# MIDTERM EVALUATION OF THE INTERNATIONAL PLANNED PARENTHOOD/ WESTERN HEMISPHERE REGION (IPPF/WHR) TRANSITION PROJECT

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by

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The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

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# ACKNOWLEDGEMENTS

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# ABBREVIATIONS

| | |
|---|---|
| AIDS | acquired immune deficiency syndrome |
| AIDSCAP | AIDS Control and Prevention Project |
| AIDSCOM | AIDS Technical Support Project, communication component |
| AUPFIRH | Asociacion Uruguaya de Planificacion Familiar |
| AVSC | Association for Voluntary Surgical Contraception |
| BEMFAM | Sociedade Civil Bem-Estar Familiar No Brasil (Brazil) |
| CA | cooperating agency |
| CBD | community-based distributor, community-based distribution |
| CPO | Contraceptive Procurement Organization |
| CYP | couple year of protection |
| DHS | Demographic and Health Survey |
| FEMAP | Federacion Mexicana de Asociaciones Privadas de Planificacion (Mexico) |
| FP | family planning |
| FPA | family planning association |
| FPATT | Family Planning Association of Trinidad and Tobago |
| HIV | human immunodeficiency virus |
| IEC | information, education, and communication |
| IMAP | International Medical Advisory Panel |
| INPPARES | Instituto Peruano de Paternidad Responsable |
| IPPF/WHR | International Planned Parenthood Foundation/Western Hemisphere Region |
| IUD | intrauterine device |
| MEXFAM | Fundacion Mexicana para Planificacion Familiar (Mexico, IPPF affiliate) |
| MIS | management information system |
| MOH | Ministry of Health |
| MSH | Management Sciences for Health |
| NA | new acceptors |
| PEF | PROFAMILIA Endowment Fund |
| PLAFAM | Asociacion de Planificacion Familiar |
| PROFAMILIA | Asociacion Pro-Bienestar de la Familia (Colombia) |
| PROFIT | Promoting Financial Investments and Transfers |
| PVO | private voluntary organization |
| SAC | Sistema para Administracion de Clinicas |
| SOW | scope of work |
| STDs | sexually transmitted diseases |
| TA | technical assistance |
| TECAPRO | Tecnologia Apropiada de Costa Rica S.A. |
| TP | Transition Project |
| UNFPA | United National Population Fund |
| USAID | United States Agency for International Development |
| VSC | voluntary surgical contraception |
| WRA | woman of reproductive age |

# PROJECT IDENTIFICATION DATA

| | |
|---|---|
| Project Title: | Expansion and Improvement of Family Planning Services in Latin America and the Caribbean: The Transition to Sustainable Programs |
| Countries: | Latin America and the Caribbean |
| Project Number: | 936-3065 |
| Cooperative Agreement Number: | CCP 3065 A 00 2018 00 |
| Project Dates: | July 1 1992 - June 30, 1997 |
| LOP Funding: | US$68,800,000 |
| Mode of Implementation: | Cooperative Agreement between USAID and the International Planned Parenthood Federation/ Western Hemisphere Region (IPPF/WHR) |
| Responsible USAID Official: | Anne Wilson |
| Previous Evaluation: | None |

# EXECUTIVE SUMMARY

IPPF/WHR is a federation of locally based non-profit family planning associations (FPAs) in Latin America and the Caribbean. Throughout the region, these FPAs have played significant roles in bringing about change in contraceptive use and fertility through advocacy, education, innovation and provision of family planning services. In June, 1992, IPPF/WHR and USAID signed a five year cooperative agreement for the $68.8 million Transition Project (TP). The following were the project's six objectives:

- Increase access to family planning services
- Broaden the range of contraceptive methods available in skewed method mix settings
- Strengthen institutional capacity of the FPAs
- Develop strategies to improve and expand services
- Evaluate performance and impact of programs
- Document and disseminate lessons learned

In December, 1993 a USAID management review concluded that service expansion was incompatible with sustainability. Therefore, IPPF/WHR and USAID agreed informally to drop the objective of expansion.

## Achievement of Objectives

*Service Volume*

Overall, the TP's objective of maintaining service volume was achieved from 1992 to 1994. This is particularly significant in light of the fact that there had been a regional increase of almost 167,000 new acceptors the year before the project began.

*Client Profile*

FPA data indicates that FPA clients are better educated (and, using education as a proxy for income, as agreed in advance by IPPF and USAID,) of a higher income status than the average woman of reproductive age surveyed in the respective countries' most recent demographic and health surveys. FPA surveys and anecdotal evidence indicate that the shift in focus to sustainability has accentuated this tendency during the past several years although for one FPA there has been little change in client profile. MEXFAM (Fundacion Mexicana para Planificacion Familiar), BEMFAM (Sociedade Civil Bem-Estar Familiar No Brasil), and AUPFIRH (Asociacion Uruguaya de Planificacion Familiar) report either being forced to phase out services which could not be made financially self-sustaining or experiencing a decline in low-income clients after fees were initiated.

The data does not permit general conclusions on the relative importance of service fees themselves or the process of introducing the fees. However, although all FPAs are committed to providing services to low-income clients and maintaining a percentage of low-income clients consistent with their mission, some degree of access to FPA services for low-income clients may be a trade-off for an institutional commitment to financial self-sufficiency.

*Quality of Care*

Quality of care was to be maintained under the sustainability focus. While the original project design contemplated redressing skewed method mixes where they existed, and some FPAs have made efforts in this area, it was dropped as an explicit objective of the TP and replaced with the objective of maintaining quality of care under the sustainability focus. Since no baseline data was collected on quality of care prior to the start of the TP, it is not possible to compare the current level of quality under a sustainability focus with quality before the TP. None the less, the team was impressed by the FPAs' commitment to quality. Most of the FPAs have quality assurance systems in place and employ a number of different approaches to monitor quality and a number of FPAs have carried out special studies and held workshops on quality of care.

**Recommendation:** As FPAs provide a wider range of services, often through contracted clinicians, attention should be given to assuring quality in these changed circumstances.

*Quality of Care Trade-offs*

There is no evidence that cost reduction or income generating efforts have resulted in lower quality of services. On the contrary, all FPA staff interviewed embrace the idea that providing quality services is fundamental to the survival of their organizations. However, as funding is withdrawn and as other services are added, FPAs are likely to face new conflicts between quality of care and financial sustainability, which will require adaptability and imagination as well as commitment to the importance of quality. The most threatened aspect of quality may be choice of contraceptive methods if some commodities prove difficult or expensive to procure.

**Recommendation:** Ensure a consistent flow of contraceptives and a range of methods.

*Financial Sustainability*

All FPAs have made the initial step of committing to sustainability. Some, however, have made the commitment more rapidly than others. FEMAP (Federacion Mexicana de Asociaciones Privadas de Planificacion), PROFAMILIA (Asociacion Pro-Bienestar de la Familia), and MEXFAM manage their operations every day with the goal of expanding surplus generating services in order to simultaneously attain greater financial sustainability and serve low-income clients. All the FPAs are also attempting to increase income through diversification of services and, to a lesser extent, by seeking other funding. PROFAMILIA has been the leader in the diversification effort with a surplus generated from patient care revenue of 189% in 1994.

One index of financial sustainability is the percent of total income supported by local income. In all cases, the FPAs have attained a higher level of financial sustainability than targeted by the TP. Using this index, MEXFAM has reached 30%, BEMFAM and INPPARES (Instituto Peruano de Paternidad Responsable) approximately 40%, PROFAMILIA 65%, and FEMAP 72% sustainability. None of the FPAs is projected to reach 100% by the end of the TP. This was not and should not be a goal.

*Project Training and Technical Assistance Resources*

The staffing configuration at IPPF/WHR, (currently 19 positions, some of which are part time) has been well suited for managing a large USAID- supported project and for assisting FPAs in changing their institutional culture to include the concept of sustainability. The configuration has been less adequate for providing direction and technical support in areas which are relatively new for IPPF/WHR and the FPAs, for example revenue diversification, costing, pricing and marketing. IPPF/WHR should have recruited a higher percentage of staff and consultants with skills in technical areas and should have paid greater attention to the areas of quality assurance and evaluation.

*Management Information System*

All FPAs have made good progress in developing their MIS systems and decentralizing them where appropriate. Most FPAs are using their systems for management decision making.

**Lessons Learned**

Several factors are critical for achieving financial sustainability. These include: institutional commitment to the concept; appropriate management structure and staff; identification of market niches and relevant strategies; activities which generate a surplus; sound pricing policies; and quality services delivered in an efficient manner.

Other conclusions made by the team are as follows:

- Sufficient time is critical for a successful transition. FPAs which have not begun to address sustainability should be encouraged to do so at the earliest opportunity.
- Adequate resources are essential to enable FPAs to develop the capability to be more self reliant, including through development of diversified services.
- FPAs must attract talented and dedicated staff who understand the business world and must compensate them accordingly.
- With the phase-out of USAID funds and donated contraceptives, and the consequent emphasis on sustainability, FPAs may be less able in the future to continue to reach substantial numbers of low income clients.

**Dissemination of Lessons Learned**

There has been significant dissemination of lessons learned within the FPAs and in international fora. In contrast, there has been less intraregional dissemination, although there have been several regional meetings and visits among FPA staff. Intraregional sharing among the three countries involved in the HIV/STDs add-on has been constrained by the three different languages represented.

**Alternatives to Current Commodities Procurement**

ALL FPAs visited rely heavily on USAID for donated contraceptives. IPPF/London is a second important source for several of the FPAs, either supplying contraceptives or providing funds for purchase of these locally. All of the FPAs are charging clients for contraceptives, with the exception of four BEMFAM clinics in low income areas.

PROFAMILIA has a well developed contraceptive procurement and marketing system. Its leadership is confident that it can secure needed contraceptives from its own resources when TP support is terminated, provided that the additional supplies currently being negotiated with USAID are forthcoming.

BEMFAM and INPPARES are planning to begin commercial marketing programs with technical and other assistance from SOMARC and/or IPPF/WHR. MEXFAM and FEMAP have decided not to implement commercial programs at present given the strong national and international competition in Mexico. The evaluation team supports the decisions of MEXFAM and FEMAP and considers BEMFAM's proposed venture somewhat risky under current circumstances.

**Endowment Fund**

USAID has provided $6 million to the PROFAMILIA Endowment Fund (PEF) in an effort to assist PROFAMILIA to achieve sustainability while maintaining a commitment of providing services to low income clients. Following a meeting with a PEF Board member and a review of the PEF Board minutes, the evaluation team concluded that the Board should be expanded from three to five persons and that it should be more proactive.

**Recommendation:** The PEF Board should be expanded to five members. The two additional members should be from Colombia.

**Project Organization, Management and Funding**

The project receives high marks from FPAs and USAID Missions in regard to responsiveness. The level of funding appears to be realistic when compared with the expectations placed on the project. It should be noted, however, that the FPAs appear not to be generating any significant savings which could be used for a no- cost extension of the project.

**HIV/STDs Add-On**

The HIV/STDs add-on is at a much earlier stage of development than the long-standing family planning activities of the FPAs. The HIV/STDs add-on has made a substantial contribution in dealing with a critical and growing public health problem, in building on the capacities of the FPAs, and in reinforcing IPPF's leadership in reproductive health. One of the key lessons from this project is the importance of orienting all staff to reproductive health and the role of HIV/STDs integration; this helped ensure interest in and commitment to a broader vision of health so that new services and approaches are seen as a critical part of care. Because of both the pioneering work in this

areas and its critical importance to safeguarding clients' reproductive health, focusing on capturing, sharing, and disseminating lessons learned should be emphasized in the future, as they will be valuable for other programs in the region and elsewhere. In Honduras and Jamaica in particular, institutionalizing the capacity to integrate HIV/STDs programming with other reproductive health services, rather than relying on IPPF/WHR for implementation, is a priority. The greatest threat to the success and credibility of the HIV/STDs program efforts is disruption of condom supplies in some countries. Funding for the HIV/STDs add-on should be considered independently of funding for the core TP. Continuation of support is recommended.

The following new challenges will need to be met as the FPAs now work on diagnosis and treatment, as well as on the prevention of STDs: follow up with clients to see whether treatment was obtained and identification of barriers to treatment; strategies to reach, treat, and ensure compliance of male partners of female clients with STDs; and technical and medical oversight of a rapidly changing field.

**Remaining Needs to be Addressed**

*Core Project*

The team endorses the plan to have FPAs develop strategic plans for the period through September, 1997. These plans should give particular attention to identifying technical and other assistance required from the TP. Based on the results of the planning effort, USAID and IPPF/WHR should determine needed changes in TP headquarters staffing. As a general principle, there should be a gradual phasing down of staff.

There is a need for increased documentation, monitoring and evaluation of the trade-offs between local self financing, client volume, client profile and quality.

We recommend a one year no cost extension of the project. FPAs which in the view of USAID and IPPF/WHR meeting their plan objectives should be eligible to receive available funds from savings. These funds should be dedicated principally to evaluating, documenting and disseminating TP results. It must be emphasized that IPPF/WHR and the FPAs, and particularly the former, would have to begin to generate savings (through underspending of their budgeted allocations for 1995-97) in order to have funds available for an extension.

The Mexico regional office should be closed within a reasonable time period and the savings should be reprogrammed for priority TP activities.

USAID should make every effort to continue to supply contraceptives to FPAs, including after the project ends. If possible, a gradual phasing down over a period of say five years would be the best arrangement.

*Family Planning Associations*

BEMFAM

- Hire a full time senior executive in sustainability.
- Strengthen BEMFAM's senior management capability to develop increased sustainability and to facilitate decentralization and diversification.
- Reassess the proposed commercial marketing venture.
- Work towards reducing administrative expenses, particularly at headquarters level.

INPPARES

- Provide management training to provincial offices in the areas of marketing, pricing and productivity.

PROFAMILIA

- The PEF Board should be expanded and PROFAMILIA representation increased.

MEXFAM

- Strengthen second level management of MEXFAM; institutionalize MEXFAM's management capability through team building.
- Expand the time scheduled for starting new health centers and increase efforts in developing both market studies and implementation strategies to increase the likelihood of success in this area.

# SUMMARY OF RECOMMENDATIONS

1. It would be useful for IPPF/WHR to determine at this stage how to identify and assess method mix trends caused by pricing changes at an early stage. While there is no indication that any FPAs have made or are considering decisions to drop particular methods which cost more than others, with pressures to improve cost-recovery, this is a possible risk in the future. (p. 15)

2. As FPAs provide a wider range of medical services, often using clinicians under contract, both IPPF/WHR and FPAs will need to focus more attention on assuring quality (e.g. clear standards, training, supervision, recruitment). Some dedicated medical capacity will be required for this purpose. (p. 16)

3. Ensure that FPAs maintain capacity for activities key to quality assurance, such as in-service updates and training and supervision, although they are often invisible, do not generate revenue, and have some associated costs. (p. 16)

4. With FPAs, and other CAs, apply or develop new measures for assessing quality of care in sustainable programs offering a diversity of reproductive health services. (p. 16)

5. Decentralize responsibility for conducting client satisfaction surveys to clinic level (rather than requiring presence of IPPF/WHR or FPA headquarters staff): provide training to develop local clinic staff capacity to conduct interviews and interpret data. (p. 16)

6. Ensure a consistent flow of contraceptives and a range of methods. If particular products are too expensive, provide reasonable alternatives, or ensure easy referral. (p. 26)

7. As FPAs seek to diversify services to generate revenue, consideration should be given not only to technology-driven services, often preferred by physicians, but to others which clients may need or desire (e.g. legal services, psychological counseling). (p. 26)

8. Ensure sufficient attention to raising client awareness about common symptoms and need for treatment of STDs, not only HIV. (p. 34)

9. Increase effort to reach and involve men to encourage use of condoms, identification and treatment of STDs (including reinforcing treatment when partner is diagnosed with STD), and the right of individuals to safe, healthy, voluntary, pleasurable sexuality. This will support these messages now aimed at women. (p. 34)

10. Increased emphasis should be placed on evaluation, so as to capture baseline information to measure change, and to document the lessons from this unfolding experience. This is an opportunity to test the new reproductive health working group indicators. Attention should be given to collecting information which is useful, and to distinguishing between information collected for the purposes of evaluation and that needed for program purposes, which will not be needed or possible when activities are expanded. (p. 35)

11. In addition to surveying current clients to gain their opinions on quality of services received and other services desired, it is important to learn more from potential clients, i.e. people in the community who haven't yet come for services. (p. 38)

12. In order for assessments of quality to have an effect, there should be rapid analysis and feedback to decision-makers and staff who were assessed. (p. 38)

13. More opportunities (at least two workshops prior to the project completion date) should be provided for informal exchanges of experience which will allow FPA staff to learn how other FPAs have overcome problems, built strong programs, etc. The workshops should include FPAs which have graduated, and involve FPA staff from regional programs (not just headquarters staff). (p. 40)

14. The PEF Board should be expanded (as permitted in the current by-laws) to five members. The two additional members should be Colombian (possibly individuals who are not members of the PROFAMILIA Board). (p. 44)

15. The team endorses the concept of requiring the FPAs to develop strategic plans for the remaining duration of the project through September 1997. These plans should be completed by the end of May at the latest and approved by the FPA Boards. They should give particular attention to determining technical needs and how they can best be met, i.e. with technical assistance, training, or staff development. IPPF/WHR, the FPAs, and USAID should determine how best to secure the required support, including local support and support from other CAs. (p. 49)

16. Contingent upon the results of the strategic planning exercise endorsed above, IPPF/WHR and USAID should determine needed changes in TP headquarters staffing. As a general principle, there should be a gradual phasing down of staff to reflect the reality that the TP will terminate in two and a half years. (p. 49)

17. There is a need for increased documentation, monitoring and evaluation of the trade-offs between local self financing, client volume, client profile and quality. A second person experienced in evaluation is needed at IPPF/WHR to work with the FPAs and document lessons learned. (p. 49)

18. The team recommends a one year no cost extension of the project. FPAs which, in the view of IPPF/WHR and USAID, are satisfactorily meeting their strategic plan objectives should be eligible to receive available funds from savings. USAID, in consultation with IPPF/WHR, should establish a ceiling on funds to be allocated for TP expenses at IPPF/WHR headquarters. These particular funds should be dedicated principally to evaluating and documenting the TP experience and disseminating the results. This could include support of workshops and other mechanisms to educate other FPAs about making a successful transition to sustainability. It must be emphasized, however, that IPPF/WHR and the FPAs would have to begin to generate savings (through underspending of their budgeted allocations for 1995-1997) in order to have funds available for the extension. (p. 49)

19. The Mexico regional office was established largely at USAID's initiative. The evaluation team members who visited Mexico believe that this office no longer serves an essential

function. This office should be closed within a reasonable time and the funds saved should be reprogrammed for other TP priorities. (p. 50)

20. USAID should make every effort to continue supplying contraceptives to FPAs, through other mechanisms besides and in addition to the TP. Supplies should continue after the end of the TP in recognition of the fact that if FPAs have to purchase contraceptives, their chances for sustainability will be hurt. A gradual phasing down of supplies over a period of approximately five years would be the best arrangement. (p. 50)

21. As recommended by the USAID management review, increasing service volume should no longer be a project objective. (p. 50)

22. BEMFAM:
    - Add additional management, legal and financial talent to the Board.
    - Hire a full time senior executive in sustainability, selected jointly by the Executive Director, the BEMFAM Board and IPPF/WHR.
    - Strengthen BEMFAM's senior management capability to develop increased sustainability and to facilitate decentralization and diversification.
    - Reassess the proposed commercial marketing venture, taking account of the CPO.
    - Organize training for regional coordinators in marketing, negotiating program contracts, MIS, and costing and pricing.
    - Work towards reducing administrative costs, particularly at the central level.
    - Undertake consumer research designed to assess BEMFAM'S image and the needs and interests of potential clients.
    - Increase minimum delivery order of commodities to avoid shortages.
    - Assess and compare integrated clinics and programs in reference to client profiles, productivity, costs and income. (p. 50)

23. INPPARES:
    - Implement a quality assurance system.
    - Provide management training to provincial offices in the areas of marketing, pricing and productivity.
    - Decentralize the MIS system to provincial offices when and where appropriate.
    - Document client profiles in the CBD program at least annually. (p. 51)

24. PROFAMILIA:
    - The PEF Board should be expanded and PROFAMILIA representation increased. (p. 51)

25. MEXFAM:
    - Strengthen second level management of MEXFAM and institutionalize MEXFAM's management capability through team building.
    - Integrate MIS information and data for use in management decisions.
    - Extend the schedule for starting new health centers and increase efforts to conduct market studies and develop implementation strategies to increase the likelihood of success in this area.
    - Document client profiles on a regular basis using existing MIS. (p. 51)

26. FEMAP:
    - Undertake a marketing survey designed to enhance FEMAP's image. (p. 51)

27. A follow-on mechanism for HIV/STDs integration should be encouraged beyond the end of the core Transition Project cooperative agreement and should be supported for a longer period of time given its stage of development and the rapidly growing regional prevalence of HIV/STDs. (p. 52)

28. Include other countries in the add-on, as recommended in the management review. Other FPAs in the region are also doing work in this area and should be included in dissemination efforts and exchanges of experience, and technical support as possible. (p. 52)

29. Place high priority on alleviating shortages of condoms and in creating rules, delivery systems and funding to maintain a continuous supply of these critical commodities. (p. 52)

30. Increased clinical attention will be needed for STD diagnosis and treatment. Some dedicated medical capacity will be required in this area from IPPF/WHR (or London) to provide direction and review progress. (p. 52)

31. Increased emphasis should be placed on evaluation in order to capture baseline information and to document lessons learned. (p. 52)

# 1. INTRODUCTION

## 1.1 Project Background

IPPF/WHR, a registered U.S. PVO, is a federation made up exclusively of locally based private, nonprofit family planning associations (FPAs) in Latin America and the Caribbean. Throughout the region, these FPAs have played a significant role in bringing about change in contraceptive use and fertility through advocacy, education, innovation and the provision of family planning services.

IPPF/WHR has received funding from USAID since 1985 to expand and improve family planning services in the region under the Matching Grant project. The Matching Grant project, which required all Federal funds awarded to FPAs to be matched with non-Federal funds, has proved to be a very effective way for USAID to assist low income and underserved populations to obtain greater access to quality services. Under the Matching Grant project the FPAs succeeded in moving toward sustainability by increasing their income from other sources.

In December 1991 IPPF/WHR presented an unsolicited proposal to USAID with two main goals: 1) to expand and improve family planning services to low-income and underserved populations throughout Latin America and the Caribbean; and 2) to assist selected IPPF/WHR family planning associations (FPAs) to make the transition from reliance on USAID population funds to sustainability without USAID funding. IPPF/WHR requested $68.8 million over five years. In April 1992 IPPF/WHR resubmitted the proposal and on June 30, 1992 IPPF/WHR and USAID signed the Cooperative Agreement for the Transition Project.

## 1.2 Evaluation Objectives

The four objectives of the evaluation are:

- To assess the extent to which the project has accomplished the objectives as set forth in the project design.
- To assess how organization, management and finances have influenced the accomplishments of the project.
- To identify what activities should continue to receive USAID support after the end of this project and under what mechanism.
- To assess USAID's management of the Project.

## 1.3 Evaluation Methodology

The Cooperative Agreement called for an evaluation to be conducted by external evaluators in the third year of the project. The evaluation was intended to assess accomplishment of project objectives; identify project results and impacts; examine the influence of the project's organization, management and finances on its accomplishments; analyze project design; and identify outstanding issues to be addressed.

The evaluation team, composed of team leader Robert Wickham, M. Roy Brooks, Laurel K. Cobb, and Cynthia Steele Verme, conducted interviews and meetings with staff members of the Office of Population, the Office of Health, and the Latin American Bureau in Washington, DC and with IPPF/WHR staff in New York. Additionally, the team conversed by telephone with significant contributors to the early design and development of the project who are no longer working with USAID and IPPF/WHR. Phased-out FPAs were requested to furnish information on their current level of local self-financing, service volume, client profile and the FPAs, to describe lessons learned, and to offer recommendations.

All four team members traveled to Brazil where Wickham and Brooks spent three working days interviewing BEMFAM (Sociedade Civil Bem-Estar Familiar No Brasil) staff in the central office and Cobb and Steele Verme spent five working days interviewing at both central and regional offices. Wickham and Brooks traveled to Colombia for three days to meet with PROFAMILIA (Asociacion Pro-Bienestar de la Familia) staff and to Mexico where they spent two days interviewing MEXFAM (Fundacion Mexicana para Planificacion Familiar) staff and one day with FEMAP (Federacion Mexicana de Asociaciones Privadas de Planificacion) staff. Cobb and Steele Verme traveled to Peru where they spent four days with INPPARES (Instituto Peruano de Paternidad Responsable) staff and Peruvian agencies. In each country, team members met with USAID mission staff on several occasions. Because the team divided into two smaller teams for specific country work and in order to standardize data collected, a questionnaire was developed based on the SOW. The team used IPPF/WHR's definition and indicators of sustainability in the questionnaire and in its work.

IPPF/WHR, the FPAs, and USAID provided copies of reports, workplans, and financial statements and gathered data for the team up to the final writing of the report. In some instances there were differences in the data provided by IPPF/WHR and the FPAs; when this occurred, the team used one or the other source consistently to demonstrate a specific trend in an FPA.

See Appendix H for a copy of the Scope of Work (SOW).

# 2. ACHIEVEMENT OF PROJECT OBJECTIVES

## 2.1 Original Objectives

The original IPPF/WHR proposal contained seven objectives, including an explicit sustainability objective ("to develop and promote strategies to achieve greater sustainability of programs") and a separate objective, "to strengthen financial and administrative management". In contrast, the Cooperative Agreement listed six objectives:

- Increase access to family planning services.
- Broaden the range of contraceptive methods available in skewed method mix settings.
- Strengthen the institutional capacity of family planning programs.
- Develop and promote strategies to improve and expand services.
- Evaluate performance and impact of programs.
- Document and disseminate lessons learned.

The two objectives in the original proposal mentioned above were combined to form the third objective of the Cooperative Agreement, namely, "to strengthen institutional capacity".

In December 1993, USAID conducted a management review of the Transition Project which concluded (and this team agrees) that the first objective of the Cooperative Agreement, increasing service volume, was incompatible with the focus on program sustainability. Therefore USAID and IPPF/WHR agreed informally that service expansion should not be an objective of the Transition Project. While FPAs might choose to expand services, service expansion should be an internal FPA decision rather than a project objective.

## 2.2 Achievement of Objectives in View of Sustainability

Although the Cooperative Agreement did not include a specific sustainability objective, IPPF/WHR went on to define sustainability explicitly as: *The ability to recover the cost of family planning services previously funded by USAID with local income and to continue providing the same volume and quality of services to low-income populations.*

In a paper presented at the American Public Health Association Conference (Williams and Townsend, 1994) IPPF/WHR staff discussed IPPF/WHR's understanding of sustainability, specifically in the context of the Transition Project, using the following four indicators of sustainability:

1) Service Volume: To what extent are the FPAs able to maintain their former volume of family planning services during the phase-out period and after USAID funding ends?

2) Client Profile: To what extent are they able to identify and serve a clientele consistent with their mission?

3) Quality: To what extent are they able to maintain high levels of service quality both during and after the phase-out period?

4) Finances: To what extent are the FPAs able to replace funds formerly donated by USAID with local income, and to what extent are they able to account for and control costs?

Figure 1 presents the conceptual framework of the Transition Project.1 As this figure indicates, IPPF/WHR has identified one FPA functional output (increased local self-financing), one FPA service output (quality) and two service utilization outputs (service volume or number of family planning clients and client profile) as critical factors integral to the outcome of sustainability.

IPPF/WHR deserves credit for designing and developing a project with a clear definition of sustainability at the output level rather than at the process level. Their definition is an addition to the field.

### *2.2.1 Service Volume*

There are two important considerations pertaining to total service volume: 1) total FPA service volume is comprised of clients reached through differing service delivery strategies who are therefore differently affected by the sustainability emphasis; and 2) FPAs report new acceptors differently.[2] All FPAs offer services in their own clinics and also work in collaboration with private and public sector providers. The collaboration potentially includes FPA provision of: TA, training, educational materials, supervision and, very importantly, contraceptives. FPAs differ in how they report new acceptors from these collaborative efforts. PROFAMILIA does not report CBD clients; INPPARES stopped in 1992 (hence the large decline), while the other FPAs continue to report them. MEXFAM has tightened its criteria for counting; it no longer counts new acceptors in joint ventures with government organizations. BEMFAM and INPPARES continue to do so. Table 1 presents the total number of new acceptors from 1991 to 1994, as reported by the FPAs (actual for all but MEXFAM, BEMFAM and INPPARES).

[1] See the Handbook of Indicators for Family Planning Program Evaluation, Jane T. Bertrand, Robert J. Magnani, and James C. Knowles, 1994.

[2] IPPF/WHR is currently working with FPAs to standardize reporting of new acceptors in various service delivery strategies.

**FIGURE 1**

**TABLE 1**

| FPA New Family Planning Acceptors, Including Those Reported in CBD Programs and in Affiliated Government and Private Sector Agreements | | | | |
|---|---|---|---|---|
| | 1991 | 1992 | 1993 | 1994 actual & projected |
| BEMFAM, Brazil | 505,246 | 658,541 | 673,642 | 653,470 |
| APROFAM, Chile | 40,373 | 37,330 | 28,127 | NA |
| INPPARES, Peru | 264,957 | 149,563 | 224,682 | 282,763 |
| PROFAMILIA, Colombia | 146,492 | 154,189 | 152,626 | 152,776 |
| MEXFAM, Mexico | 401,307 | 454,948 | 380,778 | 356,810 |
| FEMAP, Mexico | 0 | 58,577 | 47,906 | 55,572 |
| CEPEP, Paraguay | 17,394 | 9,915 | 6,396 | 5,938 |
| FPATT, Trinidad and Tobago | 3,758 | 2,513 | 2,544 | 2,468 |
| AUPFIRH, Uruguay | 6,457 | 24,643 | 19,083 | 14,606 |
| PLAFAM, Venezuela | 5,275 | 7,958 | 6,533 | 5,204 |
| TOTAL | 1,391,259 | 1,558,177 | 1,542,317 | 1,529,607 |

Source: FPAs and IPPF/WHR

Breaking out FPA statistics on direct clinical services illustrates the differing effect the sustainability emphasis had in three countries under different conditions. Table 2 presents the total number of new acceptors of direct service delivery in three FPAs in 1994 relative to 1991. During this time INPPARES received bilateral funds for service expansion in the peri-urban areas of Lima, as well as Transition Project funds.

**TABLE 2**

| Number of New Family Planning Acceptors in FPA Clinics, 1994 relative to 1991 | | | | | |
|---|---|---|---|---|---|
| | 1991 | 1992 | 1993 | 1994 projected | 1994 vol. as % of 1991 vol. |
| INPPARES Peru | 63,781 | 43,186 | 63,581 | 81,152 | 127% |
| BEMFAM Brazil | 51,841 | 23,657 | 21,202 | 19,488 | 38% |
| PROFAMILIA Colombia | 146,492 | 154,189 | 152,626 | 152,776 | 104% |

Source: FPAs and IPPF/WHR

Couple years of protection (CYP) trends are also an indicator of service volume during the project. INPPARES and PROFAMILIA increased CYP during the last two years and BEMFAM maintained volume. CYP declined in MEXFAM, PLAFAM (Asociacion de Planificacion Familiar) and AUPFIRH (Asociacion Uruguaya de Planificacion Familiar). MEXFAM's decline in new acceptors and CYP was attributed to a reclassification of new acceptors, a tightening of pass-through criteria, a closing of three centers, and the Chiapas rebellion which brought programs in that state to a standstill.

Table 3 presents CYP trends using the old (pre-1991) conversion factors. IPPF/WHR keeps total FPA CYP using the old factors so as to show trends, but presents CYP using the new factors to USAID on the activities funded by the Transition Project (a proportion of FPA activities). Brazil and Peru gave the team CYP using the new factors; that data has been recalculated and projected for 1994 using the old factors.

**TABLE 3**

| Trends in Total FPA CYP (Old Conversion Factors) 1991-1994 | | | | |
|---|---|---|---|---|
| | 1991 | 1992 | 1993 | 1994 (actual and projected) |
| BEMFAM, Brazil | 406,472 | 455,815 | 445,166 | 445,258 |
| INPPARES, Peru | 235,353 | 149,994 | 222,768 | 272,551 |
| PROFAMILIA, Colombia | 1,780,990 | 1,974,755 | 2,009,402 | 2,110,787 |
| MEXFAM, Mexico | 435,973 | 422,628 | 533,850 | 241,949 |
| AUPFIRH, Uruguay | 47,597 | 46,108 | 38,661 | 36,776 |
| PLAFAM, Venezuela | 29,654 | 34,029 | 27,236 | 28,284 |
| Total | 2,936,039 | 3,083,329 | 3,277,083 | 3,135,696 |

Source: FPAs and IPPF/WHR

Figure 2 presents percentage growth in CYP and new acceptors in PROFAMILIA, BEMFAM, INPPARES AND MEXFAM during the project.

Overall, the Transition Project's regional objective of maintaining service volume was achieved from 1992-1994. This is particularly significant in light of the fact there had been a regional increase of almost 167,000 new acceptors the year before the project began. Compared to 1991, the volume of new acceptors grew by 10%, whereas CYP declined slightly. Individual FPAs' maintenance of service volume during the first two and a half years of the project varied.

For BEMFAM and MEXFAM, a consequence of the sustainability focus has been a shift in the balance between service delivery strategies. BEMFAM experienced a decline in service volume in its own clinics and an increase in the collaborative programs. MEXFAM reclassified its collaborative efforts and set out to increase direct service delivery.

**FIGURE 2**

### *2.2.2 Client Profile*

Client profile is used to assess the effect that an emphasis on cost recovery has had on accessibility to family planning for the poorest FPA clients. Three questions must be answered to gain a clear picture of the impact:

- To what extent has the client profile in a particular FPA changed over the life of the project?
- To what extent, if any, are changes in client profile correlated with cost recovery efforts?
- How does the process of initiating and managing cost recovery efforts affect client profile outcome?

The evaluation team attempted to answer these questions using level of education as a proxy for socio-economic class, as previously agreed by IPPF/WHR and USAID.

Data Sources. There are two principal sources of client profile data; the first is clinic-based new acceptor intake forms and the second is special surveys. All FPAs collect data from new acceptors in their clinics at the time of a client's first visit. PROFAMILIA, which has a sophisticated MIS, analyzes and monitors that data on a periodic basis. MEXFAM, INPPARES and BEMFAM which are in the process of completing installation of the clinic management modules of their MIS, have data on some clinics but have not yet consolidated or used that data. FPAs routinely collect client profile data on clinic clients only - which are, in three of the four FPAs visited, a relatively small proportion of the new acceptors reported each year. For example, in 1994, new acceptors in BEMFAM's own clinics accounted for only 4% of the total number of new acceptors, in INPPARES 29%, and in MEXFAM 1%.

The second source of data are surveys, undertaken by FPAs during the Transition Project with IPPF/WHR's help. INPPARES, which is not yet producing routine clinic-based data on client profile, undertook client satisfaction surveys in four of its own clinics in 1994. One question pertained to clients' level of education. MEXFAM undertook a survey in 1991-1992 and BEMFAM has devoted considerable effort to tracking client profile; in 1992, 1993 and 1994 it undertook surveys on clients in each of its clinics and integrated programs. (See Appendix C.)

Client Profile Findings. A comparison of FPA client profile data with the most recent DHS data on level of education for women of reproductive age (WRA) indicates that PROFAMILIA, INPPARES and BEMFAM clients are considerably better educated than the average WRA in their country or region. With PROFAMILIA there has been little change over the last few years. For BEMFAM the difference appears to have increased from 1992-1994. Only 1994 data is available for INPPARES.

- The 1990 DHS indicated that 55% of Colombian WRA had primary school or less education; 45% had secondary or more than secondary school education. In 1991, 27% of PROFAMILIA's clients had primary school or less education; by 1994 that percentage had dropped slightly to 24% (see Appendix E, Table 3).

- The 1991 Northeast Brazil DHS indicated that 43% of WRA in the Northeast had not completed primary school education.[3] In 1992, 31% of BEMFAM clients had incomplete primary schooling; however, there was a marked difference between clients in BEMFAM's clinics and those in the integrated programs: 11.5% of clients in BEMFAM clinics had not completed primary education while 39.3% had completed primary education or higher in the integrated programs. In 1993, the BEMFAM average for clients with incomplete primary schooling had dropped to 16.4%; 6.7% of clients in the clinics had less than complete primary education while 20.5% of the clients in the integrated programs reported incomplete primary schooling. Preliminary data for BEMFAM as a whole is available from the 1994 survey: 15.6% of BEMFAM clients have not completed primary education. While the decline in the percentage of clients with low levels of education in BEMFAM's clinics from 1992-1993 might be related to fees for services, the reason for the decline in the integrated programs is puzzling because there was no reported reduction in the number of integrated program agreements, nor any significant drop-outs from these programs, despite BEMFAM's increase of the symbolic fee charged in each of the programs. The client profile in integrated programs should not have been affected since clients in these programs receive free services; the apparent shift to better educated women in these programs warrants further study. (See Appendix C, Table 5.)

INPPARES's surveys in 1994 in four of its clinics indicate that INPPARES clinic clients are considerably better educated than the average WRA in their region: the percentage of women with a primary school education or less in INPPARES was less than half of the percentage reported for WRA in their region in the 1991-1992 DHS. For example, 23.8% of surveyed INPPARES clients in the Chiclayo clinic had primary school or less education while 51.6% of DHS respondents in that region (Nor-oriental) did. However, it must be noted that only 28-29% of the new acceptors reported by INPPARES in the last several years are clinic clients; the majority of new acceptors are CBD users, many in the peri-urban areas of Lima, presumably low-income underserved women. (See Appendix D, Table 5.)

Client Profile and Cost Recovery. Neither the time or the data available to the team permits general conclusions on correlations between increased fees for services and client profile - or the importance that process plays in such correlations. The experience and documentation of that experience has varied in each FPA.

PROFAMILIA has maintained the same client education profile in the face of increasing levels of self-financing and has data to document it. The process of increasing cost recovery appears to have been successful.

MEXFAM closed some centers which would not be self-financing (thereby ending services for poor clients). After establishing fixed prices in clinics identified as income generators, there was a 20% decrease in low-income clients. After the price increase, overall service volume returned to its previous level within six months. Presumably low-income clients were replaced by those who could afford to pay the new prices.

[3] Nine of the eleven BEMFAM clinics and eight of the ten integrated programs are in the Northeast.

BEMFAM, whose projected number of 1994 new acceptors in its own clinics is 82% of the 1992 number, raised prices in line with inflation in 1993 and considerably above it in 1994. In 1994 the average fee for service (in US$) was almost three times that of 1993. In January 1995, BEMFAM declared all services to be free in four clinics which experienced dramatic drops in service volume after fees were initiated in January 1994. See Section 2.3 for a discussion of trade-offs in BEMFAM's Olinda clinic.

Service volume in INPPARES clinics has increased each year of the Transition Project. INPPARES increased official clinic prices in 1994 but reports there were no complaints nor drop in volume because 1) the prices were still slightly below the market; and 2) INPPARES gave clinic staff complete flexibility in adjusting fees to a client's perceived ability to pay. Women from the peri-urban areas of Lima who are referred for VSC to the main Lima clinic apparently go in great numbers despite its location in an upper middle class neighborhood and pay 10-20% of the fee charged middle class clients.

The team concludes that all the FPAs are committed to providing services to low-income clients and maintaining a percentage of low-income clients consistent with their mission. However, their current ability to monitor the proportion of institutional effort devoted to serving low-income client ranges from excellent to not good.

The *process* of introducing fees for services and/or increasing those fees appears to be as critical a factor as the fees themselves. Some FPAs need to improve their ability to manage the process. While the process in BEMFAM was so abrupt that many clients dropped out, the price increases in INPPARES were so minor that few, if any, clients commented on the price increases in client satisfaction surveys.

### *2.2.3 Quality of Care*

Since no baseline data was collected specifically on quality of care prior to the start of the Transition Project, because of time and resource constraints on both the FPAs and the IPPF/WHR, it is not possible to compare the current status of quality under the sustainability focus with levels of quality prior to the Transition Project (nor did the scope of work for this evaluation require it). Given these methodological limitations, the discussion of quality of care focuses on current levels of quality in the FPAs, issues related to method mix, approaches that IPPF/WHR and its FPAs have taken to monitor and assure quality, and implications for quality under a sustainability focus.

Current Levels of Quality of Care. Interest in issues related to quality of care among family planning professionals worldwide grew markedly in the period just before and during the Transition Project. Judith Bruce's seminal work provides a framework for quality of care assessment which encompasses the following six elements:

- provider competence.
- interpersonal relations.
- constellation of services.

- choice of methods.
- mechanisms to ensure continuity.
- information provided to clients.

The following observations were made about three of the six elements of quality of care (other elements could not be judged, given time limitations and inability to make field visits regarding quality in Colombia and Mexico).

- Choice of Methods: A wide range of methods are available in all programs. All four FPAs provide pills, IUDs, condoms, spermicides, and tubal ligation and vasectomy (by referral for the latter in the case of BEMFAM). Diaphragms and Norplant are available at several FPAs.

- Constellation of Services: The diversification of services undertaken to meet a broadened reproductive health mandate as well as to promote sustainability has resulted in a broad range of services offered through many of the FPAs. These include reproductive health services (e.g. infertility treatment, prenatal care), other health services (dentistry, minor surgeries) and other client services such as legal consultations.

- Information Provided to Clients: All FPAs have an impressive quantity and quality of client information materials in a variety of formats (e.g. brochures, posters, videos, flip charts) and on a spectrum of topics ranging from STDs to specific contraceptives to breastfeeding.

In all three of these areas of quality of care, the FPAs have demonstrated a high degree of quality. (See Appendix J.)

Choice of Methods. The revised objectives of the Transition Project called for quality of care to be maintained while focusing on sustainability. Although the original project design contemplated redressing skewed method mixes where they existed, and some FPAs have made efforts in this area, this aim was not carried forth as an explicit objective in the revised objectives.

A review of method mix patterns does not reveal any deleterious trends caused by efforts to achieve sustainability. However, it is difficult to assess this data for the Transition Project, because services and sites which are covered by the Transition Project may not be representative of the FPAs service pattern in the country, and the data itself may appear to skew the method mix. For example, since none of the men's clinics of PROFAMILIA, Colombia are covered under the Transition Project, vasectomy use under the project is very underreported.

As a rule, the Transition Project data on method use overrepresents methods available only in clinics (e.g. sterilization, Norplant, IUDs), and underrepresents methods which are available in pharmacies or through community distribution programs (such as pills and condoms).

Because the data on method mix from the Transition Project itself is not representative of patterns of contraceptive use in the FPAs or nationally (as collected by Demographic Health Surveys), it is critical that method mix should *not* be looked at as an indicator of quality without an examination of

additional elements of quality and other contextual factors. Furthermore, in some local sites, redressing imbalances in method mix may be antithetical to other quality of care goals (as would be the case for promoting use of IUDs, an underutilized method in Brazil, in communities evidencing high rates of STD prevalence).

Quality Assurance Systems. Most of the FPAs have quality assurance systems in place and employ a number of different approaches to monitoring and improving quality. These include ongoing activities such as analysis of service data; reports on complications, morbidity and mortality associated with contraceptive use; narrative reports from clinic sites; internal operational audits of clinics; and the development of supervision tools and systems. In addition, a number of FPAs have carried out special surveys and have held workshops on quality of care, showing leadership in this area.

Transition Project staff felt strongly, and stated in early discussions with USAID, that it would be neither fair or possible to burden FPA staff with comprehensive evaluation efforts at a time when FPAs were having to become more efficient, and scale down. The Transition Project provided for quality monitoring and assurance through local oversight of medical compliance with IPPF's medical norms (IMAP), through occasional visits of the IPPF/WHR quality advisor, by reviewing service data and narrative reports for trends, and by conducting specific surveys.

The IPPF/WHR quality advisor has visited three countries in the Transition Project (Peru, Paraguay, and Trinidad and Tobago) but not the others; as only 10% of his time is charged to the Transition Project, it is difficult for him to commit to a higher level of effort under this project, yet the special challenges posed by operational changes made by the FPAs to improve sustainability may require more attention to new issues regarding quality which are likely to emerge.

The project design did not allow for a more comprehensive examination of the impact on quality of a concomitant focus on sustainability. There have been time and resource constraints both at IPPF/WHR and within the FPAs which have limited the feasibility of expanding monitoring activities.

To supplement the FPAs' quality assurance activities and to better gauge client perceptions of quality, a questionnaire was developed by Transition Project staff and FPA headquarters staff were trained in its use by IPPF/WHR transition staff. A total of nearly 3000 surveys on all eight FPAs were conducted. Client satisfaction studies were undertaken in the first quarter of 1994 at least one FPA site, for a total of 28 clinics, and four follow-up studies have been conducted to measure progress made. At least 100 clients per clinic were interviewed at each site with an average of 227 clients per site. The results were shared with headquarters and clinic staff. In the future, responsibility for conducting client satisfaction surveys will be decentralized to the clinic level (rather than FPA headquarters level) by training local clinic staff to conduct interviews and interpret data.

Each item on the questionnaire for which at least 5% of clients noted that improvements could be made was classified as a "negative response case". The most frequent complaint and the item with the highest level of dissatisfaction, was waiting time. Other complaints included inconvenient hours or location; insufficient information on other methods; insufficient time with the physician; and cost of services. Because the studies were carried out less than one year prior to this evaluation, there is as yet little comparative data, however project staff feel that these studies have helped provide a client-centered basis for making service improvements, and the surveys have been well accepted by the providers.

Implications of the Sustainability Focus. IPPF/WHR evaluation staff feel that, in the future, they need to pay closer attention to client opinions regarding fee increases as they monitor interventions in fee structure, and to client dropout rates. A follow-up study in Brazil will examine the reasons for dropouts and will be replicated in Peru.

Moreover, as FPAs offer a wider range of reproductive health services, it will be increasingly important to use approaches and indicators which capture quantitative and qualitative data on this expanded range of services, some of which may not have a tangible outcome such as a contraceptive method (e.g. a legal consultation, or a pre-natal examination).

The Transition Project's focus on sustainability raises new issues with respect to quality of care. Some of the approaches being implemented to generate income and reduce costs have implications for assuring quality and may require testing imaginative and flexible solutions. For example, the diversification of services provided at FPAs implies that FPAs must not only pay attention to the quality of family planning service delivery, but a host of other services (usually health-related, but also legal, psychological etc.) which they may have little experience or expertise to assess.

FPAs will need to learn how to recruit and assess the competence of providers in specialties having little to do with family planning (e.g. ophthalmology, dentistry). As FPAs provide a wider range of medical services, often through clinicians under contract, attention will be needed by both IPPF/WHR and FPAs to assuring quality in these changed circumstances (e.g. through standards, training, supervision, recruitment). Some dedicated medical capacity will be required for this purpose.

In addition to the diversification of services, a focus on sustainability may lead FPAs into new and more flexible contractual arrangements with staff. For example, rather than having the legal and financial requirements associated with maintaining full-time permanent staff, some FPAs are moving to hire more professionals on a contract basis. FPAs may experience higher turnover with such staff, and different needs and capacity to train, to imbue a sense of institutional mission, and to oversee part-time staff. Facilities which lease their clinical space to professionals outside the FPA will also need to determine how to assure quality for services done on their premises, but by non-FPA staff.

**RECOMMENDATION 1:** **It would be useful for IPPF/WHR to determine at this stage how to identify and assess method mix trends caused by pricing changes at an early stage. While there is no indication that any FPAs have made or are considering decisions to drop particular methods which cost more than others, with pressures to improve cost-recovery, this is a possible risk in the future.**

**RECOMMENDATION 2:** **As FPAs provide a wider range of medical services, often using clinicians under contract, both IPPF/WHR and FPAs will need to focus more attention on assuring quality (e.g. clear standards, training, supervision, recruitment). Some dedicated medical capacity will be required for this purpose.**

**RECOMMENDATION 3:** **Ensure that FPAs maintain capacity for activities key to quality assurance, such as in-service updates and training and supervision, although they are often invisible, do not generate revenue, and have some associated costs.**

**RECOMMENDATION 4:** **With FPAs, and other CAs, apply or develop new measures for assessing quality of care in sustainable programs offering a diversity of reproductive health services.**

**RECOMMENDATION 5:** **Decentralize responsibility for conducting client satisfaction surveys to clinic level (rather than requiring presence of IPPF/WHR or FPA headquarters staff): provide training to develop local clinic staff capacity to conduct interviews and interpret data.**

### *2.2.4 Financial Sustainability*

Critical Factors in Achieving Sustainability. The following are critical factors in achieving sustainability:

- Institutional commitment to the concept of sustainability.
- Effective and flexible management infrastructure, systems and qualified staff.
- Identification of market niches and relevant strategies.
- Well thought out pricing strategies.
- Diversification of activities to include services that generate a surplus.
- Provision of high quality service in an efficient manner.

All of the FPAs have made the initial step of commitment to the concept of sustainability although some have made the commitment faster than others. FEMAP, PROFAMILIA, and MEXFAM manage their operations every day with the goal of expanding surplus-generating services that will enable them to simultaneously attain higher financial sustainability and serve a lower income client base that can not afford to pay for their services.

An effective management infrastructure is also a key step, and PROFAMILIA, FEMAP, MEXFAM and INPPARES all have boards of directors which provide support in policy decisions that assist their organizations in a manner that makes sustainability a high priority. It is clear that one of the lessons learned is that this infrastructure needs to be strong at all management levels, not just at the board, management, supervisor, or staff levels. With the possible exception of PROFAMILIA, all the other FPAs have some imbalance but this is not unusual for most organizations. MEXFAM has particular strengths at the board, director, and staff levels, but will need more capability and

training at the management level. FEMAP is strong at all levels, but working towards providing less operational direction from the Board. BEMFAM has excellent management strengths at the staff, supervisory, and middle-management levels, but wants to develop more business skills and input at higher levels. INPPARES, having experienced many years of management problems, has devoted itself within the last year to strengthening management at all levels. (See Appendix D.)

Another key lesson learned is that when starting any new activities, the market and potential demand for services have to be reviewed from both a clinical and economic perspective. Expanding services to serve unmet health needs is unfortunately no longer an affordable goal by itself. One also has to ask if the expansion can contribute to financial sustainability (unless the activity can be subsidized by other activities which generate surplus revenue). MEXFAM, PROFAMILIA, and FEMAP have made significant strides in using newly applied marketing techniques, and have also learned that predicting patient demand and needs cannot be done with 100% certainty when opening new services. MEXFAM and PROFAMILIA have been willing to make the decision to cut their losses, close health services that are not meeting financial goals, and move on to other service areas.

Studying the market to develop pricing strategies is also a critical factor both in initiating health services and generating optimal revenue levels. MEXFAM and PROFAMILIA thoroughly survey the market when considering prices in order to determine the competition and prices they charge, the average income level of the community to be served and their health care needs, and the marginal cost of providing the new service. Each factor, individually and in combination with the others, has to meet minimum objectives, otherwise the service will not be started.

FPAs are attempting to increase income through diversification of services as well as by seeking other donors, government subsidies, and/or government contracts in order to continue to serve clients of lower-middle and lower socio-economic status. Treating significant numbers of clients in lower income groups requires some form of transfer payments or outside subsidies - it is impossible to achieve 100% self-sustainability and treat mostly or only patients from lower income groups. To date, PROFAMILIA and FEMAP have probably been the most successful of the FPAs visited with health product diversification. FEMAP has managed to establish a hospital of approximately 24 beds to provide maternal and health care to lower income and middle income level clients. It is run at peak efficiency and capacity, with bed occupancy at over 90%, and maternity beds averaging a 30-hour turn around. In addition, the hospital is the focal point for nearly 10,000 community volunteer service family planning promoters, as well as a community drug prevention program. With all this, the hospital still manages to turn a small surplus.

PROFAMILIA has had the foresight to diversify their services, which include medical and dental specialty services, a clinic for adolescents, a clinic for men, and a number of ambulatory surgery centers throughout the country. The surplus generated through patient care revenues alone was 189% in 1994.

All of the FPAs understand that the amount that can be charged for services and the level of quality are strongly correlated, and are making significant and successful efforts to provide high quality services.

Indicators of Financial Sustainability. As expected, there have been varying degrees of success among the FPAs towards achieving financial sustainability. Financial can be analyzed using the following indicators provided that data is available:

- USAID indicator of percent of total expenses paid for through local income, and the success FPAs have had in achieving this target as established by WHR/IPPF and the transition project (actual 1994 status and trends)

- USAID Transition Project indicator of amount of USAID money that will be replaced by the FPAs through other sources when their TP funds are terminated.

- Sustainability level of patient care operations (patient care income versus patient care expenses) and potential impact on patient care once TP funds are terminated

It should be noted that there were several cases when financial data was received where the numbers were not coincident. No less than three of the FPAs provided data from different departments concerning their budgets that was not the same. This problem was compounded by a lack of agreement with the numbers submitted by IPPF. IPPF was asked to review the tables presented, and did verify that the numbers appeared correct. Part of the problem was due to the use of different exchange rates, part was due to differences in the time periods data was collected, and part was due to lack of integration either between departments within the FPA, or the FPA and IPPF. The differences in dates between IPPF and FPA data do not pose a problem, however, the differences between departments of the same FPA could warrant some assistance, but it is not considered a serious concern.

(1) Local Income as Percentage of Total Income

Table 1 in Appendix A presents an analysis of the first index of sustainability, i.e., percent of total expenses that are paid for by local resources. In each case, local income is primarily derived from patient care revenues, but all FPAs also receive some other funding primarily through local fund-raising activities (donations). In all cases, the FPAs have attained a higher level of financial sustainability than targeted by the transition project.

MEXFAM is at the lowest rate of sustainability when measured in this fashion at approximately 30%, yet this is considerably better than the TP projections of 22.84% for 1994-5. This figure is also lower due to renovation costs currently incurred to open new centers. Even though MEXFAM is at a level higher than projected, they are still concerned with some of the decreases in client demand due to exogenous factors such as the Chiapas uprising, and the unpredictable effect the fall of the Peso might have. This needs to be watched very carefully so that their expansion program of new surplus-generating health centers does not have a reverse effect on sustainability and increase recurring operational costs which can not be recovered through patient revenues. As stated throughout this report, expansion by itself is no longer a viable goal.

BEMFAM and INPPARES, are at approximately the 40% level of sustainability when considering total costs, and PROFAMILIA is 65% (nearly 69% when reserves are considered) and FEMAP is at 72%. All five FPAs have been making great strides in

increasing patient care revenues through the combined efforts of price increases and volume increases from 1992 to 1994. However, it can be seen from volume statistics presented in another section that these revenue increases are not primarily coming from new family planning acceptors (with the exception of INPPARES), but are more a result in volume increases in other diversified services and price increases.

BEMFAM has increased its revenues through price increases at the clinic level, and nearly doubled its revenues at the laboratories. However, their expenses have also been on the rise, and as a result their level of sustainability has not increased proportionately with the increase in revenues during this period. MEXFAM has increased revenues primarily though price increases, but has also managed to cut costs, resulting in improvement in sustainability. INPPARES has been holding costs down while significantly increasing revenues from family planning clients. FEMAP has been increasing prices but also using the hospital as a minor source of income and a "drawing card" for new and dedicated ambulatory patients. PROFAMILIA has used its years of experience in offering the widest array of surplus-generating health care services among the FPAs, while at the same time developing "partnerships" with companies as well as the public sector, including the Ministries of Health and Social Security. Currently, the Social Security system of Colombia contracts and pays PROFAMILIA to provide some family planning services. Appendix E discusses in more detail how PROFAMILIA is working with the MOH to pilot test a pre-paid mechanism which empowers the community and its leaders to "purchase" their health care services wherever they prefer.

As previously mentioned, all FPAs have exceeded expectations to date, and this is definitely to the credit of the joint efforts of the FPAs and IPPF. It is also clear that none of the FPAs are projected to be at 100%, and this was not and should not be a goal. Basically, there are three general scenarios that will occur when the transition project ends for each FPA - they will use other donor income to replace TP money, they will generate local income to replace TP money, or they will reduce service levels and costs. Table 1 in Appendix A shows the performance trends of each of the sources of income as well as expenses. BEMFAM, PROFAMILIA, and FEMAP are actively maintaining the donor level support or increasing it, while MEXFAM went only slightly downward, and INPPARES is losing donor support fairly rapidly. All of the FPAs are increasing local income, but all of them are also increasing their expenses. This final trend is having a net positive effect in the sense that the expenses are rising more slowly than the additional income. However, it also increases the potential downside risk of leaving the FPAs with more operations to cover in the long-run.

Lastly, it should be mentioned that although this method of measuring financial sustainability can be of some utility for measuring progress of the FPAs, it does not necessarily reflect how well the organization is performing financially in entirety. In particular, an FPA that has had considerable success in increasing other non-USAID donor funding could increase their overall budget total faster than local funding. This would have the effect of lowering the sustainability percentage, even though they are successfully replacing USAID funds and in all probability are able to provide services to a higher number of lower income clients. Once again, almost no health care service that treats lower and lower-middle income clients is self-sustaining through patient care revenues. Hospitals in the United States are an excellent example - almost all of them depend upon government

subsidies in the form of Medicaid and Medicare in order to treat a significant portion of their clients.

(2) Proportion of USAID Funding Replaced by Local Income

The evaluation team was specifically requested by USAID to assess to what extent the FPAs are going to be able to replace the USAID funds they are currently receiving, and to measure sustainability as a percent of funds they replaced. At three of the sites visited by the fiscal/sustainability analysis member of the team, the staff were requested to earmark funds that would explicitly replace USAID funds. Tables 2a, 2b, and 2c in Appendix A show sustainability projections based on breakdowns of replacement of USAID TP income.

What happens when one uses this measure for sustainability is that monies are merely pushed from one source to the other, without necessarily improving the overall bottom line of the budget. The sustainability projection tables provided by FEMAP, MEXFAM, and BEMFAM, show that FEMAP and BEMFAM intend to fully replace USAID TP money by 1987, but MEXFAM projects a 45.03% replacement at best. BEMFAM plans to do this with patient care revenues, but primarily from income projected from laboratories and their commercialization project of commodity sales. FEMAP plans to rely heavily on additional other local and international donors to replace USAID money as well as a nearly 300% increase from patient revenues in two years. MEXFAM is assuming a mix of income from patient care and donors to assist them, but even with a successful picture, they are anticipating a shortfall of $318,000. This is double the IPPF projection for 1997 which anticipates a replacement level of no more than 23% for a shortfall of over $600,000.

The fact remains that an FPA can readily project a replacement of USAID TP monies by shifting monies from other sources and still end up with an overall deficit operation. Therefore, although it would be highly desirable to know to what extent the FPA is going to replace USAID TP funds, it is recommended that not too much emphasis be given on this methodology by looking strictly at the dollar or percentage replacement since the “bottom line”, or where the FPA is in total budget terms, is more important. The sustainability projection tables in Appendix A provided by the three FPAs, however, do provide considerable insight as to the strategy the FPAs are using to replace TP funding. This is covered in the following discussion. Lastly, it should be noted that sustainability projection tables were not requested from PROFAMILIA or INPPARES, in the former case because their operations are too complex to track this money in this manner, and in the latter because it is premature to gauge how INPPARES will prepare itself for the planned phase-out around the year 2000.

(3) Sustainability of Patient Care Operations

Patient care operations are defined in this case as all patient care services that are provided by the FPA which includes family planning services. The measurement of sustainability is the percentage of expenses incurred by these programs that is paid for strictly from patient care revenues. It is a way of addressing the extent to which the patient care services are dependent upon other funding sources in order to continue. In addition, it also assists one when analyzing the potential impact the termination of USAID TP funds will have on patient

care services. The following table provides estimates of the patient care revenues for 1994, the expenses, and the percentage sustainability of strictly the patient care services. In addition, it illustrates the deficit from patient care revenues, and the amount provided in 1994 by the TP.

**TABLE 4**

| Sustainability of Patient Care Operations | | | | | | |
|---|---|---|---|---|---|---|
| | *Patient Revenues* | *Patient Costs* | *% Sust.* | *1994 Patient Care Deficit* | *1994 TP Funds* | *% Deficit/ FPA Budget* |
| Brazil/BEMFAM | 2,247 | 3,466 | 65% | -1,219 | 950 | -18% |
| Colombia/ PROFAMILIA | 18,490 | 20,721 | 89% | -2,231 | 2,514 | -10% |
| Mexico/FEMAP | 393 | 828 | 47% | -435 | 753 | -11% |
| Mexico/MEXFAM | 1,329 | 3,496 | 38% | -2,168 | 1,649 | -37% |
| Peru/INPPARES | 684 | 1,194 | 57% | -510 | 385 | -27% |

Perhaps the most striking illustration of this table is the similarity between the deficits incurred by the clinical operations and the amounts provided by the TP (1994 deficit compared to 1994 TP Funds). Even though one can not make a one-to-one correlation, it is almost as if the FPAs have expanded their clinical operations to the extent to which they can be covered by USAID TP monies!

Although each FPA projects an annual improvement in their level of sustainability between 1994 until the end of the TP, there is still considerable cause for concern for MEXFAM and FEMAP. In the case of FEMAP, it is clear that even though the 18 clinical operations supported by the TP are operating at a comparatively successful rate of sustainability, the organization as a whole is relying very heavily on TP monies. Assuming that it can replace this funding by 1997 by nearly tripling both its patient care revenues and donor funding, it is a quantum leap from where FEMAP is in 1994. One has to assume that both their family planning operations as well as other ambulatory services are at considerable risk.

MEXFAM, as mentioned, needs to have considerable success in generating income from its 17 new patient services centers all scheduled to open within the next 24 months, and even this might only replace 40% of the TP funds. Given the fact that it is not only unlikely, but not recommended that MEXFAM keep to this timetable of starting 17 new facilities this quickly, MEXFAM probably has the highest dollar (or peso) exposure of all the FPAs. Taking all these factors into consideration, this report projects that at best MEXFAM will be facing a deficit of over $1 million by year end 1997. It is for this reason that they are already having discussions with the USAID/Mexico mission about the possibility of receiving USAID funding after 1997. FEMAP should also be pursuing this possibility as well.

The outlook is different for the other three FPAs. INPPARES has an unknown number of years to reduce its dependency on USAID funding. PROFAMILIA is confident that they could "cover" this shortfall by merely raising fees approximately 10%, and do not feel this would impact the number of lower-income clients they are serving since some at the lowest income level are not paying anything for their services anyway, and those that are paying would not go elsewhere for just a 10% increase in fees (PROFAMILIA provides over 70% of all family planning services for the entire country). It should be noted, however, that PROFAMILIA anticipates only needing a minor adjustment in patient care fees, and the remaining difference will be made up from the addition of other surplus generating activities. BEMFAM, in terms of replacement of TP funds, is also in a comparatively strong position. They also anticipate making up some of this difference from increasing patient care fees. In addition, their operational costs are going to be considerably reduced when the mortgage for their nearly $2 million central office building (for 69 staff) is paid off in 1997-8 (annual payments are nearly $250,000 plus $80,000 condo fees). Much will depend on how BEMFAM succeeds with their commercialization venture which has few recurring costs (see commodity section) and their increase in laboratory service revenues. Just the same, this report estimates that their potential shortfall will not exceed 10% of their operational budget (approximately $300,000), and although it is anticipated to have an impact on patient care services, it is still a commendable achievement that could result in a comparatively small negative impact on patient services.

Table 3 in Appendix A provided by IPPF, illustrates the budget analysis for four of the FPAs from 1992 until 1997 of the project (FEMAP information was not available for this).

Management in Relation to Sustainability. A survey instrument developed by Management Sciences for Health to assess what are six key components of management development critical to a sustainable organization was used at IPPF as well as the FPAs. It assisted the team in reviewing the key management components for sustainability including organizational development, mission and planning, human resources, community participation, leadership, and finance. The issues of organizational development, human resources and leadership, MIS, and finance are discussed in detail in the following sections. Community participation focused primarily on the development and participation of the Board of Directors, the working relationship between the Board and the Executive Director, and the relations that the FPA had developed with other family planning and governmental organizations. The following table summarizes some of the results of this survey:

**TABLE 5**

As can be seen from the table, all of the FPAs have very active Boards of Directors, but the Boards function in a variety of ways. In each case all of the Executive Directors work very closely with the Board or Board Chairperson. In some cases, the Board Chairperson plays not only an active role in FPA policy, but also FPA operations. IPPF/WHR has maintained the philosophy that Boards should be responsible for policy, and be only indirectly involved in operations. Too much board involvement can have the tendency to fill gaps in the management level that are not as permanent as hiring and training qualified staff. However, in each case the Boards represented a significant asset to the FPAs in terms of both community and financial support. The support the Boards provided was always at the national level as well as the community level.

The missions were very clearly defined at each of the FPAs, and all FPAs based their annual plans on these missions. The annual plan goals and objectives were clear at the organizational level, and each FPA actively tracked the progress made on their annual objectives at least on a quarterly basis, and much of this responsibility was carried out in a decentralized manner. In all of the FPAs except BEMFAM which felt that medical directors and the clinic/program levels should not be involved in finances and administration, there was a strong sense of decentralized management that did not draw dividing lines between "administrative operations" and "medical operations" . PROFAMILIA and MEXFAM, for example, provided active training to the physicians in management, and conversely carried out operational audits of the health centers by the financial departments.

Variations primarily presented themselves in the area of personnel evaluations and incentives. INPPARES and MEXFAM were strong advocates of written evaluations of staff performance, and they were the only FPAs of those visited that tied these evaluations into salary increments (MEXFAM's evaluation system is described in more detail in Appendix F). PROFAMILIA felt strongly that people in same personnel grades should receive equal increases, but they also mentioned that individual performance objectives were explicitly stated, and that individuals that did not carry out these objectives satisfactorily were notified and if necessary, asked to leave. In addition, it should be mentioned that PROFAMILIA hires approximately 10% of their medical staff by contract based strictly on output, and that none of their medical provider staff were hired full time. BEMFAM also felt strongly that salary increases should be the same across personnel grades. However, productivity objectives were at the clinic/program level and not at the individual level. The result was a very wide range of productivity.

Finally, although the budgets were reviewed by each of the Boards of Directors, there did not appear to be a written policy as to how the money generated at the local level could and could not be spent. The majority included locally generated money in the overall budget, and this paid for all expenses. It is recommended that the FPAs consider implementing a written policy that at least presents general parameters for how money generated from patients can be spent.

### 2.3 Trade-offs in a Sustainability Focus

Good data bases are necessary for fully answering the question "What are the trade-offs in focusing primarily on sustainability?" Although FPAs are increasingly developing such data bases, except for PROFAMILIA, they did not exist at the beginning of the project. The following findings and conclusions, therefore, should be understood as impressionistic and illustrative of tradeoffs under specific contexts, rather than conclusions about which one should generalize. There is considerable work for IPPF/WHR over the last years of the project in more fully analyzing trends

and trade-offs, as the essential data is forthcoming from FPAs' management information systems. Three potential trade-offs can be envisioned: 1) between local self-financing and volume; 2) between local self-financing and service to the poor (client profile) and 3) quality of care. Each is discussed below.

### *2.3.1 Self-financing and Volume*

Total regional service volume does not appear to have been negatively affected by efforts to increase local self-financing. Of the five FPAs visited, total volume dropped significantly only in MEXFAM; MEXFAM was, however, the FPA visited which most increased its level of local self-financing over the three two years - from 13% to 30%. In both BEMFAM and PROFAMILIA the level of local self-financing varied only slightly in 1994 from 1992, (41% and 65% respectively) as did client volume. In PROFAMILIA, there was CYP growth of 5% and a new acceptor decline of 1% over the two years. In BEMFAM, CYP declined 2% and new acceptors 1%. INPPARES was the great success: it increased service volume by 89% and raised its level of self-financing from 34% to 41%.

The sustainability focus, however, did bring about shifts in the balance between various FPA service strategies. MEXFAM is opening 17 new clinics or service centers, increasing the relative importance of direct service delivery. In contrast, in Brazil, the local self-financing thrust and consequent increased clinic prices were accompanied by a decline in clinic new acceptors in all ten clinics; the projected number of new acceptors in those clinics in 1994 is 64% of the 1993 total. The projected decline in the collaborative programs in ten states, through which BEMFAM provides TA, education, training and contraceptives to municipal governments and other providers, is 7% . One can conclude that if FPAs begin to plan for local self-financing with sufficient anticipation of decreased donor funding and if they are flexible about alternative forms of service delivery, there does not appear necessarily to be a trade off between total volume and local self financing. It appears, however, that there is a shift in service delivery strategies which affects client profile.

### *2.3.2 Self-financing and Client Profiles*

Each of the FPAs is determined to fulfill its mission and continue serving low-income clients. The case of the BEMFAM clinic in Olinda illustrates trade-offs at the service delivery level and efforts which staff are making to minimize them. From 1992-1994 the clinic increased its level of local self-financing (direct costs including contraceptives) from 15.7% to 40.4%. new acceptors declined from 4495 in 1992 to 3098 in 1993 and 2254 (projected) in 1994. To continue serving the poor, recoup volume and increase levels of self-financing, BEMFAM opened a free annex clinic in Mustardinha, a low-income underserved neighborhood;[4] this annex provides services in addition to the main, underutilized, clinic in a middle-class area of the city. Staff travel between the two sites, attempting to generate sufficient income in the main clinic through a variety of expanded medical services to cover its costs and the costs in the annex where services are free.[5] Not surprisingly, the mix of services at the two sites is quite different. Most of the new family planning clients are in the

[4] The team did a quick assessment of 20 files drawn randomly of Mustardinha clients: 65% had incomplete primary school education or less compared 6.6% in the main clinic.

[5] Services included, in addition to family planning, gynecology, urology, psychology, prenatal care, cytology, pap smears and STD diagnosis and treatment.

low-income annex; most of the other services are in the middle-class clinic proper. (See Figures 1 and 2 in Appendix C which depict the relative percentages of family planning services and other services in the two sites.) Although PROFAMILIA appears to have resolved the trade-off, it seems clear that other FPAs are struggling with the dilemma and are losing low income clients. IPPF/WHR and FPAs must document more fully the trends underlying the trade-off, take management steps to minimize them in the short run and share lessons learned at the end of the project.

### *2.3.3 Quality of Care Trade-offs*

To date, this project has shown, and staff agree, that quality of care is compatible with efforts to reduce costs and generate income. There is no evidence that cost-reduction efforts, to date, have resulted in inferior quality services. All FPA staff interviewed embrace the idea that providing quality services, and developing a customer orientation (i.e. obtaining the perspectives of actual and potential clients on services received or desired) is fundamental to the survival and flourishing of their organizations. The client satisfaction surveys were conducted for this purpose, and the results used to make changes, often at low or no cost (for example, the Trinidad FPA streamlined its clinic flow to address the problem of having too many clients at particular times). A focus on sustainability is likely to result in improvements in appropriateness, availability and constellation of services. Furthermore, people who are paying for services tend to be more educated, and also to have higher expectations regarding service quality.

However, keeping the twin goals of improving quality and reducing costs may force some tough choices for FPAs that have implications for one or the other. For example, although BEMFAM clients wanted expanded hours, BEMFAM had to cut hours at its clinics to reduce costs.

The biggest single threat to quality in a program focused on sustainability is reduced method choice, if (some) commodities or procedures are difficult or expensive to procure or provide. If FPAs are unable to underwrite commodity purchases, or staff and equipment required for contraception requiring medical procedures, clients' access to the wide array of methods now available at these sites may be jeopardized. There is no evidence that more costly methods have been restricted by FPAs to date--and in fact, in some cases the most popular methods are the most expensive for the FPA to provide (as with female sterilization for PROFAMILIA, Colombia)--yet it is a future risk.

**RECOMMENDATION 6:** **Ensure a consistent flow of contraceptives and a range of methods. If particular products are too expensive, provide reasonable alternatives, or ensure easy referral.**

**RECOMMENDATION 7:** **As FPAs seek to diversify services to generate revenue, consideration should be given not only to technology-driven services, often preferred by physicians, but to others which clients may need or desire (e.g. legal services, psychological counseling).**

## 2.4 Training and Technical Assistance Resources

With the Transition Project, IPPF/WHR had the responsibility of managing a large project similar in many ways to the Matching Grant which preceded it and had two additional challenges for which there were few precedents in the organization. The first additional challenge was leading institutional change vis-à-vis donor dependency/sustainability. IPPF/WHR staff liken the change process that ensued to the stages of death and dying paradigm of Elizabeth Kubler Ross (denial, anger, negotiation, depression and acceptance). The second additional challenge was providing technical direction and support in areas relatively new to IPPF/WHR and most FPAs, such as revenue diversification, costing and pricing, marketing, cross-subsidizing and HIV/STDs. Additionally, the Transition Project, charting as it was new directions, required a major investment in monitoring and evaluating the four indicators of sustainability identified by IPPF/WHR.

The staffing configuration with currently 19 staff positions (See Appendix K) in IPPF/WHR was and is well suited to the first two responsibilities of the project: managing a large USAID project and enabling IPPF/WHR/FPA institutional mindset change. Such institutional change is never easy; commitment and leadership of senior management is essential. IPPF/WHR had and has staff enabling the change process who have been known and respected for a long time in the region; they have done a commendable job enabling a difficult task. Only four staff positions, however, are devoted to providing technical direction and support in the critical new areas of the project - and two of those four are in HIV/STDs. Only one position is devoted to the financial aspects of sustainability. There has been one evaluation staff person; currently a second half-time position is being added.

All Transition Project technical staff have a variety of functions including management, supervision and monitoring of FPA activities, technical assistance, training and staff development. When these occur in the field, they are classified under the term “technical assistance.” Additionally, IPPF/WHR arranges further support to FPAs through what it calls “Technical Assistance Among Family Planning Associations.” (See Appendix L.)

With the benefit of hindsight, the team believes IPPF/WHR should have recruited a higher percentage of staff/consultants with skills in the new technical areas of this project - financial planning and analysis, revenue diversification, costing and pricing, and marketing - as well as more effort in areas of traditional concern to IPPF/WHR such as quality assurance and evaluation. FPA need for assistance in these areas continues in several FPAs.

While all the activities IPPF/WHR classifies as technical assistance are valuable, classifying them all as technical assistance is puzzling. It would be helpful in future reports, needs assessments, etc., to more clearly distinguish among them - management, supervision and monitoring of FPA activities; evaluation; technical assistance; training; and staff development.

## 2.5 MIS

In conjunction with a very successful effort on behalf of WHR/IPPF, the FPAs of BEMFAM, PROFAMILIA, and FEMAP have made considerable advances in establishing computerized databases and financial systems, and are using these to assist them with management decisions. MEXFAM has most of the IPPF systems installed, TECAPRO (Tecnologia Apropiada de Costa Rica S.A.) and SAC (Sistema para Administracion de Clinicas) at the central level, but is just

beginning to use this in an integrated manner at the management level. Almost all of the FPAs had devoted some effort to tailoring the IPPF programs to their specific needs and preferences either by making additional purchases or programming new software. INPPARES is at the implementation and development stage as scheduled for its MIS.

The MIS, accounting, planning, and budget aspects of FEMAP, BEMFAM, and PROFAMILIA were not only accessible in a very rapid manner, but were accessible where they should be - at the management departments that needed the data to make decisions. It was very impressive to watch how quickly they could produce data requested - within hours in almost all cases. At BEMFAM, for example, the data requested was almost instantaneous, and presented each time in a comprehensible and useful fashion that clearly looked at sustainability levels among clinic, program, and laboratory operations. Only minor recommendations were made to improve the utility of their data. PROFAMILIA has a number of full-time programmers on their staff, and was able to provide the personnel, training, accounting, fiscal, planning, and budgetary information not only on the spot, but in nearly any format requested. MEXFAM also had the data systems up and running, but needs more time to be able to keep this information up to date and accessible among the different management departments in a way that is integrated among the departments themselves. It was recommended in their case that they not operate programs among the departments in such an independent manner, and they have a consultant who is assisting them with this for the accounting systems.

For INPPARES, 1995 will focus on implementation of systems and training of staff. For the other four FPAs, the emphasis will be on decentralization of the systems as appropriate. IPPF and the FPAs have determined what health care operations warrant a computer, and which ones are better served using a manual system that possibly feeds into a nearby center with a computer.

BEMFAM has three clinics that have computers, PROFAMILIA one, FEMAP one, and MEXFAM two. 1995 activities for these three organizations will be to work towards enhancing the linkage between the clinics and central levels. Some of this will be done by the installation of computers in other clinics, but many clinics and health centers do not have enough volume to warrant computers, and their information will be collected manually and batched to other clinics that have computers as appropriate. This will be important as the FPAs grow and need to decentralize management decisions.

## 2.6 HIV/STDs Add-on

### *2.6.1 Objectives of the HIV/STDs Add-on*

An add-on in the amount of $500,000, for the period 9/30/94 - 9/29/95 was given to IPPF/WHR by the USAID Office of Health to assist Family Planning Associations (FPAs) in preventing the spread of AIDS. This will be achieved by integrating HIV/STDs prevention activities and services into family planning programs in the Latin America and Caribbean region and/or expanding existing programs. Unlike the core project, the add-on is not subject to the matching fund requirement. This add-on represents the first time an Office of Health add-on has been made to an Office of Population core project.

The original and yearly amendments to the Transition Project Cooperative Agreement for the HIV/STDs add-on include the following activities aimed at expanding or integrating HIV/STDs prevention activities into family planning programs:

- FPA projects and sub-projects.
- Regional and subregional training activities for FPA staff.
- Development of regional training and education materials.
- Technical assistance to FPAs.
- Exchange of experience among FPAs.
- Monitoring and evaluation and project management.

Five countries were originally designated for support under the add-on. Two countries, Haiti and the Dominican Republic, have not been included due to political strife and the USAID Mission's request for a delay pending its own formulation of AIDS policy. The three countries currently designated for support under the add-on are Brazil, Honduras and Jamaica. These countries were chosen based on the Office of Health's priority country list for HIV/STDs, which is derived from epidemiological evidence of their prevalence.

It was estimated that five to eight subgrants would be made each year to FPAs for HIV/STDs prevention activities. In addition, support would be provided for regional activities such as training and technical assistance by IPPF/WHR.

### *2.6.2 Achievement of HIV/STDs Add-on Objectives*

IPPF/WHR established an HIV/STDs prevention unit in 1987; the Transition Project add-on builds on the experience and expertise gained since then. Early activities focused on raising awareness of HIV/STDs and of the linkages between counseling and HIV prevention within FPAs. Several regional and in-country training workshops were held during the period before the add-on, and much of the work on the training curriculum "Guia para capacitadores en salud sexual" (Guide for trainers in sexual health) was done during this period. A number of FPAs in the region participated in these early efforts, and began to incorporate a focus on HIV/STDs prevention and attention to sexual health issues into counseling and education. Results of some research conducted during this period were applied during the add-on (e.g. qualitative research with BEMFAM conducted with support from AIDSCOM was used to design appropriate client education materials).

Much of this initial work was aimed at high risk populations or clients exhibiting "high risk" behaviors. BEMFAM, for example, collaborated with AIDSCOM (the predecessor to the AIDSCAP project) in working with homosexuals, prostitutes, and street children. In 1991, just prior to the initiation of the add-on, IPPF/WHR and several of its FPAs changed their approach, in recognition of the need to work with all clients to prevent AIDS. This shift in strategy grew out of and is supported by data from Brazil. These data show a dramatic rise in the number of women who have AIDS: the ratio of male to female cases of AIDS diagnosed between 1985 and 1994 went from 30:1 to 4:1. In addition, during the period 1980-1994, the following changes in AIDS cases also occurred by category of exposure (percent of total cases diagnosed):[6]

[6] Source: AIDS Boletim Epidemiologico, Ministerio da Saude, Programa Nacional de Doencas Sexualmente Transmissiveis/AIDS, September-October 1994.

| | 1980-1987 | 1994 |
|---|---|---|
| Homosexual | 41.6 | 18.1 |
| Bisexual | 18.5 | 10.5 |
| Intravenous drug user | 7.9 | 23.9 |
| Hemophiliac | 2.7 | 0.3 |
| Blood transfusion recipient | 5.7 | 2.4 |
| Heterosexual | 1.5 | 25.4 |

Moreover, the educational approach used by the FPAs with women is targeted to helping clients recognize that they may be at risk, to puncture the conventional wisdom that AIDS is limited to homosexuals, drug users and prostitutes.

One of the key differences between the add-on and the core project, is their different stage of development. Many of the IPPF affiliates in the region have close to thirty years of experience with family planning, and many have received support from USAID as well as IPPF for much of this period. There is a solid body of knowledge, internationally and within the region, on policy, technical and programmatic aspects of contraception. As DHS surveys in countries throughout the region have demonstrated, knowledge of and use of contraceptive methods among the population is high.

In contrast, HIV has developed into a critical public health problem only during the past decade. Even within this time frame, it has been recognized only within the last few years that the threat of HIV is not limited to high risk groups. Moreover, increased awareness of the dangers of STDs as a co-factor increasing the risk of HIV has appeared equally recently.

Thus, experience in AIDS prevention is, compared to family planning, at a nascent stage. There is even less practical experience with the diagnosis of common STDs, especially in settings where there is limited access to or high costs associated with laboratory tests for this purpose. Relatively little funding has been allocated to these efforts, compared with programs extending contraceptive services. Because programming for STD (including HIV) prevention, diagnosis, and treatment is at a very different point on the learning curve compared to family planning, it is reasonable to expect more risk-taking, false starts, and calls for capturing, disseminating, and integrating lessons learned and encouraging communication among the pioneers in this field to advance the learning process.

IPPF/WHR defined four key phases in integrating HIV/STDs into family planning: level 1: staff are not knowledgeable about issues re HIV/STDs and related counseling and services are not provided; level 2: staff are knowledgeable about these issues and educate clients about preventing HIV/STDs through condom use; level 3: specific information on HIV/STDs is provided, counseling is offered, condoms are promoted and distributed, and STDs are diagnosed and perhaps treated; level 4: Services and programs are comprehensive and respond to the sexual and reproductive health needs of the client population. Identifying both the process and markers is useful for several reasons: it presents a model that can then be tested and refined based on actual in-country experience and needs and it may have broader applicability to other programs not covered by the add-on. However, caution should also be exercised with a sole model of progression to avoid suggesting that progress is linear, all countries or programs follow the same path, or all programs and countries should reach phase 4 at some point. Alternative end points and guidelines for selecting and reaching them are also needed. It would be useful for the Transition Project to assess the usefulness (e.g. for programming or raising awareness) and validity of this phase model

vis-à-vis the actual experience in Jamaica, Honduras, and Brazil. At this point, the Brazilian, Jamaican, and Honduran FPAs have all reached phase 2 or beyond.

The HIV/STDs add-on has made a needed contribution in meeting a critical and growing public health problem in the region, in building on the capacities and strengths of IPPF/WHR and the FPAs, and in reinforcing the leadership in this area as set forth in Vision 2000, IPPF's Strategic Plan: "The promotion of reproductive/sexual health for all earmarks a major direction for IPPF in the 1990s, helping people everywhere to lead socially and economically productive lives and to take control of their own destinies".

All personnel interviewed at both IPPF/WHR and the FPAs visited and those contacted by phone, are committed to the concept of a broader vision of reproductive health, which includes helping clients understand the risks of STD/HIV, how they can protect themselves, and their entitlement to sexual health. Credit for this should not be attributed solely to the add-on, as IPPF has other related initiatives and Vision 2000 has been an important force in achieving this change. Nonetheless, it is a noteworthy achievement.

Programmatic Approaches to prevention of HIV/STDs. Of the objectives given for the add-on, well developed approaches have been the orientation of all staff to the issues of sexual health and prevention of HIV/STDs; involving staff not often involved in client contact (e.g. drivers); the effectiveness of group sessions for clients; the development of client information materials to trigger discussion, the programs for adolescents and women which center on their particular needs and concerns; condom demonstrations using penis models; addressing all FPA clients rather than targeting "high-risk" populations. The latter is particularly important as the heterosexual rate of transmission is increasingly rapidly in all three countries: in Honduras, 92% of HIV cases are estimated to be by heterosexual transmission; in Brazil, according to the September-October AIDS Epidemiologic Bulletin, the ratio of male-female AIDS cases is now estimated to be 4:1.

Staff observed facilitating group discussions (the women's groups) demonstrated a high degree of comfort and confidence in talking about sexuality, which helps dissipate the nervousness of the group in talking about this subject. Group sessions in the women's project provide an opportunity to learn from one other and to share experiences; discussions with peers, which are facilitated by staff, have great potential for changing attitudes, clarifying misconceptions, providing different perspectives.

While BEMFAM welcomes men into its groups, it does not have programs designed to reach men, unlike Honduras and Jamaica. There were anecdotal reports in Brazil that many partners of female clients diagnosed with STDs do or will not take the required antibiotics, thus exposing women to re-infection. Strategies should be designed to reach and involve men in protecting their own and their partners' sexual health, and particularly to understand their role in STDs prevention and treatment.

At all sites visited there were many posters on a range of reproductive health issues, including breastfeeding, prenatal care, family planning, and HIV/STDs. Pamphlets are available on a wide range of subjects, and two special booklets were developed in Brazil ("Conversando e que a gente se entende" and "Acorda, Adelaide"), using focus group results, for use in stimulating dialogue and raising issues in the women's groups. These booklets are being adapted for use in Honduras and

Jamaica. The IPPF booklet "Talking about AIDS" is also available in these programs, as are other informational materials on STDs and AIDS.

Condom demonstrations were done effectively in all three group sessions and realistic penis models were available and used in three of the four sites visited, and in the Honduran and Jamaican programs. These have been shown to be helpful in demonstrating correct condom use, in a matter-of-fact fashion, and dissipating clients' anxiety or misconceptions about putting condoms on (themselves or a partner).

The community groups are less well developed in Brazil and have not yet been initiated in Jamaica. One of the lessons from the Honduras program is to involve staff who usually do not have direct client contact (e.g. drivers): these staff may be able to work in the communities or with certain client groups as or more effectively than traditional clinic staff and are often informal "gatekeepers" for information, and referrals.

Programs offering STD treatment and diagnosis are just underway (and were not looked at in depth during this evaluation). Providing treatment for STDs needs further exploration; clients cannot necessarily obtain (even by fee) drugs for treatment on site (in Honduras, clients must get in the public sector); it would be useful to follow-up a sample of these clients to see if and how they are affected by the cost or inconvenience of getting antibiotics or antiseptics (e.g. does it influence their getting treatment or when they start?)

There is a need to focus not only on AIDS but also to help clients recognize the symptoms of common STDs, and understand the importance of coming to the clinic for clinical diagnosis and treatment. Focusing on STDs is particularly important in areas where clinicians have detected a high prevalence of STDs in client examinations. Helping clients distinguish between normal discharge and symptoms of infection will be vital to reducing STDs, and should be a program emphasis in all countries in the future.

It should be noted that sporadic problems with the availability of condoms in some programs (e.g. Brazil) seriously undermines the effectiveness, legitimacy and credibility of all other activities related to HIV/STDs. The effectiveness of STD/HIV prevention efforts is conditional upon having condom supplies available. (See Section 3.6.1 for an explanation of condom shortages.)

Technical assistance, training and information dissemination. Under the add-on, BEMFAM has conducted 15 orientation and training events, reaching a total of 740 participants. ASHONPLAFA has conducted four training and orientation events reaching 258 staff; IPPF/WHR served as resources for two of these trainings. The Jamaican Family Planning Association has carried out five training events reaching 32 people; IPPF/WHR staff participated in two of these. In addition, IPPF/WHR staff have conducted orientations at headquarters, a training in Haiti, and a presentation for IPPF/WHR Executive directors. One of the key lessons from this project is the importance of orienting all staff to reproductive health and the role of HIV/STDs integration. This helped ensure interest in and commitment to a broader vision of reproductive health, so that new services and approaches are seen as a critical part of care rather than as a burden or extra.

In Brazil, almost all the technical assistance for the integration of HIV/STDs was provided by in-country resources. IPPF/WHR has been supportive in sending materials and technical literature. Because the FPAs in Honduras and Jamaica have had turnover of staff responsible for this project,

and have had more intensive needs for training, IPPF/WHR staff responsible for the add-on have been providing significant hands-on technical assistance.

Technical assistance from IPPF/WHR HIV/STDs staff to Honduras, Jamaica, any new countries and within IPPF/WHR itself, should focus on institutionalizing the technical and programmatic capacity to integrate HIV/STDs. Training key programmatic staff within IPPF/WHR and further developing a cadre of staff within the Honduras and Jamaica FPAs will multiply the impact of the add-on, as it will be less dependent on a few critical staff, with the attendant problems if they leave. IPPF/WHR has begun this process in Honduras. Developing institutional capacity for HIV/STDs integration within the organizations will help reinforce its integration at the program level as well. To leverage the relatively scarce human resources, developing the local capability for training and programming and building the skills of other IPPF/WHR program staff in this area, will be required.

A related area for improvement with respect to meeting project objectives is better intraregional exchange of information and experience and cross training between countries. While several orientations and workshops have been conducted for IPPF/WHR staff in New York and FPA directors, there is an unmet need to bring together clinical and program staff working directly on the integration of HIV/STDs elements into their programs. No such events have taken place to date although one is planned for this spring. The team also recommends including other FPAs in information dissemination concerning HIV/STDs integration experience (e.g. inviting staff from other countries working in this area to the 1995 meeting) and supporting the participation of key FPA staff in major international meetings on this issue. In general, dissemination of knowledge and experience gained from the TP to other professionals at an international level has been very good, with several presentations given at major international professional events. (See section on dissemination in this report).

Relationship of add-on to family planning use, sustainability and quality of care. It is difficult to measure the impact of the add-on in terms of increasing family planning use (and it is important to note that this was not one of the objectives of the project). There are several reasons for this: activities of the add-on relate to changing behavior and identifying risk and symptoms of infection; these should be measured independent of changes in contraceptive use, as well as difficulties with the collection of data regarding family planning use and attribution to the efforts of the add-on as described below.

It is also difficult to attribute changes in method use to the add-on (or other project). Because there are many messages, by numerous groups, aimed at increasing condom use, one cannot make a causal association between increases in condom use and a particular project. Condom use in Brazil has also been affected by disruptions in supply. Throughout the hemisphere, some FPAs have changed the way they are counting condoms and others do not count condoms distributed. In Brazil, schools included under the adolescent project cannot give out condoms, so it is difficult to measure the direct effect.

While there is some evidence that activities related to the add-on are increasing condom use--for example, in Jamaica, the number of condoms distributed rose by 21% in its clinics and the rural program, in the months following staff training (periods of four months and three months, before and after the training, respectively for the clinic and outreach program), and in Brazil where BEMFAM reported dual method use (i.e. using condoms as well as another contraceptive method)

among 2406 of its clients between May 1993-December 1994--the impact of the add-on should be seen as suggestive rather than direct, for the above reasons.

Including programs and services for the prevention, diagnosis and treatment of HIV/STDs reinforces the quality dimension of sustainability in several ways. It broadens the range of services available to clients and suggests a more holistic approach to reproductive health, which is not focused entirely on preventing pregnancy. Helping clients assess their risk of contracting or transmitting STDs may lead to safer and appropriate use of contraception, if clients needing protection against STDs recognize the need to use condoms (inducing as a dual method) and refrain from using methods which may expose them to greater risk (i.e. IUDs).

Providing these services may also attract additional clients and/or increase the range of services clients can access, and thus increase the potential revenue base for services. PROFAMILIA, in Colombia, has demonstrated that there is some cross-over of clients who come for one service and return at another time for other services. Selling medicines for treatment (e.g. antibiotics) is another possible source of income to consider (as well as facilitating speedier treatment for clients diagnosed with an STD). FPAs that get involved in diagnosis and treatment will need to assess the feasibility and cost of laboratory testing capacity and whether to house on-site or by contract with independent facilities.

The HIV/STDs add-on has a high demonstration potential for other NGOs and the public sector; in Brazil, there has already been such collaboration initiated at the state level for the adolescent programs in the Northeast and one for the woman's project. It is important for the future activities related to the add-on to carry forth two vital, yet possible competing goals: (1) document the successes, errors and experience with approaches as they mature and as the body of knowledge on working with HIV/STDs advances and (2) ensure that the programs are replicable. A concern in the latter case is that, while these are pilot efforts and need to be studies, they should not be implemented under "hothouse" conditions which will not be possible to replicate on a larger scale.

IPPF/WHR and FPA staff have identified the need for and interest in increased evaluation and research related to this project to capture baseline information to measure change, to assure that data is collected that lends itself readily to analysis and interpretation (some of the indicators now used are hard to understand without explanation) and to document the lessons from this unfolding experience. This is an opportunity to test the new Evaluation Project's Reproductive Health working group indicators; IPPF/WHR staff were involved in the development of these indicators and have expressed interest in using them in future evaluation efforts.

**RECOMMENDATION 8:** **Ensure sufficient attention to raising client awareness about common symptoms and need for treatment of STDs, not only HIV.**

**RECOMMENDATION 9:** **Increase effort to reach and involve men to encourage use of condoms, identification and treatment of STDs (including reinforcing treatment when partner is diagnosed with STD), and the right of individuals to safe, healthy, voluntary, pleasurable sexuality. This will support these messages now aimed at women.**

**RECOMMENDATION 10:** **Increased emphasis should be placed on evaluation, so as to capture baseline information to measure change, and to document the lessons from this unfolding experience. This is an opportunity to test the new reproductive health working group indicators. Attention should be given to collecting information which is useful, and to distinguishing between information collected for the purposes of evaluation and that needed for program purposes, which will not be needed or possible when activities are expanded.**

# 3. PROJECT OUTCOMES AND IMPACT

## 3.1 General Lessons Learned

There are a number of important conclusions which can already be drawn concerning the Transition Project:

- Several factors are critical for achieving financial sustainability. These are discussed in Section 2.2.4 of this report. They include institutional commitment to the concept; appropriate management structure and staff; identification of market niches and relevant strategies; activities which generate a surplus; sound pricing strategies; and quality services delivered in an efficient manner.

- The attitude of the executive director of an FPA is critical in making the transition to sustainability. Executive directors of FPAs have traditionally been leaders in providing family planning to the poor; they now must become entrepreneurs or cede to experts in issues related to project sustainability.

- FPAs must attract talented and dedicated staff who understand the business world and must compensate them accordingly.

- Adequate time is critical for a successful transition. FPAs which have not yet begun to address the issue of sustainability should do so at the earliest opportunity.

- Adequate resources are essential to enable FPAs to develop the capability to become more self reliant. This includes allocating resources specifically for the development of diversified activities to generate income.

- Legal constraints should be anticipated, given that FPAs' charters frequently do not permit them to engage in profit making activities.

- Expansion of services should normally not be an objective of the FPAs unless such activities generate surplus income.

- FPAs should assess carefully and understand the implications of various service delivery strategies which they are considering.

Traditionally, FPAs have worked to promote family planning service provision and contraceptive use through a variety of strategies ranging from those in which all of the inputs were under the FPAs' direct supervision (clinical service delivery in FPA clinics) to those in which the FPA provided very little (principally contraceptives) and the main responsibility lay with another institution. FPAs counted service utilization outputs (CYP and new acceptors) as FPA outputs whether all five of the following inputs were provided or only contraceptives. The sustainability focus, with the phase-down of contraceptives and funds, has altered this pattern and led FPAs to more fully count the real costs of all inputs - particularly contraceptives. (See Table 6.)

**TABLE 6**

The first strategy, clinical service delivery, appears to be the strategy with the greatest potential for full cost recovery. However, as noted elsewhere in this report, the profile of clients in FPA clinics is that of a more educated (and presumably higher income) clientele. Such clinics usually do not serve high numbers of poor, rural or underserved clients. Accessibility and client profile may be the trade-offs.

The team wonders about the second strategy - employed by MEXFAM, INPPARES and BEMFAM. When FPAs must pay the full costs of contraceptives, will FPAs be able to recover costs of this strategy? If the collaborating institution doesn't receive free contraceptives from the FPA, will they want to purchase them and pay the full costs of training and IEC. It is too early to answer that question with any certainty, but the team guesses that many collaborating institutions will not.

When contraceptives have a cost or are in short supply and FPAs are striving to become self-sufficient, the third strategy, the "pass-through" strategy where the FPA has little opportunity to recover full costs is no longer an appropriate strategy. The FPAs in Uruguay, Mexico and Colombia have tightened up on "pass-through" mechanisms.

There may be a danger of diversifying too much or too quickly with a loss of focus on family planning as a result. Market research is key. The IPPF affiliate in Uruguay decide to "stick to its knitting", when its sterilization service component did not reach expectations. Being willing to not only fail but give up unsuccessful ventures is key.

One issue which has not yet been satisfactorily addressed is the supply of contraceptives. As has been shown in other parts of this report, all FPAs except PROFAMILIA continue to rely very heavily on donated contraceptives from USAID. At such time as this source dries up, FPAs will face a radically different situation. It remains to be seen how well they will be able to cope.

### 3.2 Lessons Learned Regarding Quality of Care

In some FPAs, decisions about needed improvements in quality of care were made by senior staff and tended to address areas related to their backgrounds, i.e., medical issues. Increasingly, with the focus on sustainability, FPAs have been seeking out the opinions of clients and are experiencing a quick client response to changes that are introduced.

**RECOMMENDATION 11:** **In addition to surveying current clients to gain their opinions on quality of services received and other services desired, it is important to learn more from potential clients, i.e. people in the community who haven't yet come for services.**

**RECOMMENDATION 12:** **In order for assessments of quality to have an effect, there should be rapid analysis and feedback to decision-makers and staff who were assessed.**

### 3.3 Lessons Learned in Integrating HIV/STDs Prevention Activities

The following are key factors in the successful integration of HIV/STDs prevention activities into family planning programs:

- Staff interest in and commitment to a broader vision of reproductive health.
- Design and utilization of a phased approach which identifies goals and measures progress towards them.
- Orientation of all staff toward reproductive health and the importance of integrating HIV/STDs prevention activities into family planning programs.
- Involving staff whose jobs do not usually require client contact (e.g. drivers).
- Making use of the effectiveness of client group sessions.
- Ensuring the consistent availability of condoms

### 3.4 Dissemination of Knowledge Gained

Dissemination of new knowledge is one of the project objectives. Because the project has been operational for under three years, it is only recently that there has been sufficient experience gained to analyze, document and communicate to others.

Significant dissemination of new knowledge has occurred both within the FPAs, and in international fora. An example of the latter includes presentations to the American Public Health Association at the November 1994 APHA meeting. Presentations were given on quality of care assessment approaches and evolution of the HIV/STD integration. A poster session was conducted specifically on experience gained to date under the Transition Project by Ann Lion-Coleman and Marcia Townsend called "Sustainability in Family Planning Programs: Lessons Learned".

Experience gained from the HIV/STDs add-on was presented at the International Conference on AIDS in August 1994 in Japan by Florencia Roitstein and Julie Becker called "Reaching Women in Latin America and the Caribbean: An Integrated Approach to Safer Sex". The HIV/STDs add-on will also be the topic of a future publication of the Population Reference Bureau, focusing on lessons learned. BEMFAM's pilot experience with testing a new client record form concerning STDs will be presented at the March 1995 meeting of the Society for the Advancement of Contraception (SAC) meeting in Guatemala.

In contrast, there has been less intraregional exchange on lessons learned about sustainability although there have been several regional meetings and visits among FPA program staff working on this issue. Intraregional sharing of information among the three countries involved in the HIV/STDs add-on has been constrained by the three different languages spoken in the three countries, however, a workshop to bring together staff from the three countries participating in the HIV/STDs add-on is planned for spring 1995.

IPPF/WHR has already initiated plans to improve information dissemination. In January, 1995, IPPF/WHR inaugurated a newsletter focused on sustainability called "Sustainability Matters". The newsletter will be published in English and Spanish three times a year, and will facilitate sharing of experience.

**RECOMMENDATION 13:** **More opportunities (at least two workshops prior to the project completion date) should be provided for informal exchanges of experience which will allow FPA staff to learn how other FPAs have overcome problems, built strong programs, etc. The workshops should include FPAs which have graduated, and involve FPA staff from regional programs (not just headquarters staff).**

## 3.5 Status of Phased-Out Countries

Three FPAs have been phased out: PLAFAM, Venezuela in December 1992; AUPFIRH, Uruguay in December 1993; and FPATT, Trinidad and Tobago in December 1994. AUPFIRH, Uruguay, which received a year and a half of Transition Projects funds, has struggled to establish and maintain service volume. New Acceptors quadrupled from 1991 to 1992; this rate dropped in 1993 and 1994; however, there are still twice as many as in 1992. CYP is 80% that of 1992. The executive director indicated that time was essential for making the transition from donor dependency to local self-financing. He stated that at least two years of notice were necessary in order to institute the necessary cost cutting, cost recovery and income generation activities - and to change institutional culture. AUPFIRH has reorganized itself and re-educated both staff and clients about the new AUPFIRH. Low-income clients continue to be served with subsidized services reserved specifically for them.

## 3.6 Alternatives to Current Commodities Procurement

### *3.6.1 Current Arrangements*

All FPAs visited rely heavily on USAID for donated contraceptives. IPPF/London is a second important source of support for several of the FPAs, either supplying contraceptives or providing funds for purchase of these locally. All of the FPAs are charging clients for contraceptives, with the exception of four BEMFAM clinics in low income areas where contraceptives currently are distributed free of charge. As a general rule, there is less cost recovery from sale of contraceptives in community-based programs where clients typically have low incomes.

BEMFAM buys oral pills locally, principally with funds from IPPF, and receives condoms and IUDs from USAID. There is currently a shortage of condoms in the Integrated Program caused mainly by delays on the part of the Ministry of Health in approving and releasing imported lots. In its own clinics, because of shortages, BEMFAM sometimes asks clients to obtain contraceptives from pharmacies. BEMFAM staff stated that BEMFAM will have greater problems with contraceptives supplies starting in 1996. Without an adequate supply of contraceptives, the Integrated Program will be in danger, because if municipalities can't obtain contraceptives from BEMFAM, they will lose interest in receiving training and other support from BEMFAM. Furthermore, clients' choice of contraceptives will be compromised. The shortage of condoms has particularly serious implications for efforts to prevent STDs and HIV. BEMFAM has suggested a revision in USAID delivery of condoms. (See Table 10 of Appendix 1.)

USAID supplies MEXFAM with orals, condoms and Norplant and IPPF/London provides a budget for purchase of contraceptives as well. MEXFAM currently buys about 15% of its needed orals locally.

INPPARES receives donated contraceptives from USAID through a contract it has with another local PVO, PRISMA. There have been recent difficulties in obtaining contraceptives on time: INPPARES and PRISMA have given varying explanations for this problem, but it appears to have been resolved. Because of contraceptive shortages, INPPARES has created a revolving fund of $15,000 for the international purchase of Norplant, Depo Provera and vaginal foams (none of which are manufactured locally). IPPF/WHR is purchasing Norplant and Depo Provera for INPPARES through IPPF/London.

PROFAMILIA receives condoms, IUDs and Norplant from USAID through the Transition Project. IPPF/London provides additional support for local purchase of orals. PROFAMILIA itself bought 100,000 IUDs in 1994. Because of delays in receiving equipment from USAID, which resulted in lower income than expected, USAID is negotiating with PROFAMILIA to supply additional contraceptives to make up for the lost income.

USAID supplies FEMAP with contraceptives, although not through the Transition Project. FEMAP currently buys about 4% of its annual requirement. FEMAP staff noted that the organization needs access to a wide range of contraceptives at the prices which USAID pays.

### *3.6.2 Alternative Commodities Procurement Arrangements*

MEXFAM and FEMAP, with technical and other assistance from SOMARC and IPPF staff, have explored the possibility of commercial marketing of contraceptives. (MEXFAM modified its statutes two years ago to enable it to sell contraceptives.) However, given strong local and international competition in Mexico, both organizations have decided for the present not to implement a commercial program. Recognizing that the evaluation team had very limited time in Mexico and has limited expertise in commercial marketing, it believes that MEXFAM's and FEMAP's cautionary stance is warranted.

INPPARES is aware of the importance of understanding the commercial sector and beginning to gain experience in the area of commodities and market share in order to be prepared for USAID withdrawal of funding. Towards this end, INPPARES has begun negotiations with Schering to market orals, and is collaborating with a local organization, APROPO, in the marketing a new condom (Piel). IPPF/WHR has provided technical assistance in this area and Schering will assist with training.

BEMFAM has received technical and financial support from SOMARC and IPPF for planning a commercial marketing operation. To assist the effort, USAID is giving BEMFAM 10 million condoms, 3.5 million of which are expected to reach Brazil in February, 1995. BEMFAM has hired a marketing director and with SOMARC's help is updating its marketing plan which was prepared early in 1994. BEMFAM hopes to begin commercial sales in Rio and Sao Paulo in May of this year.

BEMFAM'S leadership has two concerns about the proposed venture: the need to strictly separate the commercial venture from distribution of donated contraceptives which it cannot legally sell; and potential strong competition from the Contraceptive Procurement Organization (CPO) which was

established by USAID to be a source of contraceptives as USAID phases out its contraceptive supply. There will also be competition from existing manufacturers and importers. Notwithstanding the team's limited time in Brazil, the team believes that it did obtain sufficient information to conclude that BEMFAM's proposed venture appears to be a risky one under current circumstances.

PROFAMILIA is in a strong position with respect to alternative commodities procurement. Table 11 in Appendix A shows that in 1994, PROFAMILIA obtained only 16% of its condom requirements from USAID and less than 20% of its oral contraceptive needs from IPPF. Most of its remaining requirements were met through purchases with income from contraceptive sales and other services. Tables 1 and 2 in Appendix E show PROFAMILIA condom and oral sales through its clinics and through commercial marketing and related channels from 1975 through 1994. These sales represent approximately one third of national condom sales and about two thirds of national sales of orals. It is clear that PROFAMILIA has a well developed contraceptive procurement and marketing system. PROFAMILIA's leadership is confident that it can secure needed contraceptives from its own resources when TP support is terminated, provided that the additional supplies currently being negotiated with USAID are forthcoming.

In addition to the efforts of the FPAs, IPPF/London had established an entity which was to provide leadership and assistance to the FPAs in commercial marketing. This unit was disbanded during the past year, but efforts continue through IPPF/WHR and consultants to provide assistance in this area.

### 3.7 Endowment Fund

Prior to 1993, USAID decided to explore the feasibility of creating an innovative funding mechanism for PROFAMILIA in the form of an endowment fund with the specific objective of assisting PROFAMILIA to achieve a high level of sustainability while simultaneously maintaining its commitment of family planning services to low income level clients and expanding its services. This plan was part of an 18-month effort by USAID, PROFAMILIA, and IPPF to strategically plan for PROFAMILIA's completion of the transition project in a successful manner.

A committee consisting of three board members of PROFAMILIA and representatives from IPPF and USAID explored several options for setting up a fund. One option consisted of using the IPPF board to manage the fund, another called for the fund to be managed by the PROFAMILIA board of directors, and a third option considered setting up a separate not-for-profit corporation. The third option was selected.

USAID devoted considerable efforts to give this option the highest probability of success. This support included hiring a fund-raising consultant as well as holding a seminar on the objectives, process, and operational aspects of an endowment fund. It should be noted at this point, with the advice of the fund-raising consultant, that it was decided to start with a smaller sized Board of Directors. One of the committee members, Rodrigo Vasquez, is currently on the three-member board of the PROFAMILIA Endowment Fund (PEF).

In 1993, projections were made of the level of potential support that the fund could provide. Originally the plan was to start with an endowment of $6 million, invested at an interest rate of 9% per year. This plan projected an initial increase in year one of $540,000, and $718,411 by year ten of the fund's operation. The interest was to be made available to PROFAMILIA at the end of the

transition project, in 1997. Depending on what exchange rate is used, the 1993 total budget for PROFAMILIA was approximately $16,420,545. Hence, the support from the endowment would have been equal to nearly 4% of the total operating budget of PROFAMILIA in 1993. Applied to the actual (and projected) FY 1994 and FY 1995 operating budgets, the total support would be around 3% since PROFAMILIA's budget increased more than the 9% projected interest rate of the fund. The 9% projected interest rate was subsequently lowered near the end of 1993 to 5%, meaning that the projected percent of support to PROFAMILIA's total budget was reduced to approximately 2%.

Both unforeseen market conditions and delays in USAID contributions to the fund have affected the projections. In 1994, the fund had $4 million which was invested under the management of Brown Brothers Harriman & Co., an investment firm chosen through a competitive bidding process. Not unlike the market in general, the fund decreased in market value by 6% to a closing value of $4,733,505 as of 12/31/94. In addition, the fund did not receive the full $6 million in USAID contributions until February, 1995.

Although this venture is very innovative and received a great deal of USAID support, PROFAMILIA feels that the opportunity cost of this fund, using hindsight, may be high when other alternatives, such as using the money for surplus generating operations, are considered. In addition, BB&H has not yet provided the PEF Board of Directors with an investment plan for FY 1995. Lastly, the PEF consists of three directors, one of whom completes his term this year, and another of whom completes his term shortly thereafter.

Following a meeting with the Colombian representative of the PEF board, the team left with the impression that the board was not as structured or as active as it should be. Mr. Vasquez mentioned that there were two meetings held last year, but each time the three members were not all able to be present, and one of the meetings was held by telephone. This was discussed with IPPF, and minutes of the meetings were requested for review (as were all minutes of the FPAs Boards of Directors). It came as somewhat of a surprise to see that the last recorded minutes of the PEF board were from October 19, 1993. In addition, the minutes indicated that only one member, Don Nicholson from PROFIT, was present, which in no way represents a quorum, and the minutes were not signed.

In essence, there is no record of any board meeting since the members were selected on May 3, 1993. Board representation and participation are needed to ensure that this fund is given the best opportunity to succeed and to serve PROFAMILIA. Two board meetings, one by phone, and no minutes for nearly 16 months do not constitute sufficient attention to this fund.

The PEF is an innovative funding mechanism with long-term potential that represents a considerable contribution of both capital and labor on behalf of USAID. The PEF is now worth $6 million, and it performed last year at below market level. The current PEF Board is carefully assessing the performance of BB&H, but recommends no change in management at this time.

The PEF Board of Directors is the only legal management entity for this endowment. It must be more dynamic and act in a concerted manner in determining the future directions of this fund. It is now time to build in more long-term sustainability in the PEF in a timely and well planned manner, and create a stronger board that is not as potentially affected by the change of an individual member. It is important to make these changes prior to the end of the Transition Project, while USAID still has indirect control of this fund.

**RECOMMENDATION 14:** **The PEF Board should be expanded (as permitted in the current by-laws) to five members. The two additional members should be Colombian (possibly individuals who are not members of the PROFAMILIA Board).**

# 4. PROJECT ORGANIZATION, MANAGEMENT AND FUNDING

## 4.1 Responsiveness of Project to Constituents

The project receives high marks from FPAs and USAID Missions for responsiveness. Further, there seem to have been good cooperation between IPPF and other CAs. BEMFAM's leadership particularly appreciated IPPF/WHR's acceptance of its proposals for project modifications and TP assistance with client satisfaction surveys. PROFAMILIA rated project responsiveness as excellent, and recognized in particular assistance to ensure that PROFAMILIA's accounting system met USAID requirements. MEXFAM acknowledged assistance in the areas of sustainability, finances, evaluation and purchasing as particularly helpful, but noted that assistance was not always based on needs assessments. Also, MEXFAM believes that IPPF/WHR did not clearly define the role of its office in Mexico vis-à-vis MEXFAM. FEMAP's leadership stated that FEMAP has always received the support it needed, including in MIS.

## 4.2 Funding

The level of funding in relationship to the expectations that have been placed on the project appears to be very realistic, particularly when comparing actual expenditures to budgeted expenditures. IPPF estimates that all of the FPAs are spending at least 98% of what has been budgeted. However, the FPAs appear not to be generating any significant savings that might be used for a no-cost extension at this point. Therefore, any no-cost extension for the FPAs would have to come from future savings (underspending) of their TP money.

The budgeted and projected income for the IPPF/WHR office itself is presented in Table 9 in Appendix A. It should be noted that it does not include accrued expenses, and the potential reserves that appear here are not actual according to IPPF. The accruals need to be added eventually since they have implications for a potential no-cost extension. The IPPF/WHR should try to generate savings for a no-cost extension.

Some of the factors that have contributed to the successful transition to sustainable programs have been the flexibility of funding and resulting ability of the FPAs to each work towards sustainability using a wide variety of methods. As previously mentioned, some have opened small hospitals and ambulatory surgery centers, some have developed partnerships that contract for care they provide, two have started or are entering the commercial market for sale of commodities, and others have diversified the health care services they provide. IPPF and the TP have encouraged this innovative approach among the FPAs, which has helped to provide a sense of ownership and motivation for them.

Some financial difficulties have detracted from the FPA progress towards sustainability. The most notable in almost all cases have been delays in receiving either commodities (contraceptives in particular) or medical equipment. The delays in commodity procurement have been particularly exacerbated in the case of Brazil as a result of new laws which require quality control testing of condoms which takes several months to accomplish. PROFAMILIA experienced a delay in receiving equipment, but USAID/Washington is working closely with them to rectify problems caused by this delay. MEXFAM is anxiously awaiting the delivery of equipment in order to meet starting dates for new health centers.

The annual budgets for each of the FPAs are presented in Appendix A, Tables 4-8.

# 5. PROJECT DESIGN

## 5.1 Original Proposal

The original project objectives and design for evaluating achievement were clear and measurable. IPPF and USAID deserve credit for designing a project with indicators at the output rather than the process level - it is one of the earliest population projects to do so.

In the original proposal, however, USAID staff assumed that FPAs could be assisted to simultaneously increase their level of self-financing, increase service volume, maintain or improve quality, and maintain their client profile. The Management Review concluded, and this team agrees, that the objective of increasing volume was unrealistic, combined with the other three objectives. While FPAs might choose to expand services, service expansion should be an internal FPA decision rather than a project objective. Moreover, on the basis of data available to date, the team questions whether, additionally, maintaining client profile was realistic in light of the other objectives, the time available, and the management development of some of the FPAs.

With the exception of PROFAMILIA, in 1992 none of the FPAs had the institutional commitment, strategies, systems or staff to balance the difficult trade-offs inherent in these four objectives. In retrospect, IPPF/WHR and USAID were naive about the effort and costs involved. Inefficient activities had to be closed down, resulting in a loss of clients. Service strategies were altered, causing a shift in client profile away from the poor.

USAID informed IPPF/WHR and the FPAs of the termination of central funding after five years of sometimes conflicting USAID/Office of Population messages on sustainability. The message that USAID would be phasing out population funding in Latin America was first widely announced to the Latin American family planning community in 1987 at the First Latin American Family Planning Conference and repeated in 1989 at the Second Conference. However, conflicting messages encouraged IPPF/WHR and the FPAs to doubt this prospect.

In 1992 USAID made the decision to terminate funding for specific FPAs in certain years without assessing the capacity of the FPAs to achieve sustainability within those time frames. Some FPAs were given very short time horizons to change their institutional culture and develop essential institutional capacity. For other FPAs, even with extended deadlines, the transition to sustainability will be a race against time. In most FPAs, one or more indicators of sustainability may not be fully achieved to the extent that the FPA, IPPF/WHR, and USAID consider desirable by the time funding ceases.

## 5.2 HIV/STDs Add-on

The add-on represents the PHN Center's first effort to integrate HIV/STD prevention with currently existing family planning programs. It is also the Office of Health's first add-on to an Office of Population program. The design of the add-on was complicated by a variety of factors: two different funding and oversight sources within USAID (i.e. Offices of Health and Population); an add-on mechanism to a cooperative agreement with different project objectives; different country priorities for both the add-on and the rest of the project, with the exception of Brazil; and the different languages spoken in the three add-on countries. Moreover, USAID programming for

family planning and integration of HIV/STDs are at different stages in the region (and in the field in general). Mature USAID family planning programs with years of experience exist in some countries while in others nascent programs are still at the stage of conceptualizing the integration of HIV/STDs into family planning activities. As the Transition Project has evolved and experience has been gained in managing an integrated program, a more cohesive management and program approach is evident.

## 5.3 USAID Project Management

### *5.3.1 Population Office*

The USAID CTO and technical advisor have been very supportive and responsive in the view of IPPF/WHR. USAID missions in Mexico and Colombia are similarly very supportive of the TP. USAID/Peru is committed to service expansion for low income and under-served women (one of the original objectives of the TP). They have been supporting such expansion through bi-lateral funds and are a key factor why INPPARES has been able to both increase its level of self-financing and increase service volume. USAID/Brazil's focus is now on the public sector and on commercial marketing. In the latter connection, USAID has been instrumental in creating the Contraceptive Procurement Organization, an entity which BEMFAM views as competitive with its own plans.

Article V. of the Cooperative Agreement provides for "substantial involvement" in the project by USAID, including in "development of an annual workplan and in other key activities such as the selection of professional staff...". Whereas a brief review of USAID files relating to the project indicates continuing substantial involvement by the CTO in many respects, it seems reasonable to say that USAID would have been well advised to be more involved in the Project's staffing configuration, including the selection of key technical staff at IPPF/WHR, and perhaps to have been more insistent regarding BEMFAM's developing an adequate staff capacity in sustainability and perhaps marketing.

### *5.3.2 HIV/STDs Add-On*

In addition to project design features, other staffing factors also contributed to complexity of managing the add-on: turnover of the Office of Health Technical Advisors, who are Senior Fellows, and IPPF/WHR staff responsible for the add-on; and the Technical Advisors may have had limited understanding of the contractual nature of an "add-on", as well as ability to sign-off on documents, etc. Despite some bumps at the beginning re coordination and communication, and responsibility for technical oversight for the add-on, these appear to have been worked out and there is greater clarity about roles, responsibilities and the mechanics of administering the project. A May 1994 memorandum of understanding helped clarify these issues; at this point in time, the project seems well managed by AID. The USAID Technical Advisors within both the Offices of Health and Population have significant experience, knowledge and interest regarding HIV/STDs which has contributed to technical oversight of the project.

# 6. ISSUES TO BE ADDRESSED

## 6.1 Core Project Recommendations

### *6.1.1 General*

**Recommendation 15:** **The team endorses the concept of requiring the FPAs to develop strategic plans for the remaining duration of the project through September 1997. These plans should be completed by the end of May at the latest and approved by the FPA Boards. They should give particular attention to determining technical needs and how they can best be met, i.e. with technical assistance, training, or staff development. IPPF/WHR, the FPAs, and USAID should determine how best to secure the required support, including local support and support from other CAs.**

**Recommendation 16:** **Contingent upon the results of the strategic planning exercise endorsed above, IPPF/WHR and USAID should determine needed changes in TP headquarters staffing. As a general principle, there should be a gradual phasing down of staff to reflect the reality that the TP will terminate in two and a half years.**

**Recommendation 17:** **There is a need for increased documentation, monitoring and evaluation of the trade-offs between local self financing, client volume, client profile and quality. A second person experienced in evaluation is needed at IPPF/WHR to work with the FPAs and document lessons learned.**

**Recommendation 18:** **The team recommends a one year no cost extension of the project. FPAs which, in the view of IPPF/WHR and USAID, are satisfactorily meeting their strategic plan objectives should be eligible to receive available funds from savings. USAID, in consultation with IPPF/WHR, should establish a ceiling on funds to be allocated for TP expenses at IPPF/WHR headquarters. These particular funds should be dedicated principally to evaluating and documenting the TP experience and disseminating the results. This could include support of workshops and other mechanisms to educate other FPAs about making a successful transition to sustainability. It must be emphasized, however, that IPPF/WHR and the FPAs would have to begin to generate savings (through underspending of their budgeted allocations for 1995-1997) in order to have funds available for the extension.**

**Recommendation 19:** **The Mexico regional office was established largely at USAID's initiative. The evaluation team members who visited Mexico believe that this office no longer serves an essential function. This office should be closed within a reasonable time and the funds saved should be reprogrammed for other TP priorities.**

**Recommendation 20:** **USAID should make every effort to continue supplying contraceptives to FPAs, through other mechanisms besides and in addition to the TP. Supplies should continue after the end of the TP in recognition of the fact that if FPAs have to purchase contraceptives, their chances for sustainability will be hurt. A gradual phasing down of supplies over a period of approximately five years would be the best arrangement.**

**Recommendation 21:** **As recommended by the USAID management review, increasing service volume should no longer be a project objective.**

### *6.1.2 BEMFAM*

**Recommendation 22:**

- **Add additional management, legal and financial talent to the Board.**
- **Hire a full time senior executive in sustainability, selected jointly by the Executive Director, the BEMFAM Board and IPPF/WHR.**
- **Strengthen BEMFAM's senior management capability to develop increased sustainability and to facilitate decentralization and diversification.**
- **Reassess the proposed commercial marketing venture, taking account of the CPO.**
- **Organize training for regional coordinators in marketing, negotiating program contracts, MIS, and costing and pricing.**
- **Work towards reducing administrative costs, particularly at the central level.**
- **Undertake consumer research designed to assess BEMFAM'S image and the needs and interests of potential clients.**
- **Increase minimum delivery order of commodities to avoid shortages.**
- **Assess and compare integrated clinics and programs in reference to client profiles, productivity, costs and income.**

### *6.1.3 INPPARES*

**Recommendation 23:**

- **Implement a quality assurance system.**
- **Provide management training to provincial offices in the areas of marketing, pricing and productivity.**
- **Decentralize the MIS system to provincial offices when and where appropriate.**
- **Document client profiles in the CBD program at least annually.**

### *6.1.4 PROFAMILIA*

**Recommendation 24:**

- **The PEF Board should be expanded and PROFAMILIA representation increased.**

### *6.1.5 MEXFAM*

**Recommendation 25:**

- **Strengthen second level management of MEXFAM and institutionalize MEXFAM's management capability through team building.**
- **Integrate MIS information and data for use in management decisions.**
- **Extend the schedule for starting new health centers and increase efforts to conduct market studies and develop implementation strategies to increase the likelihood of success in this area.**
- **Document client profiles on a regular basis using existing MIS.**

### *6.16 FEMAP*

**Recommendation 26:**

- **Undertake a marketing survey designed to enhance FEMAP's image.**

## 6.2 HIV/STDs Add-on

It is critical to allow the nascent programs a chance to develop, to become better integrated into the FPAs, to continue to show leadership in raising awareness of the issues, testing different strategies, and in incorporating international experience in this rapidly changing area. The prevalence of HIV will only increase in the region in the coming years, and the trend toward increasingly heterosexual transmission is unlikely to change. Thus HIV will not only be a larger problem, but will also increasingly affect the client population of the FPAs.

**Recommendation 27:** **A follow-on mechanism for HIV/STDs integration should be encouraged beyond the end of the core Transition Project cooperative agreement and should be supported for a longer period of time given its stage of development and the rapidly growing regional prevalence of HIV/STDs.**

**Recommendation 28:** **Include other countries in the add-on, as recommended in the management review. Other FPAs in the region are also doing work in this area and should be included in dissemination efforts and exchanges of experience, and technical support as possible.**

**Recommendation 29:** **Place high priority on alleviating shortages of condoms and in creating rules, delivery systems and funding to maintain a continuous supply of these critical commodities.**

**Recommendation 30:** **Increased clinical attention will be needed for STD diagnosis and treatment. Some dedicated medical capacity will be required in this area from IPPF/WHR (or London) to provide direction and review progress.**

**Recommendation 31:** **Increased emphasis should be placed on evaluation in order to capture baseline information and to document lessons learned.**