested by USAID were

incorporated.[7] Nevertheless, the new executive director at the time and his management staff are primarily responsible for implementing the changes—many of which were significant. The grant agreement includes a section that describes the recommendations from the midterm evaluation and the steps that PROFAMILIA had already taken to address those recommendations. Important improvements were made in the indicators used to assess performance, in the diversification of medical services, in the organization and strengthening of the CBD program, in the expansion of the adolescent program, in information, education, and communication (IEC), and in administration and financial management.

Changes and improvements have continued under the current grant, as the initial PROFAMILIA briefing for the evaluation team confirmed. One of the more impressive aspects of that briefing was the identification of planned activities that still need to be implemented. With approximately 16 months remaining, the PROFAMILIA management team appears to believe that it will accomplish almost all of the grant objectives.

Performance Indicators

The indicators are inadequate and inappropriate. There are no health or demographic impact/goal or effect/objective indicators.[8] The practical effect of such indicators is to direct organizational effort by assessing performance against health goals and health objectives. It is a well-known management principle that indicators drive behavior. This is the case in PROFAMILIA as well as in any other organization. Previously, the emphasis on achieving large CYP numbers drove the association to emphasize sterilizations to generate large numbers of CYPs. Now, PROFAMILIA is taking the opposite approach and is emphasizing temporary methods; sterilizations have plummeted as a result. Perhaps more significant is the current emphasis on expanding services, not to improve health, but to generate income so that PROFAMILIA can become self-sustaining. As several respondents reported, everything is driven now by the sustainability objective, which means that the primary decision criteria are now financial—reduce costs and increase income—rather than programmatic—improve health and lower fertility.

CONCLUSIONS

The grant has performed remarkably well over the midterm, despite serious and prolonged organizational and management disruptions. The CYP data, although not a performance indicator, suggest that the grant is not having a significant impact on health and fertility. PROFAMILIA is likely to miss its CYP target by 15–25 percentage points. However, achievements on most result indicators are positive and impressive. In addition, significant improvements have been made in PROFAMILIA's programs (both

[7] Project description, p. 25.

[8] Impact/goal indicators should measure changes in health and fertility status. Effect/objective indicators should measure changes in health and fertility attitudes, knowledge/skills, and behavior. Activity/output indicators should measure the health and fertility services and products generated by the project. Input indicators should measure the resources (human, physical, system, and financial) invested in the project.

clinical and community) as well as in management over the last several years. These improvements are likely to continue, especially since the management crisis appears to be resolved.

Unfortunately, the lack of clearly defined and measurable objectives appears to have had an unintended effect on the organization's identity. Both PROFAMILIA and USAID may have overreacted to the 1997 evaluation recommendations and lost sight of the primary mission of PROFAMILIA, which is to improve health and lower fertility. This is evidenced by an overriding concern throughout the organization (and at USAID) with sustainability, almost as an end in itself. At the same time, many staff members retain a deep commitment to PROFAMILIA's social agenda. The association has endured a very difficult period over the last two years and is clearly seeking an organizational identity. Sustainability versus social obligation is how it has been characterized by a number of staff and observers.

RECOMMENDATIONS

PROFAMILIA can work towards providing needed FH services that it can sustain. This implies developing service packages based on need and not just on cost and income potential. However, it also means providing needed services for which there is a demand. PROFAMILIA must find a way to design its program to maintain this critical balance between health needs and organizational sustainability. To do this, the leadership of PROFAMILIA (the board of directors, the executive director, and the central and regional directors) should work together to develop a new vision, mission, and strategic plan that is accepted and supported by all. The benefits of the process of reaching an agreement may exceed the outcome. PROFAMILIA's leadership must agree to work together toward a common, sustainable health goal. (See appendix E for a description of various health packages.)

PROFAMILIA should adopt relevant indicators to measure its goals and objectives, not just its activities and their outputs. As noted above, goals should measure changes in impact (health and fertility status); objectives should measure changes in health and fertility effects (attitudes, knowledge, and behavior). All results should have effect indicators, especially behavioral effects.

PROFAMILIA should not single out a specific method or class of methods as an objective. Rather than have an objective to increase temporary method use, the objective should be informed choice, with equal promotion of and access to all modern methods so that clients will be able to choose the methods that are most appropriate for them.

PROFAMILIA needs to resolve the sustainability versus social obligation dilemma as well. One solution is to separate sustainable from unsustainable activities and to apply sustainability objectives only to the former. The latter would be acknowledged as unsustainable and would not be undertaken unless subsidized.[9]

[9] The term sustainable does not imply self-sufficiency. Many programs are sustained, in part, by fundraising drives, government grants, and other means. Obviously, the more an organization is self-

Sustainable activities/programs are those that have the potential for reaching 100 percent or more sustainability. Examples are medical services and social marketing. That is, revenues would equal expenditures or a profit could be made (revenues could exceed expenditures), which could be used for a variety of purposes, including partial subsidization of unsustainable activities.

Unsustainable activities/programs have no possibility of ever becoming sustainable, although they might recover some costs and generate some income. Examples are CBD, youth programs, and promotional/educational programs. These activities would only be carried out to the extent that they were subsidized. Some of those subsidies might come from PROFAMILIA's profitable programs, but most would have to come from other donors, philanthropists, or the government.

A relevant example of this strategy is the Asociación Honduerna de Planificación de la Familia (ASHONPLAFA) in Honduras. PROFAMILIA managers should visit this program to learn about its structure and whether it could be adapted to Nicaragua. (See appendix F for a brief description of the ASHONPLAFA model, and see appendix G for suggestions on performance indicators.)

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sustaining, the less it has to rely on these outside resources.

III. CLINICAL SERVICES AND QUALITY OF CARE

EVALUATION ISSUES AND FINDINGS

Three general issues were addressed during the evaluation: the expanded service mix; quality assurance and the quality assurance system, especially the family planning component; and the adequacy of training and supervision.

Service Mix

The service mix has broadened since 1997. PROFAMILIA has begun to position itself as a full-service family health provider with services for women, men, children, and adolescents. Among the new services offered are gynecology, cancer screening, ultrasound, prenatal care, delivery, postpartum care, general medicine, pediatrics, general surgery, dentistry, and psychology. The services most in demand are laboratory services. Of direct medical services, RH is the service most requested. Table 7 shows that 6 of the top 10 services are RH and make up more than half (56 percent) of all services offered. However, clinic directors estimate that as much as 75–80 percent of services are related to RH. The majority of clients seen by general practitioners, for example, come for RH services.

Table 7
Highest Medical Service Visits, 1997–2001

Rank	Services	1997	1998	1999	2000	2001*	Total	Percent
1	**Gynecology**	24,051	31,562	44,405	53,728	50,102	203,848	26.6
3	**Pap**	13,891	16,943	21,280	22,878	21,770	96,762	12.6
4	Ultrasound	1,946	7,659	15,806	19,434	23,362	68,207	8.9
5	**Injectables (FP)**	6,263	8,400	12,122	12,780	11,594	51,159	6.7
6	General Medicine	0	4,687	10,641	20,783	9,958	46,069	6.0
7	Pediatrics	101	2,094	10,457	17,907	14,090	44,649	5.8
8	**Prenatal**	4,056	6,362	8,159	10,359	9,240	38,176	5.0
9	**IUD**	2,325	4,505	5,822	6,610	6,684	25,946	3.4
10	**Pregnancy Tests**	0	2,432	3,806	4,544	4,660	15,442	2.0
2	Other Services	9,996	16,793	28,949	55,407	63,096	177,238	23.1
	Total	62,629	100,435	163,446	226,430	214,556	767,496	100.1
	Laboratory exams	15,196	21,775	39,078	78,823	92,820	247,692	

RH services in **bold**. *PROFAMILIA projection based on January–June data.

In general, there has been a steady increase in most of these services, although the projection for 2001 shows that there will be some declines this year. This could be due to the poor economy, which some clinic directors say has reduced demand, especially in such hard-hit areas as Matagalpa. In addition, the figures for 2000 include emergency

program services, which have ended. Despite this fact, there will be some significant increases, notably in ultrasound, other services, and laboratory services.

Table 8 summarizes the least used of the services. Although some of these have only been offered for a short time in some clinics and a few have not yet begun (dental services just began to be offered in two clinics in 2001, and ophthalmology is not yet available), it is clear that there are significant differences in demand for current services. Some services are important because they are used for further diagnosis or treatment of suspected RH cancers: biopsy, mammography, colposcopy, and cauterization, in particular.

Table 8
Lowest Ranking Medical Service Visits, 1997–2001

Rank	Services	1997	1998	1999	2000	2001*	Total
1	Dental services		0	0	0	NA	>0
1	Ophthalmology			0	0	0	0
2	**Delivery**			11	34	26	71
3	Minor Surgery		135	276	353	492	1,256
4	Specialty Services			593	759	1,466	2,818
5	**Colposcopy**		360	450	967	1,060	2,837
6	Psychology			791	983	1,098	2,872
7	**Biopsies**		558	634	1,000	908	3,100
8	**Postnatal**	476	711	607	682	706	3,182
9	**Mammography**			1,125	1,231	1,322	3,678
10	**Cauterization**		382	873	1,367	1,068	3,690

RH services in **bold**. *PROFAMILIA projection based on January–June data.

One service that has had significant resources devoted to it is delivery. Based on the success of the PROSALUD model in Bolivia, PROFAMILIA expected deliveries to be a popular and profitable service. However, although the antenatal care volume is high (around 10,000 visits per year), the total number of deliveries over the past three years is only 71. The board of directors has only approved four clinics to provide deliveries, although three others carry them out on occasion. Nevertheless, among these clinics, this averages out to only about one delivery per clinic per month. This current volume is insufficient to sustain high-quality service and to contribute significantly to lowering maternal mortality, much less to income.

Among the reasons cited for low volume is competition from MINSA (which provides free hospitalization for deliveries), some private providers, and the relatively high cost of the service at PROFAMILIA, which ranges between C$1,700–2,500. The CMS franchise clinics are priced much lower, at about C$850. This is due to much lower personnel, supply, and equipment costs. CMS, for example, relies largely on obstetric nurses for deliveries, with an obstetric/gynecologic specialist on call. PROFAMILIA requires that both an obstetrician/gynecologist and a pediatrician be in attendance. This requirement and others reflect the board of directors' concern with liability, which not only raises

costs, but also restricts access. For example, clients must have made at least four antenatal visits to the PROFAMILIA clinic to be eligible for delivery.

PROFAMILIA is not set up to handle normal deliveries. To avoid liability concerns, it has prepared its clinics to handle abnormal deliveries and priced itself out of the market. This policy obviously needs to be reviewed and some compromise found if PROFAMILIA expects to attract clients for delivery services. If PROFAMILIA is concerned about maternal mortality, it needs to develop an affordable in-clinic service and provide help and advice to the majority of women that deliver at home.

This policy reflects a larger issue, which is the lack of a systematic approach to product development. There has been considerable discussion within PROFAMILIA about the extent of services appropriate and necessary to include in its service packages, but there has been little market research to assess demand, set prices, develop the packaging of the services, or promote them. PROFAMILIA has not calculated the cost of providing its services or the profit margin each will generate, if any. Instead, it has assumed that there is a demand and that the more services it offers, the more money it can make. It may well be that some services do make a profit, but others may actually lose money for the association. There is a need for PROFAMILIA to calculate unit costs for each service and determine if there is sufficient demand for each service to make it worthwhile for inclusion it in its service package.

As for family planning, the following table provides information on the number of long-term method services and contraceptive sales. Sterilizations and intrauterine device (IUD) insertions are provided in clinics and are part of medical services. Contraceptives are sold in clinics and through CBD posts. Social marketing sales of condoms account for much of the increase in condom sales in 2000 and 2001. Sales of pills and injectables are also expected to increase markedly, when the social marketing of those products is launched.

Table 9
Contraceptive Sales and Service by Year and Method

Method	1997	1998	1999	2000	2001*
Long-term Method Services					
Sterilizations (individuals)	7,400	2,600	1,700	1,400	1,160
IUDs (individuals)	762	1,700	1,400	1,500	1,628
Temporary Method Sales					
Pills (packets)	234,000	267,000	285,000	290,000	372,000
Depo-Provera (vials)	42,000	62,000	76,000	73,000	66,000
Condoms (packets)	316,000	358,000	582,000	1,600,000	1,348,000
Monthly injectable (vials)	736	1,900	5,600	9,800	2,200

*PROFAMILIA projection based on January–June data.

Even without social marketing, sales of pills and injectables have been increasing steadily. The number of users of long-term methods has stagnated at a low level (IUD) or continued to fall (sterilization). This explains why PROFAMILIA is so far off its 50 percent temporary versus 50 percent sterilization target. While pills and condoms are promoted through the efforts of the CBD network and social marketing, there is no

comparable effort to promote long-term methods. The clinic physicians and counselors attribute the lack of popularity of IUDs largely to myths. Some recruiting opportunities for sterilization are being overlooked. Some counselors visit the postpartum ward of the nearby MINSA hospital to recruit postpartum sterilization clients, while others do not.

Quality of Services

Since the 1997 midterm evaluation, PROFAMILIA has developed several components of its quality assurance program. With the help of the Quality Assurance Project (QAP), PROFAMILIA has conducted training on the concept of quality and has formed a quality committee. A list of quality standards and indicators has been drafted. Plans are in place to form quality committees at the clinic level. The staff member interviewed from QAP believes that although progress is behind schedule, momentum is now building within PROFAMILIA toward embracing and providing quality care.

Baseline studies on client satisfaction and staff knowledge about norms have been conducted. The studies indicate a high level of client satisfaction. However, such next steps as easy low-cost methods to monitor and further enhance client satisfaction, minimizing client waiting time, and increasing continuity of care between clients and physicians, have not been taken.

Norms for clinic services, nursing care and charting have been developed or adopted. However, the norms address many of the clinical services (gynecology, pediatrics, and general medicine) and laboratory and dental services in a very cursory manner. Pharmacy, ultrasound, and general surgery services are not included. Plans are in place to develop or revise 12 norms: registration and statistics, sexually transmitted infections (STIs)/HIV, breast and cervical pathology, referral mechanisms, laboratory services, prenatal care, delivery and newborn care, nursing, infection prevention, radiology, oncology, and colposcopy. Although a very sizeable number of clients come for gynecologic care, no norm development is planned for this service. Neither are any planned for general medicine, dental, pediatrics, or general surgery services.

Guidelines have been developed for the management of critical clinical tests and services: positive Papanicolaou (Pap) tests, positive biopsies, positive prostate cancer screens, positive mammograms, and failed or complicated voluntary surgical contraception (VSC). These issues are being monitored for proper management. However, there is no specific monitoring of any other positive test results, such as STIs and HIV.

Clinical management guidelines have not been developed to guide management of common or critical clinical conditions (e.g., within obstetrics/gynecology: amenorrhea, menorrhagia, irregular menses, infertility, urinary tract infections, breast problems, gestational diabetes, twins, small-for-date fetus, Rh negative mothers, threatened abortions, maternal health problems, postdate pregnancy, and breech presentations, for example). There are no current plans to develop guidelines for this level of care. The PROFAMILIA staff members interviewed during this evaluation provide only simple outpatient care and refer more complicated outpatient cases (not just those requiring

hospitalization) to MINSA. However, it is the board of directors' stated intent that PROFAMILIA provide care for more than the simplest outpatient problems.

A supervision guide is being used to ensure compliance with the norms that have been developed to date and to monitor the management of critical tests and issues. However, the supervision guide calls for monitoring issues not described in any norm. The supervision of the laboratory and pharmacy services is cursory and that of the ultrasound service is nonexistent. Although the pediatric, gynecologic, general medicine, and dental services have important differences, the issues currently identified for supervision are identical across services. Although only five to seven supervision visits per year are planned for each clinic, the supervision guide does not enlist the participation of the clinic directors to perform the supervision. Neither does the supervision guide enlist the participation of each clinic staff member to identify problems. A supervision system involving staff participation in problem identification, developed by CMS, could serve as a model for PROFAMILIA.

The above-mentioned quality assurance documents are organized illogically. There is confusion about differentiating a norm, a protocol, and a guideline. Furthermore, it is cumbersome to make additions and revisions to these documents because they are bound rather than compiled in easily exchangeable 3–ring binders. PROFAMILIA is aware of this problem and is developing guidelines and protocols to complement the norms that have already been distributed.

The quality of counseling seems excellent. All clients new to the clinic meet the counselor and are offered family planning counseling. The counselors meet their clients in private locations. They are well informed about methods, are agreeable, and have good quality client education handouts.

Improved client screening, because of a protocol developed in 1997, is reported to be lowering the incidence of some surgical problems. The few "failures" are actually cases that were not completed successfully. Only two pregnancies have been reported among the procedures performed in the past two years.

Most of the clinics have expanded their physical facilities, providing additional consulting rooms, which has created privacy for counselors, and adding space for youth club activities. The clinics have adequate and attractive space. The notable exception is the Ciudad Jardin clinic. This clinic houses the central laboratory. For lack of adequate space, clients have their blood drawn within the laboratory itself. There is no space to perform bacteriology. Physicians do not have enough examination rooms. In addition, the clinic's appearance does not convey a quality image. Furthermore, MINSA upgraded the clinic certification norms in October 2000. The PROFAMILIA clinics will need to be exempted from the new standards or upgraded to meet them.

One of the single largest opportunities for maximizing quality is at the time of staff hiring. The current physician selection process emphasizes medical qualifications and experience. By contrast, CMS has developed an innovative model that also includes an

assessment of the applicant's communication, leadership, teamwork, and problem solving skills, as well as creativity.

Prenatal service is a busy one for PROFAMILIA. However, several factors limit its quality. In some areas, case management does not conform to either World Health Organization (WHO) recommendations or to guidelines used in developed countries (e.g., no management of hookworm, no monthly dip-stick screening for glucose and protein, overuse of ultrasound). Client prenatal education, a very important aspect of prenatal care, is underdeveloped. Furthermore, physicians estimate that approximately 95 percent of PROFAMILIA's prenatal clients deliver outside of PROFAMILIA. Among those clients, a significant percent choose to deliver at home. However, this fact is not directly acknowledged. There are no special education or management strategies to optimize maternal outcomes of those choosing to deliver at home (e.g., educating clients about dangers signs, helping clients develop emergency transportation plans, sale of safe home delivery kits). In addition, the promoters are not doing any community education about safe deliveries.

There are no handouts addressing educational topics other than family planning methods. Although a significant focus of supervision is on the adequacy of verbal information given to clients about correct use of their medications, there are no printed information sheets about safe and effective medication use.

PROFAMILIA has made great progress toward helping to reduce cervical cancer. Pap tests have been added to the service mix, and it is a popular service. Of the clinics visited, all but one had adequate systems for client notification and referral. The staff reports that most clients with precancerous lesions obtain treatment. However, the clinical management by PROFAMILIA of positive tests does not conform to that of MINSA or to international standards. PROFAMILIA does not have a policy on recommended frequency of Pap smear screening (e.g., annually until three normal smears, then every three years). Furthermore, PROFAMILIA offers two pricing and service packages for Pap smears. The higher priced package (which is sponsored by the GINECOBONOS initiative) includes treatment of positive tests. The other does not, and for those with positive tests the costs are considerable. The former package, which sends its smears to an outside laboratory for analysis and an outside gynecologist for management (their work is of excellent quality), represents a form of cost sharing whereby those with negative tests indirectly help pay for the treatment costs for those with positive results.

There is considerable variance among clinics in their use of each laboratory test (e.g., VDRL, pregnancy tests, biopsies, vaginal smears, prostate-specific antigen [PSA], platelet count). Because there are no audits of laboratory utilization, any overutilization or underutilization of laboratory services cannot be identified or corrected.

Only cytology test results are automatically given directly to the physicians. The remainder of test results is given to the clients, thus depriving the physicians of feedback and oversight if the client does not return to discuss test results. Furthermore, there is no warning system to call attention to grossly abnormal laboratory test results.

Training

Since 1997, the frequency (and therefore the number) of PROFAMILIA training events has been decreased from bimonthly to monthly. The approximate number of events per year is as follows:

- Medical Director 12
- General Medicine Physician 12
- Gynecologist 6
- Pediatrician 6
- Nurse 4
- Laboratory Technician 3
- Counselor 4

Up to 70 percent of the topics are chosen based on requests from participants.

Every two years, PROFAMILIA sponsors a 2 to 3–day conference. In 2000, the results of 27 different studies conducted by PROFAMILIA staff were presented. Clinic directors, physicians, counselors, and nurses were among the investigators. Those presenting estimate that approximately 10–15 percent of their time, over two years, is devoted to these studies. The investigators propose the topics and the studies are descriptive in nature. None uses strict research methodology.

Other Training

Based on interviews, PROFAMILIA training of MINSA staff in sterilization is of good quality. The training requires at least the equivalent of 2 weeks of full-time work by PROFAMILIA staff per course. However, although postpartum is a common time for performing sterilization, the PROFAMILIA training does not include this in its hands-on training. Due to concerns about sustainability, PROFAMILIA staff has begun to charge MINSA for some types of training (e.g., in supervision) that historically have been offered without charge as a form of community service. This has led to a reduction in PROFAMILIA–MINSA collaboration, since local MINSA officials do not have adequate funds to pay PROFAMILIA for this type of service.

Emergency contraception is a politically sensitive method. The Catholic Church believes that it is a form of abortion and therefore opposes it. Although the science on emergency contraception does not support this view, and even though there are several private emergency contraception products available in pharmacies, PROFAMILIA does not want to confront the Catholic Church on this issue. For this reason, PROFAMILIA does not actively promote this method, but it will provide information upon request. In any case, requests for emergency contraception are very rare.

Only two years ago, the medical director was the sole staff member of the medical division. Currently, there are five staff members; one is on temporary loan to CMS and another is on leave. The addition of new services and the development of quality

assurance systems have required effort. However, few new key services will likely be added and training frequencies have been halved. Therefore, if budget considerations require diminution in administrative costs, the medical division could be reduced without a serious threat to quality, although priorities would need to be reevaluated.

CONCLUSIONS

While sales for pills, injectables and condoms have increased, use of long-term contraceptive methods (sterilization and IUDs) has declined and is well off the 50/50 method balance that is PROFAMILIA's target. Long-term methods are not receiving sufficient attention or promotion.

The quality assurance system that is being developed is contributing to quality. However, it is not giving sufficient priority to RH services (especially gynecology and prenatal services). Furthermore, the policy statement that PROFAMILIA is committed to the care of more complicated medical conditions is belied by the fact that there is no plan to develop clinical management guidelines.

The current volume of deliveries is too small to maintain optimal quality, be financially viable or contribute to a reduction in maternal mortality. PROFAMILIA's eligibility requirements restrict access to delivery services. In addition, it is not taking adequate steps to reduce the maternal mortality of those prenatal clients who decide to deliver elsewhere, especially at home. The CBD network is not involved in improving maternal care.

The Ciudad Jardin clinic is too small and is not attractive. It is not adequate for providing a full gamut of services and there do not seem to be any plans to resolve this problem.

Client satisfaction is being evaluated. Steps to improve it are planned, as the quality assurance system develops. However, even for an issue known to be as important as waiting time, no immediate steps (proven to be effective elsewhere, for example, in private practices and health maintenance organizations) have been taken to quickly analyze and reduce it. Similarly, steps to enhance client-physician continuity of care have not been taken.

The supervision system has been systematized. However, it does not fully utilize its own staff to conduct supervision and to identify problems. Laboratory procedures are not being supervised. The current system of releasing laboratory results is inadequate. Clinical management of Pap smears does not conform to PROFAMILIA or international standards. The lower priced package places a heavy financial burden on those with positive smears.

Currently, much of the training agenda is set primarily by participant request rather than being based on need or continuing education criteria.

The studies that PROFAMILIA staff conducts are expensive and do not address issues that will result in programmatic changes. Other organizations are better equipped to conduct operational research activities.

PROFAMILIA's evaluation process for hiring staff is narrow in its focus. Selection criteria are largely medical and somewhat subjective. Management and interpersonal skills are not highlighted. Even so, the medical division is overstaffed. It could reduce its size to contribute to cost savings without sacrificing quality.

RECOMMENDATIONS

PROFAMILIA should develop measurable objectives and indicators for long-term contraceptive method use and launch an educational and promotional campaign, addressing common myths. PROFAMILIA should study whether prices for these methods are a barrier to access.

PROFAMILIA should place priority on developing norms for its central services (gynecology, prenatal care, and prenatal education). Clinical management guidelines should also be developed, with priority given to these services.

PROFAMILIA should reevaluate the viability of the obstetric delivery service. It should reevaluate its eligibility criteria and the staffing required for deliveries, keeping in mind that the PROFAMILIA clinics are located very close to MINSA hospitals, to which referrals could be made for complications during labor, delivery, or postpartum. Most importantly, PROFAMILIA should evaluate its pricing and consider testing significantly reduced prices to analyze the elasticity of the market and determine if it can achieve sufficient volume to offset costs. It should contribute to lowering maternal mortality by focusing on expanding and improving its prenatal services and on enhancing safety for those prenatal clients (and perhaps other pregnant women in the community) who choose to deliver at home. The CBD network should be trained to help with education and referrals.

PROFAMILIA should enlarge and improve the Ciudad Jardin clinic or build a new one.

PROFAMILIA should take immediate steps to enhance client satisfaction by

- reducing waiting time by monitoring check-in and consultation visit times;
- conducting client flow analysis;
- using two rooms for each physician, where possible;
- increasing the client load of the clinic directors;
- experimenting with discounted afternoon visits;

- developing easy, low-cost, methods to monitor client satisfaction (e.g., small, periodic focus groups); and

- enhancing continuity of care by always having clients see the same physician, unless the client prefers to change physicians.

PROFAMILIA should build on its supervision strategy by involving the clinic directors more directly in supervision and by incorporating problem identification by each staff member at each clinic.

PROFAMILIA should begin laboratory utilization audits and develop a system to flag laboratory results falling outside normal ranges. Copies of each laboratory and radiology report should be given to each physician that ordered it.

PROFAMILIA should identify programmatic priorities (e.g., norms and problems identified during supervision) and use these as the primary basis for the training agenda.

PROFAMILIA should discontinue the studies.

The medical division should revise its management protocol for positive Pap smears. PROFAMILIA should reevaluate its pricing structure for Pap smears and consider eliminating the lower priced package to spread the cost of treatment over a larger population. It should change the management of abnormal Pap smears to more closely align with the management protocol used by the GINECOBONOS initiative. It should also continue its participation in the very worthwhile GINECOBONOS initiative.

PROFAMILIA should consider a more comprehensive evaluation process when it hires staff and should study the CMS process as a possible model.

The medical division should contribute to PROFAMILIA's needed reductions in administrative costs by reducing the number of its staff. The priorities of the medical division should be the development of norms, protocols, and guidelines; supervision; and training/continuing education.

IV. SOCIAL MARKETING AND COMMUNICATION

EVALUATION ISSUES AND FINDINGS

Three principal questions were addressed during the evaluation: what effect has PROFAMILIA's communications program had on improving access to information about reproductive health, what effect has the program had on the demand for PROFAMILIA's services, and what effect has it had on PROFAMILIA's sustainability.

The objective of the social marketing and communications program is to improve the reproductive health of low-income families through the promotion of reproductive health, family planning, and prevention of STD/HIV/AIDS. Through mass media, this program is targeting rural cities (at least 10,000 inhabitants) and towns (at least 2,000 inhabitants) that make up 61 percent of the (rural) women of reproductive age. Given that 39 percent of Nicaragua's population is located in rural areas, the program has introduced such innovative techniques as mobile video units to reach these areas.

Regarding HIV/AIDS, PROFAMILIA is targeting sexually active adults between the ages of 20 and 59 and adolescents 15 to 19, including couples. The key target groups for condom promotion are the approximately 1.2 million single men and men living with a woman (married or in a stable relationship but not married) and 280,000 adolescents.

Effect on Access

Access to Information

There are no comprehensive data regarding the number of people reached through PROFAMILIA's communications strategy. The 2002 Demographic and Health Survey (DHS), funded by USAID and being implemented by ORC Macro (formerly Macro International, Inc.), will provide data about increased awareness of PROFAMILIA, family planning, and HIV/AIDS. When compared with the 1998 DHS, the data should provide some indication of the number of people being reached by informational strategies. The DHS will also provide information about market share for contraceptive and RH services and on the promoter networks. Although these figures will not be specific to each of the PROFAMILIA campaigns, they will provide some idea of their impact. However, in reviewing activities, it is clear that PROFAMILIA has greatly increased access to information on RH/FP. To increase RH/FP awareness, DIMECOSA (Dirección de Mercadeo y Comunicación Social, PROFAMILIA's communications and social marketing department that has received extensive technical assistance from JHU/PCS), has conducted several informational activities. These include a 1998 radio campaign repositioning PROFAMILIA's institutional image from a provider of family planning services to a provider of comprehensive family health services. The campaign included a new logo and slogan, Más Soluciónes en un Solo Lugar. In 1999, messages were also broadcast on television and reinforced through accompanying multimedia efforts (radio, posters, brochures, billboards). PROFAMILIA followed this large effort with shorter, more targeted campaigns, including the Niño Sano 2000 campaign in November 1999,

the Juntos Decidimos and Body Guard campaigns in April 2000 (to coincide with the launch of the condom), a Mother's Day campaign in May 2000, and a Healthy Family campaign in October. In May 2001, they conducted a Mother, Father, and Child campaign.

To reach audiences living in marginal and rural areas with information about reproductive health, family planning, and contraceptive methods, DIMECOSA

- conducted the Juntos Decidimos phase II campaign,
- sold over 2 million Body Guard condoms since April 2000,
- conducted 323 mobile video presentations to over 142,000 rural inhabitants,
- prepared all the promotional materials needed to launch Duofem pills (as soon as MINSA approves it), and
- made preparations for the launch of Depo-Provera in November 2001.

An evaluation of the mobile video activities conducted in October 2000 indicated that 50 percent of the people in the region had attended the mobile video presentations and, as a result, had greater knowledge of family planning and reproductive health services.

DIMECOSA has sponsored several film forums and annual artistic festivals for youth clubs to support outreach to adolescents. During 2000–2001, DIMECOSA published 190 articles and announcements in the press and held 18 press conferences concerning PROFAMILIA and reproductive and family health activities. DIMECOSA also conducted seven regional media information campaigns during this period. DIMECOSA has provided marketing and promotion training to regional staff to strengthen the communications capabilities of the regional centers. It has assigned a member of its communications team to work with each center in strengthening its information and promotional activities. It has also given each regional office 2,000 córdobas per month for media to support local promotion efforts.

Technical Assistance

USAID–sponsored technical assistance has helped PROFAMILIA increase access to information. Many of the above activities have been supported by technical assistance from JHU/PCS. Between 1995–98, PCS helped PROFAMILIA develop a communications strategy for RH/FP. This strategy included assisting PROFAMILIA to increase demand for services, creating the interagency RH commission and positioning PROFAMILIA as a leading institution, and providing communications training to technical personnel and promoters.

PCS has an office in Managua as well as personnel working in DIMECOSA providing technical assistance to PROFAMILIA's staff in the social marketing and communications area. PCS has provided technical assistance on the development of print materials, mass

media campaigns, and social marketing activities. PCS has also worked with PROFAMILIA in the development of the mobile video activities that deliver educational messages to underserved rural areas. An evaluation of this activity conducted in October 2000 among members of 40 rural communities in four regional centers found that mobile video programming is the third most important source of information about RH and PROFAMILIA, after television and radio. PCS also provided support to the CBD program for changing the role of community-based distributors to that of community health promoters. They provided training and assisted the CBD program in the redesign of print materials and strategies. Since the 1997 evaluation, the role and efficiency of the PROFAMILIA promoters has improved dramatically.

Quality Materials

PROFAMILIA has developed sufficient, quality IEC materials. In addition to the numerous media campaigns mentioned above, JHU worked with PROFAMILIA staff to improve the print materials. These include the redesign of a series of method-specific pamphlets, a counseling flip chart, institutional brochures, and materials designed for political leaders covering the importance of reproductive health/family planning programs. All materials have been carefully pretested with individuals that are representative of the target audiences. In addition, the social marketing program has developed some very informative educational brochures to be distributed with the products. These include information about commonly held myths and rumors related to the method as well as basic education about family planning. During the past year, DIMECOSA also produced pamphlets on "Mother and Baby Care" and "Child Growth and Development." All materials were carefully pretested and evaluated. Informal evaluations by team members found the materials to be popular, informative, and well received. At times, review of materials and interference at the technical level by the board of directors and management has delayed timely release of the materials.

Trained Staff

PROFAMILIA has appropriate and adequately trained staff and counterpart relationships. The DIMECOSA director has communications training and extensive experience operating information and communications departments for several United Nations agencies (United Nations Children's Fund [UNICEF], United Nations Development Programme [UNDP], and United Nations Population Fund [UNFPA]). In addition, there is a staff of two trained graphic designers, two writer/editors, and three mobile unit communicators; all have backgrounds in communications. The staff is producing high-quality, multimedia materials. In the social marketing area, in addition to an adviser from JHU/PCS, there is a sales director, a sales assistant, 11 sales promoters (one per region), four packers, and a quality control supervisor. Since social marketing is new to Nicaragua, most of this staff, particularly the sales promoters, had to be trained by the grant. These sales promoters are well qualified for the work and have exceeded their sales goals by 160 percent. DIMECOSA and JHU/PCS have worked well together. DIMECOSA is pleased with the technical support and creative input that it receives from JHU/PCS and PCS is pleased with the well-trained, motivated staff that PROFAMILIA has provided them as counterparts.

The quality of all the promotional materials and the capability of trained staff are very good. In fact, DIMECOSA is asked regularly to conduct market research and testing by successful commercial enterprises, such as Bell South, TipTop Chicken, Banexpo, and others. Due to a lack of good quality commercial advertising agencies in Nicaragua, DIMECOSA is often asked to fill the gap.

There appears to be a conflict between the director of DIMECOSA and the management and board of directors of PROFAMILIA. It seems to have more to do with working styles and politics than technical competence. However, there have been mistakes. For example, there were some errors in the first version of the annual report that had to be corrected and the board of directors held the director responsible. This discord is unfortunate as DIMECOSA's director is very well connected with other social agencies in Nicaragua, including United Nations agencies and PVOs. If given the support to do so, he could further develop a market for PROFAMILIA's communications services.

Effect on Demand

Strategies

PROFAMILIA has made use of outreach, mass media, and other communications strategies to increase demand for services and products. The refocusing of institutional image campaigns (radio in 1998, television 1999–2000) revolved around two pivotal messages. The first was a horizontal one directed at broadening the audience segments being served by PROFAMILIA from that of women only to include that of children, men, and adolescents. The second stressed the diversification of services, which moved the institution from being a provider of family planning services only to a provider of integrated family health services.

As a result of this campaign and the corresponding increase in services that was generated, PROFAMILIA was able to increase its services income from C$700,000 per month in May 1999 to C$1.4 million per month in January 2000. Similar increases in services have been documented in the regions that had campaigns targeting specific services (pediatrics, ultrasound). A study[10] of the mobile video unit conducted in October 2000 demonstrated that 12 percent of patients attending PROFAMILIA's clinics came because of the mobile video promotions. The clinic directors interviewed thought that this referral figure might actually be higher as patients continued to come for services weeks after the events. This perception is supported by the findings in the study alluded to above, that although 50 percent of rural inhabitants in the study area said they participated in the mobile video event, 83 percent knew about it and had heard about the promotional messages.

In 2000, the Body Guard product was designed including name, logo, and slogan. To produce the design package, DIMECOSA conducted market research, which included

[10] DIMECOSA, *Evaluación del Impacto del Cine Movil*, October 2000. Interviews with members of 40 communities from four regions (Rivas, Granada, Matagalpa, and Jinotega).

validations, focus groups, and research among minorities and potential clients. The launch was conducted in April through the CBD network, a sales force of moto-promoters and the pharmaceutical distributor, Disexa. PROFAMILIA has established a sales network that includes approximately 800 pharmacies and 1,000 nontraditional sales points. This effort has had an effect on demand. In 1998, PROFAMILIA sold 362,044 plain condoms. In 1999, it sold 582,000 Body Guard and plain condoms, and in 2000, it sold 1,760,851 condoms, primarily Body Guard. As of July 31, PROFAMILIA has sold 820,877 condoms, primarily Body Guard.

Technical Assistance

As noted above, the social marketing department has had substantial technical assistance from JHU/PCS in the development of its program. Social marketing personnel were trained and receive ongoing training by the PCS technical adviser assigned to DIMECOSA. In addition, technical assistance has been provided for the development of DIMECOSA's job descriptions and other personnel management procedures. PCS has also assisted with the design and implementation of sales plans.

Despite these advances in the development of DIMECOSA's administrative capacities, the social marketing program's activities are about a year behind schedule. According to PROFAMILIA, this is principally because the executive director and the board of directors wanted DIMECOSA to focus its efforts on the institutional image campaign. They believed that a simultaneous campaign promoting PROFAMILIA's new condom might detract from this attempt to create a new image and might elicit a negative reaction from the Catholic Church. Although PCS tried to convince them to go ahead with the social marketing campaign, PCS was overruled. In the end, the social marketing campaign was launched under the auspices of the Comisión Interagencial de Salud Reproductiva (of which PROFAMILIA is a member). Another factor contributing to the delays is that since the last director left (fall of 2000), DIMECOSA has not been able to obtain internal approval for the social marketing, mobile video, and other scheduled communications activities. DuoFem (an oral contraceptive), the second product to be marketed by PROFAMILIA, has been delayed in getting launched due to a series of misunderstandings between Wyeth Pharmaceuticals and MINSA, regarding whether the product was currently registered or not. PCS had asked USAID/Nicaragua, which in turn asked USAID/Washington, to coordinate the product registration process through Wyeth. Wyeth gave them conflicting reports about the status of the registration. The health office of USAID/Nicaragua has expressed concern about this delay because it believes that JHU/PCS should have overseen the product registration process and should have ensured that it was registered. In hindsight, PCS agrees with this but states that at the time, it thought that this was the correct procedure. Since USAID is the agency that coordinates with the pharmaceutical companies, PCS had to rely on USAID/Nicaragua and USAID/Washington to work things out with Wyeth and then try to advance things as quickly as possible in Nicaragua, once the registration issues were resolved. As of this writing, Wyeth has sent the required registration renewal papers and DIMECOSA is prepared to launch the pill once the registration is approved by MINSA. The USAID health office also believes that PCS and DIMECOSA have let some opportunities pass, such as marketing Body Guard condoms through local taxis (which USAID suggested to

them). Apparently, VIVE is now employing this marketing strategy successfully. From their perspective, JHU/PCS did try to develop a project with DIMECOSA. They prepared a model project and were preparing to conduct a pilot project with 10–15 taxis that would advertise the condom. However, PROFAMILIA decided it did not want to invest in this activity and would not fund it.

Before Body Guard was launched, PROFAMILIA invited Population Services International (PSI) to join them in a unified condom social marketing strategy that would broaden VIVE's[11] market through nontraditional outlets. This was in response to USAID's interest in reaching youth and young couples. Because this offer was rejected by PSI, PROFAMILIA launched its own product. At the beginning of the Body Guard launch in Chinandega, there was an isolated conflict between a Body Guard promoter and a VIVE promoter. Since then, Body Guard promoters have been instructed not to interfere with VIVE activities and there have not been any further incidents. According to market studies, VIVE is perceived as directed at high-risk groups and Body Guard at youth. Both products are being sold at the same price (C$3 per packet), but VIVE is planning to raise its price to C$4.5 per packet. Body Guard plans to raise its price to C$4 per packet in January but is concerned about whether its target audience can afford the higher price. There was a question about why the Body Guard price was the same as that of VIVE. According to DIMECOSA, the market research showed that youth audiences judged C$3 to be the most appropriate price.[12] There is also some concern that sales of Body Guard are leveling. DIMECOSA's response is that, in addition to the economic downturn and related matters, they have not been able to obtain approval from within PROFAMILIA to launch the additional condom promotion activities that were planned. As a result, there has been no new promotion of Body Guard.

In general, the delays in approval of activities are related to PROFAMILIA'S confusion over DIMECOSA's mandate. There are three functions: education about RH/FP, promotion of PROFAMILIA's services, and setting up a sustainable social marketing program. Because of DIMECOSA's dual role of working in communications and social marketing, the priorities and distinctions have become confused. For example, PROFAMILIA's leadership has confused the principal objective of the mobile video units, which is primarily educational, with income generation.

Other factors contributing to delays include the lack of leadership at DIMECOSA. The previous director was released in early 2000; this was followed by several months of no leadership and one month of interim leadership by the program director, who was also the interim director of PROFAMILIA and thus was not able to devote complete attention to

[11] VIVE is a condom being socially marketed by Pan American Social Marketing Organization (PASMO), an organization supported by PSI that has an agreement with USAID's Central American Region to market condoms for the prevention of HIV/AIDS.

[12] See project proposal section on pricing for a discussion about the formula used by social marketers, which was that the price for one CYP should be one percent of gross domestic product (GDP) per capita. In this case, both JHU/PCS and PASMO/PSI used this formula. Using this criterion, the current price of C$1 per condom turns out to equal 1.4 percent of GDP per capita. This is high and raises questions about raising the price further by C$1.5 per condom, as the project is planning to do in January 2002.

DIMECOSA's priorities. PROFAMILIA hired a well-qualified director at the end of 2000. Unfortunately, by this time there had been so much interference in DIMECOSA's day-to-day operations by PROFAMILIA managers and directors that it was difficult for the new manager to reestablish the independent leadership needed to meet the program's objectives. That interference continues to this day. For example, the mobile units were grounded for the first 6 months of 2001 because PROFAMILIA's management decided that DIMECOSA should only be involved in activities that generated revenue for the institution. Although DIMECOSA agreed to use the mobile units to promote the opening of the new CMS clinics, as noted above, sustainability was never intended as the mobile unit's priority objective.

Effect on Sustainability

The promotional activities have increased PROFAMILIA's services and income. PROFAMILIA's income increased from C$700,000 in May 1999 to C$1.4 million in January 2000. In addition, the regional centers confirmed that the technical support from DIMECOSA and the activities of the mobile video units have helped increase services. DIMECOSA believes that a continuing effort needs to be made to promote PROFAMILIA's services, and that PROFAMILIA needs a more focused strategic vision. It also believes that DIMECOSA can help the organization build and project this vision once agreement is reached about the vision. To this end, in the fall of 2001, JHU/PCS and DIMECOSA are planning a strategic communications workshop for PROFAMILIA management staff. DIMECOSA obtained approval to use the mobile video units to promote the opening of the CMS clinics and anticipates a similar need to promote some of the new services at PROFAMILIA, such as dentistry and pediatrics.

Because of the delays in the implementation of programmed social marketing activities, the level of sustainability is only at 14 percent (it was programmed to be at 36 percent by mid–2001 and 100 percent by the end of 2002).

The social marketing program's sustainability strategy is based on selling products and depositing the revenues in a social marketing trust account. By the end of the grant, the program hopes to have $700,000 that it plans to use two ways. First, $200,000 will be set up as a revolving fund for a biannual purchase of pills, condoms, and injectables. Funds generated from the sales of products would be returned to the fund to buy additional products. The rest of the money ($500,000) will be set up as a fiduciary/trust fund, which is expected to generate a 10 percent return annually ($50,000). This amount would be sufficient to support a limited number of staff to oversee management of product sales, distribution, and warehousing, and to cover some advertising costs. In order to accomplish this, revenues need to be separated and kept in their own accounts. According to program officials, it has taken a year for PROFAMILIA to set up this account and deposit a portion of the Body Guard revenues ($100,000). It is expected that the rest of the revenues ($40,000) will be deposited within the next 2 months. The social marketing program projects that the moto-promoters will be self-sustaining. As of August 2001, their salaries have been reduced from C$1,500 per month to C$500 per month but the commission that they receive has increased from C$0.10 to C$0.20 per sale. The social marketing program is confident that the program will be able to sustain

itself based on the above calculations and projections, but the evaluation team is skeptical (see recommendations, section VI). One concern is that the current interest rate on the above- mentioned fiduciary fund has dropped to 6 percent. While the social marketing program is also concerned about this, it is hopeful that the rate will have increased by the end of the program.

CONCLUSIONS

In general, DIMECOSA has a very qualified technical staff that has produced excellent informational materials as well as media campaigns. It has carefully followed procedures for validating and pretesting messages and materials to assure that they are reaching target audiences and that the messages are correctly understood. The quality of this work has been recognized by commercial enterprises operating in Nicaragua that would like to buy more of its services.

DIMECOSA has been successful in generating demand for PROFAMILIA's services. Sales for services increased from C$700,000 in May 1999 to C$1.4 million in January 2000. Demand for condoms also increased. Sales rose from 362,044 No-logo in 1998 and 582,000 in 1999 to 1.8 million combined Body Guard, No-logo, and VIVE in 2000. However, condom sales are not increasing at as high a rate in 2001 as DIMECOSA would like (820,877 as of July 31). DIMECOSA believes that it could improve sales if PROFAMILIA's management would approve the start of programmed and budgeted marketing activities.

JHU/PCS has provided useful and appropriate technical assistance for the development of PROFAMILIA's promotional and social marketing strategies in accordance with program objectives. PROFAMILIA's counterparts are responsive to the technical assistance they have received and have developed a good working relationship with the PCS advisers.

Achievement of the social marketing sustainability objectives is behind schedule due to other institutional priorities that delayed the launch for a year and then, by conflicting interests and lack of support exacerbated by a leadership vacuum within the institution and in DIMECOSA. Other factors contributing to delays include problems with the product registration process and withholding of approval of planned activities by management and the board of directors.

DIMECOSA's dual function in communications and social marketing is contributing to confusion about programming agendas. The social marketing program has benefited from DIMECOSA's communications expertise in designing its product packaging and educational advertising. However, it has also had to postpone its marketing campaigns in deference to other PROFAMILIA communications priorities. In addition, agencies that have wanted to contract with DIMECOSA to develop media campaigns have been reluctant to go ahead because of PROFAMILIA's billing policy, which charges for both social marketing as well as communications costs because PROFAMILIA does not separate the two. For this and other reasons, including the fact that the social marketing component is supposed to become self-sufficient, there is support for setting up separate cost centers for the two components.

There appears to be a significant misunderstanding among the PROFAMILIA leadership as to these dual roles. The leadership does not seem to understand that the roles are distinct, that social marketing is limited to contraceptive sales, and that only the social marketing component has a sustainability objective. This situation may force the DIMECOSA director to leave, causing additional turnover and creating further obstacles for the program. USAID and PCS have invested substantial resources in training PROFAMILIA's staff in social marketing but the resident technical adviser is scheduled to leave at the end of 2001, which does not allow enough time to adequately train a new person on the social marketing program. The current situation is also unfortunate because PROFAMILIA has the opportunity to become a real leader in the social communications field in Nicaragua. At this time, there is a dearth of qualified communications/advertising businesses and there is extraordinary potential for this market.

RECOMMENDATIONS

PROFAMILIA's management and board of directors should fully support DIMECOSA's existing leadership in implementing its social marketing and communications objectives as defined in the grant agreement. They should do everything they can to assure that the current director remains with the institution and avoid the costs of recruiting and training new personnel.

USAID should grant PROFAMILIA a one-year extension of the social marketing activity (see section VI for details). Because of the delays in implementation noted above, the budget is underspent and the program is behind schedule.

PROFAMILIA should carefully examine market potential through market research and cost analyses before setting new prices for products. Currently, there is a difference of opinion over whether it is time to raise the price of Body Guard condoms. Market research would support the decision.

The board of directors and management should respect the technical expertise and audience-driven, decision-making process of the DIMECOSA staff regarding the design and presentation of communications materials and media. They should direct their attention to how communications efforts can best reflect and enhance institutional policy and priorities. They should also work with DIMECOSA to set goals and define the institutional perspective they want to market and the audiences they want to reach.

PROFAMILIA should set up separate cost centers for the communications program and the social marketing program and let them manage their respective budgets separately (see section VI for details).

PROFAMILIA should be willing to actively provide public leadership in the areas of family planning and reproductive health, particularly among the target audiences (youth and young couples). PROFAMILIA's leadership should work with DIMECOSA, the Comisión Interagencial de Salud Reproductiva, and others to develop strategies for dealing with potential opposition from the Catholic Church or other groups opposed to

family planning. Working with JHU/PCS and IPPF to develop strategies would be helpful as both organizations have extensive experience with this issue in other countries, such as Colombia, Bolivia, and the Philippines.

In order to improve DIMECOSA's relationship with management and for it to effectively promote PROFAMILIA's agenda, DIMECOSA should move into the central office where it can participate more regularly in PROFAMILIA's daily operations.

V. COMMUNITY-BASED DISTRIBUTION AND YOUTH PROMOTION

EVALUATION ISSUES AND FINDINGS

Improvements in cost-effectiveness, support for rural CBD, CBD training and supervision, comparison of distributors with promoters, and the effectiveness of the youth program are discussed in this section.

Improvements in Cost-Effectiveness

The CBD program has undergone many significant and positive changes since the 1997 evaluation. At that time, the program was found to have high turnover, due to inadequate supervision and training of promoters. In addition, the role was one of distribution of methods rather than actual promotion of family planning and PROFAMILIA's services. There has been a notable reorientation of the program involving training, development of support materials, a revised strategy, and restructuring of the program. The technical assistance provided by JHU/PCS, IPPF, the Family Planning Logistics Management Proejct (FPLM), the Program for International Training in Health (PRIME), and others has been well received by PROFAMILIA and has strengthened the program. The program strategy has been heavily influenced by the institution's focus on cost awareness and financial sustainability.

Improvements introduced into the CBD program since the midterm evaluation have improved the cost-effectiveness of the program. As a result of the 1997 evaluation and an evaluation of the program by PRIME in 1997–98, PROFAMILIA reorganized its CBD program. It divided the CBD workers into two categories: distributors (who work out of pharmacies) and promoters (who work out of their homes or shops). The latter were to conduct regular education and promotion activities in their communities to increase sales. Together with JHU/PCS, a training program was developed for supervisors and promoters with regular follow-up training. They improved the selection criteria for promoters and developed a strategy for their locations. It also improved the reporting, supply, and supervision systems. By 1999, the CBD network had grown and consisted of 1,042 promoters, 292 distributors, 19 supervisors, 19 drivers, 4 trainers, and 1 national coordinator. CBD became responsible for approximately 80 percent of the contraceptive methods distributed by PROFAMILIA.

IPPF and FPLM conducted an analysis of the CBD program and made some strategic recommendations. They determined that the income from the program was only covering 48 percent of costs. They also projected that MINSA's new free distribution of contraceptives and the expanding social marketing activities would affect the sales of the CBD program. They made recommendations for restructuring the program and containing administrative costs. As a result, PROFAMILIA reduced the number of staff in half to 9 supervisors, 9 drivers, 9 vehicles, and 2 trainers, and restructured the supervision system. Thus, supervisors now conduct supervision along routes (maps of the locations of all promoters are in each supervisor's office in the regional centers).

Promoters who live closest to the centers are visited monthly for resupply and on-the-job training. Those who live farther out are visited once every two or three months.

PROFAMILIA assessed the effectiveness of promoters in 2000, which resulted in the closing of nonproductive posts/promoters. In addition, some new posts were opened in previously underserved areas. As a result, the number of active posts dropped from 1,274 in 2000 to 1,081 in 2001. Improved productivity is demonstrated by the fact that the average number of CYPs per post has gone from 26 in 1998 to 44 in 2001. In spite of reductions in supervisory visits, income has remained the same or improved in all the regional programs. In addition, the CBD program is still responsible for approximately 60 percent of the temporary methods distributed by PROFAMILIA.

As a result of all the efficiencies introduced into the CBD program, its cost-effectiveness has continued to improve. Because CBD income is included with other income from clinic services, it has not been possible to separate it out and arrive at an exact figure for sustainability calculations. However, according to figures generated by PROFAMILIA's Managua clinic, CBD income was covering 54 percent of CBD costs.

Support for Rural CBD

PROFAMILIA should provide rural CBD services. PROFAMILIA has made a tremendous investment in its CBD program. It now has an established network of well-trained, well-organized, and well-supervised promoters. Their efficiency is continuing to improve, and they average 44 users per promoter. Latest estimates indicate that the program is retaining 80 percent of its promoters. Given that a key objective of the PROFAMILIA grant is to provide family planning and reproductive health services to rural women, this program is one of the few in the country that is actually succeeding. In addition, now that PROFAMILIA is further supporting rural health education and promotion of services through the mobile video units, the promoters are playing an important role in organizing community activities in their areas and bringing in additional clients.

The usual alternative for promotion of services is to conduct mass media campaigns that generate awareness about family planning needs and then direct people to services. Mass media can be used to generate awareness of a problem but it is not a good source for education, and in this case, the rural population needs to be educated about why it is important to delay pregnancies, space births, and plan for healthy families. They also need careful education and counseling about family planning and how the methods work. Time needs to be taken to address myths and rumors about the methods. It is also important to have a community resource available to address questions or problems. These issues are better handled on a one-on-one basis by trusted and respected community women who are available to the rest of the village. Understanding this need to educate rural groups is the motivation for including it in the mobile video presentations along with the media event when the units visit the rural areas. This is also why education and counseling are such an important part of the CBD worker role in addition to promotion of methods.

CBD activities should probably not be turned over to other PVOs. While PVOs certainly have a rural presence, they usually are not in a particular area for more than a few years, and often do not have health workers, equipment, and facilities. Thus, developing capacity requires a large investment, and when the project ends, the PVO usually stops. Most do not have enough of their own resources to continue the activities. In contrast, PROFAMILIA has a permanent presence in the countryside and a network of promoters and services through its regional centers. As mentioned above, PROFAMILIA and USAID have now invested a substantial amount of time and money in developing an established and relatively efficient network of rural CBD workers. If this job were to be turned over to another group, it would mean reinvesting all this effort. When interviewing PVO representatives about this, they indicated that because they do not have expertise in family planning or CBD, it is more useful for them to select and organize the promoters and then contract with PROFAMILIA to provide the training, set up the distribution systems, and conduct the follow-up supervision. Those that might be interested pointed out that someone would have to give them the training and support to take over this job. In sum, the PROFAMILIA CBD networks are more productive, cost-effective, stable, and sustainable than PVO CBD programs.

CBD Training and Supervision

The CBD workers receive adequate training in counseling, development of educational programs, and distribution and sale of contraceptives and supplies. One of the noticeable improvements after the 1997 evaluation was a significant upgrading of the training given to CBD workers. This effort was directed by JHU/PCS, which planned and implemented the CBD network-strengthening strategy and redefined the profile of the community promoter. This involved a large training effort for 750 promoters from 11 regions. Initial training included four modules: contraceptive technology, quality of care, user satisfaction, and interpersonal communication and counseling. This training effort included the development of accompanying print materials: flip charts, method-specific pamphlets, reproductive health manuals, contraceptive technology folders, STD/HIV/AIDS pamphlets, and new signs for the health posts. After the initial training, a plan was established for ongoing training of the CBD network. In addition to the training topics above, additional topics include community promotion, use of educational materials, and the lactational amenorrhea method. With the reductions in CBD management support, training events are held less frequently and now tend to be consolidated with other activities. Evidence from training evaluations indicates that, on average, promoters are retaining roughly 60 to 85 percent of the material.

Supervision of CBD workers appears to be adequate. As part of the reorganization in 1999, each regional center was left with one supervisor. At the same time, the routing of field visits was mapped and organized more efficiently so that those posts with the most sales were visited monthly and those with fewer sales were visited every two to three months. During the visits, the promoters received supplies and were assessed and coached/supervised. There was concern that the reduction in supervisors might affect the productivity of the promoters, particularly with the corresponding reductions in the number of promoters; however, that does not seem to be the case. In fact, there appear to be some increases in sales. The promoters who were interviewed all seemed pleased with

the level of supervision and felt empowered because of the training and ongoing supervision. However, the promoters that are farther out and who only receive supervision every two to three months were not interviewed.

Comparison of Distribution Outlets

The quality of services, prices for products, and efficiency in acquiring new uses are not consistent between posts, commercial pharmacies, and stores. In general, the trained CBD promoters who work out of their posts (homes) or stores tend to provide quality counseling and education to clients at the prices set by PROFAMILIA. Most of the distributors who work out of pharmacies are trained but because they are working in pharmacies, they have less time to provide counseling and do not conduct any community education or promotion. Therefore, the quality of service is not as good (although it is probably better than that of an untrained pharmacy worker). Although pharmacy distributors are asked to sell products at the PROFAMILIA prices, they have less control over them and often products are sold at higher prices.

Effectiveness of Youth Programs

Impact of Youth Program on Prevention of Adolescent Pregnancy/Sexual Activity

At this time, there are no conclusive data on the impact of youth club activities on teenage pregnancy rates. PROFAMILIA did conduct a process evaluation[13] of the clubs and their coordinators in 2000 that indicated that the clubs were reaching adolescents of the target group (15–19) and that they were responding positively to education about sex, family planning, and HIV/AIDS. The team did meet with several youth clubs and members confirmed that the sexuality training was one of the areas of greatest interest to them. They also liked the sessions on values and self-esteem and noted that the clubs were helping them understand themselves better and be more responsible in their behavior. They also noted that the clubs were helping them become better communicators with one another and with their families.

PROFAMILIA has 10 clubs (one per regional center) with 700 affiliates, giving it more national coverage than any other organization. Out of these clubs, 446 youth promoters have organized 223 mini-clubs, comprising 4,335 adolescents. To date, these groups have conducted 1,503 workshops on sexual and reproductive health and personal development.

PROFAMILIA has become a leader in this area and several United Nations agencies and PVOs have asked PROFAMILIA to help them with training and educational activities. Some have also asked them to help set up additional youth programs. CARE has recently been awarded a contract to work with MINSA on the formation of youth clubs and PROFAMILIA will be conducting the training.

[13] PROFAMILIA, *Evaluación de los Club de Jovenes de PROFAMILIA*, December 2000.

Issues Concerning Sustainability of CBD and Youth Programs

The issues are similar for both programs. Both activities respond to the USAID objectives that target rural populations and adolescents for family planning and reproductive health education and services. Also, both programs require significant programmatic inputs in order to address the FP/RH needs of the target groups but the activities do not generate much income. As noted in the above section on cost-effectiveness, in one region, the CBD program is meeting 54 percent of its costs. The youth club program does not generate income to offset the costs of operating the program, although the clubs have conducted fundraising activities to support local artistic festivals and to send one group to Managua for year-end competitions. PROFAMILIA deserves credit for developing model programs in both of these areas, despite overriding concerns regarding institutional sustainability. Because of this, PROFAMILIA is looking into additional products that the CBD networks can sell in order to generate more income, such as nonprescription drugs and eyeglasses. They are also considering income-generating options for the youth programs.

CONCLUSIONS

The CBD program has made significant progress since the 1997 evaluation. The promoters are well trained, supervised, and productive. They are also more efficient than they had been. In addition, they account for approximately 60 percent of PROFAMILIA's sales of contraceptive methods (excluding social marketing).

It is clear that PROFAMILIA is the best institution to be providing rural CBD services. Its CBD networks are more productive, cost-effective, stable, and sustainable than those of PVOs. They have a permanent presence in the country and an established, experienced, trained network of rural CBD workers with an 80–90 percent retention rate.

Qualitative evaluations indicate that the youth club program is successfully educating adolescents in the areas of sexuality, family planning, and HIV/AIDS. PROFAMILIA is recognized as a leader in the area of youth education. Given that the adolescent pregnancy rates in Nicaragua (41 percent in rural areas and 30 percent in Managua) are the highest in the region, this program is addressing a significant national health problem. One of the concerns raised during the evaluation is that the program may be overlooking out-of-school youth, who are typically at higher risk of pregnancy and sexually transmitted diseases, including HIV/AIDS. This is because of a requirement that youth club participants attend school. Although the school requirement is well intentioned, it may be keeping the program from reaching the group it needs to reach most.

Concerns over program sustainability may be interfering with program expansion into underserved areas. In order to be more efficient, the CBD program has reduced its staffing, and even though programmatic reorganization has made the remaining supervisors and CBD workers more efficient, the limited number of staff will prevent it from expanding in the future. In addition, PVOs have indicated that since PROFAMILIA now charges them for their CBD training and organizational activities, they can no longer afford to develop more CBD workers.

RECOMMENDATIONS

PROFAMILIA, in consultation with USAID, should decide whether its priority is expansion of rural and youth services or sustaining these services. One solution to this dilemma is to separately cost the non–income-generating activities associated with CBD and youth programs, acknowledging that these activities address necessary national health priorities and require continued support from outside donors (see section VI for details on costing recommendations).

PROFAMILIA should consider selling other profit-making products through the CBD network that would generate additional income and provide broad services.

PROFAMILIA should consider expanding the CBD network through the identification and development of star promoters (promotoras madres), who are promoters that excel at their work and could take over supervisory activities in their regions. They would be provided with a stock of supplies that they would distribute to their own network of promoters along with education and training support. This would extend the efficiency of the supervisors who are operating at maximum capacity and cannot reach additional promoters.

PROFAMILIA should consider joining NicaSalud in order to increase relationships with PVOs and expand its rural presence/outreach. The DIMECOSA director could be useful in facilitating this process.

PROFAMILIA should reestablish a system of paying fees to promoters for referrals to clinics for family planning services, as this would stimulate rural consultations and increase CBD cost-effectiveness. There appears to be a misunderstanding of USAID regulations in this matter that needs to be addressed. PROFAMILIA could establish a policy to pay fees for referrals to PROFAMILIA clinics rather than for any specific service.

The CBD program and DIMECOSA need to analyze the roles of distributors in their two programs and clarify/coordinate their respective responsibilities. There appears to be overlap between the two programs.

PROFAMILIA should conduct an evaluation of the youth program to measure its impact on reducing teenage pregnancy and the extent to which it is reaching low-income and rural adolescents. It should consider developing a program that targets high-risk youth, including out-of-school youth and youth engaged in high-risk behaviors.

PROFAMILIA should continue to support and expand its adolescent and youth programs in order to address rising teenage pregnancy rates, which are the highest in Central America.

VI. FINANCIAL SUSTAINABILITY

EVALUATION ISSUES AND FINDINGS

Four major sustainability issues were examined: current sustainability status and prospects, financial management, cost accounting and cost control, and absorption of the CMS franchise clinics.

Sustainability Status and Trends

In accordance with USAID guidelines, PROFAMILIA calculates the level of financial sustainability by including its total operating income, revenue, and expenses, less the operations of the emergency clinics and the social marketing program. Using this basis for calculation of sustainability, as of June 2001, PROFAMILIA is currently at 46 percent sustainability, versus the 2001 target of 57.2 percent.

Although PROFAMILIA is below its current target, it has been making a steady increase in the level of sustainability over the past several years as shown in table 10. PROFAMILIA management believes that it can reach the grant target of 60 percent by the end of 2002.

Table 10
Sustainability Trends

	Percent Sustainable			Percentage Point Change
Regional Center[14]	**1999**	**2000**	**2001***	**1999–2001**
1. Juigalpa	52	62	79	27
2. Managua	70	82	79	9
3. Masaya	44	58	78	34
4. Boaco	55	62	75	20
5. Matagalpa	51	56	67	16
6. Rivas	41	50	65	24
7. Jinotega	49	63	60	11
8. Chinandega	49	66	59	10
9. Ocotal	39	59	53	14
10. Granada	30	47	46	16
11. Estelí ***	13	48	38	25
Total	**51**	**64**	**69**	**18**
PROFAMILIA**	**30**	**45**	**46**	**16**

* January–June
** All of PROFAMILIA except social marketing
***Estelí closed at the end of April 2001

[14] Regional centers include medical services, CBD, youth, and promotion/communication programs, in addition to clinical services. This table does not include data from four new centers: León, Estelí, Somoto, and Bluefields. In 2001, Estelí was at 38 percent; the others were at 0 percent.

In fact, the level of sustainability for the organization has increased from a level of 18 percent in 1997, to the current 46 percent. There are significant differences among centers, however, as can be seen in the current (2001) column. Eight of the centers are above or near the 60 percent target for the grant and three are close to 80 percent sustainability. If social program activities were taken out, sustainability would be even higher. Unfortunately, PROFAMILIA is unable to disaggregate sustainability figures for each program at this time. The data are available, but they are not compiled and reported in this manner. It should be noted, however, that with the worsening economic situation, these current sustainability targets are going to be even more of a challenge, and this is possibly why the rate of change appears to be slowing down for some of the clinics in the above table.

The predominant reason that PROFAMILIA has not attained the desired level of sustainability is that expenses exceed income by a large amount. There are also some lost opportunities for increasing income. Among the principal factors that are limiting greater sustainability levels are the following: high central administrative and overhead costs, high personnel costs, other high operational costs, social program costs, medical services income, and physician productivity.

High Central Administrative and Overhead Costs

Although PROFAMILIA is currently spending less than budgeted in overall costs, the overhead and support costs as of June 2001 were C$7,837,170, and were nearly equal to the entire cost of operating the regional centers, which is C$8,640,401. The administration and support costs are 38.4 percent of the PROFAMILIA budget, excluding social marketing and emergency clinics (table 11).

Table 11
PROFAMILIA Costs by Program Area, January–June 2001

Program Area	Amount	Percent
Central Overhead and Support	7,837,170	38.4
Regional Centers	8,640,401	42.4
Youth	0	0
Emergency	304,731	1.5
Social Marketing	3,605,935	17.7
Total	**20,388,237**	**100.0**

High Personnel Costs

Overall personnel accounts for approximately 58 percent of all costs. Costs are high because of the large number of personnel, especially at the central level, and benefits, which amount to 40 percent of salaries. Another reason for high personnel costs is that there are no salary scales in effect. Salaries are based on seniority within professions. This has resulted in considerable disparity among employees of the same profession and among the professions themselves. For example, some nurses are paid nearly 50 percent

more than salaried physicians are paid. Physicians of the same specialty can also have more than a 50 percent difference in compensation (table 12).

Table 12
PROFAMILIA Operational Costs, January–June 2001

Rank	Operational Categories	General	Social Marketing	Total
1	Salaries	41%	35%	40%
	Fringe Benefits	16%	13%	15%
	Consultant and Professional	3%	1%	3%
2	Depreciation	10%	7%	9%
3	Basic Services	8%	9%	8%
4	Travel and Transportation	7%	8%	7%
5	Materials and Supplies	5%	3%	5%
6	Promotion and Publicity	1%	17%	4%
7	Repairs and Maintenance	3%	4%	4%
8	Other Costs	4%	1%	3%
9	Training	2%	2%	2%
10	Packaging	0%	1%	0%
	Total	100%	101%	100%
	Total Amount	**15,327,691**	**3,605,935**	**18,933,626**

General (excluding youth, emergency, and social marketing)
Not all columns add to 100% because of rounding.

Other High Operational Costs

In addition to depreciation, these include basic services, transportation, promotion, and publicity. A significant contributor to overhead cost is the number of transport vehicles used by PROFAMILIA. The central office uses no less than 16 vehicles, another 4 for the Managua Clinic alone, and 2 each for every regional center. When the operating costs (fuel, maintenance, drivers) are added to the cost of the vehicles themselves, this amounts to a significant expense.

Social Program Costs

PROFAMILIA's social programs are expensive and generate little income. Although exact figures are not available, the CBD program probably has the highest sustainability rate among the social programs, followed by youth programs and promotion/communications. This is largely because CBD produces a significant amount of income from contraceptive sales. The other programs do not have such large sources of income.

Medical Services Income

At the medical services level, income varies significantly by center and service. Table 13 shows that the top three centers account for 53 percent of income. The lowest producers (Granada and Estelí) account for only 4 percent. Estelí was closed in April 2001, and has reopened as a CMS franchise clinic.

Table 13
Income from Services and Contraceptive Sales by Regional Center
January–June 2001 (in córdobas)

Regional Center	Services	Contraceptives	Total	Percent
1. Managua	2,503,606	486,180	2,989,786	31.7
2. Juigalpa	651,739	376,801	1,028,540	10.9
3. Boaco	840,269	184,868	1,025,137	10.9
4. Masaya	566,305	267,774	834,079	8.9
5. Matagalpa	524,275	285,233	809,508	8.6
6. Rivas	457,712	179,731	637,443	6.8
7. Chinandega	408,328	226,223	634,551	6.7
8. Jinotega	468,168	142,213	610,381	6.5
9. Ocotal	358,042	118,887	476,929	5.1
10. Granada	137,916	49,839	187,755	2.0
11. Estelí (4 mo.)	162,802	23,816	186,618	2.0
Total	**7,079,162**	**2,341,565**	**9,420,727**	**100.1**
Percent	**75.1%**	**24.9%**	**100%**	

PROFAMILIA is considering closing Granada due to its poor performance. Although income data do not show whether the centers are profitable (these data are unavailable), the table gives a general idea of which centers are the most productive, at least in terms of gross income generated by medical and CBD services. Due to the lack of profitability data, it is not possible at this time to determine whether other regional centers should be closed. PROFAMILIA is expected to undertake this analysis soon, however.

Table 14 provides similar findings regarding the relative ranking of individual services. Again, the top two services provide almost half of all income and the top four produce 84 percent of total income. There is a marked drop starting with pediatrics. Again, this table does not show which services are the most profitable. When the cost of drugs, ultrasound fees, laboratory examinations, and other such costs are taken into account, the gynecologic services are likely to be the most profitable, since there are few costs other than the physician's time. PROFAMILIA also expects to undertake this analysis once the data are available. This will help management to determine which services should be continued, which need to be promoted more, and which may need to be ended.

Physician Productivity

The income from physician services is 43 percent less than planned. This affects sustainability in two ways: lost income and inefficiency. One could argue that additional

efforts in promotion need to be initiated to increase patient demand. However, the current staffing level is still too high for current patient/client demand, and probably too high to meet any increase in demand that might follow increased promotional efforts.

Table 14
Income from Medical Services by Type of Service, January–June 2001

	Services	Total	Percent
1	Pharmacy	1,774,901	24.9
2	Ultrasound	1,678,501	23.6
3	Laboratory	1,534,907	21.5
4	Gynecology	1,036,954	14.6
5	Pediatrics	293,618	4.1
6	Prenatal and Postnatal	190,129	2.7
7	General Medicine	128,958	1.8
8	VS and IUD Services	117,778	1.7
9	Other Services	105,472	1.5
10	Male Services	84,744	1.2
11	Minor Surgery	76,496	1.1
12	Specialty Services	74,790	1.0
13	Delivery	27,313	0.4
	Total	**7,124,561**	**100.1**

At the moment, the physicians are significantly underutilized and average no more than 1.4 consultations per hour, not including procedures they perform. As mentioned in the section on clinical services and quality of care, an average of 3.5 visits per hour is more the acceptable standard. Thus, even when procedures performed are considered, the physician productivity level is significantly below this standard. If the physician financial contribution to sustainability is analyzed, it can be seen (table 15) that none of the clinics are generating enough client income to pay for the physicians' salaries. In fact, as table D–6 shows, only 5 of the 21 physicians are generating enough consultation revenue from patient visits to pay for their personal salaries, much less overhead. This does not include the 10 regional clinic directors, who spend so much time on administration that they see almost no medical cases. As physicians, they contribute little or nothing to clinic revenues.

Although the social marketing program is not included in table 10, it has its own sustainability objectives and is not anywhere near them yet. The program represents a significant proportion of the overall PROFAMILIA budget (nearly 20 percent), and is currently at only 14 percent versus the target of 36 percent level of sustainability by mid–2001. It is supposed to be 100 percent sustainable by the end of the grant. Although the social marketing staff believes that that objective will be met, the evaluation team is skeptical. (See section IV for additional discussion of this issue.)

Table 15
Salaried Physician Productivity, 2001
(excludes regional directors)

Regional Center	Clients per Hour	M.D. Net Loss per Hour	M.D. Cost per Visit
Granada	NA	NA	NA
Rivas	0.61	14.02	57.17
Masaya	1.63	31.33	48.97
Matagalpa	1.31	18.84	46.51
Chinandega	0.88	-15.04	70.26
Ocotal	0.71	-13.92	79.70
Juigalpa	1.34	-8.22	61.72
Boaco	1.84	50.69	37.38
Managua	2.34	50.10	41.06
Jinotega	0.71	-13.83	89.45
Total	**1.39**	**18.00**	**57.19**

The six CMS franchise clinics are not included in table 10, either. These clinics will be turned over to PROFAMILIA in December 2001. The current level of sustainability is quite high, about 87 percent on average for the first three clinics. The six clinics are expected to be completely self-sustaining by the end of 2002.

On the positive side, table 16 shows that some units are operating at positive margins from sales (not including associated operating expenses which PROFAMILIA has not calculated at this time). It is also likely that most of the high volume services that do not require heavy overhead investments (e.g., in equipment, furnishings, and support staff) have positive margins. Examples are gynecology, general medicine, and prenatal care. At the other extreme are delivery services and, possibly, psychology and minor surgery. Lastly, the central Managua clinic has the definite potential to be at least 100 percent sustainable at this time. However, the current physical structure is restricting this clinic from even reaching 100 percent. There is no way to house the desired full-service pharmacy, new bacteriology laboratory, additional examination rooms, and other facilities in the current building.

Table 16
Percent of Net Marginal Profit

Sale Item	Margin
Contraceptives	31%
Pharmacy	22%
Diagnostics	26%
Laboratory	69%

Financial Management and Reporting

The finance department provided a detailed presentation of each of the recommendations included in the evaluation conducted in 1997, illustrating how it has addressed each issue. In addition, KPMG Peat Marwick Nicaragua, S.A., provides an ongoing external audit and technical assistance to finance, accounting, and internal audit operations. In its latest annual external audit, KPMG made it quite clear that fund accountability statements are presented fairly, internal control has no noticeable material weaknesses, PROFAMILIA is in compliance with the grant terms and regulations, and that in general, there are no significant problems. It is clear that PROFAMILIA has made significant strides in correcting the problems indicated in the 1997 evaluation as well as incorporating the suggestions of KPMG.

As of May 2001, the new client registration system has been implemented in all clinics, including the CMS clinics. This new registration system collects better and more accurate data on patient services provided. Demographic, provider productivity, efficiency, and public health issues can all be more profoundly and accurately analyzed by management.

There appears to be a two-way flow of management information between the central office and regional clinics. All regional managers that were visited during this evaluation used timely and consolidated information that they either personally collected or that they received from the central office. All regional managers also demonstrated a working knowledge of the financial reports related to their clinics. What was not apparent was a standard and consistent dissemination of these same data to the clinic providers and employees. Each clinic handled the issues of finance, cost-efficiency, and productivity in a different and sometimes inconsistent manner. As a result, there are no benchmarks or standards for acceptable procedures.

Cost Accounting and Cost Control

PROFAMILIA has made considerable improvements in its cost-accounting data. However, there is a lack of cost-control centers established by service provided so that management can make operational decisions in a financially knowledgeable and responsible manner. The most notable example of this is that social services, such as CBD, youth, communications and other non–revenue-generating services, are not separated from clinical and social marketing (revenue-generating) services. This results in an inability to properly assess the financial advantages and disadvantages of adding or maintaining the social services. The promoters, for example, are included in the regional center budgets, and from a financial sustainability point of view, represent little more than a drain on the clinics. The costs of such important programs as the adolescent program have not been calculated. For example, PROFAMILIA cannot determine the cost to set up new youth clubs. Lastly, the regional centers appear to be less sustainable than they actually are since they are carrying the social costs as well as the respective clinical costs.

MSH provided the software and technical assistance for PROFAMILIA to adopt and complete a unit cost-accounting system. At the moment, PROFAMILIA has chosen to

use this on an ad hoc basis. For example, if management wants to consider adding a new product, it has the tools to assess unit costs as well as marginal revenues. However, management has only used this system when considering new products. Existing programs that have tremendous influence on sustainability, such as laboratory, diagnostic testing, and pharmacy, have not been budgeted beyond the direct costs of the products themselves. Hence, there is no way of telling if these services are contributing to or actually decreasing the level of sustainability.

Another example of an absence of cost accounting concerns the hours of operation of the clinics. The clinics have different policies regarding times of operation and staffing beyond the normal hours of 9 a.m. to 5 p.m., Monday through Friday. The CMS clinics are open 24 hours a day for example, whereas standard PROFAMILIA clinics are staffed after hours on an ad hoc basis, depending on when deliveries are anticipated. Flexible hours of operation and staffing beyond the normal schedule should be encouraged, but the cost benefit of keeping the clinic open after hours should be assessed on an ongoing basis. This includes any after-hour operations of clinics during the evening, night, or weekend.

Although the number of client discounts and free services provided is minimal, they still represent a cost to the organization and they are not managed in a standard manner across all clinics. This free or discounted service relates not only to indigent patients but also to clinical services provided to employees and CBD workers. Considering the current falling economy, the numbers of free and discounted services is likely to increase, so this issue will need more attention. However, discount promotions to attract more clients have proven to be effective in raising income as well as increasing caseloads.

Operational costs in general are controlled much better than in the past. PROFAMILIA has spent a significant amount of effort on controlling costs at all levels. As of June 2001, it was under budget in almost all expense categories.

Absorption of CMS Franchise Clinics

Sections III and VII address the clinical and organization/management issues related to this item. This section will address the impact on financial sustainability that integration will generate. As previously mentioned, the three CMS clinics that are currently operating provide clinical and revenue-generating services. They do not have the social program expenses that other clinics have, such as the adolescent program and CBD services. Note also that the sustainability levels are steadily increasing every month, and although this table is only until July, Estelí and Tipitapa have both reported over 100 percent sustainability in July 2001. Cumulatively, table 17 shows the average levels of sustainability (not including depreciation and overhead costs) for the three CMS clinics.

Table 17
Sustainability of First Three CMS Clinics

CMS Clinic	Percent Sustainable
Tipitapa (March–July)	99
Estelí (April–July)	92
Sébaco (May–July)	57
Total CMS	**87**

The income and expenses for all six CMS clinics have been projected in their five-year plans. Unfortunately, as mentioned, they do not include depreciation costs or the recurring costs that either remain from their central office, or will be absorbed by the central level at PROFAMILIA. It was not possible to acquire an estimate of the depreciation costs during the short time period of this evaluation, but using the five-year plan in conjunction with the costs that will be included in the PROFAMILIA budget, the CMS clinics are projected to operate at a 97 percent level of sustainability. It is important to note that this assumes that they will all be operating at an 80 percent level of capacity. It is therefore clear that although these clinics have the potential to average a high level of sustainability, it may still be at a net cost to the grant as a whole.

At the moment, PROFAMILIA is considering keeping no less than four of the current CMS administrative and support staff and hiring them as salaried employees. This includes a physician supervisor, a nurse supervisor, a social marketing supervisor, and an accountant. It is estimated that their salaries would be about $52,000 a year. A vehicle would cost at least an additional $5,000 a year.

From the standpoint of assimilating the systems of CMS into those existing at PROFAMILIA, both organizations have worked hard at minimizing differences in accounting, finance, software, procurement, patient registration, and human resources policies and procedures. Both are using the same or completely compatible systems, policies, and procedures. The salient operating difference is that the physicians are not salaried but are contracted and paid according to the number of clients seen. If the current staffing policy were applied to the CMS clinics, their costs would rise substantially. However, the PROFAMILIA executive board of directors reinforced its intention to maintain the current compensation plans for the CMS physicians and, in the future, to adopt this model for its current clinics. In fact, the new clinic in Bluefields has adopted this compensation scheme. The clinics in Ocotal and Granada will also adopt the model soon.

CONCLUSIONS

PROFAMILIA has made considerable improvement in its level of sustainability from 18 percent in 1997 to over 47 percent as of July 2001. The regional centers have performed even better. As a group, they have exceeded the 60 percent target for the grant. Four are already between 75–80 percent sustainable. This has been a very impressive trend.

Whether this trend can continue will depend largely on the economy and whatever steps PROFAMILIA takes to increase income and decrease costs.

The finance department has implemented a number of financial management procedures since the 1997 evaluation. There is excellent managerial communication between the central office and the regional directors. The weak point is managerial communication between the regional directors and their staffs. There are no standard benchmarks or procedures for communicating financial management information at that level.

PROFAMILIA and the finance department have made considerable strides in improving their cost accounting and cost control systems. PROFAMILIA was under budget as of July 2001. A weakness is that services are not structured by cost center so there is no way to assess how each of them is doing in terms of individual sustainability. In addition, unit cost accounting is not used sufficiently to assess the cost of maintaining or implementing new services or products.

There is a need to establish cost structure by service as well as to completely separate the unsustainable social program budgets from the sustainable clinical and social marketing program budgets. The clinics should not feel burdened with social services and social services should not be penalized for working well with the community.

The physicians and other provider services are considerably underutilized. Although a targeted increase in promotion may increase the demand for clinical and RH services, it is clear that this in itself will not be sufficient to resolve this problem. Currently, almost all physicians, with the exception of the CMS physicians and a few part-time physicians, are full-time employees of PROFAMILIA and are not paid in a manner that is significantly related to their patient load. This has not only eliminated the financial incentive for physicians to see patients, it has also led to a gross disparity in compensation among the physicians.

In addition to the physicians, there is currently little or no incentive for the nonproviders to work towards improving the sustainability level of the grant. In fact, there is actually a disincentive since the employee who works more hours usually receives no additional compensation for this effort.

The physical building of the Managua clinic does not meet certification standards; therefore, it remains uncertified by the Ministry of Health. In addition, the physical layout and overall size constricts both the growth potential and quality of services delivered. It seems perfectly justifiable, for example, that the clinic could set up a profitable and high-quality, full-service pharmacy with a pharmacist if it had the space. Other examples of how additional space could be used include a bacteriology laboratory, two examination rooms per physician for faster service, additional dental services, and distinct service areas for services for men and adolescents. Lastly, the current clinic structure is not coincident with the new image it is trying to convey as a provider of high-quality care.

The overhead costs of the central administration and support services are considerably higher than they should be. Overhead costs of approximately 38 percent of operating costs are unsustainable.

Social marketing is not going to be financially sustainable by the end of year 2002 as planned. Due to some of the constraints mentioned in sections IV and VII, they are currently underspent in budgeted USAID funds.

PROFAMILIA is prepared to take over the CMS clinics only from a technical standpoint, but not managerially (see section VII for further details). The financial, patient/client registration, and accounting systems are all in place and currently operating in a parallel fashion with PROFAMILIA. If no employees from the CMS central office are maintained beyond a year, the CMS clinics will likely continue to operate at a 97 percent level of sustainability, in accordance with their five-year plan. However, this does not include depreciation or central office administrative and support costs. Nor does it include any cost of social programs. If those are added by PROFAMILIA, the sustainability of the CMS clinics will likely decline to that of the other PROFAMILIA regional centers.

RECOMMENDATIONS

The administration and the central office must reduce overhead costs drastically and soon. Specific targets should be set, such as "a minimum 25 percent by the end of 2002," and "an additional 10–15 percent by mid–2003." The actual amount and percentage reduction should take into account the future level of funding from USAID as well as future increases in revenue projections. Sections III and VII have indicated various areas where decreases in administrative and support services would not be detrimental to the organization as a whole and a similar reduction in the finance and accounting departments would also not be detrimental to the overall operations. The actual reductions are the responsibility of the management and staff of PROFAMILIA and should be part of the strategic plan that is developed once the board of directors and management clarify the direction and goals of PROFAMILIA. USAID should contribute by providing PROFAMILIA with realistic estimates of future funding scenarios.

Personnel and operating costs need to be reduced as well. Central staffing need to be reduced and functions consolidated. Delegation of authority to the regional centers has the advantage of achieving this objective while empowering local management. Salary scales need to be established and discrepancies that are based on seniority rather than productivity should be eliminated. Rationalization of physician compensation should also be a priority (see below).

Other operational costs that are high should be examined and reduced, such as vehicle and transportation costs.

Although it was not possible to assess the cost-effectiveness of the various clinics and medical services, PROFAMILIA plans to do this in the near future. Available data show significant disparities among the more productive, moderately productive, and less

productive clinics. The board of directors and management need to examine the existing (and proposed) clinics from a financial cost/revenue point of view and decide which clinics should be retained. The same should be done for medical services, some of which are exactly in line with PROFAMILIA's health objectives and are profitable, others of which are less so. Costs and revenues should not be the only criteria used in deciding the services to continue, expand, or drop, but they should be included in the analysis.

Following discussions with the PROFAMILIA finance department, the separation of social and clinical programs is both desirable and feasible and can be implemented by January 2002. This provides the added advantage of accounting for the CMS and PROFAMILIA clinics in a similar fashion (e.g., both the CMS clinics and existing PROFAMILIA clinics would become cost centers that would be responsible for their own medical service costs and revenues).

The current level of productivity of the physicians is too low. It is essential that the system of full-time physicians compensated with little reference to their productivity be converted to employment under contracts that provide incentives, bonuses, commissions, or a combination of all three. This would mean terminating the existing physician full-time employment agreements and offering them contracts related to productivity. These new contracts would need to be carefully analyzed so that 1) they provide a mutual benefit to both the physician and the organization, 2) the compensation system is significant enough to offer a real incentive to enhance individual productivity at little or no risk to the organization, and 3) they include ceilings on productivity and compensation to ensure that high-quality care is maintained throughout the process. These ceilings can be easily implemented in the form of a maximum number of clients per hour and/or maximum compensation from incentives. This would ensure that quality of care does not become a victim of overproductivity. Similarly, there would be no additional incentives for ancillary services, such as laboratory tests and drugs ordered. A monthly physician productivity report should be distributed to all clinic physicians as a stimulus for promoting greater productivity. Table D–7 in appendix D is an example of such a report.

Equally important, all of the regional directors should see patients and generate revenue. With the possible exception of the Managua regional director, all should attend to patients a minimum of 50 percent of their time and physician-staffing levels at each clinic should take this into account. This conversion of salaried physician contracts should be completed for all physicians at the same time and within a distinct period so as not to prolong the stress of change. However, it should be strongly noted that PROFAMILIA has the budget to do it now, and this will probably not be the case at the time of renewal, when donor support is significantly less.

Following the initiation of a contract system for the physicians and targeted promotion programs (6 months or some agreed-upon timeframe), the staffing levels of the physicians must be reduced or expanded to meet the existing, not projected, levels of demand. Section III addresses this issue, and a minimum level of, for example, three patients per hour, should be established by specialty. The advantage of a contract system is that it not only provides incentives for provider productivity; it also enables management to periodically adjust staffing levels based on the actual demand for services.

A form of profit sharing should be set up that covers all staff. This would help ensure that all departments and employees have an incentive to promote sustainability. This could include earmarking a significant percentage (e.g., 30 percent) of the raises of the department heads to their joint success in improving the sustainability level of the organization. It could also include profit sharing at the regional clinic level so that all staff knows that working harder to get more patients into the clinic will have a significant effect on their compensation at the end of the year.

Once the contracts and new compensation systems are in place, the sustainability levels for every clinic should also be reestablished. Specifically, a minimal sustainability level should be maintained. The actual minimal sustainability level will have to be discussed between USAID and PROFAMILIA, but it should probably be no less than, for example, 75 percent, depending on whether PROFAMILIA believes it important to keep a center or clinic open by cross-subsidizing it. This might result in significant reductions of the overall staffing levels of some clinics. It may also result in the expansion of services in some clinics.

USAID should provide a no-cost extension to the social marketing component of DIMECOSA. This is needed to allow enough time to launch, promote, and establish a stable market for new contraceptive products and to reach its 100 percent sustainability target. This allows social marketing nearly two full years to become self-sufficient.

DIMECOSA's social marketing program should have budgetary control of both its income and expenses. The social costs incurred by DIMECOSA for promotion of PROFAMILIA services and social programs should be separated from those used for social marketing. DIMECOSA needs to be able to use the existing social marketing funds for the launching and promotional campaigns for its new contraceptive products. It also need to use expected profits to fund its contraceptive revolving fund and its investment fund. Both are critical to the continued sustainability of the social marketing program.

PROFAMILIA should develop financial plans for the absorption of the new CMS clinics. The plans should be designed to ensure that the clinics remain fully sustainable. No unsustainable programs or services should be added unless and until the clinics produce surpluses that exceed what is needed to cover depreciation and overhead costs. If a surplus is generated, the financial plan should state how it would be used (e.g., for expansion of clinic facilities and services, for youth programs, for CBD).

Under no circumstances should any of the current CMS central administrative and physician staff be hired by PROFAMILIA as salaried employees. They should be hired on a contract basis and only for a maximum of one year to ensure a smooth transition of the clinics to PROFAMILIA and adaptation of CMS systems to other PROFAMILIA clinics.

PROFAMILIA should work with USAID to find the most mutually feasible manner to fund a new Managua clinic and associated renovations during 2002. This should include exploring potential loans from the CMS SUMMA Foundation.

Key physicians and management staff should visit associations where similar incentive systems have been successfully implemented. Honduras, Guatemala, and Bolivia are excellent examples.

VII. ORGANIZATION AND MANAGEMENT

The scope of work focused on the following issues: the adequacy and sustainability of the organizational structure of PROFAMILIA, the roles and adequacy of PROFAMILIA's leadership, and the management capacity of PROFAMILIA, especially human resources, management systems, technical assistance, and readiness to absorb the CMS franchise clinics.

EVALUATION ISSUES AND FINDINGS

This has been a tumultuous four years for PROFAMILIA, beginning with the 1997 evaluation that precipitated the resignation of the executive director shortly thereafter. That was followed by a wholesale restructuring of the organization and management of PROFAMILIA under the new executive director; his tenure ended in August 2000. The next executive director was hired in January 2000 and resigned 2 weeks later. PROFAMILIA was without an executive director for 9 months, during which time the board of directors became very involved in day-to-day operations. The current executive director was hired in June 2001 and has inherited a mammoth challenge. There are significant organizational, leadership, and management problems that need to be addressed promptly.

Organizational Structure and Roles

At the current time, the organizational structure of PROFAMILIA is not adequate to achieve grant goals and results, including sustainability. PROFAMILIA is still fragmented and top heavy. Despite the 1998 reorganization, there is still some overlap and duplication among departments. The social marketing unit seems to be a separate, quasi-independent entity with its own general objectives, organization chart, facility, and adviser. There are tentative plans to expand some programs, such as CBD, even though the future of the current program is uncertain and its sustainability unlikely. Six new clinics are about to be turned over to PROFAMILIA by CMS, even though it is not yet clear how they will fit into the current organization. Regional center performance is uneven and it is likely that one or more centers may be closed while others are doing very well and probably should be given more autonomy. There is an urgent need to examine the current organization of PROFAMILIA and rationalize it, consolidate functions, and trim staff. To do this systematically, PROFAMILIA will need to redefine the association's vision, mission, and strategic objectives; develop a strategic plan; and then reorganize the institution accordingly.

Leadership

The roles and functions of the board of directors, the executive director, and the management council are not clear and followed. The current leadership is not adequate to achieve current grant goals and results. In addition to the changes in executive directors, there have been changes in the directors of administration and finance, medical services, and at least three regional centers. A director of regional centers was appointed as was an

internal auditor and assistant administrators for each regional center. One third of the supervisors have been replaced. There have also been changes in the board of directors. All of these changes have had an effect on the composition of the leadership of PROFAMILIA. At this point, it is difficult to determine staff responsibilities.

The roles of the board of directors, the executive director, and the central department directors are no longer clearly demarcated. This has led to confusion, inefficiency, and conflicts that are sometimes petty and often dysfunctional. The board of directors has reduced, but not ended, its involvement in day-to-day operations. Department directors are still divided on fundamental issues and sometimes interfere with one another's responsibilities. Roles need to be clearly defined, adhered to, and respected. The board of directors needs to limit itself to its policymaking role. The department directors need to limit themselves to their departmental functions. They must also learn to collaborate and support one another. The executive director is new and must be given time to learn his job. He must not be pressured either by the board or his department heads to make precipitous decisions or to resolve interpersonal disputes. This is a time for teamwork and mutual support.

Regional center directors are the key field managers. They should be delegated the authority to do their own planning and manage their own resources, from personnel to funds. One way to reduce central functions is to delegate them to the field centers.

Management Capacity

Human Resources

Most of PROFAMILIA's managers (both in the field and at central headquarters) are committed, competent, and capable. Most are eager to learn and improve themselves. One of the principal objectives of the current grant (result 6) is to strengthen management capacity. PROFAMILIA has made good progress in this area and can be expected to continue with help from its technical advisers.

One area that deserves attention is the staffing of the regional centers. All of the directors are physicians and many of them have public health degrees as well. This is appropriate in those centers where medical skills are needed and administrative responsibilities are limited. The CMS franchise clinics, for example, estimate that their directors spend 80 percent of their time on medical services and 20 percent on administrative issues. Regional center directors seem to have the opposite ratio: 20 percent on medical services and 80 percent on administration. Some of these directors have become excellent managers. However, in future staffing decisions, it may be more appropriate to hire directors for their management experience and skills instead of their medical skills. An ideal candidate would be a physician with strong management experience. Another option would be to delegate more administrative responsibilities to the administrative assistants so that the directors could spend most of their time on medical services. PROFAMILIA should take a careful look at the recruiting procedures and the staffing pattern of the CMS clinics. CMS, for example, emphasizes leadership, creativity, problem-solving capability, and similar traits in recruiting its directors.

Systems and Procedures

Management systems and procedures have been upgraded. The information system (SISFASE) is a good example. This system has simplified data collection and input while expanding the production of useful management information at the clinic and central levels. PROFAMILIA has linked the system to its new financial system (developed by PricewaterhouseCoopers) and has developed procedures for linking it to its new logistics system (developed with help from JSI). All of these systems have been introduced over the past three to four years and have improved productivity greatly while reducing effort and costs.

A new personnel (human resources) management system is under development with help from MSH and should fill a significant management gap. A quality assurance system is also under development with help from URC. Planning has improved but more needs to be done. Assistance was provided to PROFAMILIA in 1999 and 2000 to develop strategic plans but the procedures have not been installed yet due to the delays in stabilizing PROFAMILIA's leadership. Staff believes that all the elements are in place and that a strategic plan could be developed in 2 months. Related to that is the lack of consolidated annual plans and the (still) centralized development of regional center plans. Supervision and training systems still need to be strengthened. The strengthening of the quality assurance and planning systems will contribute indirectly to the strengthening of these systems.

Technical Assistance

Technical assistance from MSH, URC, JSI, PricewaterhouseCoopers and JHU has been critical to the strengthening of management capacity. Their advice has not always been followed, usually due to internal turmoil and turnover constraints, but in general, it has been well received and valued. KPMG Peat Marwick has done an excellent job on an ongoing basis, providing technical assistance through periodic external audits that has helped to greatly improve the financial management and accounting systems. The director of finance has made considerable efforts to implement its suggestions. On the other hand, the MSH technical assistance for installing a cost-accounting program has not yet produced results.

CMS Franchise Clinics

PROFAMILIA is not yet prepared to take over the management of the six CMS clinics, even though CMS is ready to turn the clinics over to PROFAMILIA. CMS has drafted a transition manual that is currently under review by USAID. The plan has been developed in consultation with PROFAMILIA managers. The clinics are designed to be turnkey operations. All of the staff, equipment, supplies, building, and all systems are ready and operational. The staff members are already PROFAMILIA employees, and the information, financial, and other systems are PROFAMILIA systems. Some systems will require adjustments, of course. The medical supervision systems are not the same; there are differences in the service packages, and the compensation plans for physicians are

different. PROFAMILIA only needs to provide management support, CMS will transfer current management staff to PROFAMILIA.

In reality, PROFAMILIA is not ready to integrate these clinics into its organization. A transition committee exists but it does not include anyone from CMS and there is no complementary plan. One may not be needed if no changes are planned, but that is not certain. There is some concern that the medical staff will be replaced, that they will be hired as employees rather than as contractors, that CBD and youth programs will be added, and that, in other ways, the CMS clinics will not serve as models that PROFAMILIA will emulate but that CMS clinics will be converted into regular PROFAMILIA clinics. The lack of consensus within PROFAMILIA on this issue only heightens concern. The board of directors, however, has stated its policy clearly. Both models will be managed independently for a short period of time. Over time, various features will be analyzed and, if appropriate, introduced into the other model. Eventually, one standard service delivery model will be implemented in all PROFAMILIA clinics.

This is a critical issue because USAID and some PROFAMILIA managers view the CMS model as one that should be applied to all PROFAMILIA clinics. They see it as a superior delivery system that is also designed to be self-sustaining. However, it does not include some of the social programs that PROFAMILIA believes are important, such as CBD and youth programs. Social marketing is not included, either, and promotion is limited.

Perhaps the most difficult issue is the payment system for physicians. The CMS model involves contracting physicians (general practitioners and specialists) and paying them by client visits. As consultants, the physicians are not entitled to benefits, which amounts to 40 percent of staff salaries at PROFAMILIA. The CMS model rewards productivity and physicians can actually earn more money than they could as PROFAMILIA employees—if the demand is high enough. The regular PROFAMILIA system is more attractive to physicians when caseloads are low and security is a major concern. For this reason, some of the regional directors—and some of the central staff—are opposed to adopting this model. As described in more detail in section VI, many of PROFAMILIA's physicians only see 1.3 clients an hour, as opposed to the CMS norm of 3.2. This large difference in productivity needs to be remedied.

At this time, there are tentative plans to try out the CMS model in two PROFAMILIA sites: Ocotal, where the regional director is interested in applying the model; and Granada, which may be forced to close unless it can find a better way to operate.

USAID–PROFAMILIA Relations

USAID–PROFAMILIA relations remain strong, although the relationship is more parent to child than a partnership. PROFAMILIA seeks guidance and direction from USAID, especially as it relates to its grant. It is not the classic independent grantee that uses the funds to carry out its own program. For a number of legitimate reasons, that guidance and direction have not been as strong as usual. For the past two years, USAID has been preoccupied with reconstruction projects to address the devastation caused by Hurricane

Mitch. The health portfolio expanded significantly, but not staff. At the same time, PROFAMILIA was experiencing a painful transition and needed help. USAID provided much of its help through technical assistance contractors and concentrated on political and management issues as much as it could. The net result was a diminution in guidance and direction when it was most needed. PROFAMILIA carried on, nevertheless, doing surprisingly well considering the turmoil within PROFAMILIA.

PROFAMILIA is at a critical juncture in many ways and is again looking for guidance. A major concern of both parties is future funding. PROFAMILIA expects to receive as much as or more than it does now; USAID expects to provide less. USAID and PROFAMILIA need to discuss this issue. PROFAMILIA needs to know what support it can count on from USAID over the next five years. This would be an appropriate time to provide that input so that it can be factored into the strategic plan.

CONCLUSIONS

The current organizational structure is inadequate and unsustainable. It is still overly centralized and top heavy. This may get worse. The central staff could grow if the expansion plans are implemented and some of the CMS administrative employees are added to PROFAMILIA's staff.

The roles of the board of directors, executive director, central department heads, and even the regional department directors are no longer clear. There is overlap, duplication, and conflicts about roles and responsibilities that are disruptive and dysfunctional.

Management capacity is quite good and improving. Most of the management staff is committed and competent. Technical assistance over the past few years has been very helpful, not only in building up essential management systems, but in strengthening the knowledge and skills of the managers, as well.

PROFAMILIA is technically but not managerially prepared to take over the CMS clinics, although CMS has prepared a transition plan and is ready to give the clinics to PROFAMILIA. A number of policies and procedures still need to be developed before the transition.

Relations between USAID and PROFAMILIA are strong but have weakened over the past few years as USAID has been preoccupied with reconstruction efforts and PROFAMILIA with its internal management problems.

RECOMMENDATIONS

PROFAMILIA's first priority should be to clarify its vision, mission, and strategic objectives. Then, it should develop a realistic strategic plan (including a new organizational structure) to achieve those objectives. This should include a plan to integrate the CMS clinics into the association and a plan to adapt as much of this model as appropriate to the current regional clinics. PROFAMILIA needs to begin to take steps to reduce its core functions and staff, delegating more authority to the regional directors

and allowing them to become semiautonomous entities, responsible for their own planning, monitoring, and funds management. All of this planning should be carried out in consultation with USAID to ensure that support expectations—financial, political, and technical—are realistic.

At the same time, PROFAMILIA needs to involve all personnel—from the board of directors to the drivers—in teambuilding exercises so that they will commit to the plan. The board of directors needs special attention to help it reform. Board of directors' training, which has been provided by IPPF in the past, would be a timely intervention. The leadership must learn to limit itself to its assigned responsibilities and to respect each other's roles.

Technical assistance has been helpful and should continue until the gaps in the management systems are filled. These include human resources management, quality assurance, supervision, and training. USAID and PROFAMILIA should work out a specific timetable for the completion and installation of these new systems.

PROFAMILIA needs to start working immediately on a transition plan for absorption of the CMS clinics. Any proposed change in the structure, staffing, systems, or service package of these clinics should be worked out beforehand and should not jeopardize the sustainability and autonomy of the clinics.

USAID and PROFAMILIA need to work closely together over the next 16 months to make sure that the recommendations included in this evaluation are implemented. PROFAMILIA should develop a concept paper for the follow-on agreement with USAID. This concept paper should anticipate significantly reduced USAID financing.

VIII. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

This grant has performed remarkably well given the turmoil in leadership and management that it has endured, almost from the beginning. Achievements are modest with respect to the improvement of health and fertility, quality of services, CBD, adolescent and youth programs, social marketing, and sustainability. There have been some improvements in all of these areas, as well as in management. Nevertheless, the overall impression is of an organization that is in need of an organizational identity and strong leadership.

Achievements have been modest. There has been a slight increase in CYPs (6 percent from 1997–2001), but this is well below the annual targets. It is unlikely that the overall grant targets will be met. PROFAMILIA has performed well on its seven grant results. The use of temporary methods has increased, probably too much. The target was 52 percent temporary and 48 percent permanent by the end of 2002. It is now at 84 and 15 percent, respectively. RH services have expanded rapidly, but without focus and without a clear health objective. Access for rural and marginal areas has been increased through CBD, but it is not a sustainable program. Nevertheless, it does generate users and some revenue. Sustainability is slow. Expenses are too high and there is no plan or strategy yet for reaching the modest grant target of 60 percent.

Quality of care has improved and a quality assurance system is under development, but much more needs to be done in developing clinical standards and guidelines. Not enough attention is being given to RH services, especially gynecologic and prenatal services. Delivery, even normal delivery, is restricted by PROFAMILIA regulations that are more oriented toward avoiding liability than improving health. As a result, the volume of deliveries is too small to maintain quality, be financially viable, or contribute to a reduction in maternal mortality. No steps are being taken to improve home deliveries. The CBD network is not involved at all. Long-term family planning methods are not receiving sufficient attention. Supervision has been systematized but it is not yet integrated into quality assurance, where it would be more oriented toward problem identification and problem solving. Laboratory procedures are not being adequately supervised. Clinical management of Pap smears, a high volume service, does not conform to PROFAMILIA, much less international, standards. Medical training or continuing education is more driven by provider requests than service standards or need. Physician recruitment and selection criteria are largely medical and somewhat subjective rather than reflective of the need for management and interpersonal skills.

Social marketing was to be the focal point of the new grant. Unfortunately, it was combined with communications, and that has confused much of the leadership of PROFAMILIA. DIMECOSA has had the dual responsibility of launching a set of private sector contraceptives while also promoting PROFAMILIA contraceptives and medical services. The leadership has often had trouble making this distinction and has sometimes

used DIMECOSA funds budgeted for a social marketing activity for a communications activity. Technically, the DIMECOSA staff has produced excellent material for both components. The quality of this work has been recognized by commercial and United Nations organizations that would like to buy their services. Technical assistance from JHU/PCS has been very useful and accepted by DIMECOSA counterparts. DIMECOSA's programs have increased sales, increased demand for services, and generated revenue. The social marketing component has a 100 percent sustainability objective (communications does not) and it is well behind schedule due to a variety of delays, several of which came from PROFAMILIA itself. Other delays are the result of problems with contraceptive registration. The leadership's inability to recognize the value of this asset is unfortunate, to say the least.

CBD and Youth Programs: The CBD program has made significant progress since the 1997 evaluation. The promoters are well trained, supervised, and productive. They are also more efficient. They account for approximately 60 percent of PROFAMILIA's sales of contraceptive methods (not including social marketing). It is clear that PROFAMILIA is the best institution to be providing rural CBD services. Its CBD networks are more productive, cost-effective, stable, and sustainable than those of PVOs. It has a permanent presence in the country and an established, experienced, trained network of rural CBD workers with an 80–90 percent retention rate. In addition, PVOs have indicated that since PROFAMILIA now charges them for their CBD training and organization activities, they can no longer afford to develop additional CBD workers. Qualitative evaluations indicate that the youth club program is successfully educating adolescents in the areas of sexuality, family planning, and HIV/AIDS. PROFAMILIA is recognized as a leader in the area of youth education. Given that the adolescent pregnancy rates in Nicaragua (41 percent in rural areas and 30 percent in Managua) are the highest in the region, this program is addressing a significant national health problem. One of the concerns identified in the evaluation is that the program is limited to in-school youth and may be missing high-risk individuals in the out-of-school population. Concerns over program sustainability may be interfering with program expansion into underserved areas. Reductions in CBD supervisors and workers are limiting the extension of activities.

Financial sustainability is an all-encompassing concern at PROFAMILIA. What CYP achievement was in 1997, sustainability achievement is now. Overall, sustainability is now at 46 percent (60 percent is the grant target). The regional centers are well ahead of this, at 69 percent. The CMS clinics are even higher, at 87 percent. If social program costs were taken out (as in the CMS clinics), many centers would be practically self-sufficient now. Contributors to low sustainability include high overhead costs, high operational costs (especially personnel and transport), continued support of regional centers and medical services that have low income related to costs, social programs (CBD, youth, communications) that produce little income, physician productivity (low visit rates and high salaries), and inadequate supply to meet demand (the Managua clinic).

Financial management procedures have been strengthened. Communication between central and center levels is excellent. The cost-accounting and cost-control systems have improved greatly. Due to cost-reduction strategies, PROFAMILIA was under budget as of July 2001. A weakness is the lack of cost centers, which makes it impossible to assess

how well each center (e.g., gynecology, laboratory, and ultrasound) is doing in terms of sustainability. Unit cost accounting is not used to assess the viability of new services or products. CMS clinics, which are to be absorbed in December, should be assimilated easily as far as financial management is concerned. They use the same systems as other PROFAMILIA clinics.

Management and organization are significant problems. Not only has the history of leadership changes affected operations, the current structure is unsustainable. As noted above, lack of consensus on PROFAMILIA's direction, role conflicts, the top-heavy nature of central administration, overlap, duplication, and conflicts over roles and responsibilities all contribute to an inefficient and costly organizational structure. Fortunately, PROFAMILIA is about to begin anew. There is a new executive director and a new board of directors is expected to be elected in September or October. A commission that was established a few months ago to draw up new statutes is expected to submit its report to the General Assembly by September 28, 2001. PROFAMILIA is technically but not managerially prepared to take over the CMS clinics in December. However, there is still time for PROFAMILIA to prepare a transition plan and resolve a number of the policies and procedures that are not quite in harmony.

Oddly enough, management capacity at PROFAMILIA is quite good and improving. Most of the management staff is committed and competent. Technical assistance over the past few years has been very helpful, not only in building up essential management systems, but in strengthening the knowledge and skills of the managers, as well. Relations with USAID remain strong and now that their preoccupation with Hurricane Mitch reconstruction is ending, USAID should be able to devote more time to PROFAMILIA.

RECOMMENDATIONS

The team is optimistic not only that PROFAMILIA can survive, but that it can blossom. This will require commitment more than money or labor. There are two overriding recommendations:

Defining PROFAMILIA: PROFAMILIA needs to redefine its vision, its mission, and set strategic objectives for achieving them (including measurable indicators). Then, it needs to develop a strategic plan for meeting those objectives (including a new organizational structure). This is the most important recommendation. It is the starting point for providing direction and eliminating confusion. The current mission and vision statements are acceptable, but they are not embraced by everyone. Even if the new vision and plan are similar to the existing ones, the benefits of the process of reaching an agreement that is accepted by all may exceed the outcome. The leadership of PROFAMILIA needs to manage this process and agree on a common goal and plan. That must be followed by teambuilding exercises to bring all employees, volunteers, and contract personnel to that same agreement.

Resolving the sustainability-social mission dilemma: This issue has divided the organization, pitting those who are concerned with the survival of the organization against those who want to help the helpless. Both ends are laudable. Needed RH services that can be sustained should be provided. This implies developing service packages based on need, and not just cost or income potential. It also implies providing services for which there is a demand. The operational mechanism proposed is to separate sustainable from unsustainable programs/activities and apply sustainability objectives only to those that are sustainable. The unsustainable programs/activities would not be undertaken unless subsidized.

- **Sustainable:** have sustainability targets of at least 100 percent (clinics, social marketing). Surpluses over 100 percent might be used to cross-subsidize some unsustainable programs/activities.

- **Unsustainable:** do not have sustainability targets, must be subsidized (CBD, youth, promotion). Cost recovery could reduce the needed subsidies.

If the above recommendations are accepted, then the remaining recommendations could follow.

Quality of care should be given much more emphasis, especially in reproductive health, which is the core service area. Standards of care and procedural guidelines are needed for all subservices of gynecology and maternal care, at a minimum. The quality assurance system should be completed and installed systematically so that it permeates the entire organization, not just medical services. Steps should be taken immediately to respond to basic client concerns, such as waiting time, continuity of care, and interpersonal communications. PROFAMILIA should design and launch a campaign to promote appropriate contraceptive methods and informed choice, not just temporary methods. Long-term methods (sterilization and IUDs) are appropriate for many women, especially those over 30 who do not want any more children. PROFAMILIA should reevaluate its maternal care services (ANC, delivery, postpartum) and decide what it can do to increase safe outcomes and reduce maternal mortality, not only in its clinics, but also in its catchment areas. The management protocol for positive Pap tests should be updated to conform more closely to that being utilized in the GINECOBONOS initiative.

Social marketing is an important and well-run program within PROFAMILIA and deserves the support and respect of the leadership, which should cease interfering with the technical and financial prerogatives of the program and approve its budgeted activities. USAID should grant a one-year, no-cost extension to the social marketing component to allow it to carry out these activities, launch its remaining two contraceptive products, establish a market niche, and reach its sustainability objectives. As with other components of PROFAMILIA, separate cost centers should be set up to separate social marketing from communications. DIMECOSA should be given complete control of its social marketing budget, including the use of revenues to establish approved revolving and support funds. Both are critical to the future sustainability of the program. PROFAMILIA should also take advantage of the DIMECOSA expertise to commission

market research on current and new products and services. Currently, PROFAMILIA has no basis for deciding the services or products to offer. Market research can help determine demand, appropriate prices, appropriate packaging, and positioning.

CBD and Youth Programs: PROFAMILIA should decide whether its priority is expansion of CBD and youth services or sustaining them. One solution is to cost the non–income-generating activities associated with CBD and youth programs separately, acknowledging that these activities address necessary national health priorities and require continued support from outside donors. If PROFAMILIA decides to expand CBD, then it should consider the following:

- selling other profit-making products through the CBD network that would generate more income and provide broader services;

- expanding the CBD network via star promoters (promotoras madres) who excel at their work and could take over supervisory activities in their areas. They could be provided with a stock of supplies that they would distribute to their own network of promoters along with education and training support. This would extend the efficiency of the supervisors who are operating at maximum capacity and cannot reach additional promoters;

- joining NicaSalud to increase relationships with PVOs and expand its rural presence/outreach; the DIMECOSA director could be useful in facilitating this process; and

- reestablishing a system of paying fees to promoters for referrals to clinics for family planning services, as this would stimulate rural consultations and increase CBD cost-effectiveness.

The CBD program and DIMECOSA need to analyze the roles of distributors in their two programs and clarify/coordinate their respective responsibilities. There appears to be overlap between the two programs. PROFAMILIA should conduct an evaluation of the youth program to measure its impact on reducing teenage pregnancy and the extent to which it is reaching low-income and rural adolescents. It should also consider developing a program that targets high-risk youth, including out-of-school youth and those engaged in high-risk behaviors.

Financial sustainability is possible, as long as PROFAMILIA takes steps to reduce costs and augment income. Priority issues are:

- reduce overhead costs drastically, as soon as possible;

- reduce personnel and other high operational costs (such as transport and vehicles);

- identify inefficient clinics and medical services that should be ended;

- identify new clinic sites and medical services that could contribute to increased sustainability;

- place unsustainable activities and programs in a nonsustainable category that is exempt from sustainability goals;

- and improve physician productivity.

Other related initiatives that should be taken include:

- set minimal caseloads for physicians;
- establish sustainability targets for clinics;
- establish a profit-sharing incentive plan; and
- construct a new Managua clinic capable of meeting client demand.

Management and organization priorities have already been described. The first priority must be the clarification of PROFAMILIA's mission and objectives. As part of this, the sustainability versus social responsibility issue needs to be resolved. In addition, technical assistance to fill the gaps in management systems (such as human resource management and quality assurance) should be continued. A transition plan for the absorption of the six CMS clinics needs to be developed, ideally as part of an overall strategic plan. USAID and PROFAMILIA need to work much more closely together over the next 16 months to make sure that the recommendations included in this report are discussed and, where appropriate, implemented.

APPENDICES

A. Statement of Work
B. Persons Contacted
C. References
D. Statistical and Financial Tables
E. PROFAMILIA's Service Package
F. ASHONPLAFA Sustainability Strategy
G. Performance Indicators
H. PROFAMILIA Organization Chart

APPENDIX A

STATEMENT OF WORK

(from USAID)

STATEMENT OF WORK

MIDTERM EVALUATION OF THE PROFAMILIA GRANT WITH USAID NICARAGUA

1. BACKGROUND

USAID/Nicaragua has maintained a donor relationship with the Nicaraguan NGO *Asociación para el Pro Bienestar de la Familia Nicaraguense* (PROFAMILIA) since 1992. PROFAMILIA, which as the national affiliate of IPPF has a history in family planning in Nicaragua of over 30 years, has been transformed by the relationship and assistance from USAID in the 1990s. Under the previous Cooperative Agreement (1993-1998) USAID helped PROFAMILIA expand from two modest urban family planning clinics in urban Managua to a network of a dozen Regional Centers providing coverage for thousands of Nicaraguan families in virtually all of western and central Nicaragua, and a rural network of hundreds of community based distribution (CBD) volunteers and promoters. A midterm evaluation conducted by POPTECH in March 1997 criticized PROFAMILIA's performance and management under the cooperative agreement and raised the possibility of the termination of assistance. Evaluators also recommended strongly that USAID change reporting requirements that stressed Couple Years of Protection (CYPs) because this encouraged PROFAMILIA to focus excessively on fertility-termination methods of family planning (i.e., voluntary surgical contraception) rather than temporary methods of contraception.

The midterm evaluation provided substantial guidance to PROFAMILIA and USAID that led to leadership and organizational changes, focused USAID assistance towards helping PROFAMILIA expand coverage in temporary methods, develop an ambitious social marketing program and meet ambitious sustainability targets. These targets were built into the new grant provided to PROFAMILIA in 1998 and which runs until December 2002. The targets were meant to guide PROFAMILIA to reaching 30% cost recovery in locally generated income in 1999, 47.9% in 2000, 57.6% in 2001 and 64.5% by the end of the grant. However, performance in this area reached only 38.9% in 2000, and it is unclear whether the 2001 target is likely to be met.

To support these efforts, USAID has also provided PROFAMILIA, outside of the grant parameters, a substantial supply of annually donated contraceptive supplies intended largely for the social marketing program. USAID has also channeled to PROFAMILIA ample technical assistance from a range of collaborating agencies. The JHU Population Communication Services program has major responsibilities for designing and managing PROFAMILIA's advertising programs and product launch campaigns and has a team of consultants in-country dedicated to this task. Other GPHN programs providing technical assistance to PROFAMILIA include *inter alia* support from the MSH Family Planning Management Development project, the URC Quality Assurance Project, the JSI Family Planning Logistics Management project. These and other G/PHN programs have provided extensive training and technical assistance to PROFAMILIA management and staff.

In 1999, as part of the Hurricane Mitch Reconstruction and Recovery Program, USAID Nicaragua obligated $5.6 million to the G/PHN Commercial Market Strategies (CMS) project with the purpose of building 6 self-financing primary health care centers in the Mitch-affected parts of the country. These centers were conceived as forming a network of franchised health clinics, under the name and logo of PROFAMILIA. CMS' responsibilities included not only the construction and equipping of these centers but the development, in coordination with PROFAMILIA staff, of a social franchise approach to clinic management that would convert much of the high fixed costs of paying staff to variable costs, through the sharing of revenues generated by the clinic's performance and the use of incentives for the staff that would stimulate greater coverage and patient utilization. The social franchise also focused significant attention to establishing a high standard for quality of care and customer satisfaction. These centers are currently under construction; the first three in Tipitapa, Estelí and Sébaco will be inaugurated over a six-week period from early March to mid-April 2001, to be followed by a second group of three clinics for Rio Blanco, Somoto and Jalapa to be finished by August 2001.

These 6 new centers built by CMS will increase by at least 50% the size of the PROFAMILIA network. They are intended to become fully self-sufficient by the end of 2002 and should in fact return a profit over and above operating expenses to cover a portion of PROFAMILIA's central costs. They have important implications for the rest of the network because the medical and professional staff of the 6 CMS facilities will not be earning fixed salaries but honoraria linked to performance and utilization. Moreover, the CMS oversight of this initiative will conclude by December 31st 2001 and PROFAMILIA will need to assume direct management of all these facilities at that time.

Following a period of increasingly overt political involvement the PROFAMILIA Executive Director resigned in August 2001. A lengthy process has ensued to identify an adequate replacement finally led to the selection of a new Executive Director in March. The Assembly of the PROFAMILIA will be convened and should elect a new Board of Directors in June.

2. PURPOSE

USAID Nicaragua seeks the services of a POPTECH team to conduct an evaluation of its $10.6 million grant with PROFAMILIA. The estimated date for this evaluation would be July 2001. USAID/Nicaragua seeks to obtain from this evaluation a limited number of actionable recommendations, prioritized, with a timeframe attached and the name of who should implement the recommendation if accepted by the Mission.
Through this evaluation, USAID seeks to better enable PROFAMILIA to fulfill its mission and mandate to **consolidate itself as the premier NGO provider of family planning and MCH services in Nicaragua.** USAID requires constructive guidance to help PROFAMILIA focus managerial attention and responsibility on carrying out whatever actions are required to meet that organizational mission. At this midpoint in the most important grant for the USAID SO3 team, USAID and PROFAMILIA need to

assess progress in planned activities and results, and identify any changes that the PROFAMILIA Senior Management Team and Board of Directors need to undertake. USAID anticipates that this evaluation will **provide a clear managerial mandate for the new executive director and PROFAMILIA managers, as well as specific guidance for the new Board of Directors.** Moreover, given the **conclusion of the CMS Technical Assistance funded under the Hurricane Mitch Reconstruction and Recovery Program by December 31st, 2001, and the transfer of responsibility to PROFAMILIA**, it is particularly timely that USAID support this midterm evaluation. USAID will use this evaluation to contribute to decisions on the structure, nature and emphasis of future USAID assistance beyond the life of the current grant.

The evaluation should address comprehensively the following questions:

1. **Achievement of Activity/Project Goal and Purpose:** Is the project on schedule to achieve its goal? Does PROFAMILIA provide quality services for its customers? How has PROFAMILIA progressed since the 1997 POPTECH evaluation?

2. **Financial Sustainability:** How can PROFAMILIA improve progress towards assuming an increasing share of its recurrent costs? How can core costs of the PROFAMILIA administration and HQ attributed to the grant be systematically reduced without weakening the institution?

3. **Organizational Sustainability:** Are the organization, staffing and management of PROFAMILIA adequate to achieve the activity purpose and goal? If not, what changes are required to do so? Are the strategic plan and annual operating plan adequate and utilized by key managers? Are human resources management policies and procedures articulated and put into practice? Assess the roles, responsibilities and division of labor between the Senior Management Team, the Board of Directors and the Assembly?

3. AREAS TO BE ANALYZED BY THE EVALUATION TEAM

3.1 Achievement of Activity/Project Goal and Purpose:

Is the project on schedule to achieve its goal and purpose? Does PROFAMILIA exemplify quality services for its customers?

3.1.1. QOC and Service Delivery

USAID/Nicaragua has received reports from several different sources that suggest that service delivery; QOC and effective technical supervision of clinicians and clinics may be areas that have weakened lately. PROFAMILIA does not appear to have a systematic approach to improving care, and appears to rely heavily on monthly training sessions on selected topics. We are aware that at least in some clinics, ghost customers have not been well treated, and long waits can be a problem. Medical supervision does not appear to follow a formal protocol or algorithm. PROFAMILIA has received some

technical assistance in these areas in the past through the Quality Assurance Project, MSH's previous Family Planning Management Development project, etc, but the lengthy delay in selecting a new Executive Director and turnover of some key technical and administrative staff in the year 2000 has reduced the institutional memory of PROFAMILIA and led to the departure of some people who had been previously trained.

In addition, since 1999 PROFAMILIA has widened its core services to include a much broader range of MCH services. This has been positive, yet in many locations clients are still not accustomed to think of PROFAMILIA as a provider of these services. At the same time, local political pressure and periodic efforts of the Church and some governmental authorities to claim that PROFAMILIA acts as an abortion provider has led PROFAMILIA to act far more cautiously in some areas of reproductive health services. For example, vacuum suction D&C has been eliminated as a therapeutic intervention because of the fear that it might give the appearance of support of PROFAMILIA to elective abortions.

USAID/Nicaragua requests that the consultants assess the systems and structures in place for QOC and enhancing service delivery, and make recommendations on what if any changes are required for PROFAMILIA to improve in this area.

3.1.2 Communications

Substantial investment has been made under this grant to develop capabilities for communications and social marketing in DIMECOSA. In addition, USAID/Nicaragua has provided technical assistance under Johns Hopkins's PCS and IEC programs, including in-country resident advisors. Despite this investment, the launch of the new Bodyguard condom was delayed nearly 10 months as a result of internal managerial issues, and the introduction of other family planning products, such as Duofem and Depo-provera are also delayed. In addition there have been some internecine conflicts between promoters of USAID's Bodyguard and VIVE products, to some extent influenced by technical assistance PROFAMILIA has received.

USAID/Nicaragua wants the consultants to assess how effective this investment in communications capabilities has been in supporting increased client access to information about reproductive health and family planning and modern contraceptive methods, improved counseling, and more effective outreach for services and products. The consultants should offer recommendations on how these areas could be improved or make more efficient use of resources.

3.1.3 CBD

The 1997 midterm evaluation found that CBD was an expensive area for PROFAMILIA with little real return on investment. While CBD appears to be run more efficiently than in the past, there are still high training costs associated with it, exacerbated by the fact that PROFAMILIA appears to run a high turnover on CBD promoters. USAID/Nicaragua has not dedicated major attention to this area in the wake of the 1997 evaluation and would request the consultants to re-visit the area, and determine to what extent PROFAMILIA's CBD arrangements, those internally managed and those "out-sourced" with other NGOs and PVOs, contribute to services, coverage and the identification of new users in a cost-effective manner.

3.2 Financial Sustainability

Is PROFAMILIA making adequate progress towards assuming an increasing share of its recurrent costs? How can this progress be improved?

As part of the grant, financial sustainability targets were set. The targets were meant to guide PROFAMILIA to reaching 30% cost recovery in locally generated income in 1999, 47.9% in 2000, 57.6% in 2001 and 64.5% by the end of the grant. However, performance in this area reached only 38.9% in 2000, and it is unclear whether the 2001 target is likely to be met.

What are the best options for PROFAMILIA to recover lost ground and accelerate efforts to achieve financial sustainability? How can core costs of the PROFAMILIA administration and HQ funded by the grant be reduced without weakening the institution?

Moreover, in light of the introduction of the franchised clinic model under the CMS project, USAID/Nicaragua needs to determine if PROFAMILIA is truly prepared to monitor and manage the financial performance of CMS franchised health clinic network of 6 new facilities in such a way to facilitate the review and application of the lessons learned to the original PROFAMILIA Regional Centers. What would be required to ensure this takes place?

3.3 Organizational Sustainability

Are the organization, staffing and management of PROFAMILIA adequate to achieve the activity purpose and goal? What changes would enhance this?

PROFAMILIA has grown sharply. Yet management systems do not appear to have fully accommodated this growth. While ample technical assistance has been provided under JSI's FPLM and the DELIVER projects, a capability to accurately forecast and order contraceptives does not appear to be fully institutionalized. Last year USAID/Nicaragua had to intervene to insure the prompt destruction of contraceptive products approaching their expiration date.

PROFAMILIA has developed a capability in research and evaluation, yet these areas do not appear to contribute significantly to PROFAMILIA's planning or decision-making.

Support under various Cooperating Agencies during 1999 and 2000 was geared to develop a strategic plan for PROFAMILIA and better define the organogram and institutional structures. Closure was never reached in these areas, due to the lengthy departure of the previous Executive Director, his centralizing tendencies, and the vacancy of that position for nine months. The new Executive Director has sought assistance to recover lost ground in these areas. However, during the vacancy the Board of Directors grew accustomed to taking on functions and roles that should not continue over the longer term. There is a need to re-assert and strengthen the appropriate roles for the Assembly, the Board, the Executive Director, the Senior Management Team, and the regional center directors.

The consultants should assess the status of this area and offer specific recommendations on how to best address problems that have developed, and insure the consistent application of outside technical assistance.

4. LEVEL OF EFFORT

This evaluation will require the services of a team comprised of four members for a period of three weeks: one week of preparation time and report writing time in the U.S and two weeks in Nicaragua. A six-day workweek is authorized. The International Planned Parenthood Federation may provide an observer to accompany the team during the evaluation.

Chief of party/Expert in Management of Reproductive Health and Family Planning Programs: Position requires a Masters or Ph.D. in public health or related social science with at least ten years of experience designing, managing and evaluation reproductive health and family planning programs. Demonstrated analytical and writing skills required. Spanish fluency at the 3+, 3+ level required. Familiarity with AID grant and cooperative agreement procedures is desirable.

The Chief of Party is expected to provide overall leadership and guidance to the evaluation team. S/he will be the principal author, uniting the input from other team members into draft reports for USAID. S/he will coordinate the interaction with the PROFAMILIA senior management team and the Board of Directors.

Family Planning Clinical/Quality of Care Expert: Requires medical degree with specialization in integrated reproductive health care and at least five years of clinical experience in reproductive health and family planning. Knowledge of state-of-the-art surgical and temporary contraceptive procedures required as well as familiarity with international standards of clinical care. Experience with medical and nursing chart audit procedures or related methods of quality of care assessment required. Spanish fluency at the 3+, 3+ level.

The Family Planning QOC Expert will provide principal technical leadership to address the QOC and Service Delivery questions raised in this scope of work. S/he should also identify any other related outstanding technical issues pertinent to the objectives of this evaluation.

Cost Recovery/Financial Management Expert: Advanced degree in health economics or health care management with emphasis in financial management, cost analysis, cost recovery or pricing of services. Should have strong experience in the area of cost recovery for reproductive NGO health or family planning programs, some of which must be in a developing country and/or non-profit setting. Proven analytical and written communication skills required. Spanish fluency at the 3, 3+ level strongly preferred.

The Cost Recovery/Financial Management Expert will provide analysis and insights on the budgetary and financial management systems in place. Careful attention will be paid to the questions raised in the financial sustainability section of the scope of work. S/he will need to assess progress to date and offer specific sound guidance on the possible modification of PROFAMILIA procedures and practices to enhance financial sustainability, taking into account other programmatic givens.

Expert in Family Planning Organizational Analysis and Institutional Development: Advanced degree in business or public management with an emphasis in organization analysis/organization development. At least five years of experience conducting organizational analysis and development for non-profit organizations. Spanish fluency at the 3+, 3+ level.

The Organizational Analysis and Institutional Development expert will provide the expertise and capabilities to address comprehensively the issues of organizational development raised in this scope of work. These include an analysis of key staffing and management systems, including the effectiveness of preparations for PROFAMILIA to assume the management of the 6 CMS facilities by the end of 2001, and integrate them into the wider regional center network.

5. DELIVERABLES

While in Nicaragua, the contractor shall provide two oral briefings:

1. A final presentation of findings, conclusions and recommendations to USAID; and

2. A presentation to PROFAMILIA's Board of Directors.

The contractor shall present a written report in English summarizing the evaluation findings, conclusions and recommendations in prioritized fashion, not to exceed 50 pages, including *inter alia*:

1. A summary not to exceed five pages of the major findings, conclusions and prioritized recommendations (in Spanish and English);

2. The body of the report (Spanish and English), with clearly stated and documented findings, conclusions, and prioritized recommendations, and;

3. A PowerPoint presentation of the major findings, conclusions and prioritized recommendations (in Spanish) for presentation to the PROFAMILIA Board of Directors.

The contractor shall submit a draft of the report in English (minus the appendices) with an electronic copy at the time of the final debriefing. USAID will have five working days to respond with comments. Once USAID/Nicaragua's comments have been received, the contractor shall have seven working days to finalize the report. Eight days after receiving USAID's comments, the contractor shall have sent two complete copies of the report in English via air courier to the Health Development Officer of USAID/Nicaragua. An accurate and vetted Spanish translation of the report should be completed within two additional weeks.

APPENDIX B

PERSONS CONTACTED

PERSONS CONTACTED

PROFAMILIA

Headquarters

Lic. Julio Martínez, Executive Director
Dr. Carlos Jarquín, Medical Director
Dra. Claudia Evans, Training and Research
Dr. José Medrano, Medical Supervision
Ing. Ramiro Mayorga, Financial Director
Lica. Nora Delgado, Director of Programs
Lica. Verónica Matus, Community Promotion and Youth
Lic. Eddy Tercero, Chief Administrator
Lic. Alfredo Rocha, Chief of Statistics
Arturo Zamora, Director, Communications and Social Marketing

Board of Directors

Dra. Vonny Vado, President
Lica. Julia Mena, Vice President
Dr. Gustavo Alvarez Alvarado, Secretary
Dr. Jerónimo Sequeira, Treasurer
Dr. Ivan Valdivia
Dr. Gutiérrez Guant

Regional Centers

Boaco

Dra. Judith Largaespada, Director
Karla Cartillo, Administrative Assistant
Nimia Chavere Alarcon, Supervisor of Promoters
Luz Marina More, Promoter
Telma Vargas, Promoter
Tamara Gómes Almanza, Youth Promoter

Rivas

Dra. Lissette Grillo, Director
Danelia Miranda, Administrative Assistant
Glades Valleda, Promoter
Susana Alvarado Montealto, Community-based distribution (CBD) Supervisor
Gerald Rodríguez Salananca, Laboratory Technician

Masaya

Dra. Darling Cuadra, Director
María Celena, Administrative Assistant
Carina Leonor Carrion Cruz, Receptionist
Flor de María Fanina Pérez, CBD Supervisor

Matagalpa

Dra. Irene Hernández, Director
Wilma Raquel Garcia, Administrative Assistant
Dra. Vanessa Montel, General Medicine

Dr. Christian Castillo, Gynecology
Alba Luz, Counselor
María de los Angeles, Supervisor of Promoters
María Isabel Rivas, Promoter
Rosario Ubeda Ortiz, Promoter

Managua

Dr. Carlos Vílchez, Director
Guadalupe Salinas, Laboratory Technician

Chinandega

Luisa Amanda Caballero, Director
Cecilia Salazar, Supervisor of Promoters
Leonora Guerrero, Promoter

Clinics

Sébaco

Fatima Mendosa, Nurse/Promoter
Erexy Seledon Bernard, Receptionist

Tipitapa

Dr. Agosto Rivas, Director

USAID/Nicaragua
Katie McDonald, Chief of Human Investment Office
Alonzo Wind, Health Development Officer
H. Paul Greenough, Office of Planning and Coordination of Programs

Ministry of Health (MINSA)
María Lydia, Nurse, MINSA Health Post, Rivas

Commercial Market Strategies Project (CMS) Headquarters
Lica. Pilar Sebastián, Project Director
Dr. Rodríguez, Medical Supervisor
Donaldo Muñoz, Marketing Coordinator
María Elena Rojas Gutiérrez, Infrastructure Coordinator, Architect
Leonara Jessie Ebanks Pardo, Information Systems Coordinator
Elena Montenegro, Assistant Administrator

PROSALUD
Barry Smith, Chief of Party

Institution Centroamericano de la Salud
Micol Salvetto, Coordinator of the Program of Prevention of Cervical Cancer

Quality Assurance Project
Dr. Oscar Nuñez, Coordinator

Johns Hopkins University/Population Communication Services (JHU/PCS)
Philippe Lemay, Social Marketing Specialist
Margarita Gurdian, JHU/PCS Representative for Nicaragua

Adventist Development and Relief Agency International (ADRA)
Isidro Rodríguez, Programs Director

CARE
María Elena McEwan, Director of Health Programs

Management Sciences For Health (MSH)
Sarah Johnson, Senior Program Officer, Boston

KPMG Peat Marwick Nicaragua, S.A.
Indiana Bonilla, Consultant

APPENDIX C

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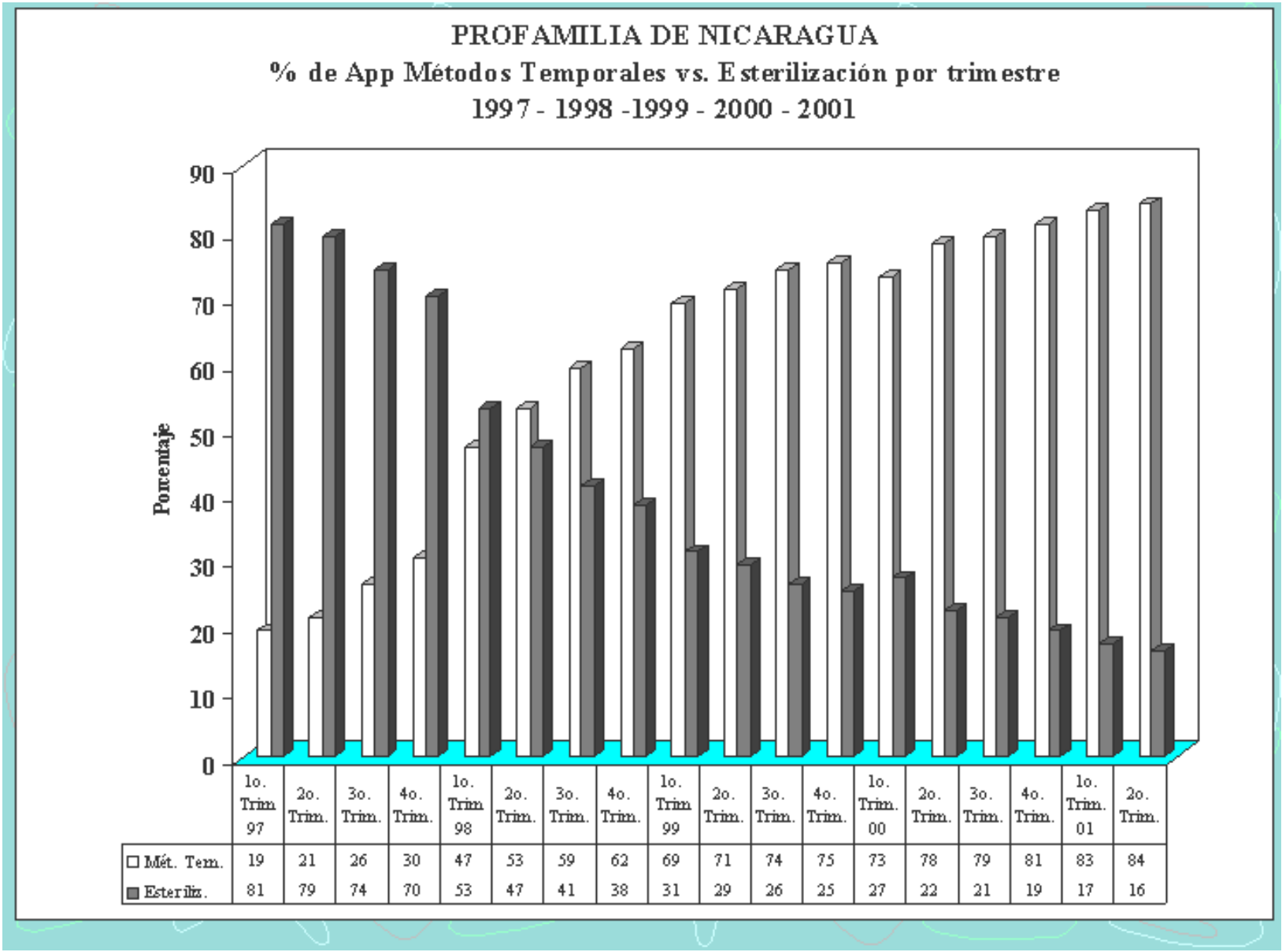
APPENDIX D

FINANCIAL AND STATISTICAL TABLES

CHART D-1: CYPs BY TEMPORARY AND STERILIZATION METHODS, 1997-2001
(from PROFAMILIA)



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Mét. Tem.	19	21	26	30	47	53	59	62	69	71	74	75	73	78	79	81	83	84
Esterilix.	81	79	74	70	53	47	41	38	31	29	26	25	27	22	21	19	17	16

TABLE D-1: CYPs BY TYPE OF CONTRACEPTIVE, 1999-2001

		1999			2000			2001*			Total	
Contraceptive	**Plan**	**Actual**	**Percent**	**Plan**	**Actual**	**Percent**	**Plan**	**Actual**	**Percent**	**Plan**	**Actual**	**Percent**
Oral pills	19,212	21,950	114%	18,060	22,348	124%	20,040	28,951	144%	57,312	73,249	128%
Condoms	2,092	4,850	232%	2,400	13,385	558%	2,870	11,231	391%	7,362	29,466	400%
Depo-Provera	17,410	19,098	110%	17,480	18,253	104%	19,990	16,543	83%	54,880	53,894	98%
Mesygina	0	430	0%	0	756	0%	0	1,111	0%	0	2,297	0%
Vaginals	161	156	97%	80	0	0%	0	0	0%	241	156	65%
IUD	5,782	4,956	86%	6,937	5,186	75%	8,323	5,698	68%	21,042	15,840	75%
Sterilization	41,260	16,860	41%	44,560	14,340	32%	47,230	11,600	25%	133,050	42,800	32%
Total CYPs	85,917	68,300	79%	89,517	74,268	83%	98,453	75,134	76%	273,887	217,702	79%
Subtotal Temporary	44,657	51,440	115%	44,957	59,928	133%	51,223	63,534	124%	140,837	174,902	124%
Subtotal IUD + VS	47,042	21,816	46%	51,497	19,526	38%	55,553	17,298	31%	154,092	58,640	38%

*PROFAMILIA projection based on January-June data.

TABLE D-2.1: MEDICAL SERVICE VISITS, 1997-2001

	Services	1997	1998	1999	2000	2001p	Total	Percent	Rank
1	DIU	2,325	4,505	5,822	6,610	6,684	25,946	3.4%	9
2	Inyectables	6,263	8,400	12,122	12,780	11,594	51,159	6.7%	5
3	Ginecología	24,051	31,562	44,405	53,728	50,102	203,848	26.6%	1
4	Papanicolaou test	13,891	16,943	21,280	22,878	21,770	96,762	12.6%	3
5	Prenatal	4,056	6,362	8,159	10,359	9,240	38,176	5.0%	8
6	Postnatal	476	711	607	682	706	3,182	0.4%	
7	Prueba de Embarazo		2,432	3,806	4,544	4,660	15,442	2.0%	10
8	Pediatria	101	2,094	10,457	17,907	14,090	44,649	5.8%	7
9	Cauterización		382	873	1,367	1,068	3,690	0.5%	
10	Biopsia		558	634	1,000	908	3,100	0.4%	
11	Colposcopia		360	450	967	1,060	2,837	0.4%	
12	Cirugía Menor		135	276	353	492	1,256	0.2%	
13	Ultrasonido	1,946	7,659	15,806	19,434	23,362	68,207	8.9%	4
14	Masculino	460	1,153	2,028	4,093	4,472	12,206	1.6%	
15	Mamografía			1,125	1,231	1,322	3,678	0.5%	
16	Servicios Especializados			593	759	1,466	2,818	0.4%	
17	Partos			11	34	26	71	0.0%	
18	Psicología			791	983	1,098	2,872	0.4%	
19	Oftalmologia			-	-	-	-	0.0%	
20	Medicina General		4,687	10,641	20,783	9,958	46,069	6.0%	6
21	Otros Servicios	9,060	12,492	23,560	45,938	50,478	141,528	18.4%	2
	Total	62,629	100,435	163,446	226,430	214,556	767,496	100.0%	
	Examenes de Laboratorio	15,196	21,775	39,078	78,823	92,820	247,692		

TABLE D-2.2: SUMMARY OF SERVICES AND SALES, 1997-2001

(from PROFAMILIA)

		1997	1998	1999	2000	2001 Proy.	Total
1	**Consultas Medicas**	**62,629**	**100,435**	**163,446**	**226,430**	**214,556**	**767,496**
1.1	**Consultas**	**32,740**	**51,248**	**83,447**	**111,808**	**92,428**	**371,671**
	DIU	2,325	4,505	5,822	6,610	6,684	25,946
	Inyectables	6,263	8,400	12,122	12,780	11,594	51,159
	Ginecología	24,051	31,562	44,405	53,728	50,102	203,848
	Medicina General	-	4,687	10,641	20,783	9,958	46,069
	Pediatría	101	2,094	10,457	17,907	14,090	44,649
							-
1.2	**Atencion CaCU**	**13,891**	**18,243**	**23,237**	**26,212**	**24,806**	**106,389**
	Papanicolaou test	13,891	16,943	21,280	22,878	21,770	96,762
	Cauterización	-	382	873	1,367	1,068	3,690
	Biopsia	-	558	634	1,000	908	3,100
	Colposcopia	-	360	450	967	1,060	2,837
							-
1.3	**Atencion Embarazo**	**4,532**	**7,073**	**8,766**	**11,041**	**9,946**	**41,358**
	Control Prenatal	4,056	6,362	8,159	10,359	9,240	38,176
	Control Postnatal	476	711	607	682	706	3,182
							-
1.4	**Consultas Diagnosticas**	**1,946**	**7,659**	**16,931**	**20,665**	**24,684**	**71,885**
	Ultrasonido	1,946	7,659	15,806	19,434	23,362	68,207
	Mamografía	-	-	1,125	1,231	1,322	3,678
							-
1.5	**Partos y Cirugias Menores**	**0**	**135**	**287**	**387**	**518**	**1,327**
	Partos	0	0	11	34	26	71
	Cirugías Menores	0	135	276	353	492	1,256
							-
1.6	**Otras consultas medicas**	**9,520**	**16,077**	**30,778**	**56,317**	**62,174**	**174,866**
	Masculino	460	1,153	2,028	4,093	4,472	12,206
	Psicología	-	-	791	983	1,098	2,872
	Servicios Especializados	-	-	593	759	1,466	2,818
	Consulta para Prueba de Embarazo	-	2,432	3,806	4,544	4,660	15,442
	Otras consultas	9,060	12,492	23,560	45,938	50,478	141,528
							-
2	**Esterilizaciones Quirúrgicas**	**7,384**	**2,633**	**1,686**	**1,434**	**1,160**	**14,297**
							-

		1997	1998	1999	2000	2001 Proy.	Total
3	**Consultas Enfermería**	**59,288**	**49,231**	**65,344**	**92,163**	**93,862**	**359,888**
	Planificación Familiar	50,963	23,521	26,152	31,122	26,360	158,118
	CaCU	1,225	2,479	5,822	8,764	10,106	28,396
	Prueba Embarazo		1,654	2,118	2,844	2,366	8,982
	Otras	7,100	21,577	31,252	49,433	55,030	164,392
							-
4	**Examenes de Laboratorio**	**15,196**	**21,755**	**39,078**	**72,823**	**93,820**	**242,672**
							-
5	**Ventas**						-
	Orales	**234,098**	**266,838**	**285,356**	**290,495**	**371,710**	**1,448,497**
	Clínicas	8,369	18,642	16,652	25,688	30,036	99,387
	DCA	225,729	248,196	268,704	264,807	341,674	1,349,110
	Preservativos	**316,155**	**358,457**	**581,996**	**1,606,309**	**1,347,774**	**4,210,691**
	Clínicas	16,561	26,346	42,209	31,826	197,114	314,056
	DCA	299,594	332,111	539,787	362,694	262,660	1,796,846
	Dimecosa				1,211,789	888,000	2,099,789
	Inyectable Trimestral	**42,279**	**62,348**	**76,390**	**73,016**	**66,180**	**320,213**
	Clínicas	8,540	12,179	12,981	11,520	9,634	54,854
	DCA	33,739	50,169	63,409	61,496	56,546	265,359
	DIU	**762**	**1,692**	**1,416**	**1,481**	**1,628**	**6,979**
	Clínicas	755	1,692	1,118	792	942	5,299
	DCA	7	-	298	689	686	1,680
	Vaginales	**2,224**	**1,869**	**934**	**14**	**-**	5,041
	Clínicas	270	432	166	-	-	868
	DCA	1,954	1,437	768	14	-	4,173
	Inyectable Mensual	**736**	**1,896**	**5,598**	**9,837**	**14,444**	**32,511**
	Clínicas	209	824	2,214	3,800	5,636	12,683
	DCA	527	1,072	3,384	6,037	8,808	19,828

TABLE D-3.1: CBD POSTS AND PROMOTERS, 1998-2001

	1998	1999	2000	2001*
Active posts (Jan. 1)	1,037	1,227	1,274	1,081
Posts opened	508	356	110	47
Posts closed	318	309	303	101
Active posts (Dec. 31)	1,227	1,274	1,081	1,027
Supply visits	11,943	13,799	9,903	4,381
Supply visits/post	9.7	10.8	9.2	4.3
CYPs	31,577	42,451	41,644	45,683
Average CYP/post	26	33	39	44
Active Promoters	905	920	834	775
Active Distributors	322	354	247	252

* PROFAMILIA projection based on January-June data.

TABLE D-3.2: NEW AND CONTINUING CLIENT VISITS BY REGIONAL CENTER, 1998-2001

	1998			1999*			2000			2001**		
Regional Centers	**New**	**Old**	**Total**	**New**	**Old**	**Total**	**New**	**Old**	**Total**	**New**	**Old**	**Total**
Managua	2,806	13,126	15,932	1,698	13,636	15,334	3,103	41,475	44,578	354	2,972	3,326
Matagalpa	4,474	8,421	12,895	2,126	6,117	8,243	3,897	8,891	12,788	NA	NA	NA
Boaco	3,219	12,307	15,526	1,604	16,253	17,857	2,402	41,185	43,587	1,165	24,559	25,724
Juigalpa	4,067	16,055	20,122	2,744	12,682	15,426	3,088	20,839	23,927	NA	NA	NA
Chinandega	5,976	27,395	33,371	3,123	21,956	25,079	6,062	36,828	42,890	NA	NA	NA
Rivas	2,154	6,962	9,116	1,151	6,481	7,632	4,250	10,447	14,697	2,304	5,086	7,390
Masaya	4,767	15,326	20,093	1,875	16,400	18,275	4,859	36,437	41,296	3,961	15,600	19,561
Jinotega	2,952	22,386	25,338	1,611	17,421	19,032	1,663	35,975	37,638	712	22,375	23,087
Ocotal	617	2,560	3,177	1,807	6,587	8,394	10,697	22,613	33,310	12,369	15,654	28,023
Total	**31,032**	**124,538**	**155,570**	**17,739**	**117,533**	**135,272**	**40,021**	**254,690**	**294,711**	**20,865**	**86,246**	**107,111**

*January-June figures only: reporting was suspended. **PROFAMILIA projection based on January-June data. No reports in 2001 from three centers.

TABLE D-4: YOUTH PROGRAM MINI-CLUBS AND PARTICIPANTS, AS OF JUNE 2001

	Mini-clubs		Participants		
Regional Center	Plan	Actual	Plan	Actual	**Rank**
Rivas	20	40	200	720	1
Managua	20	32	200	525	2
Boaco	20	32	200	467	3
Matagalpa	20	29	200	441	4
Chinandega	20	17	200	357	5
Ocotal	20	22	200	350	6
Granada	20	30	200	339	7
Esteli	20	32	200	320	8
Masaya	20	20	200	304	9
Juigalpa	20	15	200	302	10
Jinotega	20	27	200	210	11
Total	220	296	2,200	4,335	
Percent of Plan		135%		197%	

TABLE D-5: PROFAMILIA SUSTAINABILITY, JANUARY-JUNE 2001

(from PROFAMILIA)

ASOCIACION PROBIENESTAR DE LA FAMILIA NICARAGUENSE

PROFAMILIA

RESUMEN DE AUTOSOSTENIBILIDAD DE LOS CENTROS REGIONALES CORRESPONDIENTE AL MES DE JUNIO-01 (Expresado en córdobas)

2001

C.Regional	Descripción	Enero	Feberero	Marzo	Abril	Mayo	Junio	TOTALES	Real 2000	Diferencia
	Ingresos	149,773	110,523	145,238	117,018.20	131,553.77	143,456.91	797,562	742,592	
	Costos	75,656	47,349	59,125	51,128.14	67,813.53	99,241.08	400,313	376,555	
	Gastos	139,780	128,037	147,074	106,105.03	137,018.36	139,956.53	797,971	755,493	
Matagalpa	Utilidad/Pérdida									
	%	70%	63%	70%	74%	64%	60%	67%	66%	1%
	Ingresos	169,947	156,428	162,314.89	151,086.38	180,600.47	187,606.35	1,007,983	830,535	
	Costos	75,226	47,673	69,927.21	81,116.06	88,170.91	100,550.95	462,664	394,087	
	Gastos	137,230	129,220	150,975.43	106,478.98	143,824.47	147,567.71	815,297	818,427	
Juigalpa	Utilidad/Pérdida									
	%	80%	88%	73%	81%	78%	76%	79%	68%	10%
	Ingresos	139,519	155,952	197,238.58	144,939.59	184,153.63	193,216.60	1,015,019	900,821	
	Costos	63,278	39,326	95,604.05	92,015.30	84,079.64	114,497.87	488,801	354,860	
	Gastos	156,062	128,036	162,890.83	121,603.71	146,980.13	156,164.68	871,738	901,603	
Boaco	Utilidad/Pérdida									
	%	64%	93%	76%	68%	80%	71%	75%	72%	3%
	Ingresos	103,113	89,575	96,680.95	92,314.03	112,516.22	102,119.98	596,318	680,966	
	Costos	44,725	28,849	40,434.84	64,994.69	81,965.50	28,177.03	289,146	294,190	
	Gastos	114,228	105,256	140,330.07	100,427.63	139,042.92	128,206.17	727,491	652,556	
Chinandega	Utilidad/Pérdida									
	%	65%	67%	53%	56%	51%	65%	59%	72%	-13%
	Ingresos		83,936	104,559.63	82,609.62	114,530.95	110,175.11	613,233	502,485	
	Costos		38,880	47,018.38	29,352.00	89,495.07	59,493.87	323,546	223,480	
	Gastos		113,102	111,942.37	73,093.39	99,462.46	107,445.62	618,819	678,462	
Rivas	Utilidad/Pérdida									
	%	68%	55%	66%	81%	61%	66%	65%	56%	9%
	Ingresos	136,829	130,138	129,256.10	128,436.97	146,782.11	150,896.83	822,338	588,804	
	Costos	34,662	33,942	69,399.54	109,460.83	79,007.11	82,444.64	408,916	270,101	
	Gastos	107,363	121,647	119,777.81	77,674.06	102,529.01	110,158.05	639,149	646,284	
Masaya	Utilidad/Pérdida									
	%	96%	84%	68%	69%	81%	78%	78%	64%	14%
	Ingresos	114,266	106,322	107,957.95	83,451.51	92,891.25	99,482.40	604,372	705,853	
	Costos	54,189	50,224	57,259.28	45,325.40	53,306.97	69,939.91	330,244	389,907	
	Gastos	117,597	113,451	128,605.20	86,230.29	110,686.87	120,038.57	676,609	645,987	
Jinotega	Utilidad/Pérdida									
	%	67%	65%	58%	63%	57%	52%	60%	68%	-8%
	Ingresos	78,744	78,805	79,365.75	70,736.08	83,601.33	75,110.31	466,363	625,745	
	Costos	32,007	34,067	36,568.60	40,144.04	37,362.48	38,756.53	218,905	270,247	
	Gastos	111,223	106,184	119,027.78	87,129.98	108,887.09	129,570.17	662,022	638,177	
Ocotal	Utilidad/Pérdida									
	%	55%	56%	51%	56%	57%	45%	53%	69%	-16%

C.Regional	Descripción	Enero	Feberero	Marzo	Abril	Mayo	Junio	TOTALES	Real 2000	Diferencia
	Ingresos	0	0	0	0	0	0	0	0	
	Costos	0	0	0	0	0	0	0	0	
León	Gastos	1,772	1,772	2,684.15	987.02	1,797.36	1,784.32	10,796	10,061	
	Utilidad/Pérdida									
	%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Ingresos	28,447	25,972	32,051.40	28,260.24	35,021.40	36,010.93	185,763	181,796	
	Costos	16,297	11,363	14,686.93	15,401.66	31,794.75	22,946.19	112,489	73,308	
Granada	Gastos	47,986	47,509	49,495.52	45,398.77	52,406.66	48,270.25	291,066	298,066	
	Utilidad/Pérdida									
	%	44%	44%	50%	46%	42%	51%	46%	49%	-3%
	Ingresos	452,808	419,188	487,848.75	458,114.00	486,085.99	507,845.19	2,811,890	2,442,531	
	Costos	135,289	207,618	224,244.20	264,291.95	259,867.00	319,990.43	1,411,300	932,425	
	Gastos	318,568	349,454	422,072.16	305,810.68	402,544.43	362,666.01	2,161,116	1,729,889	
Managua	Utilidad/Pérdida									
	%	100%	75%	75%	80%	73%	74%	79%	92%	-13%
	Ingresos	59,013	49,254	60,415.76	5,569.25	-	-	173,717	303,273	
	Costos	32,847	16,837	27,263.78	11,778.53	12,455.29	2,877.78	104,060	134,616	
	Gastos	89,611	83,386	83,450.14	28,709.93	47,059.50	18,999.33	351,215	462,733	
Estelí	Utilidad/Pérdida									
	%	48%	49%	55%	14%	-1%	-1%	38%	51%	-13%
	Ingresos	0	0	0	0	0	0	0	0	
	Costos	0	0	0	0	0	0	0	0	
	Gastos	4,001	6,505	2,872.53	0.01	0		13,495	0	
Somoto	Utilidad/Pérdida									
	%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Ingresos	0	0	0	0	0	0	0	0	
	Costos	0	0	0	0	0	0	0	0	
	Gastos	2,618	0	0	1,000.00	0	0	3,618	0	
Bluefields	Utilidad/Pérdida									
	%	0%	0%	0%	0%	0%	0%	0%	0%	0%
SUB-TOTAL	Ingresos	1,549,880	1,406,093	1,602,927	1,362,536	1,567,402	1,605,721	9,094,559	8,511,103	583,456
CENTROS	Costos	623,482	556,128	741,532	805,009	885,318	938,916	4,550,385	3,713,776	836,609
REGIONALES	Gastos	1,461,811	1,433,559	1,641,198	1,140,649	1,492,239	1,470,944	8,640,401	8,237,738	402,663
	Utilidad/Pérdida									
	%	74%	71%	67%	70%	66%	67%	69%	71%	-2%
	Ingresos							0.00	465,510	-465,510.00
	Costos							0	582,520	-582,520.00
OFICINAS	Gastos	1,141,083.75	967,196.67	1,111,880.33	746,369.92	1,325,032.20	1,395,609.55	6,687,172	8,484,906	
CENTRALES	Utilidad/Pérdida									
								0%	5%	-5%
	Ingresos	1,549,880	1,406,093	1,602,927	1,362,536	1,567,402	1,605,721	9,094,559	8,976,613	117,946
GRAN TOTAL	Costos	623,481	556,128	741,532	805,009	885,318	938,916	4,550,384	4,296,296	254,089
PROFAMILIA	Gastos	2,602,895	2,400,756	2,753,078	1,887,019	2,817,271	2,866,554	15,327,574	16,722,644	-1,395,070
	Utilidad/Pérdida									
	%	48%	48%	46%	51%	42%	42%	46%	43%	3%

Nota: Los gastos de oficinas Centrales no incluyen: Mercadeo Social, Overhead y Proyectos de Emergencia

TABLE D-6: PROFAMILIA BUDGET, INCOME AND EXPENSES, JANUARY-JUNE 2001 (Total, all of PROFAMILIA)
(from PROFAMILIA)

PROFAMILIA

SEGUIMIENTO PRESUPUESTARIO

AÑO PRESUPUESTADO : 2001
CENTRO REGIONAL : TODA LA ASOCIACION
MES REPORTADO : ACUMULADO A JUNIO 2001

	ACUMULADO A LA FECHA			Porcentaje	PLAN	PENDIENTE
	Plan	Real	Variación	de Variación	ANUAL	DE EJECUTAR
INGRESOS						
Donaciones						
Efectivo USAID	15,879,034	11,259,158	(4,619,876)	-29.1%	30,947,578	19,688,420
Efectivo IPPF	1,572,732	1,572,016	(716)	0.0%	4,013,677	2,441,661
Efectivo otros	0	37,918	37,918	N.A.	0	(37,918)
Overhead	1,582,390	1,150,000	(432,390)	-27.3%	3,360,300	2,210,300
Especies USAID	2,222,382	2,138,118	(84,264)	-3.8%	3,826,652	1,688,534
Especies IPPF	484,697	847,664	362,967	74.9%	484,697	(362,967)
Especies otros	0	65,372	65,372	N.A.	0	(65,372)
Total donaciones	**21,741,235**	**17,070,246**	**(4,670,989)**	**-21.5%**	**42,632,904**	**25,562,658**
Ingresos locales						
Venta de anticonceptivos	3,436,960	2,585,101	(851,859)	-24.8%	7,501,431	4,916,330
Productos farmacéuticos	1,685,692	1,605,593	(80,099)	-4.8%	3,449,212	1,843,619
Venta de servicios médicos	3,510,231	1,997,781	(1,512,450)	-43.1%	7,068,869	5,071,088
Servicios de lab. y diagnostico	3,633,755	3,195,306	(438,449)	-12.1%	7,435,802	4,240,496
Otros servicios y productos	78,300	274,994	196,694	251.2%	195,750	(79,244)
Total de ingresos locales	**12,344,938**	**9,658,775**	**(2,686,163)**	-21.8%	**25,651,064**	**15,992,289**
TOTAL INGRESOS	**34,086,173**	**26,729,021**	**(7,357,152)**		**68,283,968**	**41,554,947**
Costos de los productos y servicios vendidos						
Anticonceptivos	2,533,070	2,232,824	300,246	11.9%	5,861,764	3,628,940
Productos farmacéuticos	1,532,897	1,371,218	161,679	0	3,136,647	1,765,429
Servicios médicos	326,240	293,175	(33,065)	(0)	652,290	359,115
Servicios de lab. y diagnóstico	1,895,872	1,410,816	(485,056)	-25.6%	3,810,244	2,399,428
Otros servicios y productos		61,886	61,886	N.A.	0	(61,886)
Total costos de lo vendido	**6,288,079**	**5,369,919**	**5,690**	0.1%	**13,460,945**	**8,091,026**
Margen Bruto	**27,798,094**	**21,359,102**	**(7,351,462)**	-26.4%	**54,823,023**	**33,463,921**
Costos operacionales						
Salarios	8,100,780	7,734,972	365,808	4.5%	16,983,368	9,248,396
Beneficios socials	3,193,226	2,909,969	283,257	8.9%	6,646,369	3,736,400
Consultorías y serv. profesionales	729,427	508,149	221,278	30.3%	1,211,025	702,876
Gastos de viajes y transporte	1,809,701	1,308,387	501,314	27.7%	3,656,439	2,348,052
Servicios básicos	1,780,881	1,612,620	168,261	9.4%	3,534,835	1,922,215
Materiales y suministros	2,066,533	956,443	1,110,090	53.7%	3,701,183	2,744,740

	ACUMULADO A LA FECHA			Porcentaje	PLAN	PENDIENTE
	Plan	Real	Variación	de Variación	ANUAL	DE EJECUTAR
Costos operacional						
Material de empaque	692,508	34,602	657,906	95.0%	764,508	729,906
Promoción y publicidad	2,371,322	753,718	1,617,604	68.2%	3,282,989	2,529,271
Reparaciones y mantenimiento	844,633	671,631	173,002	20.5%	1,735,468	1,063,837
Gastos generales	646,468	678,702	(32,234)	-5.0%	1,310,731	632,029
Depreciación	1,716,946	1,732,515	(15,569)	-0.9%	3,520,373	1,787,858
Gastos de capacitación	776,104	336,649	439,455	56.6%	1,556,626	1,219,977
Total costos de Operación	**24,728,529**	**19,238,357**	**5,490,172**	22.2%	**47,903,914**	**28,665,557**
Utilidad (Pérdida) en operaciones	**3,069,565**	**2,120,745**	**(1,861,290)**	**-60.6%**	**6,919,109**	**4,798,364**
Otros ingresos: Intereses/var. cambiaría	**83,680**	**392,821**	**309,141**			
Total utilidad (pérdida) del período	**3,153,245**	**2,513,566**	**(1,552,149)**			
% de sostenibilidad	**39.8%**	**39.3%**	**-0.6%**		**41.8%**	**43.5%**

TABLE D-6.1: PROFAMILIA BUDGET, INCOME AND EXPENSES, JANUARY-JUNE 2001

(All of PROFAMILIA except Social Marketing, Youth and Emergency Programs)
(from PROFAMILIA)

PROFAMILIA

AÑO PRESUPUESTADO : 2001
CENTRO REGIONAL : TODA LA ASOCIACION, SIN MERCADEO SOCIAL, PROY. JOVENES, NI EMERGENCIA
MES REPORTADO : ACUMULADO A JUNIO 2001

	ACUMULADO A LA FECHA			Porcentaje	PLAN	PENDIENTE
	Plan	Real	Variación	de Variación	ANUAL	DE EJECUTAR
Ingresos locales						
Venta de anticonceptivos	2,922,400	2,304,881	(617,519)	-21.1%	5,872,311	3,567,430
Productos farmacéuticos	1,685,692	1,605,593	(80,099)	-4.8%	3,449,212	1,843,619
Venta de servicios medicos	3,472,611	1,974,308	(1,498,303)	-43.1%	6,993,629	5,019,321
Servicios de lab. y diagnóstico	3,585,395	3,195,306	(390,089)	-10.9%	7,339,082	4,143,776
Otros servicios y productos	0	13,871	13,871	N.A.	0	(13,871)
Total de ingresos locales	**11,666,098**	**9,093,959**	**(2,572,139)**	-22.0%	**23,654,234**	**14,560,275**
Costos de los productos y servicios vendidos						
Anticonceptivos	1,927,012	1,685,708	241,304	12.5%	3,876,189	2,190,481
Productos farmacéuticos	1,211,897	1,199,290	12,607	1.0%	2,485,047	1,285,757
Servicios medicos	326,240	287,879	(38,361)	-11.8%	405,858	117,979
Servicios de lab. y diagnóstico	1,772,656	1,410,816	(361,840)	-20.4%	3,810,244	2,399,428
Otros servicios y productos	0	0	0	N.A.	0	0
Total costos de lo vendido	**5,237,805**	**4,583,693**	**(146,290)**	-2.8%	**10,577,338**	**5,993,645**
Margen Bruto	**6,428,293**	**4,510,266**	**(2,718,429)**	-42.3%	**13,076,896**	**8,566,630**
Costos operacionales						
Salarios	6,679,308	6,323,489	355,819	5.3%	14,070,169	7,746,680
Beneficios socials	2,635,874	2,395,215	240,659	9.1%	5,503,940	3,108,725
Consultorías y serv. Profesionales	599,301	471,776	127,525	21.3%	941,625	469,849
Gastos de viajes y transporte	1,374,701	1,013,277	361,424	26.3%	2,786,439	1,773,162
Servicios básicos	1,326,241	1,238,404	87,837	6.6%	2,625,555	1,387,151
Materiales y suministros	1,801,179	841,787	959,392	53.3%	3,175,275	2,333,488
Material de empaque	0	0	0	N.A.	0	0
Promoción y publicidad	216,575	141,112	75,463	34.8%	446,425	305,313
Reparaciones y mantenimiento	691,633	535,652	155,981	22.6%	1,479,468	943,816
Gastos generales	433,556	606,571	(173,015)	-39.9%	918,307	311,736
Depreciación	1,476,436	1,487,441	(11,005)	-0.7%	3,039,352	1,551,911
Gastos de capacitación	626,104	272,967	353,137	56.4%	1,276,626	1,003,659
Total costos de Operación	**17,860,908**	**15,327,691**	**2,533,217**	14.2%	**36,263,181**	**20,935,490**
Dif. entre ingresos locales y costos totales	**(11,432,615)**	**(10,817,425)**	**(185,212)**	**-1.6%**	**(23,186,285)**	**(12,368,860)**
% de sostenibilidad	**50.5%**	**45.7%**	**-4.8%**		**50.5%**	**54.1%**

	ACUMULADO A LA FECHA			Porcentaje	PLAN	PENDIENTE
	Plan	Real	Variación	de Variación	ANUAL	DE EJECUTAR

ANALISIS DE MARGENES CONTRIBUCION

Venta de anticonceptivos	995,388	619,173	(376,215)	-37.8%	1,996,122	1,376,949
Productos farmacéuticos	473,795	406,303	(67,492)	-14.2%	964,165	557,862
Venta de servicios médicos	3,146,371	1,686,429	(1,459,942)	-46.4%	6,587,771	4,901,342
Servicios de lab. y diagnóstico	1,812,739	1,784,490	(28,249)	-1.6%	3,528,838	1,744,348
Otros servicios y productos	0	13,871	13,871	N.A.	0	(13,871)
Total márgenes de contribucion	**6,428,293**	**4,510,266**	**(1,918,027)**	-29.8%	**13,076,896**	**8,566,630**

ANALISIS DE MARGENES CONTRIBUCION PORCENTUAL

Venta de anticonceptivos	51.7%	36.7%	-14.9%		51.5%	
Productos farmacéuticos	39.1%	33.9%	-5.2%		38.8%	
Venta de servicios médicos	964.4%	585.8%	-378.6%		1623.2%	
Servicios de lab. y diagnóstico	102.3%	126.5%	24.2%		92.6%	
Otros servicios y productos	N.A.	N.A.	N.A.		N.A.	
Total márgenes de contribucion	**122.7%**	**98.4%**	**-24.3%**		**123.6%**	

Table D-6.2: PROFAMILIA BUDGET, INCOME AND EXPENSES, JANUARY-JUNE 2001 (Regional Centers only)
(from PROFAMILIA)

PROFAMILIA

SEGUIMIENTO PRESUPUESTARIO

AÑO PRESUPUESTADO : 2001
CENTRO REGIONAL : Centros Regionales
MES REPORTADO : ACUMULADO A JUNIO 2001

	ACUMULADO A LA FECHA			Porcentaje de Variación	PLAN ANUAL	PENDIENTE DE EJECUTAR
	Plan	Real	Variación			
Ingresos locales						
Venta de anticonceptivos	2,922,400	2,304,881	(617,519)	-21.1%	5,872,311	3,567,430
Productos farmacéuticos	1,685,692	1,605,593	(80,099)	-4.8%	3,449,212	1,843,619
Venta de servicios médicos	3,472,611	1,974,308	(1,498,303)	-43.1%	6,993,629	5,019,321
Servicios de lab. y diagnóstico	3,585,395	3,195,306	(390,089)	-10.9%	7,339,082	4,143,776
Otros servicios y productos	0	13,871	13,871	N.A.	0	(13,871)
Total de ingresos locales	**11,666,098**	**9,093,959**	**(2,572,139)**	-22.0%	**23,654,234**	**14,560,275**
Costos de los productos y servicios vendidos						
Anticonceptivos	1,927,012	1,685,708	241,304	12.5%	3,876,189	2,190,481
Productos farmacéuticos	1,211,897	1,199,290	12,607	1.0%	2,485,047	1,285,757
Servicios médicos	326,240	287,879	(38,361)	-11.8%	405,858	117,979
Servicios de lab. y diagnóstico	1,772,656	1,410,816	(361,840)	-20.4%	3,810,244	2,399,428
Otros servicios y productos	0	0	0	N.A.	0	0
Total costos de lo vendido	**5,237,805**	**4,583,693**	**(146,290)**	-2.8%	**10,577,338**	**5,993,645**
Margen Bruto	**6,428,293**	**4,510,266**	**(2,718,429)**	-42.3%	**13,076,896**	**8,566,630**
Costos operacionales						
Salarios	3,825,020	3,862,977	(37,957)	-1.0%	7,968,311	4,105,334
Beneficios sociales	1,494,542	1,431,358	63,184	4.2%	3,110,675	1,679,317
Consultorías y serv. profesionales	0	32,509	(32,509)	N.A.	0	(32,509)
Gastos de viajes y transporte	699,221	569,834	129,387	18.5%	1,425,162	855,328
Servicios básicos	707,173	627,191	79,982	11.3%	1,401,975	774,784
Materiales y suministros	1,211,070	527,795	683,275	56.4%	2,228,270	1,700,475
Material de empaque	0	0	0	N.A.	0	0
Promoción y publicidad	186,575	55,514	131,061	70.2%	386,425	330,911
Reparaciones y mantenimiento	428,322	332,451	95,871	22.4%	944,568	612,117
Gastos generales	130,403	157,949	(27,546)	-21.1%	297,079	139,130
Depreciación	899,478	958,142	(58,664)	-6.5%	1,885,468	927,326
Gastos de capacitación	225,156	84,681	140,475	62.4%	438,604	353,923
Total costos de Operación	**9,806,960**	**8,640,401**	**1,166,559**	11.9%	**20,086,537**	**11,446,136**
Dif. entre ingreos locales y costos totales	**(3,378,667)**	**(4,130,135)**	**(1,551,870)**	**-45.9%**	**(7,009,641)**	**(2,879,506)**
% de sostenibilidad	**77.5%**	**68.8%**	**-8.8%**		**77.1%**	**83.5%**

	ACUMULADO A LA FECHA			Porcentaje de Variación	PLAN ANUAL	PENDIENTE DE EJECUTAR
	Plan	Real	Variación			
ANALISIS DE MARGENES CONTRIBUCION						
Venta de anticonceptivos	995,388	619,173	(376,215)	-37.8%	1,996,122	1,376,949
Productos farmacéuticos	473,795	406,303	(67,492)	-14.2%	964,165	557,862
Venta de servicios médicos	3,146,371	1,686,429	(1,459,942)	-46.4%	6,587,771	4,901,342
Servicios de lab. y diagnóstico	1,812,739	1,784,490	(28,249)	-1.6%	3,528,838	1,744,348
Otros servicios y productos	0	13,871	13,871	N.A.	0	(13,871)
Total márgenes de contribucion	**6,428,293**	**4,510,266**	**(1,918,027)**	-29.8%	**13,076,896**	**8,566,630**
ANALISIS DE MARGENES CONTRIBUCION PORCENTUAL						
Venta de anticonceptivos	51.7%	36.7%	-14.9%		51.5%	
Productos farmacéuticos	39.1%	33.9%	-5.2%		38.8%	
Venta de servicios médicos	964.4%	585.8%	-378.6%		1623.2%	
Servicios de lab. y diagnóstico	102.3%	126.5%	24.2%		92.6%	
Otros servicios y productos	N.A.	N.A.	N.A.		N.A.	
Total márgenes de contribucion	**122.7%**	**98.4%**	**-24.3%**		**123.6%**	

TABLE D-6.3: PROFAMILIA BUDGET, INCOME AND EXPENSES, JANUARY-JUNE 2001 (Social Marketing)
(from PROFAMILIA)

PROFAMILIA

SEGUIMIENTO PRESUPUESTARIO

AÑO PRESUPUESTADO : 2001
CENTRO REGIONAL : MERCADEO SOCIAL
MES REPORTADO : ACUMULADO A JUNIO 2001

	ACUMULADO A LA FECHA			Porcentaje	PLAN	PENDIENTE
	Plan	Real	Variación	de Variación	ANUAL	DE EJECUTAR
Ingresos locales						
Venta de anticonceptivos	514,560	280,220	(234,340)	-45.5%	1,629,120	1,348,900
Productos farmacéuticos			0	N.A.	0	0
Venta de servicios			0	N.A.	0	0
Servicios de lab. y diagnóstico			0	N.A.	0	0
Otros servicios y productos	78,300	261,123	182,823	233.5%	195,750	(65,373)
Total de ingresos locales	**592,860**	**541,343**	**(51,517)**	**-8.7%**	**1,824,870**	**1,283,527**
Costos de los productos vendidos						
Anticonceptivos	606,058	547,116	58,942	9.7%	1,985,575	1,438,459
Productos farmacéuticos			0	N.A.	0	0
Servicios médicos			0	N.A.	0	0
Servicios de lab. y diagnóstico			0	N.A.	0	0
Otros servicios y productos		61,886	(61,886)	N.A.	0	(61,886)
Total costos de lo vendido	**606,058**	**609,002**	**(2,944)**	**-0.5%**	**1,985,575**	**1,376,573**
Margen Bruto	**(13,198)**	**(67,659)**	**(54,461)**	**412.6%**	**(160,705)**	**(93,046)**
Costos operacionales						
Salarios	1,269,414	1,269,950	(536)	0%	2,601,478	1,331,528
Beneficios sociales	497,028	456,523	40,505	8%	1,018,763	562,240
Consultorías y serv. profesionales	130,126	36,373	93,753	72%	269,400	233,027
Gastos de viajes y transporte	393,000	280,847	112,153	29%	786,000	505,153
Servicios básicos	390,500	328,571	61,929	16%	781,000	452,429
Materiales y suministros	144,054	93,973	50,081	35%	283,308	189,335
Material de empaque	692,508	34,602	657,906	95%	764,508	729,906
Promoción y publicidad	2,154,747	612,326	1,542,421	72%	2,836,564	2,224,238
Reparaciones y mantenimiento	153,000	133,852	19,148	13%	256,000	122,148
Gastos generales	94,412	52,136	42,276	45%	155,424	103,288
Depreciación	240,510	243,100	(2,590)	-1%	481,021	237,921
Gastos de capacitación	150,000	63,682	86,318	58%	280,000	216,318
Total costos de Operación	**6,309,299**	**3,605,935**	**2,703,364**	43%	**10,513,466**	**6,907,531**
Dif. entre ingresos locales y costos totales	**(6,322,497)**	**(3,673,594)**	**2,648,903**	**42%**	**(10,674,171)**	**(7,000,577)**
% de recuperacion de costos	**8.6%**	**12.8%**	**4.3%**		**14.6%**	**15.5%**

TABLE D-7: PROFAMILIA CLINIC PHYSICIAN PRODUCTIVITY (excluding regional directors)
(actual as of June 2001)

Physician Number	Clinic	Clients per Hour	M.D. Net per Hour	M.D. Cost per Visit
1	Managua	2.87	129.16	14.02
2	Boaco	2.75	83.94	27.48
3	Boaco	1.89	71.63	20.66
4	Masaya	2.38	71.40	27.94
5	Managua, CJ	2.74	69.70	32.27
6	Matagalpa	1.43	57.67	18.26
7	Managua	2.36	24.72	46.24
8	Chinandega	0.84	17.67	36.30
9	Rivas	0.61	14.02	57.14
10	Matagalpa	1.75	8.86	51.27
11	Boaco	0.88	-3.50	64.00
12	Juigalpa	1.34	-8.22	61.72
13	Jinotega	0.74	-8.25	71.19
14	Masaya	0.88	-8.75	70.00
15	Matagalpa	0.75	-10.00	70.00
16	Jinotega	1.10	-10.42	64.81
17	Ocotal	1.04	-11.18	66.07
18	Ocotal	0.38	-16.67	93.33
19	Jinotega	0.28	-22.83	132.34
20	Managua, M	1.38	-23.19	71.72
21	Chinandega	0.92	-47.75	104.23
	Average	**1.39**	**18.00**	**57.19**

Physicians Grouped by Regional Center, Excluding Regional Directors

Number of Physicians	Clinic	Clients per Hour	M.D. Net Loss/Hr	M.D. Cost per Visit
0	Granada	NA	NA	NA
1	Rivas	0.61	14.02	57.14
2	Masaya	1.63	31.33	48.97
3	Matagalpa	1.31	18.84	46.51
2	Chinandega	0.88	-15.04	70.26
2	Ocotal	0.71	-13.92	79.70
1	Juigalpa	1.34	-8.22	61.72
3	Boaco	1.84	50.69	37.38
4	Managua	2.34	50.10	41.06
3	Jinotega	0.71	-13.83	89.45
21	**Average**	**1.39**	**18.00**	**57.19**

APPENDIX E

PROFAMILIA'S SERVICE PACKAGE

PROFAMILIA'S SERVICE PACKAGE

This evaluation recommends that PROFAMILIA and USAID consider the scope of services that should be supported. The current project agreement calls for a broad expansion of services well beyond family planning (FP) and even reproductive health. It also includes some elements of primary health care (PHC). PROFAMILIA's promotional campaign attempts to position the association as a "Family Health" provider serving women, men, adolescents, and children. Given the need to clarify PROFAMILIA's mission and strategic objectives, the following description of various health packages may be of some help.

1. The Family Planning Package

PROFAMILIA's initial service package was limited to family planning, which was made up of counseling, IEC, and services for:

- **natural/traditional contraceptive methods (**Billings, calendar, withdrawal, etc.); and
- **modern contraceptive methods**: condoms, pills, IUDs, injectables, vasectomy, and tubal ligation.

2. The Reproductive Health Package

Since the International Conference on Population and Development (ICPD) held in Cairo in 1994, many countries and donors (including USAID) have tried to go beyond FP and offer a comprehensive package of reproductive health (RH) services. The full range of reproductive healthcare services includes the following:[1]

- **family planning** counseling, IEC, and services;
- IEC and services for **prenatal care, safe delivery and postnatal care**, especially breastfeeding and infant and women's health care;
- prevention and appropriate treatment of **infertility**;
- **abortion**,[2] including prevention of abortion and the management of complications arising from abortion;
- treatment of **reproductive tract infections**, STDs, and other reproductive health conditions; and
- IEC and counseling, as appropriate, on **human sexuality**, reproductive health, and responsible parenthood.

These services are to be provided through the **primary health care system**. Another expectation is that **referrals** for further diagnosis and treatment are to be made as required for family planning services (especially for such clinical services as voluntary sterilization and

[1] United Nations Population Fund (UNFPA), "Implementing the Reproductive Health Vision: Progress and Future Challenges for UNFPA," Office of Evaluation and Oversight, Issue 17, June 1999.

[2] Ibid., paragraph 8.25, which states, inter alia: "in no case should abortion be promoted as a method of family planning. In circumstances where abortion is not against the law, such abortion should be safe."

implants); complications of pregnancy, delivery and abortion; infertility; RTIs; breast cancers and cancers of the reproductive system; and STDs, including HIV/AIDS.

UNFPA has set priorities among these components:

> priority should generally be given to **family planning, maternal care, prevention of RTIs and prevention of abortion** because of their overall greater impact on improving sexual and reproductive health. Within these four components, priority again should be given to specific interventions which are most likely to have a significant impact on sexual and reproductive health, bearing in mind cost/benefit ratios.[3]

Primary Health Care

PHC is usually defined as a range of services delivered at the community and district levels, with the district defined as the lowest administrative level in a country. The basic distinction is between health centers (primary) and hospitals (secondary). The following is a comprehensive list of PHC services:[4]

- **General**: PHC household visits, health education;
- **Maternal care**: Antenatal care, safe delivery, postnatal care, family planning;
- **Child care**: Breastfeeding, growth monitoring, nutrition education, immunization, acute respiratory infection, diarrhea disease control, oral rehydration therapy; and
- **Other health care**: water supply, hygiene, and sanitation; school health and childhood disabilities; accidents and injuries; sexually transmitted diseases; HIV/AIDS; malaria; tuberculosis; treatment of minor ailments; and chronic, noncommunicable diseases (hypertension, diabetes mellitus, anemia).

PROFAMILIA's Current Package

- **Family planning**: IUD, injectables, condoms, vaginals, vasectomy, tubal ligation
- **Maternal care**: pregnancy tests, antenatal, delivery, postpartum
- **Other RH**: gynecology, cancer detection (mammography, Pap test, biopsy, cauterization, colostomy)
- **Child health**: pediatrics
- **Other**: General medicine, ultrasound, minor surgery, psychology, special services, other services, laboratory, pharmacy

[3] Ibid., p. A-9.

[4] Primary Health Care Management Advancement Programme. The Aga Khan Foundation, 1993.

APPENDIX F

ASHONPLAFA SUSTAINABILITY STRATEGY

ASHONPLAFA SUSTAINABILITY STRATEGY[1]

EXECUTIVE SUMMARY

Problem Statement. Fertility and unmet need for family planning (FP) remain high in Honduras, especially in rural areas. The Mission's strategic plan calls for a two-pronged strategy to increase FP use. The Honduran Family Planning Association (ASHONPLAFA) has been concentrating on expanding services in urban areas and the Ministry of Health (MOH) and nongovernmental agencies (NGOs) in rural areas. However, the MOH has been lagging behind for years and ASHONPLAFA has been attempting to expand its service in both urban and rural areas.

ASHONPLAFA—at USAID's urging—has also been trying to increase its financial sustainability. Although it has been successful in reaching 58 percent self-sufficiency in 1999, its achievements in FP coverage have remained below pre-project levels. In 1999, ASHONPLAFA only reached 86 percent of 1995 couple year of protection (CYP) achievements.

ASHONPLAFA is caught in a dilemma. The more it tries to expand services to rural areas, the less sustainable it is, and vice versa. The midterm evaluation recognized this when it concluded, "Financial self-sufficiency and increases in CYP achievement are mutually incompatible objectives."

The challenge is to identify mechanisms to continue the trend toward ASHONPLAFA's financial independence while also expanding its contribution to serving the critical unmet needs of those who cannot afford to pay fully for effective FP services, especially in rural areas. This is essential if USAID is to meet its Strategic Objective 3 of sustainable improvements in family health.

Strategic Approach. The proposed solution is to reorganize ASHONPLAFA's service components so that urban and rural services are financially separated. The urban services component will continue to provide (and expand) clinical, social marketing, and urban outreach services in its urban and peri-urban catchment areas and will become 100 percent self-sufficient by the end of the project extension in 2005 (possibly before that time). Rural services will be expanded to increase outreach services to needy couples in hard-to-reach, low prevalence areas where coverage might take precedence over sustainability. This service component will not be expected to become self-sufficient but will include modest cost-recovery targets. It will be subsidized by special funding from USAID and, eventually, in part, from surpluses generated by ASHONPLAFA's urban services.

ASHONPLAFA will attempt to raise additional funding from other donors and an annual fundraising campaign to support a special subsidy fund. This fund will be used to make up the difference between what needy people can afford and the established prices for FP services and

[1] Extracted from Jack Reynolds, Margarita Quevedo and Rodolphe Ellert-Beck, et. al., *Results Package for Intermediate Results 3.1.1., Improved Delivery of Sustainable Reproductive Health Services by ASHONPLAFA, Private Sector Population III Project in Honduras 2001-2005,* POPTECH Report No. 99-169, February 2000.

contraceptives. ASHONPLAFA will also set up a sustainability fund to enable it to continue providing at least some rural services after USAID funding ends. The association has requested technical assistance from USAID in fundraising, social marketing, and fund management.

Expected Results. USAID will provide a significant budget increase that will be directed largely at expanding ASHONPLAFA's rural services, with the objective of achieving significant increases in CPR and reductions in fertility. Over the five-year project extension period (2001–2005), CPR is expected to increase 1 percentage point per year in both rural and urban areas as a result of this intervention. Overall, CPR will increase from an estimated 54 percent in 2000 to 59 percent by 2005; rural CPR will increase from 44 to 49 percent and urban CPR will rise to 68 from 63 percent.

Significant improvements are also expected in two other key indicators: quality of care and urban sustainability. Quality of care is expected to show significant gains by 2005. The urban services will reach 100 percent financial sustainability by 2005 and, depending on the success of the fundraising activities, ASHONPLAFA should be able to continue approximately 18 percent of the subsidized rural services by the end of the project.

Activities. ASHONPLAFA already utilizes a variety of approaches to provide rural and urban services. These include urban family health centers and clinics, private VS clinics, urban and rural health posts, rural outreach brigades, community doctors, and urban social marketing. All of these will be expanded to varying degrees, depending on the needs in a given area, availability of other providers and services, potential for increased acceptance, costs, and potential sustainability.

ASHONPLAFA will also expand its support activities in rural areas, especially promotion; information, education and communication; external training of MOH and NGO personnel; quality assurance; and MOH and NGO coordination. A new service for adolescents is under development and will be expanded to rural areas.

ASHONPLAFA has a solid management track record that has improved significantly over the last three years. No changes will be required in the current organizational structure, management, or administrative procedures except to account for and report on urban and rural services separately. ASHONPLAFA will continue to submit quarterly and annual progress reports as well as annual work plans. Standard monitoring, reporting, and accountability procedures (including annual audits) will continue. Midterm and end-of-project evaluations will be scheduled by USAID.

Financing. Additional USAID support for the rural service component is essential since there are no other sources of funds at this time except ASHONPLAFA's own income, which is inadequate to support this expansion. A proposed contribution of $13.2 million is requested by ASHONPLAFA ($10.3 million for the cooperative agreement and $2.9 million for contraceptives), of which $11.2 million (85 percent) is for support of expanded rural services. Another $1 million is requested to continue service provision by other NGOs.

Implementation. USAID/Honduras expects to extend the current cooperative agreement with ASHONPLAFA through 2005. Funding will be obligated annually based on USAID–approved annual work plans and budgets.

APPENDIX G

PERFORMANCE INDICATORS

PERFORMANCE INDICATORS

USAID requested suggestions for performance indicators that could be used to monitor and evaluate grant achievements. The following list is taken from *Module 5: Monitoring and Evaluating Programmes*, of the PHC MAP series.[1] The module provides an annotated list of selected indicators for the following health services and management activities.

PHC Services

General PHC
- General PHC household visit
- Health education

Maternal Care
- Antenatal care
- Safe delivery
- Postnatal care
- Family planning

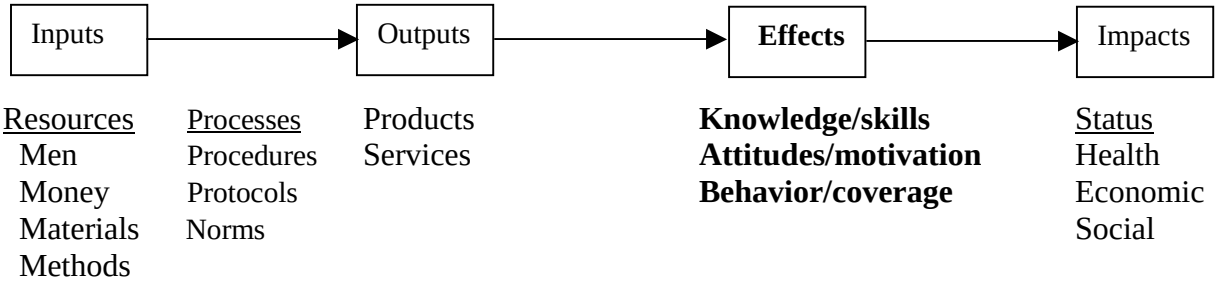
Child Care
- Acute respiratory infections
- Breastfeeding
- Diarrhea disease control/oral rehydration therapy
- Childhood disabilities
- Child immunization
- Growth monitoring/nutrition education

Community Health
- Water supply, hygiene, and sanitation

Other Health Care
- Accidents and injuries
- Chronic, noncommunicable diseases
- Malaria
- Treatment of minor ailments (general curative care)
- Tuberculosis
- Sexually transmitted diseases, HIV/AIDS

Management Activities
- Planning
- Personnel management
- Training
- Supervision
- Financial management
- Logistics management
- Information management
- Community organization

This appendix only covers the effects indicators for maternal care, since both USAID and PROFAMILIA are principally interested in exploring ways to assess RH results. However, the module also includes input, output, and impact indicators. The following diagram shows how the indicators are related to one another.



[1] *Primary Health Care Management Advancement Programme*, Aga Khan Foundation USA, 1993. These modules were translated into Spanish by the URC Quality Assurance Project staff in Peru and may be available from URC in Nicaragua from Dr. Filiberto Hernández, who was one of the URC advisors in Peru.

Impact indicators are used to assess Strategic Objectives (goals or purposes). Effect indicators are used to assess Intermediate Results (improvements in the knowledge, attitudes, and behavior of target populations). Some examples are:

Effect indicators (improvements in knowledge, attitudes, and practices of target populations):

- **Coverage** (e.g., percent of children fully immunized),
- **Behavior** (e.g., number of women whose deliveries are handled by trained providers),
- **Knowledge** (e.g., number or percent of adolescents who know how AIDS is transmitted), and
- **Skills** (e.g., number or percent of mothers who can administer ORT correctly).

The following are some potentially relevant effect indicators for RH, especially maternal care and FP.

Antenatal care

- Number or percentage of pregnant women identified that are high risk[2]
- Number or percentage of women who made three or more prenatal visits during their last pregnancy[3]
- Number or percentage of women who received two doses of tetanus toxoid to confer protection prior to delivery[4]
- Number or percentage of women who complied with iron folate supplementation regime during last pregnancy[5]
- Number or percentage of women gaining less than 1 kg/month during the second and third trimester

[2] High risk includes maternal age less than 16 or over 35, first pregnancy over 30 years of age, 5-8 past pregnancies, over 10 years since last pregnancy, previous caesarean section, previous delivery complications, previous still birth, two or more previous miscarriages, previous neonatal death, three or more abortions, two or more infant deaths, previous low birth weight baby, maternal height less than local standard, small pelvic outlet, maternal limp/polio leg, bleeding since last period, clinically anemic, fever, blood pressure greater than 140/90, sputum AFB positive, diabetes, heart disease, pre-eclampsia, abnormal fetal presentation, sickle cell, malaria, AIDS, breech presentation or transverse lie, large for date pregnancy, and suspected twins.

[3] Information for these indicators can be obtained from rapid or mini-surveys of women having delivered within the last 12 or 24 months, depending on local concerns. The norm for the number of visits should be adapted to local policy.

[4] This indicator shows how well women complete the necessary tetanus toxoid injections during their last pregnancy. The numerator is the number of women that receive the full coverage; the denominator is all ever-pregnant women.

[5] This information can be gathered in a survey by asking if iron pills were taken during pregnancy.

Safe Delivery[6]

- Number or percentage of deliveries in preferred locations (e.g., hospital, maternity clinic, health clinic, midwifery or birthing center)[7]
- Number or percentage of births attended by trained health provider (physician, nurse, midwife, CHW, TBA)[8]
- Number or percentage of mothers with knowledge of danger signs and where to go if complications arise (danger signs include malaria, diabetes, hypertension, liver disease, etc.)
- Number or percentage of families with members (men, women, mothers-in-law) aware of danger signs of pregnancy, labor, delivery and puerperium
- Ratio of positively treated obstetrical complications to all complications during the last 3–6 months[9]
- Percentage of women with optimum weight gain (i.e., no more than 13 kg and no less than 6 kg from pre-pregnancy to childbirth)[10]

Postnatal care

- Number or percentage of women receiving postnatal care from health workers
- Number or percentage of postnatal women who return for follow-up visits
- Number or percentage of women who have delivered and know when and where to return for a postnatal follow-up visit

Family planning[11]

- Number or percentage of eligible women knowing at least one modern FP method and where to obtain it[12]
- Number or percentage of women of child-bearing age currently using modern FP methods[13]

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[6] Most of the effect indicators can be obtained from survey interviews of women having delivered during the last 12 months.

[7] This indicator measures women's practice in using preferred facilities. The indicator is only relevant if the women have reasonable access. This indicator could be used to focus only on mothers from low socioeconomic status.

[8] The indicator is only relevant if the women have reasonable access to a trained provider. The numerator is the number using a trained provider; the denominator is the number of women with access.

[9] Positive treatments refer to complications that are successfully treated versus unsuccessful treatments that result in maternal mortality or chronic morbidity. This information can be gathered from a review of records in obstetrical care facilities. If the information is gathered directly from patients, a large sample of women will be required in order to collect data from those with complications.

[10] This indicator can be measured by using hospital records and surveys.

[11] The effect indicators can be measured by surveying eligible women or couples. The women should live in a conjugal relationship and still be at-risk for pregnancy.

[12] Modern methods include pills, injectables, IUDs, implants, sterilization and condoms.

[13] This indicator measures the coverage of contraceptive use among women of reproductive age, usually 15–49 years.

- Number or percentage of last pregnancies that were not intended[14]
- Average length of time current contraceptors of modern methods have used the method[15]
- Number or percentage of births with less than 24 months spacing among younger women 15–29 years[16]
- Ratio of births to women below 19 or above 34 years[17]

Data Collection

These data are usually collected through surveys, although some may be available in clinic records. Population-based surveys can be expensive, especially if they are national in scope. There are less expensive alternatives, however, that have been applied in many countries. One that is population based but small in sample size is known as a rapid survey, mini-survey, or multi-indicator survey. The rapid survey is discussed in depth in another PHC MAP module.[18] The module includes instructions for designing and carrying out quick surveys as well as prototype short- and long-form questionnaires on each PHC service. These surveys usually require 30 clusters of nine or more respondents and can be completed in a few days or weeks, depending on the geographic spread of the clusters and the number of questions asked.

The Philippines has conducted multi-indicator surveys as part of its local government unit development program. This survey collects data on four indicators (fully immunized children, tetanus toxoid coverage, vitamin A coverage, and contraceptive prevalence). Local provinces carry these surveys out annually through local universities.

Some indicators can be integrated into the service statistics system and recorded for each visit. Many of those listed above for maternal care fall into this category.

Finally, qualitative methods can also be used to collect this information through focus groups, exit interviews with clients, observations, and indepth interviews.

[14] This indicator measures unwanted pregnancies resulting in unwanted births or abortions. It provides a measure of the unmet need for FP services. The numerator is unwanted last pregnancies; the denominator is the number of women reporting one or more pregnancies.

[15] This measure is obtained for each contraceptive method and indicates the continuity of effective use. An alternative indicator is to determine if the current method has been used continually for the last 6 or 12 months. The numerator is current contraceptors continually using; the denominator is all current users (by method).

[16] This indicator measures the spacing of children among young women to improve both the health of the mother and baby. Information can be gathered from a survey of mothers.

[17] Women 15–19 and 34+ years should have substantially lower fertility levels. As women delay marriage and older women limit additional pregnancies, fertility should be concentrated in the 20–34 year age group. This indicator is appropriate for programs that are targeting young women, either to delay marriage or to space births, and targeting older women to use long-term or permanent contraceptive methods.

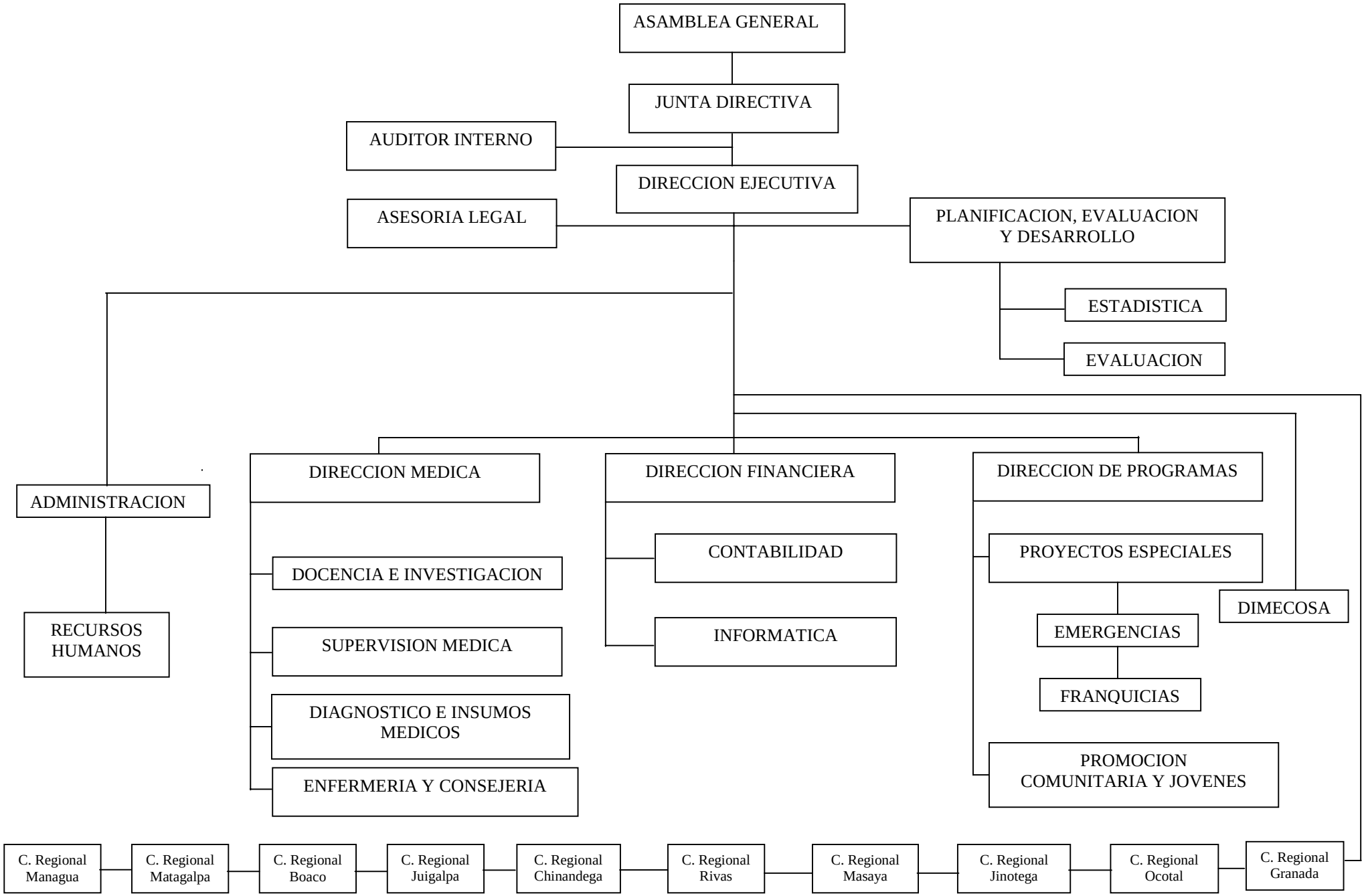
[18] *Module 2: Assessing Community Health Needs and Coverage*

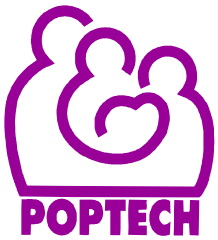
APPENDIX H

PROFAMILIA ORGANIZATION CHART

(from PROFAMILIA, June 2001)

PROFAMILIA ORGANIZATION CHART





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