United States Agency for International Development
Reproductive Health/Family Planning NGO Program Strategy Evaluation: Dominican Republic

Report of Findings and Recommendations

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ACRONYMS

ADOPLAFAM	*Asociación Dominicana de Planificación Familiar, Inc.*
AIDS	Acquired Immunodeficiency Syndrome
CA	Cooperating Agency
CBD	Community-based distributor
CMS	Commercial Market Strategies
CONECTA	Family Health International USAID-funded project
CPR	Contraceptive Prevalence Rate
CYP	Couples-Year-Protection
DHS	Demographic and Health Surveys
DR	Dominican Republic
FP	Family Planning
FY	Fiscal Year
GSM	Grant Solicitation and Management
GTZ	German Society for Technical Cooperation
HIV	Human Immunodeficiency Virus
IDI	International Dominican Information (a Dominican NGO)
IDSS	Dominican Social Security Institute
IPPF	International Plan Parenthood Federation
IEC	Information Education and Communication
IR	Intermediate Result
IUD	Intrauterine Device
KFW	German Technical Cooperation Agency
MIS	Management Information Systems
MMR	Maternal Mortality Rate
MOE	Ministry of Education
MOH	Ministry of Health
MUDE	*Mujeres en Desarrollo Dominicana, Inc.*
NGO	Nongovernmental organization
OC	Oral contraceptives
PAHO	Pan-American Health Organization
Profamilia	*Asociación Dominicana Pro-Bienestar de la Familia*
PSI	Population Services International
PVO	Private Voluntary Organization
REDSALUD	The Health Reform and Decentralization Project
RD$	Currency of the Dominican Republic
RH	Reproductive Health
SESPAS	Secretariat of State of Public Health and Social Assistance
SO	Strategic Objective
SP/CD	Social Promotion/Community Development
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

Since the 1970s, in addition to its work to strengthen the public health sector, the U.S. Agency for International Development has supported the development of RH/FP NGOs as important sources of subsidized services to the poor and vulnerable groups as well as to adolescents. In August 2004, USAID/Dominican Republic commissioned an evaluation of the relevance, viability, and feasibility of its NGO program support in the areas of reproductive health and family planning (RH/FP), placing a particular emphasis on programs providing services to vulnerable populations and adolescents. The resulting findings and recommendations, presented in this report, are expected to guide decisions about the future directions of support to RH/FP programs in the context of expected funding limitations and a national macroeconomic crisis in the Dominican Republic.

In September 2004, the evaluators, a multidisciplinary team with expertise in RH/FP program management, social marketing, finance, and organizational development (see Annex A for a list of team members), collected data in the Dominican Republic. This report, a product of the evaluation team's findings, addresses the success of USAID's strategy in strengthening the financial position and sustainability of the NGOs, while continuing to serve vulnerable populations, and recommends possible directions for future support from USAID.

Following USAID's guidance, the Initiatives team focused their evaluation efforts on the three RH/FP NGOs that are the largest recipients of USAID financial and technical assistance: *Asociación Dominicana Pro-Bienestar de la Familia, Inc.* (Profamilia); *Mujeres en Desarrollo Dominicana, Inc.* (MUDE); and *La Asociación Dominicana de Planificación Familiar, Inc*. (ADOPLAFAM).

USAID asked the team to explore five key questions, summarized here (see Section 8 for the team's full conclusions and recommendations).

Question 1: How successful has the strategy been in strengthening the financial position of the NGOs?

The team's findings indicate that the strategy, as defined by the IR indicator *Percent of Total Expenses Covered by the NGO's Generated Resources*, has been largely successful. All three organizations significantly improved their sustainability positions during the project period by an average of 33 percentage points (see the table below): from 2002 to 2004, MUDE increased its sustainability indicator from 26 to 68; ADOPLAFAM, 19 to 59; and Profamilia, 71 to 89.

Table 1. Percent Change in the RH/FP NGO Sustainability Project Performance Indicator: *Percent of Total Expenses Covered by the NGO's Generated Resources*, 2000-2004

Organization	2000* (%)	2004** (%)	Percent Change
Profamilia	71	89	18
MUDE	26	68	42
ADOPLAFAM	19	59	40

Source: CMS data * October 2000 data; **June 2004 data

Expectations for end of project (June 2005) as defined in the NGO grant agreements are that Profamilia's sustainability indicator could reach 90 and ADOPLAFAM's 70 percent. For MUDE, the expectation was that after 2005, MUDE would continue its health program with the proceeds from its micro-credit loan program.

The team believes that each of the three NGOs is highly committed to reaching vulnerable populations and have improved their sustainability positions without losing the focus of their mission: to serve vulnerable groups. Given this commitment to the mission, however, the NGOs' situation has become increasingly complex in the last few years given the public health sector's inability to provide services to-hard to-access population of extreme poverty and the dramatic increase of poor people between 2000 and 2004.

Profamilia, ADOPLAFAM, and MUDE have improved their sustainability positions as defined by the IR indicator chosen by USAID: *Percent of Total Expenses Covered by Revenues Generated by the NGOs*. The team found gaps and deficiencies, however, that were not captured by the indicator. Given the brief time remaining in the grant period, the team does not recommend changes to indicators or sub-indicators, although additional sub-indicators that might be easily collected to cross-check sustainability and estimate levels of services to the poor are: (1) amount of costs recovered (from fee-for-service, etc.) as a proportion to all expenditures; and (2) the total number of non-paying clients as a proportion of all clients served.

It is important to note that all developed countries subsidize, to a greater or lesser extent, health services to the poor. Thus, it is unrealistic to expect long-term sustainability of services to the poorest of the poor without the NGOs identifying alternative sources to replace the financial gaps left when support from international donors ends. Although the team would have liked to estimate the ratio of paying to non-paying clients the NGOs could serve while maintaining their sustainability, the brief period available for evaluation activities did not allow for the level of analysis required for an effective projection.

Question 2: Which NGO(s) utilized the support most efficiently to the benefit of their service provision and overall financial position?

Of the three organizations, Profamilia has utilized support most efficiently. Although its sustainability indicator increases less strikingly than that of ADOPLAFAM or MUDE (Table 2, below), Profamilia has achieved the highest diversification of revenue sources and has been able to consolidate its projects and services, which are for the most part self-sustaining.

Table 2. Percent of NGOs' Total Income Generated from International Donors: 2004

NGO	YEAR 2004 (%)
Profamilia	26
ADOPLAFAM	60
MUDE	75

Source: Budgets provided by each NGO.

Although all three NGOs have substantially improved their sustainability positions, they continue to have to have a high level of dependence on international donors. Profamilia's dependence, however, is significantly less than that of the other NGOs.

Question 3: Which NGOs (if any) are closest to program sustainability and what should be the role of USAID in terms of possible future support?

The severity of the economic downturn (three percent negative growth in 2003) in the past two years has, to varying degrees, adversely affected (reduced income) the sustainability level of all three NGOs. Although Profamilia is the closest of the three to program sustainability, the institution is approaching its "sustainability ceiling" because of its social mission and the economic crisis. ADOPLAFAM and MUDE have not been able to respond as effectively to the changed economic and health environment.

The team feels that USAID should address the gaps and deficiencies identified in this evaluation (see Section 8.1).

Question 4: What specific support should be provided to specific NGOs?

One of the team's key conclusions is that NGO RH/FP service delivery has become more important as the ability and willingness of the public sector to serve an increasing number of vulnerable populations has declined during recent project years. Therefore, the team feels that:

1. In the short term, USAID should continue providing financial and technical support to Profamilia and MUDE (to 2007, the end of USAID's current health strategy).
2. Financial and/or technical support to Profamilia and MUDE should be very specific to address gaps and deficiencies identified by the team.
3. USAID should carry out a comprehensive evaluation of ADOPLAFAM's current financial and service delivery performance and make decisions about future support to ADOPLAFAM on the basis of whether past support has generated sufficient positive change to suggest that future support will be an effective investment.
4. None of the support to ADOPLAFAM should be given for operating costs—especially not for salaries. Rather, support should be limited to income-generating activities.

Social Marketing Recommendations

For Profamilia, USAID should provide: limited, well targeted technical assistance in the evaluation of marketing and business decisions related to future product line direction and product/clinical service introductions; one-time financial support for an advertising and promotional campaign to revitalize Profamilia's commercial sales of oral contraceptives; and targeted technical assistance in developing a broader, stronger base of support for subsidized clinical services delivery to targeted vulnerable populations.

For MUDE, the team recommends technical assistance in: developing and implementing cost accounting systems/cost centers necessary to analyze costs of products sold and for effective management of income-generating activities; developing improved contraceptive commodity needs projections and an improved contraceptive commodity logistics system; evaluating and developing solutions for the organization's cash flow situation, especially in regard to contraceptive commodities and cash flow management. USAID should also provide technical

assistance in the process of development, management, and revision of business and marketing plans for both bakery and contraceptive products.

Financial Recommendations
For Profamilia, USAID should support a program of institutional strengthening with the aim of achieving financial sustainability; diversifying products and services within a strategy that would increase marginal revenues while controlling marginal costs; identify and penetrate new market niches; and augment the use of institutional overhead as a mechanism to generate new resources in the administration of new projects.

Organizational Development Recommendations
USAID should guide all three NGOs in developing a Social Promotion (SP) and/or Community Development (CD) service product under the Subsidized Regime component of the Health Sector Reform.

For MUDE and ADOPLAFAM, USAID should develop and implement a realistic donor fund development strategy.

For Profamilia, USAID should select a successful mentor model in Latin America to study and deepen the primary health service delivery business formula for clinic models. PROSALUD in Bolivia used to provide a good example for mentoring and study; however, this may not be the best model under current circumstances.

Additional findings and conclusions specific to organizational development issues are presented in Annex F.

Question 5: What form should support take and what is the optimal mechanism to deliver it?

The team identified three options for future support based on the information available at the writing of this report:

1. Through the CONECTA subgranting mechanism, include the three NGOs as potential recipients of subgrants and technical assistance.

2. Explore the feasibility of using the PHR Service Delivery Improvement Division's PVO/NGO Flex Fund Project to provide future technical support to the NGOs.

3. Consider the use of cooperative agreements to increase USAID's direct involvement with outcomes and hold the NGOs to a higher level of compliance and geographic coverage.

General Recommendations

In general, the team recommends that USAID continue to provide financial and technical assistance only for activities that will generate income, with the exception of assistance for developing and implementing cost accounting systems/cost centers. USAID should provide short-term support for the subsidy/coupon program, including technical assistance to assist each NGO in developing a broader and stronger base of funding for subsidized services delivery.

Whatever mechanism USAID uses, the team recommends indicators more appropriate to business. USAID should ensure baseline data are available/collected to allow evaluation of impact on targeted vulnerable populations.

In addition, the team recommends that USAID provide technical assistance to the three NGOs in developing strategies for: (1) delivering RH/FP services to marginalized segments of the population not covered by Social Security (how to reach them, with what services, and how to fund); and (2) competing for service delivery contracts under Social Security.

The Profamilia model should be documented to identify its potential for replication; USAID should encourage interchange of "best practices" among the three NGOs as well as with those HIV/AIDS NGOs supported by CONECTA.

Finally, the team recommends that USAID encourage other donors, as the opportunity arises, to support these NGOs.

Reproductive Health/Family Planning (RH/FP) NGO Program Strategy Evaluation
USAID/Dominican Republic

1. BACKGROUND

1.1 Introduction

In August 2004, USAID/Dominican Republic approved and funded a Task Order Proposal, submitted by Initiatives Inc. under the *Technical Assistance and Support and Support Contract* (TASC2 Global Health), for an evaluation of its Reproductive Heath/Family Planning (RH/FP) Nongovernmental Organization (NGO) Strategy. USAID commissioned this assessment of the relevance, viability, and feasibility of its NGO programs providing RH/FP services to the poor and vulnerable populations. The findings and recommendations resulting from the evaluation, presented in this report, are meant to guide USAID's decisions about the future direction of financial support in the context of expected funding limitations and a national macroeconomic crisis in the Dominican Republic.

Following USAID's guidance, the evaluation team focused their efforts on three RH/FP NGOs that are the largest recipients of USAID financial and technical assistance:

- *Asociación Dominicana Pro-Bienestar de la Familia, Inc.* (Profamilia)
- *Mujeres en Desarrollo Dominicana, Inc.* (MUDE)
- *La Asociación Dominicana de Planificación Familiar, Inc*. (ADOPLAFAM)

In June 2001, USAID awarded five-year grants to each NGO totaling $2.3 million ($1.4 million to Profamilia; $600,324 to ADOPLAFAM; $297,134 to MUDE). The grant period ends in June 2005.

USAID's financial and technical assistance to the three NGOs has centered on improving the quality of RH/FP service delivery, diversifying services, developing management systems, and creating cost recovery strategies as a foundation for financial sustainability, while continuing to serve vulnerable populations. The NGOs' RH/FP programs contribute to USAID's overall health Strategic Objective of "Sustained Improvements in the Health of Vulnerable Populations in the Dominican Republic" and to a specific sub-intermediate result "Improved NGO Sustainability to Continue Provision of Quality Services for the Poor and Adolescents."

The Initiatives evaluation team, a multidisciplinary group of four independent consultants with expertise in RH/FP program management, social marketing, finance, and organizational development, began their work in the Dominican Republic on September 13, 2004 (see Annex A for a list of team members and Annexes B and C for the team's workplan and timeline). The in-country fieldwork included a two-day preparatory meeting to draft the timeline, workplan, and data collection schedule; approximately two weeks of data gathering; and an initial debrief to USAID of the team's preliminary findings on September 28, 2004. This report, submitted to USAID/DR in December 2004, describes the team's full findings and recommendations.

1.2 Objectives and Key Questions

This report, a product of the evaluation team's findings, addresses the success of USAID's strategy in strengthening the financial position and sustainability of the NGOs, and recommends possible directions for future support, in the context of the following questions posed by USAID:

- How successful has the strategy been in strengthening the NGOs' financial position?
- Which NGO(s) utilized the support most efficiently to the benefit of their service provision and overall financial position?
- Which NGOs (if any) are closest to program sustainability and what should be the role of USAID in terms of possible future support?
- What specific support should be provided to specific NGOs?
- What form should that support take and what is the optimal mechanism for delivery?

1.3 Health Sector

In 2002, the population of the Dominican Republic was estimated at 8.6 million, with population growth at 1.5 percent. The trend since the 1970s toward lower growth rates reflects acceptance of a norm of smaller family size that is expected to continue into the future. This trend has been supported over the last two decades through major investments by USAID and other donors in support of the Dominican Republic's health sector programs. Despite improvements in many health indicators and higher rates of economic growth in recent years, however, health services to vulnerable populations—including women, children, adolescents, and the poor—remained deficient at the time USAID's current seven-year health strategy was developed.

The present macroeconomic crisis in the Dominican Republic appears to have worsened the public sector's ability to provide universal health coverage to the Dominican population. Inflation and other economic factors associated with the ongoing financial crisis are eroding the middle class and increasing the numbers of poor. Current World Bank projections estimate that the poor and indigents constitute about 64 percent of the population, or 5.4 million people. In addition, the transition to new leadership in the public health sector, as a result of the new government headed by President Leonel Fernandez (August 2004), appears to have hindered implementation of health services during the last six months.

In addition to its work to strengthen the public health sector, USAID since the mid-1970s has supported the development of reproductive health and family planning NGOs as important sources of subsidized services to the poor and vulnerable groups, and as a means to improve the quality of service delivery. The 1996 DHS estimated that RH/FP NGOs provided family planning services to 15 percent of the population. Although the 2002 Demographic and Health Survey (DHS) estimated service coverage only for Profamilia, most donors and family planning practitioners believe that RH/FP NGOs continue to be important sources in the provision of family planning to vulnerable groups and adolescents and are continuing to provide RH/FP services to over 15 percent of contraceptive users in the country.

Some major accomplishments in reproductive health, based on data from the 1996 and 2002 DHS surveys, are shown in the following table.

Table 3. Selected Indicators from the Demographic and Health Surveys: 1996 – 2002

Indicator	Urban 2002	Rural 2002	Nat'l Average 2002	Nat'l Average 1996
Total Fertility Rate	2.8	3.3	3.0	3.2
CPR, All Methods	69.8	69.8	70.0	64.0
CPR, Modern Methods	65.5	66.3	65.8	59.2
CPR, Fem. Sterilization	44.2	48.7	45.8	40.9
CPR, OCs	14.1	12.4	13.5	12.9

The Total Fertility Rate (TFR), an indicator that summarizes the average number of children that would be born to a woman by the end of her childbearing years, has declined from 7.4 in 1990 to 3.2 in 1996 and 3.0 in 2002. Although not shown in the table above, it is important to note that in 2002 the urban TFR remained at the 1996 level, but the rural TFR declined from 4.0 in 1996 to 3.3 in 2002. The Contraceptive Prevalence Rate (CPR)—the percent of women in union using a method of contraception—increased from 66 in 1996 to 70 percent in 2002, with most women, (45.8 percent) choosing female sterilization as the most popular method and 13.5 percent of women using oral contraceptives (OCs) as the second most popular method. These positive trends indicate that access to family planning services is relatively good for most urban and rural women, and that high levels of contraceptive use are contributing to lower fertility.

As pointed out by the Pan-American Health Organization (PAHO) Representative in the Dominican Republic, however, there are gaps and deficiencies in the reproductive health scenario as reflected by: (l) a high level of maternal mortality in comparison to other countries of similar socioeconomic development; and (2) the pattern of childbearing which includes early sexual union, high rates of adolescent pregnancies, unwanted pregnancies leading to abortion, early first birth, short birth intervals, and early surgical sterilization following achievement of desired family size. These are complex problems that appear to be related to lack of access to reversible contraceptive methods in the public sector and inability to pay in the private sector delivery system.

According to 2002 DHS data, although 99 percent of births were institutional births and prenatal visits were generalized (98 percent), one woman dies every 24 hours from complications related to pregnancy and/or childbirth. The DHS estimates the Maternal Mortality Rate (MMR, the number of women who die as a result of complications of pregnancy or childbearing in a given year, per l00,000 live births) at 178[*]. Additional data indicates that 50 percent of sterilizations are carried in public sector health facilities. Factors that may contribute to the high level of sterilizations include the unavailability of long-term reversible methods; the public health sector's inability to provide long-term, reversible methods on a consistent basis; and that the procedure is free when carried out at a public sector site.

To summarize, problems in the delivery of RH/FP services identified by USAID in 2002 still persist at the time of this evaluation and include the sustainability of RH/FP services to vulnerable groups, the quality of services, and the policy environment. These issues are discussed in more detail in Section 7: "Cross-Cutting Issues."

[*] The accuracy of the DHS MMR is debated among the health community.

1.4 Commercial Pharmaceutical Environment

Both commercial and NGO markets for temporary contraceptives, especially oral contraceptives (OCs), have experienced declines in sales during the past 12 to 24 months. In a discussion with a member of the evaluation team, Schering Dominicana marketing management called this period a "disaster." Schering's overall OC unit sales, for example, have gone from a steady annual increase of four to five percent from 2000 to 2003, to a steady decrease in 2003 and 2004. Schering's management estimates that the value of the total Dominican market—in all sectors—has diminished by 20 percent during this period.

The significant decline in OC sales is attributed by representatives of both the commercial and NGO sectors to: (1) the economic "crisis" as it affects purchasing decisions of middle and lower economic classes in particular; and (2) the presence of contraband products in the marketplace, which are sold at very low prices to both wholesalers and end users. The presence of contraband products in the marketplace is especially troublesome at this time, when at least 60 percent of the market (those living in/near poverty) make most of their purchasing decisions based on price. In fact, using household income to purchase contraceptives at all is thought by marketers interviewed to be a relatively low priority for cash-strapped families.

Interestingly, Schering Dominicana reports that while current economic conditions have significantly affected sales of lower-priced products (such as the brands carrying the Profamilia logo), sales of higher-priced OCs have not been as strongly affected. Schering reasons that higher-priced brands are purchased by wealthier consumers whose purchasing power is still relatively strong, and that higher-priced brands are newer introductions to the marketplace and may benefit from this "freshness" among prescribing physicians.

The profitability of product sales has also declined for the commercial sector. The instability of the exchange rate—as the Dominican Republic Dollar devalues during the passage of time between purchase/importation of product and collection of sales revenues for product sold—means that importers and distributors pay for their supplies with more valuable Dominican Republic Dollars (RD$) but receive sales revenues in less valuable RD$. Extension of credit to lower levels of the distribution chain exacerbates the problem. Representatives of Schering Dominicana state that the instability of the exchange rate is the most serious constraint on their business at this time.

2. METHODOLOGY

2.1 Summary of Evaluation Methodology

The team began the evaluation process with a review and analysis of extensive literature and documentation provided by USAID/Dominican Republic. The literature covered topics ranging from USAID's overall health strategy in the NGO sector to documentation on NGO grant agreements, monitoring and evaluation plans, sustainability strategies, and NGOs' quarterly reports of results, audits, and budget data.

In a preparatory meeting that took place in Santo Domingo on September 13 and 14, 2004, the evaluation team developed individual questionnaires in each team member's particular area of expertise—RH/FP program management, social marketing, financial analysis, and organizational development—and a set of financial report templates to allow comparative analysis of the NGOs' performance.

During the last two weeks of September 2004, the team conducted a series of visits and in-depth interviews in Santo Domingo with:

- Leadership and key staff at Profamilia, ADOPLAFAM, and MUDE
- Current and former staff at the Ministry of Health, the Secretariat of State of Public Health and Social Assistance (SESPAS)
- Other USAID-funded projects such as CONECTA, PSI, and REDSALUD
- Bilateral and multilateral donors such as the German Technical Cooperation (GTZ), the United Nations Fund for Population Activities (UNFPA), and the Pan-American Health Organization (PAHO)

2.2 Limitations of the Evaluation

This evaluation has been a relatively rapid analytical effort undertaken to answer specific RH/FP NGO management questions to guide decisions about the future direction of USAID funding, in the context of reduced RH/FP funds. The limitations of the evaluation are twofold:

- Because no appropriate baseline data were collected at the beginning of the Project, it is not possible to comment with certainty on the impact of NGO project activities on the targeted vulnerable populations.

- There is limited data on customer profiles to allow the team to determine the socio-economic status of the population being served.

3. USAID RH/FP NGO STRATEGY

The current USAID Strategy, covering FY2002 to FY2007, has as its health Strategic Objective (SO) the "Sustained Improvements in the Health of Vulnerable Populations in the Dominican Republic." Funding for this SO amounts to $41.3 million, and includes four program components over the life of the Strategy: HIV/AIDS and STI Prevention and Control; Reproductive Health; Child Survival; and Health Sector Reform.

Within the Reproductive Health component, the evaluation is addressing the Intermediate Result (IR) 10.2: "Sustainable, Effective Reproductive Health/Family Planning Services Provided by the Public and Private Sectors" and Sub-IR 10.2.1: "Improved NGO Sustainability to Continue Provision of Quality Services for the Poor and Adolescents." There are three additional sub-indicators for IR 10.2.1: (1) percent of clients served who are poor, (2) adolescents reached by IEC activities and 3) percent of clients who are adolescents.

The performance indicator for improved NGO sustainability is "Percent of Total Expenses Covered by the NGO's Generated Resources."

USAID Budget Data for FY2005 indicate that planned levels for RH services (under IR 10.2) will be $2.1 million, to continue support for: (1) improvements of maternal health services in nine hospitals participating in a USAID funded project with Family Health International; and (2) NGOs, contingent upon recommendations by this external evaluation team.

USAID's vision under IR 10.2 is that by the end of the Strategy period in 2007, sustainable and effective RH/FP services would be delivered through the private and public sectors. This would include an NGO private sector: (1) capable of carrying out its mission of serving vulnerable groups without USAID support; and (2) competitive enough to sell health care services to either the "contributive" or the "subsidized" systems, as contemplated under the Social Security Law, in the context of the Health Reform process.

Activities under this IR were designed to ensure the long-term viability of the NGO sector as major RH/FP service providers for peri-urban women and as a source for subsidized services to adolescents and the poor. USAID recognized that NGO sustainability and expanded service provision to the poor are goals that may conflict; however, USAID believed that this challenge would be met if NGOs were strengthened through financial and technical assistance to allow planning and execution of strategies aimed at fundraising, cost recovery, and developing alternate funding strategies like cross-subsidization and expanded sales of other health products. Additionally, to ensure NGOs would continue the provision of subsidized RH/FP services to adolescents and the poor, USAID established a system of reimbursing the NGOs for the redeemable coupons provided to these clients.

The Strategy has included financial and technical assistance to the three RH/FP NGOs that have been major partners to USAID in the provision of services: Profamilia, MUDE, and ADOPLAFAM. USAID anticipated that by the final year of the Strategy, each NGO would be institutionally and financially strengthened.

In addition to five-year grant agreements with each organization (discussed in the following section), USAID has funded the following activities:

- Technical assistance through the USAID-funded Commercial Market Strategies (CMS) project, which ended in 2003:

    - Developing strategic plans for sustainability, introducing creative and innovative strategies, and revising them as needed
    - Carrying out social marketing studies
    - Elaborating business plans and proposals to other donors to diversify funding sources
    - Elaborating/revising and implementing organizational manuals and procedures
    - Revising and updating management information systems (MIS)
    - Training staff in reformulated procedures and systems

- Technical assistance under PRIME II, also completed in 2003:

    - Training and supervision of staff in the application of national norms for clinical service delivery in NGO clinical centers
    - Conducting periodic user satisfaction surveys
    - Developing a system for the identification and distribution of free coupons to target poor and adolescent clients in need of RH/FP services
    - Establishing a supervision system to assess the proper distribution and execution of the coupons and the delivery of quality services

- Creation of an Incentive Fund to provide funding for creative and innovative proposals for increased sustainability of the institutions.

Earlier plans to support NGO proposals for an endowment fund were abandoned due to lack of funds.

4. DESCRIPTION OF THE NGO GRANTS

4.1 Grant Agreement with MUDE

Mujeres en Desarrollo, Inc. (MUDE) is a non-profit organization established in 1979 to invest in the development and health of poor, rural women. The NGO was initiated with funding from Variety Club International's "Sunshine Wheels Program" and has received support from USAID since 1994. Under USAID funding (1994-2001), MUDE reached approximately 150 communities—key results included providing services to over 50,000 rural women through a network of 284 trained volunteers and 110 contraceptive sales points, with a referral system for clinical services. In 2001, USAID awarded MUDE a $297,143 five-year grant (June 30, 2001 to June 30, 2005).

Table 4. MUDE Grant Budget, Years 1-4

Category	Year 1	Year 2	Year 3	Year 4	Total	Percent
Service Provision	47,602	50,675	47,580	44,403	189,860	64%
Coupons	28,682	26,986	25,874	23,132	104,674	35%
Audits	2,600				2,600	1%
Total	*78,884*	*77,661*	*73,454*	*67,135*	*297,134*	*100%*

MUDE's contribution to the program is $614,883.

By the end of the project, MUDE expects to achieve the following results:

1. Better access to quality RH services for 75,000 women of reproductive age
   MUDE will increase the size of the volunteer network by training 116 additional volunteers, for a total of 400, to reinforce the coupon and referral system and introduce wholesalers and sales distribution units for health products in rural areas.

2. Increased availability of health products and services in rural areas of difficult access
   MUDE will carry out studies with TA from CMS, such as feasibility studies, systems designs, and training of wholesales to introduce new services and products, diversify the supply, and increase the organization's presence in the rural market.

3. Increased demand for contraceptives and related services
   MUDE will carry out a social marketing campaign for RH/FP services to increase demand for contraceptives and related services. Activities will include a marketing plan for basic health services, design of a communication campaign, and volunteer training.

4. Increased institutional capacity to sustain health programs
   MUDE will construct a health fund based on a $300,000 loan from the SUMMA Foundation to invest in its micro-credit program. Proceeds from these loans will repay the loan and build a fund, which, at the repayment period, will reach approximately $180,000, enabling MUDE to sustain its health program after 2005.

Other activities include training to improve the technical capacity of project staff and volunteer network, establishment of a price structure based on costs analysis and profit margins, and the introduction of control tools to ensure quality of services.

4.2 Grant Agreement with ADOPLAFAM

La Asociación Dominicana de Planificación Familiar (ADOPLAFAM) is a non-profit NGO established in 1986 to provide services in RH/FP, HIV/AIDS prevention, and environmental sanitation to vulnerable groups in the Dominican Republic. The organization has received financial and technical assistance from USAID since 1993. In June 2001, ADOPLAFAM received a five-year USAID grant for $600,324 to implement a reproductive health program (June 30, 2001 to June 30, 2005).

Table 5. ADOPLAFAM Grant Budget, Years 1-4

Component	Year 1	Year 2	Year 3	Year 4	Total	Percent
Diagnostic Center	82,431	48.323	55,091	40,204	226,048	37.6%
RH Education	40,403	30,280	35,680	30,441	136,804	22.8%
Community Network	16,245	9,829	7,769	4,797	38,640	6.5%
Prepaid Services (Coupons)	57,089	46,594	46,005	36,900	186,589	31.0%
Audits	3,061	3,061	3,061	3,061	12,243	2.0%
Total	*$199,229*	*$138,086*	*$147,606*	*$115,043*	*$600,324*	*100%*

ADOPLAFAM would contribute with an equivalent of US$1,540,527. The program has four components:

1. Diagnostic center including clinical services
   ADOPLAFAM established a Diagnostic Center in the northern municipality of Santo Domingo with a population of about 310,000 residents. The Center offers consultations in RH/FP, a broad range of diagnostic and laboratory tests, and provides services to coupon holders and referrals from community programs.

   ADOPLAFAM's objectives supported by the grant include the expectation that the Center will produce a profit by its third year of operation, income which will be used to cross-subsidize ADOPLAFAM's social interventions.

2. Adolescent Education and Orientation Program
   The community outreach program will train 150 youth volunteers in RH and HIV/AIDS prevention to act as multipliers (for about 3,000 participants).

3. Community Networks Program
   The program's purpose is to sustain the existing network of ADOPLAFAM community workers and volunteers, composed of promoters and other community agents like barbers and beauticians who provide clients with information on RH/FP and act as distributors

of barrier methods of contraception. The institution will distribute an average of 400,000 oral cycles, 320,000 condoms, 800 IUDs, and 7,000 injectables yearly.

4. Prepaid Health Services Program (coupons)
   As a means of ensuring access by poor populations while pursuing institutional sustainability, ADOPLAFAM developed a strategy of prepaid services (coupons), which are free to the client. Community workers identify clients with unmet needs for RH/FP services through a short form describing clients' socioeconomic data. Once a client and service have been identified, the client obtains a coupon that can be redeemed at the Diagnostic Center or referred to another NGO or public health service. Funding for some 17,000 clients is planned. USAID will subsidize these services for four years.

A fifth component, technical assistance though CMS, provides for improvement of institutional sustainability. In March 2001, ADOPLAFAM submitted its sustainability strategy plan for 2001 to 2005, which had been elaborated with assistance from CMS. During the grant period, ADOPLAFAM was to implement sustainability strategies as designed in its Strategic Plan (2001-2005). It was expected that the overall institutional financial sustainability would reach about 70 percent by the end of the grant period.

4.3 Grant Agreement with Profamilia

Asociación Dominicana Pro-Bienestar de la Familia (Profamilia), the Dominican affiliate of the International Planned Parenthood Federation (IPPF), was established in 1996 by the Evangelical Dominican Church. Profamilia, a pioneer in RH/FP services in the Dominican Republic, also works with adolescents and HIV/AIDS prevention. Profamilia has received support from USAID since 1987 (Projects 517-0299 and 517-0259). In 2001, USAID awarded Profamilia a five-year grant (June 30, 2001 to June 30, 2005) for $1,412,000.

Table 6. Profamilia Grant Budget, Years 1-4

Category	Year 1	Year 2	Year 3	Year 4	Total	Percent
Health & Sexual Rep. Education (Youth): Community Programs	121,972	120,268	129,302	139,209	510,751	36.2
RH and San Francisco de Macoris Clinic	44,203	31,858	9,655		85,716	6.1
Financing of RH services reaching underserved population (coupons)	163,136	150,863	119,460	130,733	564,192	39.9
Santo Domingo Oriental Clinic Center		97,470	53,871		151,341	10.7
Equipment Purchases	60,000	40,0000			100,000	7.1
Total	*389,311*	*440,459*	*312,288*	*269,942*	*1,412,000*	*100%*

By the end of the project, Profamilia expects to achieve the following:

1. Community Programs
   Increased knowledge and improved attitudes and practices in sexual and reproductive health and HIV/AIDS prevention in the target population; improved knowledge and access to contraception in young populations; improved attitude of parents and community leaders towards these actions; and dissemination of policies and actions favorable to sexual and reproductive health.

   Impact will be measured through a monitoring and evaluation component from the beginning to the end of the project, including a KAP baseline and the development of a management information system. Approximately 60 percent of the cost of the program will come from the USAID grant, with 40 percent from counterpart cash or in-kind contributions from Profamilia, from voluntary work of the peer multipliers, provision of contraceptives and IEC materials.

2. Funding of services to indigent populations (Coupons)
   Funding for some 24,000 clients is expected in the provinces of Azua, Barahona, San Juan de la Maguana, Santiago, Salcedo, Duarte and the DN.

   Execution of this component is planned to yield some 36,961 couple-year-protection (CYP) at an estimated cost of $6.55 per CYP. The intervention will also facilitate 18,710 related services in sexual and reproductive health (e.g., detection of cervical cancer, therapy for victims of violence, minor surgeries) at an average cost of $10.26 per service.

3. San Francisco de Macoris Center
   Staff at the center will conduct outreach to the community and orientation to the clinic. The center will be a training site in RH for medical staff of the public sector at the province level. Approximately 90 percent of its cost will be funded through client fees and USAID contribution through Profamilia, the remaining 10 percent borne by SESPAS. The grant will fund operations until December 200,3 by which time it is expected that the center will reach close to 94 percent sustainability.

4. Santo Domingo Oriental Reproductive and Sexual Health Center
   Approximately 50 percent of the total estimated cost will be funded through the grant, with the remaining 50 percent from client fees, up to the second quarter of 2004. It is expected that by July 2005, the center's cost recovery rate will reach 75 percent.

5. Institutional Sustainability
   During the grant period, Profamilia will implement sustainability strategies designed in its Strategic Plan 01-05, with technical assistance from CMS. It is expected that overall institutional financial sustainability could reach 90 percent by 2005. Quarterly progress reports with financial sustainability indicators will be submitted to CMS and USAID.

5. DESCRIPTION OF NGO PROGRAMS

5.1 Profamilia

5.1.1 Social Marketing

In general, Profamilia appears to have an organizational structure and management process in place that provides the necessary support for successful marketing activities. Financial data necessary for decision making and evaluation are available for managerial analysis. Sales and related data are readily available through the organizational MIS. There is a well-articulated marketing strategy for both products and clinic services that includes apparently well-considered plans for future expansion. Profamilia has a standing professional relationship with a US-based consultant in pharmaceutical marketing with long-term experience in the Latin American market and who works with Profamilia's Marketing Director to develop product marketing strategies.

Organization of the Marketing Division

The marketing division of Profamilia is organized under the leadership of the Director of Marketing and Sales. Proposed budgets and revenue projections for the marketing and sales division are developed annually by the director and presented (as are the budgets of all other divisions within the organization) to the Director of Strategic Planning, who incorporates them into an overall business/strategic plan. Proposed budgets may be modified during this process according to institutional priorities and available resources.

Reporting directly to the Director of Marketing and Sales are three supervisors and one coordinator: supervisor of the community network sales, supervisor of medical promotion, supervisor of commercial sales, and coordinator of clinical services marketing.

The supervisor of community network sales is currently responsible for nationwide community sales and must travel from the head office at least every second week. She oversees and coordinates the work of 70 tecnicas/distributors who supply approximately 150 promoters/ community salespersons with Profamilia contraceptives for resale in their assigned sales areas. Product price is marked up 33 percent by the tecnicas/distributors when they resell product to promoters/community salespersons, who in turn mark up the price 33 percent when they sell to end users. In an effort to lower the price to end users (to better compete with low-priced contraband products and to reach deeper into very poor populations), Profamilia is planning to "collapse" the tecnicas/distributors and promoters/community salespersons into a single level in the distribution chain. Elimination of one level of price mark-up will enable Profamilia products to enter the community market at a lower retail price without diminishing revenue realized by Profamilia itself from community product sales. To assist the community sales network supervisor in monitoring and motivating the proposed single-level community sales force, Profamilia management anticipates hiring a coordinator or assistant to work with the community sales supervisor to provide the managerial support necessary for community workers to achieve their goals.

The supervisor of medical promotion plans and directs the work of four Profamilia medical representatives; these representatives call on approximately 2,000 gynecologists twice each year to promote the organization's products. The number of visits per year that each gynecologist

receives from a Profamilia medical representative depends on the importance of that physician—in order words, on the size of his/her practice, on his/her support through prescribing practices of Profamilia products, and on his/her influence in his field.

The commercial sales supervisor coordinates the work of the sales forces that distribute Profamilia products. Profamilia does not maintain a distribution/sales force of its own. Rather, Profamilia contracts with commercial pharmaceutical distribution companies for these services. The commercial sales supervisor ensures that distribution of product by these companies is regular, timed to support promotional activities, and effectively supports sales of Profamilia products to the trade. She also plans and implements promotional activities directed to the trade and to commercial market consumers.

The coordinator of clinical services marketing works with the management and staff of each of Profamilia's clinics to promote services within each clinic's geographical area. This coordinator is also responsible for promoting and marketing Profamilia's institutional image.

Income Generated From Sales

According to data received from the Executive Director of Profamilia, approximately 80 percent of the Profamilia budget is generated through sales of its various products and services. Of this 80 percent, 56 percent comes from income generated by its clinics, 33 percent from sales of contraceptives and other products, and 11 percent through other channels.

Product Sales

The contraceptive methods currently marketed by Profamilia include oral contraceptives (five brands: Microgynon 21, Microgynon CD, Triquilar, Microlut/Microval, Duofem), condoms (four brands: Protector, Escudo, Long Life, Pante), injectables (two brands: Cyclofemina, Depo-Provera), IUDs (two brands: CuT380a, Slimline), and subdermal implants (one brand: Norlevo). Profamilia also markets emergency contraception (Imediat N; Norlevo).

Currently, Profamilia purchases all of the contraceptive products that it resells. However, a small supply of IUDs and injectable contraceptives previously donated to Profamilia by USAID remain in Profamilia's warehouse pipeline for distribution and sale.

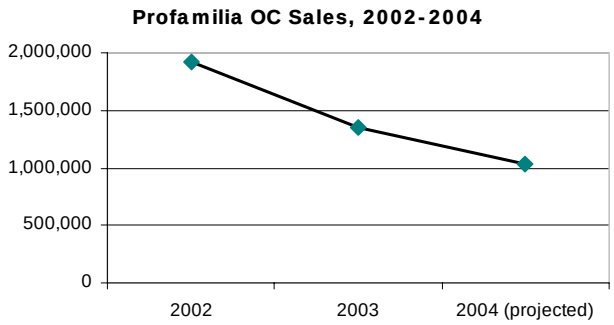
Profamilia sells its contraceptive products through three channels: the commercial market, its own network of community promoters, and other NGO institutions.

Commercial Sales

Commercial sales of Profamilia products occur almost entirely through pharmacies—except for Pante condoms sold as part of an HIV/AIDS prevention project funded by USAID and coordinated by PSI. Pante condoms are sold to motels by Profamilia promoters.

Projections made by Profamilia staff prior to 2004 (*Plan Estrategico y de Sustentabilidad, 1 Enero 2004 - 31 Deciembre 2006*) indicate an expectation for overall product sales to generate revenues equal to almost 100 percent of the total costs of sales in 2004 (101% in commercial sales, 100% in institutional sales, and 97% in community sales), about 113

percent in 2005 (114% commercial, 100% institutional, 112% community) and about 116 percent in 2006 (118% commercial, 100% institutional, 115% community).



Profamilia's sales of OCs, however, have diminished steadily since 2002. Profamilia's sales of OCs (all brands) reached 1,925,558 units in 2002; declined to 1,350,159 units in 2003; and in eight months of 2004 have reached 682,427 units. If sales in 2004 are projected at their current rate, they can be expected to reach approximately 1,035,000 units by the end of the year. From 2002 through 2004, then, Profamilia's OC sales will have declined at an annual rate of approximately 25 to 30 percent.

As do pharmaceutical marketing managers in the commercial sector, Profamilia marketing management attributes the decline in OC sales to the economic crisis and to price competition from contraband products widely available in the marketplace. The size of the decline in OC sales is of considerable concern to Profamilia staff, especially since income from sales of OCs is needed to fund a planned change in branding and packaging of several of Profamilia's OC products in the near future. The breadth of the product line, the extent of clinic services offered, and other sources of Profamilia funding prevent the current downturn in OC sales from threatening the overall financial position of the organization.

Despite the current decline in OC unit sales, Profamilia marketing management believes that oral contraceptives represent, of all its contraceptive products, the largest potential for future growth. Both the revenue returned to project/unit and the number of units sold can likely be increased, according to Profamilia managers. Both the value and volume of OC sales can be increased, management believes, through new promotion/advertising campaigns and through re-branding (in fact, over-branding) strategies that will allow Profamilia the flexibility to purchase products from manufactures with lower prices while maintaining a consistent Profamilia-owned brand name.

Additionally, the Profamilia ownership of the marketed brand name that over-branding will allow will protect Profamilia from any changes in Schering's willingness to continue to collaborate with them in product supply. Profamilia/DR management is very aware of Profamilia/Colombia's experience, where Schering withdrew its products from the marketing program after Profamilia/Colombia had made enormous investments of its own resources in promoting and establishing those Schering brands. Over-branding DuoFem with the PilFem brand name will also assist Profamilia's marketing efforts, in the opinion of Profamilia marketing management, by removing it from direct price competition with the widely available contraband product of the same name and from direct price competition with its own community-distributed OC of the same brand name.

In the past, the Profamilia logo/brand image was so strong among consumers that Profamilia management did not see a need for significant investment in product promotion. During the

current economic "crisis," management believes that price is more important to consumers than brand, and promotion may be required to sustain or revitalize brand performance. An increased investment in promotion and the additional costs (for packaging, etc.) associated with Profamilia's re-branding strategy will require Profamilia marketing management to revise its prior sustainability/profitability projections for contraceptive product sales. Any necessary revision will be undertaken in collaboration with Profamilia's department for strategic planning.

Market research in the field will provide the data on which Profamilia management will base decisions about whether or how to proceed with implementation of a new/revised marketing plan for oral contraceptives.

Profamilia's director of marketing indicates that an additional "contingency" strategy—in the event of further decline in product sales—is heavier promotion of Profamilia's clinical services which, he reports, are now being used more frequently than before (due to the economic environment) by middle class consumers still able to pay Profamilia prices for their clinical service needs.

Sales of condoms, unlike those for oral contraceptives, have increased significantly from CY 2003 (1,415,935 units) to CY 2004 (2,220,557 units in the first eight months). This growth in sales has occurred despite the difficult economic times that have negatively affected sales of oral contraceptives. Profamilia marketing management believes that the difference between its OC and condom sales performance is directly attributable to the promotion of condoms and of the Pante brand provided by PSI through its HIV/AIDS project, and to the MOH investment in the HIV/AIDS prevention campaign for condom use. The campaign includes television and radio ads on the importance of condom use, and consumer awareness of and interest in condom use has increased. The market has responded positively through both commercial and Profamilia community channels. Additionally, the retail price of Pante condoms is very low and judged to be very accessible to mass market consumers even during this period of economic downturn.

Injectable contraceptives are a relatively small part of Profamilia's overall product sales. Combined unit sales of the one- and three-month injectable products reached a high of 43,600 units in 2002 and declined in 2003 to 31,800 units. Unit sales in 2004 appear to remain steady with the 2003 level. Somewhat more than 20,000 units have been sold during the first eight months of 2004.

One other (non-contraceptive) product now sold by Profamilia is a pregnancy test.

Community Distribution Channels

In addition to sales of contraceptives and other products through commercial channels, Profamilia also markets a limited number of contraceptive brands through its community distribution channel. Currently, one community-based distribution supervisor reports directly to the overall marketing director. (Previously, Profamilia had employed five supervisors for the community-based distribution network, but diminishing USAID funding and a focus on cost cutting for improved financial sustainability led to the elimination of four of these supervisory positions.) This supervisor oversees the work of 70 "volunteers" who receive

product from the supervisor and in turn supply product (at a 33% mark-up) to 150 promoters/CBD workers who sell (at an additional 33% mark-up) to end users.

To respond to the current importance of price in OC sales, Profamilia marketing management plans to "collapse" the two distribution tiers of volunteers and promoters into a single distribution tier, eliminating one 33 percent mark-up in the price structure. This "savings" will be passed along to end users in a lower retail price that may be more competitive in the community marketplace.

The total value of Profamilia product sales, according to Profamilia's marketing director, is currently distributed as follows: 60 percent oral contraceptives, 35 percent condoms, and five percent remaining products.

Product Line Expansion

Profamilia's product line expansion strategy is based on the close long-term relationship it has developed with Dominican obstetricians/gynecologists. Profamilia staff plan to add only those products to the current product line for which OB/Gyn physicians either have or can generate a need. New product introductions anticipated in the near-term future include multivitamins for pregnant women and infants, anti-acids for use during pregnancy, and suppositories for treatment of vaginal infections. A Tylenol-type analgesic for both adults and children may also be added to the product line.

This strategy allows Profamilia to take advantage of its existing strengths in the marketplace with a minimum of additional promotional and distribution costs. This strategy may also protect Profamilia from the reported requirement, under new NGO legislation, to pay sales tax on all products sold that are not directly related to its mission.

A second element in Profamilia's product expansion strategy is to add only those products that can be obtained from local producers. Buying locally avoids the business and financial problems associated with unstable exchange rates (no hard currency transactions are required), transportation and insurance costs, and delays in delivery. Additionally, overall sales of locally produced pharmaceutical products have grown approximately 50 percent in the Dominican marketplace during the last one or two years, according to Profamilia's marketing director, while sales of imported pharmaceutical products have grown only about 10 percent. This phenomenon is likely due at least in part to the lower retail prices of locally produced pharmaceutical products.

Currently, all products marketed by Profamilia are imported, and Profamilia seeks to diminish this business risk. Whenever international suppliers' prices have increased during the last two years, usually due to changes in the exchange rate for hard currencies, Profamilia has had to raise its retail price for those products commensurately and unit sales have dipped for a period of several months.

Negotiations are already underway with local producers of selected products, and price quotations from these suppliers are expected shortly.

Clinic Services

According to the marketing director, six Profamilia clinics are now operating in various parts of the country. These clinics include Centros de Salud Integral Dra. Rosa Cisneros, Dra. Evangelina Rodriguez, San Francisco de Macoris, Sabana Perdida, San Juan de la Maguana, and La Sierra. In addition, an office for psychological counseling is located within the Profamilia headquarters building in Santo Domingo. This office is considered a seventh clinic in the organization's strategic business plan.

Each Profamilia clinic is different in some respects from the other clinics within the system. The cultural, economic, religious, and political environments surrounding the clinics vary from place to place. Good business/marketing practice has dictated that Profamilia management base decisions about pricing, promotion, and service menu on each clinic's particular environment. Sustainability and profitability expectations are, therefore, different for each clinic. The San Juan de Maguana and La Sierra clinics, for example, are situated in an area where residents are very poor, contraceptive prevalence low, religious influences powerful, and cultural traditions strong. These clinics have been designed to permit the very poor to access health services through the provision of providing low cost, basic services on an *a la carte* basis, and the clinics are not expected to be fully self-sustaining. In contrast, the San Francisco de Macoris clinic is very nearly fully cost recovering according to the marketing director. It is further anticipated, as reported in the current *Plan Estrategico y de Sustentabilidad*, that both the Dra. Rosa Cisneros and Dra. Evangelina Rodriguez clinics will be operating at a small profit by the end of 2004.

According to the Executive Director of Profamilia, approximately 70 percent of all clinic clients pay for what they receive; the remaining 30 percent are "coupon," or subsidized, clients. Clinics serving coupon clients receive payment for coupon-covered services from funds held in account by Profamilia and provided for that purpose by international bilateral donors, private sector donors, and international charitable organizations. It is projected by Profamilia managers (*Plan Estrategico y de la Sustentabilidad, 1 Enero 2004-31 Deciembre 2006*) that the overall clinic system will generate revenues equal to approximately 96.8 percent of total costs in 2004, 99.9 percent in 2005, and 105.2 percent in 2006.

Revenues are generated by the clinic system, in addition to provision of a range of medical services, through a blood bank operated at the Santiago clinic, a pharmacy at the Dra. Rosa Cisneros clinic, and a cafeteria at the Santiago clinic. The Profamilia blood bank is relatively new and has not yet fully demonstrated how it will contribute to overall sustainability/ profitability goals. The pharmacy's sales potential is limited, in that the pharmacy is open only to clients of the clinic at the time of their visit—for example, for a first cycle of prescribed oral contraceptives or for an antibiotic prescribed for treatment of a diagnosed illness. Expanded operation of the pharmacy, according to the marketing director, would be seen as infringement on commercial sector pharmacy business. At least three Profamilia clinics have their own laboratories, where tests and diagnostic procedures are done both for clinic clients and for neighboring physicians without their own labs. The Profamilia clinics that do not have labs send their tests to one of the other Profamilia labs for processing and analysis.

Profamilia has also developed effective relationships with private practice physicians in the areas neighboring their clinics, and these relationships are used to increase the revenues and

profitability of the clinic system. For example, a local private practice physician may refer his/her clients to Profamilia clinics for services that the he/she cannot provide. Profamilia also rents operating room space in its clinics to private practice physicians for use when Profamilia service providers do not need it.

According to the Profamilia marketing director, expansion of the types of clinical services offered is a primary strategy for increasing clinic revenues and profit. The addition of obstetric delivery services is currently being tested at the Santiago clinic. If the revenues generated exceed the costs associated with adding the services (for example, relevant medical personnel available around the clock, equipped delivery rooms, emergency procedures, and the like), then obstetric delivery services may be added at one or two of the larger, existing Profamilia clinics.

Another Profamilia strategy for expanding revenues generated by clinical services delivery is to contract or otherwise collaborate with large employers in industrial free-zones for providing IEC and RH/FP services to their employees. To date, Profamilia has not found many of these employers willing to provide time or space even for free IEC services offered by Profamilia. Employment-based services, however, is an area that Profamilia management wishes to explore further.

Conclusions

1. Profamilia's sources of marketing income are sufficiently diverse so that a decline in one does not threaten the existence of the institution as a whole.

2. Profamilia has a good marketing management structure. Its marketing personnel are competent to plan, implement, and manage the marketing of its products and clinical services.

3. Profamilia marketing staff have developed and are implementing well-reasoned strategic marketing plans for both products and services. These marketing plans have been integrated into the institutional business plan.

4. Current plans for product line expansion take appropriate, cost-efficient advantage of Profamilia's favorable reputation among OB/GYN physicians and of Profamilia's existing channels of promotion and distribution to these physicians. Plans to focus product line expansion on locally produced products will alleviate the potential negative impact on its business of the unstable exchange rate, costs of transportation and insurance, and delays in deliveries. Marketing management could effectively use limited, well targeted "outside" technical assistance in the evaluation of important marketing and business decisions related to future product line direction and product/clinical service introductions.

5. Profamilia's experience with condom sales versus OC sales during the past 18 to 24 months has demonstrated the importance of advertising and promotion during a period of economic downturn and potentially declining sales.

6. While the overall financial sustainability of Profamilia clinics is improving, some clinics (due to their location among the most vulnerable targeted populations) should not be

expected to become fully self-sustaining financially. The clinics serving these very vulnerable clients will require either internal cross-subsidies or subsidies from donors (such as the government, international agencies, and/or the private sector) in order to be fully sustainable.

7. Under the grant, limited (if any) assistance was provided to Profamilia or to the other two NGOs in developing a broader/stronger base of sources of support for subsidized clinical services delivery to targeted vulnerable populations (e.g., for the coupon program).

8. Successful models of public/NGO and private sector/NGO partnerships already exist within Profamilia's clinical operations, which can be replicated within Profamilia or by other NGOs.

Recommendations

1. *USAID should provide limited, well targeted "outside" technical assistance to Profamilia in the evaluation of important marketing and business decisions related to future product line direction and product/clinical service introductions.*

2. *USAID should provide one-time financial support for an advertising and promotional campaign to revitalize Profamilia's sales of oral contraceptives through its commercial distribution channels. This financial support could also include the initial costs of new packaging for Profamilia's over-branding of selected OC products.*

3. *USAID should provide well targeted technical assistance to Profamilia in developing a broader/stronger base of sources of support for subsidized clinical services delivery to targeted vulnerable populations (e.g., for the coupon program).*

5.1.2 Financial and Institutional Analysis

From its inception, Profamilia has received strong support from international donors and from public and private institutions in the Dominican Republic and abroad. This support has been the underpinning that allowed the organization to achieve its social mission and expand its RH/FP services throughout the years.

Income

In addition to financial assistance from donors such as IPPF, USAID, the Government of Japan, Population Council, PAHO, the United Nations, and the Government of the Dominican Republic (provides an annual subsidy), other sources of revenues of the institution include locally generated income from sales of products, client fees, and interest from investments.

A review of financial data on resource development shows that the three major sources of local income are Profamilia's three basic health programs: clinics, commercial, and community-based distribution systems.

- The clinic program produces the highest level of income, followed by the commercial and community programs. The first two programs have been self-sufficient during the

last few years. The community program, although it continues to improve its sustainability indicator, currently shows a deficit.

- The annual rate of growth of locally generated income grew by 23 percent between 2002 and 2003: earnings in 2002 were RD$100.4 million and in 2004 RD$151.4 million.
- Sales of products and patient fees amount to over 80 percent of total income.
- If Profamilia maintains the current rate of growth during the next five years, its estimated total revenue would be around RD$420.3 million.

Income Generated from Donors

- Total earnings from all donor sources has gone up in recent years.
- Income generated from all donors in 2004 represented 25.9 percent of Profamilia's total budget.
- Historically, IPPF and USAID have accounted for 65 percent of donor-generated income annually (USAID alone accounted for 30 percent).
- USAID's contribution, as a percentage of total donor-generated revenues, has been declining. In 2004, USAID funds accounted for only 7.3 percent of all donor-generated income.

Costs

Profamilia's total costs have been diminishing in the last few years. As shown in the following table, the expected annual rate of growth for costs in 2004 is 34.4 percent, a decline from 35.1 percent in 2003. The increase shown in the table between 2002 and 2003 (from 21.0 to 35.1) reflects a pattern found in most Dominican institutions as a result of the economic crisis that the country has faced during those years.

Table 7. Selected Indicators for Costs: 2001-2004 (RD$)

Category	2001	2002	2003	2004
Total Expenditures	82,248,024	99,539,316	134,441,247	180,709,708
Annual Rate of Growth (%)		21.0	35.1	34.4

Sources: Audit data (2002 and 2003); Profamilia's projections (January-June 2004)

The largest component of expenditures are personnel costs and fees for services, which together represent 65 percent of total costs. Estimated personnel costs for 2004 will represent 33.2 percent of total costs.

Sustainability Index

Data indicates that Profamilia has significantly improved it financial sustainability from 71 percent in 2000 to 89 percent in 2004.

Table 8. Percent of Total Expenses covered by NGO's "Financial Resources" USAID's Sustainability Indicator: 2000-2004

Organization	2000 (%)	2004 (%)	Change (%)
Profamilia	71	89.9	18

Institutional Sustainability

Although it is difficult to measure precisely the contribution made by the USAID-funded sustainability program to the institutional strengthening of Profamilia, the team found evidence that USAID support and CMS technical assistance were essential components of the institution's ability to improve its sustainability position (as defined by the IR indicator). Specifically, the financial objectives in expansion of services and sales of products established at the beginning of the project would have not been attained without technical assistance from CMS.

Conclusions

1. Profamilia has been able to consolidate its internal control structure with high management capacity and an efficient administration.

2. The institution has been able to internalize a business approach mentality without losing sight of its social mission.

3. The implementation of projects and programs by Profamilia are administered with cost centers to determine the programs' cost-effectiveness.

4. The institution has improved its sustainability position (as defined by the IR indicators) during the project period.

5. The variety of projects and services offered by the organization are strong points of its sustainability strategy.

6. Historically, Profamilia has counted on donor support for program implementation.

7. In terms of resource development, the institution is approaching a ceiling, given its social mission of providing services to the poorest of the poor.

Recommendations

USAID should support a program of consolidated institutional strengthening with the aims of:

- *Diversifying products and services, following a strategy that would increase marginal revenues while controlling marginal costs.*
- *Identifying and penetrating new marketing niches.*
- *Augmenting the use of institutional overhead as a mechanism to generate new resources in the administration of new projects.*

5.2 ADOPLAFAM

5.2.1 Social Marketing

ADOPLAFAM generates income from two business sources: sales of contraceptive products through its community network and sales of clinical and laboratory services through its Centro Diagnóstico.

Product Sales

ADOPLAFAM currently sells oral contraceptives, condoms, injectables, and IUDs through its network of community volunteers, barbers, beauty shops, and co-ops to individuals living in poverty within defined geographical areas.

Currently, there is no marketing director within the ADOPLAFAM organizational structure. ADOPLAFAM managers state that the Executive Director and the Director for Finance and Administration manage contraceptive commodity logistics from acquisition to storage to sale with the support of the Director of Planning and Development. In product sales, two coordinators and eight community workers report, according to ADOPLAFAM's current organizational chart (see Annex F), to the Director for Technical Services and come to the headquarters office in Santo Domingo to receive contraceptive supplies. There may also be some provincial distributors who are supplied by the two coordinators. These 10 workers and any participating provincial distributors supply the contraceptives to about 400 community volunteers (such as barbers, beauty shop operators, small market owners, and local physicians), who in turn sell the contraceptives to end users. The two coordinators and six of the community workers receive no salary from ADOPLAFAM. (Two of the community workers also work part-time for the Centro Diagnóstico and receive a small salary for that work.) They do, however, sell the product to the volunteers at a mark-up of 15 percent over the price repaid to ADOPLAFAM. The volunteers, in turn, sell to end users at a price that is marked up by 30 to 35 percent over the price paid to coordinators and community workers for their contraceptive supply.

Contraceptive products—OCs (DuoFem) and condoms (a few remaining “no logo” condoms)—are purchased by ADOPLAFAM from Profamilia at the same price at which Profamilia sells these products to any of its distributors. Additionally, ADOPLAFAM purchases condoms

(Pante) through a USAID-funded/PSI implemented HIV/AIDS project. A supply of CuT380a IUDs and injectable contraceptives (Depo-Provera) remains from a USAID donation.

During the past 12 months, USAID made a one-time donation of oral contraceptives (DuoFem) to ADOPLAFAM to create a back-stock that will protect ADOPLAFAM from future product outages due to cash flow problems, which would limit its ability to repurchase needed OCs. In meetings with ADOPLAFAM managers, evaluation team members learned that in return for this donation of DuoFem, ADOPLAFAM management agreed to put all income generated during the first six months' sale of the donated products into an account that will be used for future contraceptive purchases. Sale of the donated products began only in early June 2004; consequently, the amount to be set aside for future contraceptive purchases is not yet known.

According to data supplied by ADOPLAFAM management, sales of DuoFem OCs have been declining since 2002, when approximately 295,200 cycles were sold. In 2003, about 227,200 cycles were sold and to date in 2004 only 65,900 cycles are reported sold. Sales of Pante brand condoms, however, have increased from approximately 103,000 units sold in 2003 (the year ADOPLAFAM began to sell this brand) to over 1,000,000 units sold to date in 2004. Sales of Depo-Provera (5,415 units in 2003 and 1,125 units to-date in 2004) and of the CuT380a IUD (1,167 units in 2003 and 398 units to-date in 2004) are relatively negligible.

ADOPLAFAM management attributes the decrease in sales of most of its products to the current economic conditions and to the presence in the markets they serve of very low-priced contraband products. The ability of their community volunteers to make money on sales has so declined with the diminishing sales volume that the community volunteer network has shrunk considerably in size. Shrinkage in the sales force/number of sales outlets has, in turn, further diminished sales. There are now only an estimated 150 barrio volunteers, 110 beauty shops, 100 barbers, and 50 to 60 cooperatives remaining in a network that in CY2000 included about 1,500 members.

There are two interrelated sustainability issues for ADOPLAFAM—and for other NGOs—in regard to its marketing efforts: the sustainability of its volunteer network, and the sustainability of the organization as a whole. ADOPLAFAM's volunteer network is the mechanism through which the NGO reaches its target populations with health information and promotion, contraceptive products, and referrals for clinical services. Considerable investment has been made by ADOPLAFAM in the identification, training, motivation, and supervision of these volunteers. Turnover in volunteer personnel significantly reduces the return on this investment and diminishes the social and health impacts that ADOPLAFAM can have on target populations.

To sustain the volunteer network at peak efficiency (that is, with lowest possible turnover) and with sufficient coverage of the targeted populations, the interests of the community volunteers must be successfully engaged. Currently, the financial opportunity afforded by the sale of ADOPLAFAM products appear to be the key factor in maintaining volunteer interest and, therefore, the sustainability of the network. The relationship of potential income to retention of volunteers has been demonstrated in ADOPLAFAM's recent past. In 1995, ADOPLAFAM was losing its volunteer workers at a rate of about 30 percent per year, according to current management. When collateral products, such as shampoos and rinses, were added to the volunteers' product line, the volunteers initially earned more money through expanded sales, and

the turnover rate significantly declined. Competition with lower-priced products and problems with inventory control/shelf life led ADOPLAFAM to drop these collateral products from the volunteers' product line. Current price competition from contraband contraceptive products has diminished sales of even the volunteers' contraceptive products. The rate of volunteer dropouts has again increased, and now the red communitaria has declined in number as described above.

While a package of products sufficiently profitable to keep the interest of outreach volunteers could likely be designed (CMS conducted a feasibility/market research study of new product possibilities in 2002), the implementation of that marketing effort will not necessarily contribute to the financial sustainability of the organization as a whole. In other words, a sales/marketing program that keeps volunteer workers engaged and effectively performing their community outreach work will not necessarily be a program that generates sufficient income to contribute to ADOPLAFAM's overall financial sustainability. The value of the volunteer network to the social mission of the institution must be assessed by ADOPLAFAM management, and the costs of maintaining that network, which may be diminished by—but probably not fully covered by—income generated from network sales, must be figured into the organizational financial/ sustainability plan.

It is not possible to assess the contribution to ADOPLAFAM's organizational sustainability that product sales make because the NGO does not have a financial management system in place that allows for calculation of the cost of sales/unit for any of their products. While income generated from sales is tracked and known, there is no way to ascertain the profitability/non-profitability of those sales without knowing the costs of those sales. If it is found that the current retail price and price structure of ADOPLAFAM's products cannot cover the costs of the products themselves, as well as the prorated costs of the management, promotion, and distribution systems required to sell them, then each product sold only increases the "losses" or the need for subsidy of the organization. Useful strategies for increasing the ADOPLAFAM product line in the hope of increasing organizational sustainability cannot be developed without a solid knowledge of associated costs.

The pricing environment for ADOPLAFAM products (as well as for MUDE) is somewhat complicated by the fact that the NGOs have agreed upon a common retail price for the brands they sell in common. This agreement was made in order to diminish the possibility of "leakage" of products/brands purchased cheaply in one area and transported to another area for sale at a higher price. However, the costs of sales are not likely to be the same for each of the NGOs. Consequently, the agreed-upon price may be more sustainable or more nearly sustainable for one NGO than for others.

A further pricing constraint is the current economic "crisis" in the Dominican Republic. It is widely perceived by NGO managers that product prices cannot be effectively raised at this time.

Clinic Services

ADOPLAFAM operates one clinic, the Centro de Diagnóstico, Salud Sexual, Reproductiva e Infantil, located in the municipality of Sante Domingo Norte. This clinic provides services to

the general population in its geographic area* with emphasis on priority groups such as mothers, young children, and adolescents/young adults at risk for STIs and HIV/AIDS. Services available for clients at the Centro de Diagnóstico include gynecology/obstetrics, pediatrics, general medicine, cardiology, counseling for couples, laboratory, and X-ray.

According to the Director for Planning and Development, income generated through operation of the Center comes from the following sources: 44 percent from laboratory tests; 27 percent from diagnostic procedures such as X-ray, sonogram, etc.; 26 percent from physician consultations; and three percent from sales of products and specula. In other words, 71 percent of all income generated by the Centro Diagnóstico comes from operation of the laboratory.

The lab is now operating at full capacity given current staff levels. Consequently, ADOPLAFAM management is planning to hire a second lab technician who will be paid primarily on the basis of productivity. In addition to a small base salary, the technician will be paid a percentage of revenue generated by lab tests. Current lab staff have already been shifted to this productivity-based method of payment. Management believes that this method of payment will ensure that the addition of a laboratory technician will not negatively effect the sustainability position of the Center and will positively increase the potential for increased income generation through additional lab services provided.

Between 90 and 95 percent of all lab work done now comes from the Center's own clients. When the Center first began to operate, lab work done for private practice physicians in the general area of the Center was an important part of the lab's income generation. However, as these neighboring physicians saw the profitability of lab services at the Centro Diagnóstico, they began to establish labs, as reported by ADOPLAFAM managers, within their private clinics. Consequently, most lab work at the Center now is generated by the needs of the Center's own clients.

While the Center's client load fluctuates from day to day, ADOPLAFAM managers estimate that on average it currently operates at about 70 percent of its client capacity. Clinic capacity could be increased, according to management, if ADOPLAFAM could find a pediatrician for morning clinic hours and a sonogram specialist and a cardiologist available on three currently unscheduled days. In its revised strategic workplan, ADOPLAFAM managers project approximately 8,900 client consultations for the period from July 2004 to June 2005.

Among all clients of the Center, approximately 60 percent now pay for services while 40 percent are coupon, or non-paying, clients. Fifty percent of the operating costs of the Centro de Diagnóstico are estimated by ADOPLAFAM management to be covered by revenues generated by the Center's current delivery of services. The Director of Planning and Development suggested to the evaluation team that a client mix of 85 percent paying and 15 percent non-paying or coupon/subsidized would be "ideal." In his opinion, this 85/15 client mix is consistent with the social mission of the organization, since the fees charged paying clients for services received are below the fees charged for similar services in the commercial/private sector.

* The total population of health area III, where the clinic is located, is estimated at 310,000

Clinic services in the past have been promoted through a budget created, with USAID's permission, from unused funds remaining in ADOPLAFAM's sustainability project grant. A promotional plan was developed and implemented through a contract with a local agency. Promotional activities have included billboards, banners, flyers, brochures, community visits, and loudspeaker announcements. Currently, a team of adolescent volunteers supervised by the Director for Planning and Development goes out about three times a year into surrounding communities to distribute promotional flyers door-to-door. ADOPLAFAM's network of community workers also promotes the clinic among communities and outreach clients.

Conclusions

1. ADOPLAFAM is too exposed to risk by its limited sources of income (one clinic, a diminished community network for contraceptive sales, and one principal donor) for sustainability security.

2. Whether for reasons of cost-cutting to advance institutional sustainability or for other reasons, ADOPLAFAM has diminished its marketing management structure to the point that it cannot support effective marketing planning, implementation, and management. Cost-cutting measures have eroded ADOPLAFAM's capacity to maintain and expand service delivery through its clinic and its network of community workers.

3. Diminished support from within the institutional budget and diminished sales of contraceptive products have contributed to a sharp decline in the size of ADOPLAFAM's network of community promoters/workers.

4. ADOPLAFAM management should not expect its community network to be fully self-sustaining financially. An effective community network will likely require subsidies from within the institutional budget.

5. ADOPLAFAM does not have sufficient knowledge of costs of doing business for accurate and full assessment of the contribution to financial sustainability that sales of their products and services currently make. Lack of cost data has constrained the effective development of institutional sustainability.

6. At least to the extent that ADOPLAFAM's current business plan does not appropriately include/account for costs of sales and services delivery, that business plan is not fully useful.

7. ADOPLAFAM does not currently have sufficient knowledge of its costs of services delivered and of products sold for development of useful strategies for product line expansion and/or expansion of clinical services.

8. Insufficient technical assistance appears to have been given to ADOPLAFAM in developing effective marketing plans and in the process of implementing, managing, and revising marketing plans as market conditions necessitate.

9. Limited, if any, assistance was provided to ADOPLAFAM under the project in developing a broader/stronger base of sources of support for subsidized services delivery to targeted vulnerable populations (e.g., for the coupon program).

Recommendations

- *If USAID decides, on the basis of the results of a comprehensive evaluation, to provide any further financial and/or technical assistance to ADOPLAFAM, none of that support should be given for operating costs—especially not for salaries. USAID support to ADOPLAFAM should be limited to activities that will generate income, with the exception of technical assistance in the development and implementation of cost accounting systems/cost centers. Income should be broadly defined to include subsidies for the coupon program, collaboration with public and private sector entities that will support (in-kind or cash) ADOPLAFAM activities, other donor support, corporate sponsorships, etc., and should not be limited to sales of products and services.*

- *If USAID decides, on the basis of the results of a comprehensive evaluation, to provide any further financial and/or technical assistance to ADOPLAFAM, no financial or technical assistance should be provided for marketing activities until: (1) the costs of ADOPLAFAM's product sales and clinical services delivery are fully and accurately known; (2) the organizational structure is sufficient to support the marketing process effectively; and (3) there is an institutional commitment to support/sustain an expanded community network for provision of contraceptives and other outreach services to targeted client populations.*

5.2.2 Financial and Institutional Analysis

Members of the team met with the leadership and key personnel at ADOPLAFAM to carry out the financial analysis. Most of the data used is derived from information provided by the NGO.

Income

ADOPLAFAM has two main sources of revenues: (1) sales of products and services; and (2) donor funds. During project years 2001 to 2004, ADOPLAFAM experienced an average annual reduction in income of 3.03 percent. Moreover, between 2003 and 2004, ADOPLAFAM's total income declined 16.8 percent. These reductions in total income appear to have affected the sustainability of the institution.

Taking into account the information provided by ADOPLAFAM and assuming that there will be no short-term economic improvements in the country, the team believes that total revenues will continue to decline in future years.

Income Generated from Donors

Historically, ADOPLAFAM has relied heavily on funding from international donors, and it is unquestionably these donor resources that have allowed the organization to carry out its social mission and to expand RH/FP services to vulnerable groups. Between 2001 and 2004,

donated resources represented, on average, 60 percent of total income, of which USAID funds accounted for 50 percent in 2003.

Costs

Between 2001 and 2004, ADOPLAFAM's costs resulted in negative rate of growth of 13.6 percent. This appears to have been based on the institution's desire to improve its sustainability index and the concurrent macroeconomic crisis. However, the team was able to conclude that the reduction in personnel costs has adversely affected ADOPLAFAM's ability to operate efficiently.

Conclusions

ADOPLAFAM has improved its sustainability index by 40 percentage points, from a base of 19.0 in 2000 to 59.0 in 2004, as shown in the following table.

Table 9. Percent of Total Expenses Covered by NGO's "Financial Resources" USAID's Sustainability Indicator: 2000-2004

Organization	2000 (%)	2004 (%)	Change (%)
ADOPLAFAM	19.0	59.0	40.0

1. The institution has created a market niche with potential for growth.

2. Products and services offered are compatible with the social goals of the organization.

3. ADOPLAFAM has improved its market position within its geographical coverage that will allow for future expansion of services and products.

4. ADOPLAFAM's fundraising capacity has been enhanced in terms of international donors.

5. Cost-cutting measures at ADOPLAFAM have eroded its capacity to maintain and expand service delivery.

Recommendation

- *If USAID decides, on the basis of the results of a comprehensive evaluation, to provide further financial and/or technical assistance to ADOPLAFAM, none of that support should be given for operating costs—especially not for salaries.*

5.3 MUDE

5.3.1 Social Marketing

MUDE generates income through three channels: (1) sales of products made at its two bakeries; (2) sales of contraceptive products through its network of community workers and distributors; and (3) the interest paid by clients of its micro-business credit program.

According to MUDE managers interviewed by the evaluation team, the income generated by the three businesses above can be apportioned as shown in the following table.

Table 10. MUDE's Income-generating Activities

	June 2003	June 2004
Credit programs	54%	37%
Bakeries	36%	42%
Sale of contraceptives	10%	21%

Only the marketing of MUDE's bakery products and its contraceptive products will be considered here.

Bakery Sales

In the overall sustainability plan of MUDE, sales of bakery products are expected to (1) cover the costs of the bakery operation itself, and (2) support minimum core staff necessary to implement the organization's projects.

MUDE has a salaried manager responsible for bakery operations and marketing, who reports that the organization's bakery operations are now profitable and are not subsidized. However, management also mentioned that the position of a bakery supervisor has been funded by USAID and that future bakery performance would be enhanced with the continuation of donor funding for this position. It is therefore unclear whether or not all costs attributable to bakery operations have been included in management's calculation of bakery "profitability." In any event, MUDE managers report that the bakeries do not now cover either the administrative costs or expenditures (costos ni gastos administrativos) of MUDE overall. Managers further report that bakery income represented 36 percent of MUDE's total budgeted income in 2003, while bakery costs and expenditures represented 28 percent of MUDE's total budgeted costs and expenditures.

Operation of the bakeries has encountered some difficulties in the overall political and financial environment of the past two years. First, the rate of inflation has caused increases in the costs of raw materials needed for baking by as much as 500 percent in some cases. Bags of flour, which cost at the beginning of the sustainability project RD$380, now cost RD$1500. Cans of cooking oil, previously RD$180 each, now cost RD$810. Second, natural disasters have limited access to some markets, and political transition has caused some difficulties in the continuation of contracts with the Ministry of Education (MOE) for provision of bread for school breakfasts. Finally, the arrival of delivery vehicles donated by USAID was considerably delayed, and these vehicles have not been available to expand the

markets the bakery is able to serve. Without its own delivery vehicle in the south, MUDE has had to use a distributor to get its bread to these markets and thus has "lost" to the distributor a percentage of its margin—limiting the overall profitability of the bakery's operation.

Despite these constraints on its business operations, MUDE bakeries came close to achieving their sales goals set within MUDE's current sustainability strategy. From 2003 to 2004, sales at one bakery increased from RD$160,000 to RD$650,000; in the other bakery, sales increased from RD$180,000 to RD$800,000. MUDE managers attribute these increases to an increase of more than 100 percent in sales to local markets; a 25 to 32 percent increase in prices to the MOE for the school breakfast program; and a sale of products in June 2004 to an international NGO for disaster relief in Jimani.

Marketing and financial managers report that currently 64 percent of all bakery sales (value) are to the Ministry of Education and 36 percent are to local/commercial markets.

According to MUDE managers, current bakery structures and equipment can support increased production of bakery goods without further investment. MUDE believes that bakery sales can be increased and has developed a marketing plan that is based heavily on the mobility and access to new markets that the two USAID-donated delivery vehicles will provide. The MUDE strategy includes a plan for each driver to visit 100 markets/day with the bakery's goods. Since these markets are mostly small bodegas frequently located in close proximity to each other, marketing managers do not believe that this is an unrealistic sales call goal. MUDE managers are also exploring the possibility of additional contracts with the MOE for provision of bread for school breakfasts.

Since the MUDE bakeries are located in/near the geographical areas where the organization's target clients (marginalized populations, hard-to-access populations, and those in poverty) live, bakery pricing generally conforms to those populations' ability to pay. The possibility of selling some bakery products at higher prices to a higher income segment of the population—to increase overall bakery profitability—is thus limited by the bakeries' locations, since fresh bread needs to be sold within an area that can be reached in a timely manner.

A possible future constraint on the profitability of MUDE's bakeries lies in the interpretation/implementation of recently proposed laws governing the organization, registration, and operation of NGOs in the Dominican Republic. It is reported by NGO directors that under the new law, any products or services sold by an NGO that are not directly related to the mission of the organization may be subject to sales tax. Bakery products are not likely to be deemed by revenue authorities as directly related to the mission of MUDE; consequently, MUDE may be required to pay tax on bakery sales at some point in the near future.

Product Sales

The second mechanism through which MUDE generates income is the sale of contraceptive products by a network of community workers. MUDE's mission is to augment essential services for the poorest of the poor and for those who live in hard-to-access areas of the country. MUDE serves this mission through a network of community workers who promote healthy behaviors, provide health-related information, and refer those with needs for medical services to area

clinics. The sale of contraceptives by MUDE's community workers is designed not only to get vital products into the hands of vulnerable and under/unserved populations but also to create a financial incentive, through their margin, to the community promoters to provide (and continue to provide) designated services on behalf of MUDE to its targeted clients.

The contraceptive methods that MUDE supplies its community workers for resale include oral contraceptives (DuoFem), condoms (Pante), injectables (Depo-Provera), and an IUD. MUDE purchases oral contraceptives and Depo-Provera from Profamilia at the price Profamilia charges all its distributors. Pante condoms are purchased by MUDE from PSI.

The same manager directs the marketing and sales of both contraceptive products and of bakery products. Reporting to the marketing manager is a group of technical supervisors, under whom work nine area promoters and a number of community volunteers.

MUDE headquarters delivers contraceptive products to technical supervisors who in turn supply the promoters responsible for each of MUDE's nine geographically defined areas. Products are assigned to the technical supervisor at a small mark-up, and community promoters come to the supervisor to obtain products for resale. The promoters are assigned products at the same marked-up price given to the technical supervisor. The technical supervisors do not pay for product they receive from MUDE and do not share in the income generated by product sales since product is passed along to community workers without a second mark-up.

The nine promoters are each paid a monthly salary of RD$6,000. In addition to this monthly salary, promoters are allowed—as an incentive to increase contraceptive distribution—a five percent mark-up on oral contraceptives and a 30 percent mark-up on Pante brand condoms as they resell these products to community volunteers. Community volunteers are allowed a significantly higher mark-up on the contraceptives they sell since they are not salaried workers. A community volunteer pays, for example, RD$0.68 for a box of Pante condoms and resells it to the end user for RD$2.50. Volunteers pay RD$24.50 per cycle of DuoFem and resell each cycle to the end user for RD$30.00.

MUDE managers had hoped that product sales would be sufficiently profitable for its promoters that MUDE would no longer be required to pay them salaries in order to keep them working on behalf of the organization. With few exceptions, this level of profitability for the individual promoters has not been reached, and all promoters continue to receive salaries.

Each technical supervisor is responsible for estimating the contraceptives needed for his/her area and requests from MUDE headquarters the purchase of those products. MUDE works on a two-month cycle of re-supply to technical supervisors. The nine geographical areas in which MUDE's contraceptive distribution network operates include 179 communities and 195 volunteers. More than one volunteer may work in a given community, depending on the size of that community.

During a baseline period of January 4 to September 30, 2001, MUDE sold 28,495 cycles of OCs; 26,464 condom units; and 1,079 vials of Depo-Provera. During that same period in 2002, MUDE appears to have sold 46,000 cycles of OCs; 39,416 condoms units; and 1,455 vials of Depo-

Provera. In 2003, during the same period, MUDE's sales of OCs dropped to 19,380 cycles; sales of condoms rose to 53,258 units; and sales of Depo-Provera dropped to 346 vials. The downward trend in OC sales and the upward trend in condom sales echo the recent experience of Profamilia and ADOPLAFAM.

Commodity logistics appears to be an area of weakness within the MUDE contraceptive sales system. Managers report that there are frequent stock outages, sometimes for extended periods. A successful marketing program requires a consistent supply of product. Worldwide, outages of contraceptive stock contribute not only to business losses but even more importantly to increased incidence of unplanned pregnancies, transmission of STIs, and incidence of abortions.

Stock outages within the MUDE sales system may be attributable to several factors: (1) managers/supervisors do not project future commodity needs with sufficient accuracy to ensure steady supply; (2) managers/supervisors do not make projections sufficiently in advance of need to receive supplies in a timely manner; (3) management does not place orders with its supplier sufficiently far in advance to receive product before an outage occurs; and (4) MUDE does not have sufficient funds to purchase all the contraceptives needed.

Recent expansion of the geographical area MUDE covers with its contraceptive sales program and recent significant increases (reported by MUDE managers as 200 to 300 percent in some areas) in demand for contraceptives are factors that MUDE management believes have contributed to inaccurate projections of commodity needs.

Profamilia marketing management reports that it has sometimes been difficult to get contraceptive orders from MUDE in time to “fit” with Profamilia’s cycle of ordering from its international suppliers. Profamilia marketing management also reports that in at least one instance, MUDE appeared to have distributed or sold its entire three-month order of commodities in a single month. Profamilia has tried to accommodate MUDE’s short-notice need for additional contraceptive stocks when it has been possible through the small excess stocks Profamilia maintains as insurance for its own needs, but cannot afford to maintain large stocks of “extra” products at Profamilia’s cost to protect other organizations from inadequacies in commodities management.

The reason for MUDE’s lack of funds to purchase sufficient contraceptive stock to supply its clients’ demand is not clear but may be due to one or more of the following factors: (1) institutional priorities for resource allocation; (2) current level of overall institutional self-sustainability; (3) retail price of product too low to recover cost of increasing product need; (4) costs of the community distribution system too high a percentage of income generated from product sales; and (5) cost of credit extended down through the distribution system, including uncollected receipts.

Because MUDE’s social mission is to provide services to the poorest of the poor and to those among the most vulnerable segments of the population, its policy is to extend credit down through its distribution chain. Community promoters are given product on credit, and in turn they extend credit to the clients to whom they resell product. At least in theory, payment for all product (both by the community promoters to MUDE and by clients to the promoters) is received

before the following round of product supply—a period of about two months. Especially during a time of economic instability and decreasing value of RD$, a two-month period might produce a loss in the value of funds collected that could be significant for a program operating with very little capability to sustain any financial loss with impunity.

MUDE managers stated in meetings with the evaluation team that the extension of credit is essential to MUDE's mission; however, credit may have business consequences for the organization, and MUDE managers reported that they do not know the cost to the organization of the credit extended as part of its product sales program. It is MUDE management's belief, however, that the total amount of credit extended is small and that the cost of that credit is a small factor in the overall cash flow issue related to product supply. No financial data are currently available to shed light on this issue.

Whatever the cost of extending credit to the distribution chain, the situation is exacerbated by the fact that MUDE must pay cash to Profamilia at the time it places each order for contraceptive products. These products are reportedly received in country by Profamilia and then by MUDE on average three months after the order is placed and paid for.

The only strategy that MUDE appears to have considered in order to resolve its problem with commodity supply and stock outages is to diversify its sources of supply. They have reportedly discovered, however, that the volume of their contraceptive requirements is insufficient to obtain prices any lower than those already offered to them by Profamilia and PSI.

Conclusions

1. There is considerable business risk in having one large client on whom the majority of sales depend. The MOE has become such a client for MUDE's bakery.

2. In marketing, MUDE does not appear to have sufficient knowledge of its costs of products sold for development of fully useful strategies for product line expansion.

3. Insufficient technical assistance appears to have been given to MUDE in development of effective marketing plans and in the process of implementation, management, and revision of marketing plans as market conditions necessitate. This appears to be especially true in regard to the sale of contraceptive products.

4. MUDE's contraceptive sales are constrained by two important factors: (1) an inadequate system for commodities needs projections/commodity logistics; and (2) inadequate cash flow management.

5. MUDE management should not expect its community network to be fully self-sustaining financially. An effective community network will likely require subsidies from within the institutional budget.

Recommendations

- *USAID should provide technical assistance to MUDE in developing and implementing cost accounting systems/cost centers necessary to analyze costs of products sold and for effective management of activities that are sources of organizational income.*

- *USAID should provide technical assistance to MUDE in the development of improved contraceptive commodity needs projections and an improved contraceptive commodity logistics system.*

- *USAID should provide technical assistance to MUDE in evaluating its cash flow situation, especially in regard to the purchase of necessary contraceptive commodities; in developing solutions for the current cash flow problem; and in improving its systems for managing cash flow.*

- *USAID should provide technical assistance to MUDE in the process of development, management, and revision of business and marketing plans for both bakery and contraceptive products. Bakery marketing planning should include specific strategies for diffusing the risk created by a single large client, such as the Ministry of Education. All marketing plans should include projected costs of the marketing strategies proposed; projected income from the strategies proposed; quantitative goals that facilitate evaluation of the contribution of marketing to increased revenues and profitability; and organizational strategies for management and evaluation of marketing activities.*

5.3.2 Financial and Institutional Analysis

Income

MUDE has four main sources of revenue: (1) interest from loans, (2) bakery sales, (3) contraceptive sales, and (4) donations. As shown in the following table, total income grew by an average of 35 percent between 2001 and 2003. However, this growth has mainly occurred as a result of an increase in donations, which more than doubled in 2003.

Table 11. MUDE's Total Revenues by Funding Sources: 2002-2004 (RD$)

Income, by Source	2001	(%)	2002	(%)	2003	(%)
Interest from Loans	6,627,565	21.3	7,379,292	21.3	8,983,470	16.3
Bakery Sales	2,210,041	7.1	2,204,837	6.4	3,221,963	5.9
Contraceptive Sales	398,541	1.3	770,708	2,2	1,462,458	2.7
MUDE's Own Income	9,236,147	29.7	10,354,837	29.9	13,687,891	24.8
Donations	21,834,701	70.3	24,306,478	70.1	41,374,272	75.2
Total	*31,070,848*	*100.0*	*34,661,315*	*100.0*	*55,042,163*	*100.0*

Source: Data provided by MUDE

It is important to note that:

- MUDE has a high dependence on international donors, which in 2003 represented 75.2 percent of the total income of the organization.

- In 2003, USAID's contribution represented 31.0 percent to MUDE's total income.

Costs

The evaluation team's review of MUDE's costs showed that from 2001 to 2002, the organization was able to diminish costs and expenditures by about 20.2 percent. However, in 2003 the macroeconomic crisis resulted in an increase in costs and expenditures. MUDE's largest category is personnel—salaries account about 45 percent of total costs.

Sustainability Index

MUDE has shown a significant increase in its sustainability index. Despite high dependence on international donors, MUDE's efforts to control operating costs are worth noting, particularly at a moment when all institutions have been adversely impacted by socioeconomic crises. MUDE achieved a sustainability index of 68 percent in 2004, increasing the rate by 42 percentage points between 2000 and 2004, as shown in the following table.

Table 12. Percent of Total Expenses Covered by NGO's "Financial Resources." USAID's Sustainability Indicator: 2000-2004

Organization	2000 (%)	2004 (%)	Change (%)
MUDE	26.0	68.0	42

Conclusions

1. MUDE has developed an appropriate corporate image that serves the institution well in its fund-raising in the Dominican Republic.

2. The institution has improved its sustainability position (as defined by the IR indicators) during the project period.

3. MUDE has developed an important capacity to raise funds from international donors, a factor which has allowed the organization to maintain and expand its social programs.

4. The organization has a strong rural presence, particularly through its micro-credit program.

5. Historically, international assistance has been an important source of support.

6. Bakery sales are highly dependent upon sales to the Ministry of Education for its School Breakfast Program, which represents a risk to MUDE in terms of potential budget cuts by the central government.

7. MUDE does not have cost centers to allow analysis of its cost data in terms of unit costs.

Recommendation

- *USAID should provide technical assistance to MUDE in the development and implementation of cost accounting systems/cost centers necessary for analysis of costs of products sold and for effective management of activities that are sources of organizational income.*

6. COMPARATIVE ANALYSIS

6.1 Financial Analysis

The evaluation team reviewed the sustainability achievements of the NGOs using the performance indicator established by USAID, "percent of total expenses covered by NGOs' financial resources," and found that the three NGOs have been successful in increasing the sustainability indicator by an average of 33 percentage points. The table below shows that the highest increase was achieved by MUDE, increasing the indicator from 26 to 68 percent during the four-year period, 2000 to 2004.

Table 13. Evolution of the Sustainability Performance Indicator: 2000-2004

Organization	2000* (%)	2004** (%)	Percentage Change
Profamilia	71	89	18
MUDE	26	68	42
ADOPLAFAM	19	59	40

Source: CMS data * October 2000 data; **June 2004 data

ADOPLAFAM also had a significant increase (40 percentage points) in its sustainability indicator of, increasing from 19 to 59 percent during the four-year period.

Paradoxically, Profamilia was the organization that showed a less significant increase in its sustainability indicator during the project years, increasing by only 18 percentage points. However, when the team reviewed the revenues generated by the internal structure of the three NGOs, it was evident that Profamilia has the highest diversification of sources of revenue. Moreover, the organization has been able to consolidate its projects and services, which are, for the most part, self-sustaining. In addition, Profamilia has a solid administrative and financial base and efficient internal organizational systems.

Another element to highlight in Profamilia's case is that the organization has apparently reached its ceiling in terms of its sustainability performance given their social mission as described in other sections of this report. The team estimates that every percentage point of increase in its sustainability rate will only be achieved through extraordinary efforts in terms of institutional performance.

6.2 Social Marketing

The table below describes key elements of the three NGOs' performance in the social marketing area during project years 2002 to 2004 as discussed in the earlier sections.

Table 14. Key Elements of NGO Performance, by Organization

	ADOPLAFAM	MUDE	Profamilia
OC units sold, 2003	227,200	19,380 (9 mos.)	1,350,159
Condom units sold, 2003	103,000 (first year of sales)	53,258 (9 mos.)	1,415,935
OC brands sold, 2004	1	1	5
Condom brands sold, 2004	1	1	4
Pharmacy outlets served, 2004	NA	NA	Abt. 1900
Clinics, 2004	1	NA	6 medical 1 psych. counseling
Community workers selling contraceptives, 2004	Abt. 410	195	225
Sources of income generated, 2004	1 clinic, community network contraceptive sales	micro-credit network, 2 bakeries, community network contraceptive sales	6 medical clinics, 1 counseling clinic, contraceptive sales to pharmacies, contraceptive sales to other institutions, community network contraceptive sales, non-contraceptive sales to pharmacies and other commercial outlets

7. CROSS CUTTING ISSUES

7.1 Current Role and Effectiveness of the Public Sector in Promoting RH/FP Services

In the Dominican Republic, public health services are provided by several entities: the Secretariat of State and Public Health and Social Assistance (SESPAS) and its network of hospitals, clinics and health posts; the Dominican Social Security Institute (IDSS); and the Social Security Institutes for the Armed Forces and the National Police. Reproductive health and family planning services are provided by SESPAS as well as by the private sector and NGOs. Data from the 2002 DHS shows that 53 percent of users of modern contraceptive methods obtain their services from the private sector, which includes private clinics and physicians, pharmacies, supermarkets, and NGO clinics and promoters.

The effectiveness of the public sector in promoting RH/FP services continues to be held back by institutional weaknesses like low quality of care and inability to provide services to hard-to-access populations in extreme poverty. In 2002, the Population Council's Strategic Assessment of Reproductive Health in the Dominican Republic found that access to family planning services was constrained by irregular hours at service delivery points, lack of method choices, and low-quality IEC and counseling. The study also pointed out that because "few service delivery points were staffed, physicians…artificially limited access by a rationing system whereby only 25 percent of the women who attended on a given day received appointments…logistics and stocking were irregular at all public sector family planning sites…most sites were dirty and unpleasant."

It appears that this situation has been exacerbated by the fact that donors have stopped donating contraceptives to SESPAS for national RH/FP programs. (UNFPA continues to provide contraceptive commodities to specific regions.) UNFPA staff told the evaluation team that the only purchases of contraceptives made by SESPAS between 2002 and 2003 were a small purchase of about $10,000, and an even smaller purchase in the local market at the end of 2004.

The weak current role of the public sector in promoting RH/FP services exists within the framework of a health sector reform that began in the early 1990s as a response to a demand from improvements in health care from the community and health professionals. The new health reform laws approved in 2001, the General Health Law and the Social Security Law, established a legal framework that called for separation of functions, decentralization, and health care financing through universal social insurance. The role of SESPAS is envisioned to be one of stewardship in setting health policies, enforcing the separation of services and ensuring the quality of care. USAID supports the reform process through its REDSALUD Health Reform and Decentralization Project. The World Bank, the Inter-American Development Bank, and the European Union are providing additional support.

Currently, there is uncertainty about when health sector reform will be implemented. Two contributing factors are the turnaround at the highest echelons of the public health sector (at national, provincial, and local levels) as a result of the new government (August 2004), and the current economic crisis. Evaluation team members met with current SESPAS staff (who at the

time had been in their current jobs for less than a month). The General Director of "Materno Infantil y Adolescentes," told the team that he perceives the RH/FP NGOs to be well positioned to sell their services to regional directorates and play the role of service providers within the new law. However, the team recognizes that the NGOs will need to transform themselves into new "entities" capable of competing in a totally changed environment. Given that under the new law the price and content of the basic service package will be predetermined, competition will be based on quality of care, an area where the NGOs already have an advantage. Moreover, the team was told that about 10 percent of the population would not be covered by Social Security since the system will only cover "citizens." This undocumented population would also be a niche that could be filled by NGOs.

The team concluded that the importance of NGOs' RH/FP service delivery has increased as the ability/willingness of the public sector to serve an increasing number of vulnerable populations has declined during recent project years because of the instability of public-sector stock commodities.

Mid-and Long-term Recommendation

USAID should provide technical assistance to the three NGOs in developing strategies for: (1) delivering RH/FP services to marginalized segments of the population not covered by Social Security (i.e., how to reach them, with what services, and how to fund) and (2) to compete for service delivery contracts under Social Security.

7.2 Collaboration between NGOs and the Public Sector

Nongovernmental organizations, the building blocks of civil society, usually move into areas in which government services are not available, and this is the case in the Dominican Republic. Currently, there is no apparent "formal" coordination between NGOs and SESPAS in areas of RH/FP service delivery or geographic coverage. The evaluation team was told by the new health team at SESPAS that they look forward to a close collaboration with NGOs, and that SESPAS intends to enlist them as members of the current SESPAS team to ensure a coherent plan to achieve national coverage in the provision of RH/FP services. Indeed, there are numerous examples of excellent cooperation between NGOs and the public sector, such as at the Profamilia clinic in San Juan de la Maguana, where health staff (comprised of physicians, nurses and health technicians) are paid by SESPAS. The local hospital that is unable to offer RH/FP services refers their clients to the Profamilia clinic to satisfy existing demand.

The team concluded that Profamilia's operations already include successful models of public sector/NGO partnerships, which could be replicated, although opportunities have not yet been created within the project for the interchange of "best practices" among the NGOs.

Mid-and Long-term Recommendation

USAID should document the Profamilia model to identify its strengths and weaknesses for potential replication and should encourage interchange of "best practices" among the three NGOs as well as with those HIV/AIDS NGOs supported by CONECTA.

7.3 Contributions Made by Each NGO in Reaching MCH/FP Expectations

In terms of MCH/FP expectations, the Dominican Republic agreed in the Millennium Summit in September 2000 to contribute to the achievement of the 11 Millennium Development Goals by 2015, including an agreement to drastically reduce infant and maternal mortality and contribute to the eradication of extreme poverty and hunger. Moreover, when asked about their MCH/FP expectations, the new leadership at SESPAS responded that they are currently developing their own health goals and objectives for the immediate future.

The evaluation team concluded that because no appropriate baseline data were collected at the beginning of the project, it is not possible to comment with certainty on the impact of NGO project activities in the targeted vulnerable populations.

Mid and Long-term Recommendation

In future support to the NGOs, USAID should ascertain that baseline data is collected at the beginning of the project to allow for impact evaluations.

7.4 Current and Planned Support to NGO by Other Donors

Other than USAID, two other international donors are present in the Dominican Republic and are now or may in the future provide support for social marketing: the United Nations Fund for Population Assistance (UNFPA) and the German development assistance dyad of KFW and GTZ.

In the past, the UNFPA has donated contraceptive products to the Dominican public sector. From 1991 to 1997, the UNFPA provided contraceptives for use throughout the whole country. When its funds were reduced by about 50 percent in 1997, the UNFPA reduced its contraceptive donations to targeted regions with the lowest social indicators.

Previously, UNFPA policies prohibited the resale of its donated contraceptives; consequently, UNFPA contraceptives could not be used in social marketing programs. Now, according to the Assistant Representative for the Dominican Republic, issues of contraceptive security have led the UNFPA to revise its prohibitive policies on resale of donated commodities. However, the UNFPA does not consider the donation of contraceptive products to create a revolving fund for re-supply presently feasible in the Dominican Republic, because marketplace prices for contraceptives are too low.

The UNFPA is currently collaborating with IDI, a Dominican NGO, on a project that provides services to 50,000 direct beneficiaries and 50,000 indirect beneficiaries in 12 marginalized neighborhoods in Santo Domingo. As part of the project, IDI is interested in the social marketing of contraceptives to targeted beneficiaries, and UNFPA program staff are discussing social marketing strategies with IDI management. To date, IDI has found it possible to sell oral contraceptives and IUDs but has not been able to sell condoms because of stiff price competition from other brands.

The Director of GTZ's reproductive health project informed evaluation team members that GTZ provides technical assistance while KFW is the source of funding for development assistance provided by the German government. A KFW consultant was expected to arrive in the Caribbean region in late September 2004 to undertake a one-month study of the feasibility of funding social marketing in the region, including the Dominican Republic. Results of the feasibility study will not be known until later in 2004.

GTZ has also been funding the Sexual and Reproductive Health project (2002-2005) with technical assistance from EPOS health consultants—the Dominican partner for this project has been SESPAS. A midterm evaluation of the project showed that SESPAS collaboration with civil society institutions, in the management of prevention campaigns and in the promotion of the population's health, was a successful pilot effort that might help in the implementation of health reform. The evaluation team was told that because of funding cuts in the health area for Latin America, there will be no follow-up project.

Mid and Long-term Recommendation

USAID should encourage other donors, as the opportunity arises in donor coordination, to support the RH/FP NGO programs.

7.5 Review of USAID Programmatic Goals and Strategy for RH/FP

This report has highlighted that USAID financial and technical assistance to Profamilia, MUDE, and ADOPLAFAM has centered on improving the long-term sustainability of the NGOs, creating cost recovery strategies as a foundation for financial sustainability, improving and diversifying services and developing management systems, while continuing to serve vulnerable populations. These activities as implemented were to contribute to USAID's overall health strategic objective of "Sustained Improvements in the Health of Vulnerable Populations in the Dominican Republic" and to a specific sub-intermediate result "Improved NGO Sustainability to Continue Provision of Quality Services for the Poor and Adolescents."

There are three additional sub-indicators of the sub-intermediate result: (1) percent of clients served who are poor, (2) adolescents reached by IEC activities, and (3) percent of clients who are adolescents. The performance indicator selected by the Mission to measure sustainability was the "Percent of Total Expenses Covered by the NGO's Generated Resources.

As stated earlier in the report, one of the evaluation team's most important conclusions is that the major goals and objectives of the strategy are still valid; the team does not recommend any changes to the strategy. USAID-funded RH/FP NGO programs are important sources of subsidized services to the poor and vulnerable groups in the Dominican Republic and mechanisms to improved quality of care. The 1996 DHS estimated that RH/FP NGOs provided family planning services to 15 percent of the population. Although the 2002 Demographic and Health Survey (DHS) estimated service coverage only for Profamilia, most donors and family planning practitioners believe that RH/FP NGOs continue to be important providers of family planning services to vulnerable groups and adolescents, and are continuing to provide RH/FP services to over 15 percent of contraceptive users in the country.

Although the three NGOs have improved their sustainability positions as defined by the IR indicator chosen by USAID, gaps and deficiencies remain. Given the short time left in the grants, the evaluation team does not recommend any changes to indicators at this time, although the following sub-indicators might be easily collected within the current grant agreements to cross check sustainability and estimate levels of services to the poor: (1) amount of costs recovered (from fee-for-service, etc.) as a proportion to all expenditures; and (2) the total number of non-paying clients as a proportion of all clients served. Future design efforts could include sustainability indicators that would cover financial sustainability, institutional sustainability, and sustainability of services.

The rationale and conclusions to seek specifically targeted future technical assistance to the NGOs to address gaps and deficiencies include:

1. In the short-term, USAID needs these committed NGO partners more than ever given the increasing weakness of the SESPAS system in delivering RH/FP systems.

2. NGOs are not yet operating optimally, although they are at very different places in the development continuum.

3. Profamilia, MUDE, and ADOPLAFAM are USAID's "capital assets" in the delivery of RH/FP services.

4. Severity of the economic downturn (three percent negative growth in 2003) in the last two years has adversely affected (reduced income) the sustainability level of all three NGOs—although to varying degrees.

5. The economic crisis is resulting in increasing number of marginalized and hard-to-access populations not reached by the SESPAS RH/FP system.

6. The support provided by the USAID-funded CMS to the three NGOs was vital to the strengthening and improvement to their sustainability indicators.

7. CMS technical assistance, though successful in improving the sustainability status of the NGOs, was not as successful in strengthening the institutional capacities of the NGOs.

8. The effectiveness of CMS assistance appears to have been weakened because of its tendency to use a "one size fits all" approach to technical assistance, rather than tailored to the level at which each NGO was operating.

9. Perhaps because of the influence of the "macro" level IR indicator/sustainability index, technical assistance to the three NGOs did not include appropriate attention to development of cost center/cost accounting systems.

Recommendations

- *Whatever mechanism is used to provide financial and technical assistance, USAID should include indicators more appropriate to business and ensure baseline data are available/collection for evaluation of impact on targeted vulnerable populations.*

- *Short-term support for the subsidy/coupon program should include technical assistance for each NGO in development of a broader and stronger base of funding for subsidized services delivery (e.g., internal cross subsidies, corporate sponsorships, GODR public sector, endowments, additional bilateral donor/foundations, and the like).*

- *USAID should provide financial and/or technical assistance only for those activities that will generate income, except for TA in the development and implementation of cost accounting systems/cost centers. Income should be broadly defined to include subsidies for the coupon program, collaboration with public and private sector entities that will support (in-kind or cash) NGO activities, other donor support, corporate sponsorships, and so on, and should not be limited to sales of products and services.*

8. RESPONSES TO QUESTIONS—FUTURE STRATEGIC DIRECTIONS

USAID asked the team to examine five key questions with regard to future strategic directions for the RH/FP NGOs. This section explores the team's conclusions and recommendations.

8.1 How successful has the strategy been in strengthening the NGOs' financial position?

The strategy has been successful as defined by the IR indicator: Percent of Total Expenses Covered by the NGO's Generated Resources. All three NGOs significantly improved their sustainability positions during the project period by an average of 33 percentage points (see the table below). From 2000 to 2004, MUDE increased its sustainability indicator from 26 to 68, ADOPLAFAM from 19 to 59, and Profamilia from 71 to 89 percent.

The expectations for the end of the project (June 2005), as defined in the NGO grant agreements, were as follows:

- Profamilia's sustainability indicator could reach 90 and ADOPLAFAM's 70 percent.

- Although no percentage figure was given in the MUDE grant in terms of the indicator, the expectation was that after 2005, MUDE would continue its health program on a sustained basis with the proceeds from its micro-credit loan program.

Table 15. Percent Change in the RH/FP NGO Sustainability Project Performance Indicator (Percent of Total Expenses Covered by Revenues Generated by the NGOs): 2000-2004

Organization	2000* (%)	2004** (%)	Percent Change
Profamilia	71	89	18
MUDE	26	68	42
ADOPLAFAM	19	59	40

Source: CMS data * October 2000 data; **June 2004 data

The team believes very strongly that Profamilia, MUDE, and ADOPLAFAM are highly committed to reaching vulnerable populations and have improved their sustainability positions without losing the focus of their mission of serving vulnerable populations. However, the NGOs' mission has become increasingly complex in the last few years, given the public health sector's inability to provide services to-hard to-access populations in extreme poverty, and given the dramatic increase in numbers of poor people between 2000 and 2004. It is important to note that all developed countries subsidize, to a greater or lesser extent, health services to the poor. Thus, it is unrealistic to expect long-term sustainability of services to the poorest of the poor without the NGOs identifying alternative sources to replace the financial gaps left by the international donors' phase-out.

Although the evaluation team would have liked to estimate the ratio of paying to non-paying clients the NGOs could serve while maintaining their sustainability, this could not be predicted on the basis of a two-week overview. The number of poor clients an organization can afford to subsidize depends on many elements, such as cost control, level of fees charged to paying

clients, types of services offered (profitability, volume, demand, etc.). The financial sections of the report, however, attempt to use available data to predict future sustainability for each NGO.

8.2 Which NGO(s) utilized support most efficiently to the benefit of their service provision and overall financial position?

Of the three organizations, Profamilia has utilized support most efficiently to benefit its service provision and financial positions. Although Profamilia showed a less striking increase in its sustainability indicator—increasing only 18 percentage points as compared to approximately 40 points for the other two NGOs—Profamilia has achieved the highest diversification of revenue sources and has been able to consolidate its projects and services, which for the most part are self-sustainable. Moreover, Profamilia is an efficient organization with a solid administrative and financial base.

Although all three NGOs have substantially improved their sustainability positions, they continue to have to have a high level of dependence on international donors. In the case of Profamilia, however, this dependence is significantly less.

Table 16. Percent of NGOs' Total Income Generated from International Donors: 2004

NGO	YEAR 2004 (%)
Profamilia	26
ADOPLAFAM	60
MUDE	75

Source: Budgets provided by each NGO

The team concluded that the support provided by CMS to the three NGOs has been vital to the strengthening and improvement to their sustainability indicators. However, CMS technical assistance, while successful in improving the sustainability levels of the three NGOs, was not as successful in strengthening overall institutional capacities.

The effectiveness of CMS assistance appears to have been weakened because of its "one size fits all" approach, rather than tailoring TA to the level at which each NGO was operating.

8.3 Which NGOs (if any) are close to program sustainability and what should the role of USAID be in terms of possible future support?

The severity of the economic downturn (three percent negative growth in 2003) in the past two years has adversely affected (reduced income) the sustainability level of all three NGOs, although to varying degrees. Although Profamilia is the closest of the three NGOs to program sustainability, the institution is approaching its "sustainability ceiling" because of its social mission and the economic crisis. ADOPLAFAM and MUDE were not able to respond as effectively to the changed economic and health environment as was Profamilia.

In the future, USAID should address the gaps and deficiencies identified in this evaluation as outlined in the next section.

8.4 What specific support should be provided to specific NGOs?

The evaluation team's recommendations for specific support to NGOs are:

1. USAID should continue financial and technical assistance in the short-term (to the end of USAID's current health strategy in 2007) to Profamilia and MUDE. The team found that the current USAID RH/FP Strategy has been comprehensive, viable, and correct. No changes in the strategy are proposed.

2. USAID should make the financial and/or technical assistance given to Profamilia and MUDE very specific to the individual needs of each of them to address gaps and deficiencies identified by the team.

3. Profamilia

    a. USAID should provide limited, well-targeted "outside" technical assistance to Profamilia in the evaluation of important marketing and business decisions related to future product line direction and product/clinical service introductions.

    b. USAID should provide one-time financial support for an advertising and promotional campaign to revitalize Profamilia's sales of oral contraceptives through its commercial distribution channels. This financial support could also include the initial costs of new packaging for Profamilia's over-branding of selected OC products.

    c. USAID should provide well-targeted technical assistance to Profamilia in developing a broader/stronger base of sources of support for subsidized clinical services delivery to targeted vulnerable populations (e.g., for the coupon program).

    d. USAID should support a program of consolidated institutional strengthening that would aim to: (a) continue to improve its sustainability position; (b) diversify products and services following a strategy that would increase marginal revenues while controlling marginal costs; (c) identify and penetrate new market niches; and (d) augment the use of institutional overhead as a mechanism to generate new resources in the administration of new projects.

4. MUDE

    a. USAID should provide technical assistance to MUDE in the development and implementation of cost accounting systems/cost centers necessary for analysis of costs of products sold and for effective management of activities that are sources of organizational income.

    b. USAID should provide technical assistance to MUDE in the development of improved contraceptive commodity needs projections and an improved contraceptive commodity logistics system.

c. USAID should provide technical assistance to MUDE in evaluating its cash flow situation, especially regarding the purchase of necessary contraceptive commodities, in developing solutions for the current cash flow problem, and in improving its cash flow management systems.

d. USAID should provide technical assistance to MUDE in developing, managing, and revising its business and marketing plans for both bakery and contraceptive products. Bakery marketing planning should include specific strategies for diffusing the risk created by a single large client such as the Ministry of Education. All marketing plans should include projected costs of the marketing strategies proposed; projected income from the strategies proposed; quantitative goals that facilitate evaluation of the contribution of marketing to increased revenues and profitability; and organizational strategies for management and evaluation of marketing activities.

5. ADOPLAFAM

a. USAID should carry out a comprehensive evaluation of ADOPLAFAM's current financial and service delivery performance. Current status should be compared with status at the beginning of the project. USAID should make its decision regarding future support for ADOPLAFAM on the basis of this comparison—in other words, on the basis of whether or not past support has generated sufficient positive change to suggest that future support will be an effective investment of limited program funds. USAID should refer to CONECTA's current assessment of the three NGOs' institutional strengths for further guidance.

b. If USAID decides, on the basis of the results of the comprehensive evaluation, to provide any future financial and/or technical assistance for ADOPLAFAM, none of that support should be given for operating costs—especially not for salaries. USAID support to ADOPLAFAM should be limited to activities that will generate income.

8.4.1 General Recommendations

1. Provide financial and/or technical assistance only for those activities that will generate income, except for technical assistance in the development and implementation of cost accounting systems/cost centers. Income should be broadly defined to include subsidies for the coupon program, collaboration with public and private sector entities that will support (in-kind or cash) NGO activities, other donor support, corporate sponsorships, etc., and should not be limited to sales of products and services.

2. Short-term support for the subsidy/coupon program should include technical assistance for each NGO in developing a broader and stronger base of funding for subsidized services delivery (e.g., internal cross subsidies, corporate sponsorships, endowments, GODR public sector, additional bilateral donors/foundations, and the like).

3. Whatever mechanism is used to provide financial and technical assistance, USAID should include indicators more appropriate to business and ensure baseline data are available/collected for evaluation of impact on targeted vulnerable populations.

4. USAID should provide technical assistance to the three NGOs in developing strategies for: (1) delivering RH/FP services to marginalized segments of the population not covered by Social Security (i.e., how to reach them, with what services, and how to fund) and (2) competing for service delivery contracts under Social Security.

5. USAID should document the RH/FP NGOs' best practices, such as Profamilia's public/NGO partnership in the San Juan de Managua clinic and MUDE's use of cross-subsidies, to identify strengths and weaknesses for potential replication. In addition, USAID should encourage the interchange of "best practices" among the three NGOs as well as with the HIV/AIDS NGOs supported by CONECTA.

6. USAID should encourage other donors, as the opportunity arises in donor coordination, to support the RH/FP NGOs.

8.4.2 Summary of Conclusions

The following is a summary of the conclusions that led the team to make the above recommendations.

1. The importance of NGO RH/FP service delivery has increased as the ability and willingness of the public sector to serve an increasing number of vulnerable populations has declined during recent project years.

2. Because appropriate baseline data was not collected at the beginning of the project, it is not possible to comment with certainty on the impact of NGO project activities on the targeted vulnerable populations.

3. All three NGOs have a high dependence on international donors, but in the case of Profamilia this dependence is significantly less than the others. Sixty percent of ADOPLAFAM's total income, 50 percent of MUDE's; and 26 percent of Profamilia's came from international donors.

4. All three NGOs improved their sustainability positions (as defined by the IR indicator) during the project period.

5. Given the social missions of the three NGOs, it is not reasonable to expect any of them to be fully self-sustainable financially.

6. The severity of the economic downturn (three percent negative growth in 2003) during the past two years adversely affected the sustainability level of all three NGOs—although to varying degrees.

7. ADOPLAFAM and MUDE were not able to respond as effectively to the changed economic and health environment, as was Profamilia.

8. The support provided by the USAID-funded Commercial Market Strategies (CMS) to the three NGOs was vital to the strengthening and improvement to their sustainability indicators.

9. CMS technical assistance, although successful in improving the sustainability status of the three NGOs, was not as successful in strengthening the institutional capacities of the NGOs.

10. Most technical assistance (like that of CMS) has so far been "one size fits all" without sufficient regard for the different place of each in the organization development continuum. This appears to have weakened the impact of the assistance.

11. Especially at ADOPLAFAM, cost-cutting measures, adopted perhaps to enhance its financial sustainability level as defined by the IR indicator, have eroded the NGOs' capacity to maintain and expand service delivery.

12. Perhaps because of the influence of the "macro" level IR indicator/sustainability index, technical assistance to the three NGOs did not include appropriate attention to development of cost centers/cost accounting systems within each NGO.

13. At least to the extent that current NGO business plans do not appropriately include/account for all costs of sales and services delivery, those business plans are not fully useful.

14. MUDE and especially ADOPLAFAM are too exposed to risk by their limited sources of income for sustainability security.

15. ADOPLAFAM does not have sufficient knowledge of its costs of doing business for accurate and full assessment of the contribution to financial sustainability that sales of its products and services currently make. Lack of cost data has constrained the effective development of institutional financial sustainability.

16. Although MUDE has information on actual costs, it has no cost centers within its financial structure.

17. In marketing, ADOPLAFAM and MUDE do not currently have sufficient knowledge of their costs of services delivered and of products sold for development of useful strategies for product line expansion and/or expansion of clinical services.

18. Technical assistance to MUDE and ADOPLAFAM appears to have been insufficient in the development of effective marketing plans and/or in the process of implementation, management, and revision of marketing plans as market conditions necessitate.

19. Limited, if any, assistance was provided to the three NGOs in developing a broader/stronger base of sources of support for subsidized services delivery to targeted vulnerable populations (e.g., for the coupon program).

20. Corporate social responsibility appears not to have been explored during the project as a source of funding for NGO service delivery to targeted vulnerable populations.

21. It appears that no opportunity has been created within the project for the interchange of "best practices" among the three NGOs.

22. Profamilia's operation already include successful, replicable models of public sector/NGO and private sector (not-for-profit) NGO partnerships.

8.5 What form should that support take and what is the optimal mechanism to deliver it?

The team identified three options based on the information currently available. These options, including potential advantages and disadvantages for each mechanism, are prioritized and described below.

8.5.1 Option 1: CONECTA Subgranting Mechanism

CONECTA Project leadership informed the evaluation team that there is an option in CONECTA's agreement with USAID to include the three RH/FP NGOs as potential recipients of subgrants and technical assistance. The team also understands that USAID's decision on the option is pending.

Potential Advantages

This option is very viable, and will reduce the management burden at USAID.

The team was impressed with the technical and managerial quality of the CONECTA project staff: the activities that the project is carrying out in the NGO community in support of HIV/AIDS services; their in-depth knowledge of the not-for-profit sector in the Dominican Republic; and the clarity of their vision—where the sector should be heading in the near and long term (i.e., during the transition and after the implementation of the health reform law).

The inclusion of the three RH/FP NGOs, particularly Profamilia, in the larger NGO community would support transfer of best practices/lessons learned to other NGOs.

The CONECTA project has hired the former CMS Local Coordinator of the RH/FP NGO Sustainability Project, carried out a baseline survey of the three RH/FP NGOS to determine levels of organizational development, and planned to provide technical assistance to MUDE and ADOPLAFAM to strengthen their financial systems in early October 2004.

Potential Disadvantages

CONECTA informed the evaluation team that an overheard rate has been negotiated. The team is concerned that a high overhead rate will limit the financial resources available to pass on to the NGOs.

An additional concern is that Profamilia, unless specifically targeted by USAID, would not receive the individualized technical assistance it requires, since in most areas Profamilia does not need the basic training CONECTA provides to other NGOs.

8.5.2 Option 2: PVO/NGO Flex Fund Project

The PHR Service Delivery Improvement Division (USAID/Washington) has been developing a PVO/NGO Flex Fund Project entitled Grant Solicitation and Management (GSM). This project, which was to have been awarded in June 2003, would accept field support and is envisioned to assist field mission and GH/PHR to solicit applications, award, and manage small to medium-sized subagreements, subgrants, or subcontracts to PVO/NGOs and other partners for family planning program implementation and related activities (e.g., special studies, documentation, and coordination).

This USAID/Washington project appears to have been designed to strengthen the RH/FP NGO sector around the world. USAID/DR should explore with USAID/Washington whether this would be an appropriate mechanism. Other centrally-funded projects may be able to accommodate future technical assistance to the NGOs.

Potential Advantages

Because USAID/Washington would accept field support, this option will also reduce the management burden of USAID/Santo Domingo.

Given that the current NGOs grants do not end until the summer of 2005, the Mission would be able to judge the performance of this new project by EOP.

Potential Disadvantages

The team is concerned over high overhead rates, loss of control by Mission staff inherent in the use of field support, and appropriateness of this project for a large NGO like Profamilia.

8.5.3 Option 3: Cooperative Agreements vs. Grants

The Mission could consider using Cooperative Agreements rather than Grants.

Potential Advantages

The cooperative agreement mechanism will ensure USAID is more directly involved in the outcome of the activities.

Recipient organizations will be held to a higher level of compliance in terms of objectives and geographic coverage.

Potential Disadvantages

The mechanism will be very time consuming for the Mission in terms of developing a solicitation and for the NGOs in terms of developing proposals.

The burden of grant management burden will not be reduced.

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ANNEXES

A. Evaluation Team Members
B. Workplan
C. Timeline
D. Organizations and Persons Contacted—Dominican Republic
E. Findings in Organizational Development
F. Organization Charts
G. Full Financial Analysis, Spanish Version (F. Vásquez)

Annex A. Evaluation Team Members

Maria E. Mamlouk, MA	Team Leader and RH/FP Program Evaluation
Betty Butler Ravenholt	Social Marketing
David A. Schrier, PhD	Organizational Development
Franklin E. Vásquez	Financial Analysis

Annex B. Workplan

The team will address the 12 key questions posed by USAID in the Scope of Work following the attached timeline (see Annex C). To accomplish this work, the team will address the following issues drawn from the key questions: organizational development, financial analysis, social marketing, and cross-cutting issues.

Organizational Development:

- Ascertain achievements of the three NGOs assessed: Profamilia, ADOPLAFAM, MUDE
- Identify NGO constraints encountered while trying to achieve objectives as per grant documents
- Ascertain degree of appropriate use of financial and technical resources
- Ascertain impact of USAID assistance on NGO operations
- Ascertain impact/changes on NGO's target population
- Ascertain level of NGO effectiveness and utilization of service delivery systems
- Assess NGO human resource capacity, deployment, workload, and preparation for jobs
- Ascertain impact of USAID assistance in the enhancement of NGO operations, management systems and processes
- Ascertain NGO client profiles and level of satisfaction
- Provide relevant lessons learned/best practices from other countries

Financial Analysis:

- Ascertain financial position of each of the three NGOs
- Ascertain the appropriateness of the financial strategies followed by the NGOs
- Describe the evolution of the financial systems and procedures as a result of USAID-funded technical assistance
- Ascertain cash flow
- Ascertain impact of economic crisis on NGOs' operations and identify current strategies used to deal with economic instability
- Estimate investment costs associated with future recommendations

Social Marketing:

- Ascertain current level of sustainability for each NGO
- Review marketing strategies for each NGO
- Describe and Assess organizational structures used by NGOs to support their marketing strategies
- Identify constraints: (1) marketing and (2) legal, regulatory
- Suggest possible future directions: products, promotion, market segments, etc.
- Suggest possible opportunities for collaboration between NGOs and other private and commercial sector entities
- Ascertain other donor plans for support and social marketing activities
- Provide relevant lessons learned/best practices from other countries

Cross-Cutting Issues:

- Report on current role of public sector in promoting MCH/FP and effectiveness of the public services in terms of meeting MOH's goals
- Define contribution of each NGO towards achieving national RH/FP goals

- Identify opportunities for future collaboration between public and NGO sectors
- Report on current and planned support to NGOs by other donors
- Review USAID programmatic goals and strategy for RH/FP NGO support and potential contribution of NGO support to USAID's goals
- Provide relevant lessons learned/best practices from other countries

Timeline:

As per the timeline (Annex C), the team will set up introductory meetings with the three NGOs on September 16 to 18. A preliminary outline of the report will be presented to USAID by Monday, September 20. During the following two weeks, the team will gather necessary data through meetings, interviews, and visits. Presentation of preliminary findings and recommendations to USAID is planned for September 29. The team will depart the DR on October 1, and the final report will be sent to USAID by the team leader on October 8.

Methodology:

- Review documents provided by USAID, including grant agreements, monitoring and evaluation plans, and other relevant documents
- Develop a set of tools for the comparative analysis of NGO performance: a list of questions and a set of financial report templates which will be presented to each NGO, outlining the type of data needed by the team
- Interview USAID and NGO staff, visit clinics and field activities
- Interview representatives of other donors involved in the provision of RH/FP as well as current and former MOH officials in MCH/FP
- Interview current and past users of RH/FP services provided by NGOs
- Meet with outside opinion leaders, as needed

Annex C. Timeline

September – October 2004

ACTIVITIES	SEPTEMBER																		OCTOBER							
	M	T	W	TH	F	S	S	M	T	W	TH	F	S	S	M	T	W	TH	F	S	S	M	T	W	TH	F
	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	1	2	3	4	5	6	7	8
1. DEVELOP WORKPLAN, TIMELINE & CONCEPTUAL FRAMEWORK																										
2. MEETING USAID – WORKPLAN & TIMELINE																										
3. VISIT TO THE NGOs																										
4. DAY OFF																										
5. INDIVIDUAL MEETINGS																										
6. DAY OFF																										
7. MEETING ROOM NEEDED																										
8. MEETING USAID (PRESENTATION); Preliminary Findings & Recommendations																										
9. TRAVEL CONSULTANTS																										
10. DAY OFF																										
11. FINAL REPORT CONSULTANTS & SEND TO TEAM LEADER																										
12. FINAL REPORT																										

Annex D. Dominican Republic Contacts

ADOPLAFAM	Dr. Ramon Portes Carrasco, Executive Director
	Margarita Baez de Corletto, Director of IEC
	Luis Rafael Perez Bido, Director of Planning and Evaluation
Dr. Victor Calderon	Dr. Victor Calderon, Private Physician, Former Director de la Direccion General Materno, Infantil y Adolescentes at SESPAS
CONECTA	Dr. Martha Butler, Director
	Dr. Judith Timyan, Deputy Director
	Dr. Humberto Blanco, Health Policy and Institutional Development
	Maria de Moya, Former CMS Project Director
	Dr. Sonia Brito, Medical Advisor
Farmacia Brazil	Bella Vista Santo Domingo
Farmacia de Familia	Santo Domingo
Farmacia Tania	Julisa Oviedo, Av. Romulo Betancourt Santo Domingo
GM Grupo Gestion Moderna	Angela Rodriguez
GTZ/EPOS	Dra. Ermela Riedlberger, Project Director, Reproductive Health Project
MUDE	Rosa Rita Alvarez, Executive Director
	Leonor R. Alfonso, Directora de Planeación y Evaluación
	J. Graciela Castillo, Encargada Financiera
	Juan Mendez, Supervisor de Costo y Mercadeo Enc. Proyecto Pante
Pan-American Health Organization (PAHO)	Dra. Socorro Gross, Representative to the Dominican Republic

Profamilia	Magaly Caram de Alvarez, Executive Director
	Juan Miguel Houellemont, Director of Marketing and Sales
PSI/Dominican Republic	Elizabeth Beachy, Executive Director
REDSALUD	Patricio Murgueytio, Director
	Dr. Luis G. Morales, Asesor en Descentralización
Schering Dominicana	Diego Degaudenzi, Marketing Director
Schering las Americas	Luis Lora, Product Manager, Fertility Control
SESPAS	Dr. Rafael Schiffino, Sub-Secretario de Estado de Atención Primaria y Salud Colectiva, Secretaria de Estado de Salud Publica y Asistencia Social
	Dr. Hector Eusebio, Director General, Materno Infantil y Adolescentes, Secretaria de Estado de Salud Publica y Asistencia Social
UNFPA	Gilka Melendez Fernandez, Assistant Representative
	Arlette Palacio de Grateraux, Program Associate
	Dr. Luz Mercedes, Medical Consultant

Annex E. Findings in Organizational Development

RH/FP NGO Strategy Evaluation, USAID/Santo Domingo
OD Component Technical Report
By David Schrier, Initiatives Inc. Evaluation Team

I. Recommendations: Current Project through EOP (2005)

1. Using funds from CMS, request proposals from the three NGOs to take over (or build out a shell) and manage a government clinic. PRIME should provide longitudinal measurement and results tracking with controls and placebo.

2. Under REDSALUD guidance and funding, REDSALUD should request proposals from the three NGOs to take over (or build out a shell) and manage a government clinic. PRIME should provide longitudinal measurement and results tracking with controls and placebo.

3. Immediately:

    - Initiate weekly meetings of the three NGOs, REDSALUD, and USAID to develop a way to modify the health sector reform Subsidized Regime (SR)

    - Lobby this modification through legislative bodies whereby the Subsidized Regime component provides a structural base component for NGOs' long-term sustainability (as envisioned by USAID's Health Activities Approval Document for Strategic Objective FY2002 thru FY2007 and USAID Strategies (2002-2007). USAID moves from observer to activist role.

II. Recommendations: New Project Following EOP (2005)

The above three recommendations should carry forward if unfinished at end of project.

1. Launch a sustainability project directed to the same NGOs at the same funding level as the current project. Broaden indicators to accommodate contextual factors to include social factors:

    - Heavy business planning loaded on the front-end at the CEO and direct report level.

    - Business plans should include coupon use; NGOs should only spend coupons on services provided by the other two NGOs.

    - Prior to project design, guide the three NGOs in a workshop to recommend to USAID specific needs to the sector in a cooperative design appropriately deploying relative strengths and weaknesses among the NGOs.

USAID should acknowledge the strengths of these NGOs; exploring deeper two-way teaming on ideas through some notions of "partnership" may be worthwhile for consideration at this time.

III. NGO-Specific Recommendations

One category of NGO-specific recommendations regarding sustainability and HSR would not emerge until a later date following meetings of the NGOs, REDSALUD, and USAID. Such recommendations, targeting the Subsidized Regime of the HSR, should include a clearly defined learning curve and primary health care service delivery "business model" that may become revenue-generating vehicles.

Implementation would be best suited during the transition of HSR upon the scheduled separation of MOH from clinic/hospital control.

ADOPLAFAM

Develop and implement a realistic donor fund development strategy, as described in the recommendations of CMS study "Valoracion de la Sostenibilidad de ADOPLAFAM, INSALUD, MUDE y Profamilia" March 26, 1999 (page 19 No. 5).

Develop a SP/CD service product under the Subsidized Regime component of the Health Sector Reform as per recommendation three above.

MUDE

Spin-off microfinance under the banking sector with shares held by MUDE, using the widely successful Bolivian model (note: the NGO with social goals would be the sole owner of MUDE Microfinance to insure dominance of social goals and allow MUDE to focus on that mission without distraction).

Develop and implement a realistic donor fund development strategy, as described in the recommendations of CMS study "Valoracion de la Sostenibilidad de ADOPLAFAM, INSALUD, MUDE y Profamilia" March 26, 1999 (page 19 No. 5).

Develop a Social Promotion (SP) and/or Community Development (CD) service product under the Subsidized Regime component of the Health Sector Reform as described in recommendation 3 under "Current Project" above.

Profamilia

Develop an SP/CD service product under the Subsidized Regime component of the Health Sector Reform as described in recommendation 3 under "Current Project" above.

Select a successful mentor model in Latin America to study and deepen the primary health service delivery business formula for clinic models. PROSALUD in Bolivia used to provide a good example for mentoring and study; however, this may not be the best model under current circumstances. Profamilia may face a one-time-only opportunity for "ramping up"

and building out clinics under potential HSR scenarios, where the scale of rapid growth might parallel PROSALUD's growth from 1989 through 1995.

Deepen understanding and penetration of HSR under the HMO-type tier already underway. This tier is not readily available to ADOPLAFAM and MUDE without clinic ownership.

IV. Conclusions and Findings in Support of Recommendations

With regard to organizational development, the project was bold and perhaps overly ambitious regarding levels of absolute sustainability to be achieved by EOP; nonetheless, results from each NGO were worthwhile and remarkable under the circumstances. Due to the execution of the project and constraints described in the following sections, USAID might have appropriately developed global concerns that the NGOs were not using a business approach, and that they were not cooperating sufficiently.

In spite of gaps and deficiencies in technical assistance for business planning, the three NGOs are quite strong in their business approach. Moreover, there is both desire and potential for deep, long-term cooperation. Exercises to reveal potential for such cooperation included the three NGOs and REDSALUD in a meeting on October 4, 2004, to review HSR and NGO sustainability. General agreement was reached to continue meeting for developing deeper understanding of the matter and possible intervention in the SR section of the HSR, and that, "in principle," the three NGOs agreed to explore the notion of joint cooperation for implementing clinic demonstrations. Information describing their business approach is provided in this annex to support the notion of a high level of business acumen.

Constraints Affecting NGO Performance 2001 through Present

Unanticipated constraints impacted the NGOs' sustainability to a very large extent. The economic crisis damaged 10 years of development experience; the target population grew perhaps from 40% to 60%; and degrees of poverty worsened. Most immediately, however, there has been a downward and dramatically cascading discretionary income level where co-pay or fee for service potential almost disappeared.

Another constraint was USAID's key sustainability indicator: "Percent of total expenses covered by NGOs' financial resources." The isolation of this absolute measure did not adequately address either contextual issues in the Dominican Republic or independent contextual issues faced by each of the three NGOs. Unintended consequences of sub-optimization of important "contextual" factors forced by unbalanced emphasis on the absolute definition of sustainability were significant, not the least of which was erosion of social networks in ADOPLAFAM where SP/CD is their capital base. Profamilia is a brick and mortar clinic base and while SP/CD is an important component of their capability, it is not Profamilia's primary capital base.

The literature is consistent with broad-based emphasis on sustainability and the need for context-specific approaches. Benton and Monroy, for example, define sustainability as "a generic concept, defined more by the context of its application than by any settled meaning" and later state that "[m]uch of the dissent over financial sustainability can be attributed to the multiplicity

of contexts and program designs in the social marketing field. A challenge for practitioners and donors is to identify appropriate financial sustainability strategies for a given context, consistent with a program's desired health outcomes."

USAID's primary sustainability indicator is addressed in USAID's Request for Task Order Proposal, July 2004 "Key Questions to Be Addressed by the Evaluation Team," where Question 7 asks, "Were the indicators reasonable, logical and achievable?" In addition to sub-optimization of factors not addressed by the primary indicator and goal, USAID's sustainability measure does not accommodate or report the dynamic nature of achieving sustainability with respect to measuring the specific challenges faced by each NGO. Two NGOs started without even one clinic while another started with five. Some NGO programs serve populations dramatically less able to pay fee for service. Furthermore, institutions delivering social promotion and community development goals will have a more difficult time building profit centers than institutions with brick and mortar clinic assets delivering primary medical services. This was a key point in the USAID study of sustainability of these same NGOs (Cuellar, Ruparel, and Herrera; CMS March 26, 1999).

One concern for organizational development of the NGOs is that USAID will apply a "one size fits all" approach, expecting all NGOs to have the same capacity to achieve an absolute level of non-USAID revenue to total cost, and use this result to make decisions in a matrix.

While CMS technical assistance on the institutional strengthening side was very well implemented by Dominicans, and at very low cost, inadequate business planning assistance by CMS was a third constraint and a detriment to NGO sustainability. Had appropriate business planning TA been delivered, it is likely that problems in the NGOs' lack of costing capability and subsequent impact would have been lessened.

Business planning requires application of graphic break-even points (BEP). Had BEP been undertaken and executed properly, cost accounting would likely have become a "felt need," where leadership in each NGO might have driven for a capability to pinpoint costing early in the project. CMS assistance could have responded by designing these capabilities more deeply than was the case, thus allowing the organizations to "pull through" changes in cost accounting rather than changes being "pushed through" by CMS.

This project did not have a midterm evaluation, so unnoticed issues that might have otherwise been addressed continued without critical review.

Shortcomings in business planning TA created an impression that the NGOs did not apply a "business approach." Yet in spite of gaps in this key project area, the NGOs show a very high level of business skills, though there are some deficiencies in their business vocabulary. Given the constraints affecting their performance, the three NGOs function at a high level of professionalism and were well selected by USAID for this project.

Business Planning Technical Assistance: CMS

USAID appropriately requested support for findings/conclusions that identify shortcomings in CMS's business planning TA and how this was a significant constraint. The following sections address this request. It should be noted that due to the short period of the evaluation, the organizational development specialist was not able to determine the causes for how business planning assistance was implemented. There was discussion that at the start of the project characterizing CMS's role as finishing a job already largely completed by Development Associates. This was the impression apparently held by many even with respect to accounting systems thought to have already been in place and functioning. Some discussion suggested that CMS did propose more comprehensive and appropriate business planning TA, but was scaled back due to USAID's view of budget limitations. This inquiry was limited to a review of technical assistance in and impact of business planning.

Additional support was found in reviews and discussion with MUDE and ADOPLAFAM of each report/study that addressed any aspect of business, planning, market study, financial projections for revenue generation; for example, in reviews of CMS's "Business Plan Training Program" (August 2001). In this case, MUDE and ADOPLAFAM explored all sections of the workbook that set the standard for business planning and served as the guide for ongoing visits by CMS/Washington staff to deepen and apply each NGO's business plans over a two-year period.

- Neither MUDE nor ADOPLAFAM sent key staff to the Business Training Course. CMS, for whatever reason, did not convey the critical nature of education in business planning, nor indicate in advance the appropriate level of management to attend. The result was that business planning as a key function was not connected to appropriate hierarchical levels and subsequently follow-up to the course over the next year did not yield results.

- It should be noted that Profamilia chose not to utilize business planning and, compared to MUDE and ADOPLAFAM, was not very involved either with the course or subsequent business planning assistance.

- The Business Planning training materials are generic and refer to factors appropriate to strategic plans more than to business plans. For example, considerable attention is given to the need for planning; defining the company's mission statement; policies, rules and controls; how to write an executive summary; a section on organizational adjustments that include mission and goal connections, human resource linkages, legal issues, property rights, etc. Where business issues are addressed they are flawed; for example, under evaluation of the market, it speaks of aggregate market size, potential growth of the product (note: this application would be more appropriate for "new products," not the mature products and services contemplated), identifying clients' objectives with regard to the product, and how the product will be sold to the client. A section on price and profit talks about all costs in generic terms, how price is determined, mentions competition to only introduce it as a general concept.

Inadequacies and the negative impact of the business planning training, materials, studies, and overall technical assistance can be seen two ways: misdirected energy through time wasted, and lost opportunity. Challenging business planning would have included focused

workshops and direct assistance follow-up to MUDE, ADOPLAFAM and Profamilia. What would such business planning have looked like?

- First, specifically targeted courses for attendees from individual NGOs, to allow the development of proprietary ideas by decision makers within each enterprise. There is an increased importance to see the future and take action to transition profit and cost centers; this is a sensitive matter for each NGO, not suited to training in the presence of "outsiders."

- Rather than starting at the market level, the course would begin with the definition of the industry as a sector and look at rivalry in distribution. Profamilia and condom sources at the distributor level is a good example for examining what the sector looks like; i.e. is it about to consolidate? Are distributors showing any signs of intentions to sell direct? If so, are NGOs ready to private label or preparing themselves for other competitive response to such a scenario? Industry maps, the sequence of inquiry, and so on, should be examined in the course.

- The course should reflect proper business planning sequence; market and demand studies are normally the last step in business planning (because it is the most expensive and time consuming of tasks), and use a comprehensive approach to history, trends, and forecast. For example: Are providers/rivals entering or exiting and what is the nature of their exit and entry? Are profit margins increasing or is the product/service mature?

- Rather than long-winded examples of generic financial concepts, present simple managerial accounting tools requiring the application of graphic break-even points. Had this sequence been followed, with reliance on BEP, it is likely that the costing issues in social marketing and financial management would have been improved. If the right staff at an organization understand how to use a tool like graphic break-even point, and therefore value its use, they will insist that accounting provides cost data so that the notion of break-even points is easily applied to provide timely information and facilitate decisions regarding profit centers, cost centers, business formula, deployment of resources, development of business formulas and competitive strategies.

- Business planning workshops should use actual or "live" exercises, that is, sending teams of three participants to quickly build industry group maps; analyze competitors; identify trends in entry and exit of firms to a specific profit center; identify trends in profitability; and so on. These homework assignments should be given each day during the course with presentations and suggestions for improvements. The course as it was taught was static, overly abstract, classroom bound, and did not focus on *how to do business*.

- Business planning workshops should develop exercises that build industry group/industry sector maps where all channels of distribution are graphically presented with numbers of enterprises in each channel; and, do so in a dynamic scenario model of history, trends and forecasts. For each scenario, at least four enterprises (rivals, suppliers, the actual client base for the business concept entertained by the NGO) in the target channel are segmented out for deeper study. Such study might segment two enterprises as a success model and two as a failure model. Then scenarios showing history, trends, and forecast

could be developed to discover what factors are driving the successful enterprises and what factors are driving the failing enterprises.

- This sequence and order for inquiry (that is up-front sector maps and studies that would logically follow later if called for after first completing this work in forward channels) is not apparent in the CMS business planning model, in the Business Planning Workshop materials follow-up CMS TA from Washington or in contracted studies. (Note: the Dominican component of CMS was successfully implementing at very low cost the institutional development component.) CMS business planning TA missed appropriate discussion of market concepts defined by "products and product substitutes," the nature of rivalry, and the range of response through competitive strategies.

For ADOPLAFAM, in business planning adventures when the NGO stepped outside of CMS TA and did focus groups for clients, their results were very solid. A good example of this was their work for PRO COMUNIDAD, a client that bought an ADOPLAFAM study in the East, South and NE to determine community needs for civil engineering infrastructure. CMS TA relied heavily on the business planning course and for two years, on follow-up to the course.

For MUDE, much of the bakery projection was based on moving averages drawn from MUDE's historical experience. By the time the business plan was built (2003, for Duverje and Santiago Rodriguez), MUDE knew more about the bakery business than market study contributions from CMS in bakeries. Rather than relying on CMS's business planning contribution for bakeries, MUDE was guided by its prior experience. CMS provided substantial business planning TA for the beauty supplies profit center concept—MUDE eventually decided not to pursue this venture.

It should also be noted that because the project did not have a mid-term evaluation, these unnoticed issues that might have otherwise been addressed, continued without critical review.

Health Sector Reform, Subsidized Regime

USAID promised that health sector reform would provide avenues for the NGOs' sustainability in the future. This is not the case. Under the health sector reform (HSR), NGOs are not part of the subsidized regime (SR) and instead, SENASA distributes funds exclusively to MOH medical facilities. The SR refers to one of three categories of the HSR and is the only one directed to "the poor." Since the macroeconomic crisis in the Dominican Republic, "the poor" have increased from 40 to 60 percent of the population. Social promotion and community development do not appear to be addressed in the SR.

SENASA is the entity receiving funds from the treasury for distribution to MOH medical facilities. The overall procedure calls for SENASA to receive funds from the treasury based on an actuarial table whereby expected actual primary health services per capita are held for distribution to MOH regions according to the respective MOH Regional proposal. The HSR SR does not address participation of NGOs. In addition to having been left out of the HSR law, and given the nature of job protection and political appointees' leadership governing regional and local decisions for distributing funds, NGOs under this scenario still would not stand much of a chance for participation, even if SP/CD were covered services under the HSR SR. MUDE and ADOPLAFAM are devoted primarily to SP/CD. Profamilia also offers these services as one of

several components of their service model. Profamilia will participate in all issues raised in this HSR review and recommendation; however, Profamilia will continue to penetrate the HMO type tier based on their clinic strength in that section of the law. In essence, NGOs have been left out of the HSR.

As of October 2004, REDSALUD has been successful in building the MOH proposal related to institutional capabilities to manage incoming funds from SENASA in Region 5. Unfortunately, those funds have yet, at the time this report was written, to be distributed to the MOH clinics. In Region 4, SENASA has distributed more than RD$30 million which sits today as unmoved pipeline to the MOH clinic and health facilities because Region 4 has not built the institutional capabilities of their colleagues in Region 5.

This brief overview is intended to support the recommendation for weekly meetings with the three NGOs, REDSALUD, and USAID, to address NGO sustainability and SR as defined by the law. Both REDSALUD and the NGO Sustainability Project have eight months to EOP.

USAID is committed to the sustainability of NGOs under HSR and "will make clear and major contributions in attaining this goal. USAID will focus on three major areas of health risks in the Dominican population: HIV/AIDS prevention and care; child survival; and reproductive health/family planning (RH/FP). A fourth area of emphasis, and one which provides the organizational underpinnings for the other three, is health sector reform. The strategy will target vulnerable population groups defined generally as those living under the poverty line, with a focus on children, adolescents and women of reproductive age… The combined results of these four areas will help the Mission reach the objective of sustained improvement in the health of vulnerable populations in the Dominican Republic."

And in another planning document, *Sustainable, Effective, Reproductive Health/Family Planning Services Provided by the Public and Private Sectors*, USAID states:

> …It is expected that NGOs will have attained the capability to continue provision of quality services to vulnerable groups with their own or national resources. The RH/FP activities will also have a public/private sector focus, with quality of attention will increase the sustainability of family planning services... Our intent is to involve the public sector more in RH/FP services, again taking advantage of the Ministry network of health centers and hospitals... At the same time, the three major family planning NGOs will continue to receive technical assistance to fine tune and implement financial sustainability plans allowing them to reduce dependence on USAID and develop local public/private partnerships to address the most difficult target populations.… Our work in RH/FP would complement REDSALUD's efforts in overall local management, would allow for the creation of a regional model within the context of HSR and would ensure sustainability.

Within USAID's four-component institutional framework in health, REDSALUD is an important player in assuring NGOs are included in the SR section of the HSR. The project is expected to contribute to IRs 10.2 and 10.3, promoting "sustainable and effective reproductive health and family planning services by the public and private sectors."

V. Review of NGO Grant-Related Achievements

The project has eight months remaining and the results presented will advance during this period. The NGOs built graphic presentations linking grant components through operational definitions, activities, indicators selected for monitoring results, and results achieved. These graphics, presented within each organization's description that follows, are intended to allow a project overview without a tedious rehashing of quarterly and annual reporting; this is particularly relevant in light of the extensive reporting by the NGOs and financial audits throughout the project period.

The task view, or result, of building these graphics was an overview of each NGO's performance, linking the grant to activities and measurement. In addition, the process of building these graphics revealed how each NGO deployed and managed its human resources with respect to delegation of authority, teamwork, distribution of capabilities, and hierarchy within the organization. Levels of institutional development were revealed in a strategic task with a time certain deadline.

ADOPLAFAM

ADOPLAFAM chose to invest approximately 70% of its grant assistance for the construction of a clinic, The Diagnostic Center (Centro Diagnostico), just outside the city limits North of Santo Domingo. Since all coupons were given to clients for spending on services in the Diagnostic Center, the grant's coupon amount was added to the Center's main line item, yielding just under 70% of the total grant amount. Remaining of project funds were divided by investment in ADOPLAFAM's network for delivering Social Promotion and Community Development services to the very poorest levels of the rural target population.

Three summary tables present the components of the grant agreement in a graphic sequence, defining: (1) operational program definitions used; (2) goals ADOPLAFAM used to link operational definitions to activities; (3) measurement indicators chosen to monitor performance achievements accomplished through June 30, 2004—annual units as percentage spent/accounting line items by goal/line items by percentage of actual spending (each of the three graphics addresses one of these). ADOPLAFAM refers to these graphics as their logical framework; the categories are well linked, front to back.

USAID's primary indicator for the project measuring sustainability, "percent of total expenses covered by NGO's financial resources," is approximately 59 percent, according to the Initiatives team's financial analyst. Considering ADOPLAFAM began the project with a 19 percent figure, and notwithstanding constraints, the dynamic nature of improvement is impressive. Yet this could be misleading without considering the deterioration in ADOPLAFAM's productive capacity with respect to its social network over the same period.

ADOPLAFAM balanced sustainability—at great cost to its capital base, social networks—through cost reduction, where it was simply not possible to further increase fee for service revenue as per impact of the crisis.

Where ADOPLAFAM applies the sustainability measure to the Diagnostic Center, it reports complete achievement of this project goal and the impressive improvement in co-pay to coupon subsidy, having achieved a 60 to 40 percent level (a reserve of unspent coupons remain on-hand). ADOPLAFAM reports completion of goals set in the grant component "Community Network," as measured by sales of products and gross revenue. This was as defined by the early CMS TA and remained in place as envisioned under product sales. Sub-optimization of factors resulting from overemphasis on the project's sustainability measure appears to have diminished ADOPLAFAM's red comunataria—at start-up 1,500 to 2,000—to 600 in October 2004. ADOPLAFAM is now implementing measures to rescue the loss and restore its volunteer network, recognizing this as its primary capital base.

The project's impact on ADOPLAFAM was powerful and a great success with respect to completing a 20-year struggle to link a clinic strategy to its community network strength in SP/CD. It is worthwhile to explore this struggle with respect to ADOPLAFAM's business model.

ADOPLAFAM distinguishes itself among other NGOs by providing the deepest community development and social promotion; however, ADOPLAFAM recognized in 1989 that this strength was not balanced at the clinic level. Applying a business framework, ADOPLAFAM's strength has always been in the forward position in the sense of "market" (i.e., at the individual level through groups in communities) and in its ability to make things happen at this point of contact. Yet ADOPLAFAM was mindful that a connection for achieving health related impact was needed at the clinic level, and experimented with a turnkey franchise model (meaning the buyer/owner needs only to "turn the key" to make the enterprise work) whereby the NGO leased 10 rural clinics complete with staff and equipment and engaged ten doctor/owners for six months. ADOPLAFAM provided clients through SP/CD; the "owner" was an entrepreneur.

This turnkey franchise approach added the backward vertical integration to balance ADOPLAFAM's dominance at the market level. The connection to ADOPLAFAM's investment of approximately 70 percent of project funds in a brick and mortar investment to achieve ownership of the diagnostic center is that it executes a consistent long-term strategy to build a backward vertically integrated enterprise model.

It appears that three or more of these clinics still function within a strategic alliance; if this is the case, then the investment is a sustainable achievement. This achievement notwithstanding, however, the model's reliance on marginal cost was inadequate, largely because without ownership of the physical plant enabled property owners to control events in the long term. The USAID project facilitated the unavoidable investment and completed the enterprise model. It is still early to describe outcomes. ADOPLAFAM continues to apply its earlier enterprise model that avoids fixed costs of staff and instead uses profit sharing formulas on a profit center basis.

PRIME's assistance was highly valued by ADOPLAFAM, where the instruments developed are reported to have successfully guided decisions to improve quality and achieve a continued and growing patient base at the diagnostic center.

ADOPLAFAM is on a path to achieve project objectives by EOP and has maintained financial reserves to guide demand in the diagnostic center in a strong finish during the months ahead.

METAS Y LOGROS PROYECTO SUSTENTABILIDAD USAID-ADOPLAFAM-JULIO 2001-JUNIO 2004-A

El proyecto está enmarcado en el RI 2.2.1 de la estrategia global de USAID:Mejorada la sustentabilidad de las ONG para continuar la provisión de servicios ala población pobre y a adolescentes
PRESUP. RD$15,725,264.00
EJEC. RD$10,829,056.00
72%

COMPONENTES DEL ACUERDO	DEFINICIÓN OPERACIONAL	METAS ESTABLECIDAS POR ADOPLAFAM EN UNIDAD DE AÑO	INDICADORES CORRESPONDIENTES A LAS METAS	LOGROS ACUMULADOS AL 30 DE JUNIO DEL 2004	% GASTADO
CENTRO DIAGNÓSTICO SSR RD$7,177,572.11	Aferta de servicios de salud materna e infantil, prevención y atención de enfermedades transmisibles, salud sexual y reproductiva, medicina general y cardiologia. Oferta de servicios de laboratorio automatizados, sonografia, colposcopia y RayosX	10,941 Consultas 25,000 Pruebas de Laboratorio y otras Beneficios al 3er año subsidio cruzado para intervenciones sociales de ADOPLAFAM	No. De Familias Censadas No. De Cupones No. De consultas Cantidad de Médotos anticonceptivos No. De Eqiopos e Instrumentos No. De exámenmes de laboratorio por día No. De sonografía No. De Radiografías Centro funcionando No. De material Educativo de promoción	18,118 Consultas 33,503 Pruebas Diagnósticas Electrocardiografias Corposcopias Programa Calidad servicos PRIME Rayos X	**55%**
EDUCACIÓN Y ORIENTACIÓN SSR PARA ADOELESCENTES RD$3,160,311.82	Programa de capacitación y seguimiento para Adolescentes Multiplicadores que orientan a sus Beneficiarios directos e Indirectos en el retardo de las primera relación sexual, prevención de embarazos y de la ITS/VIH/SIDA , derechos sexuales y reproductivos, autoestima, valores y toma de decisiones prevención de violencia y participación comunitaria.	150 adolescentes multiplicadores capacitados en SSR/ITS/VIH/SIDA 3,000 Beneficiarios directos Padres/Madres/tutires/Líderes que apoyan las actividades del programa Reproducción y distribución de Materiales de IEC Jornadas de retroalimentación Multiplicadores Visitas dominicillarlas a Beneficiarios, Padres y Lideres comunitarios.	No. De Multiplicadores capacitados No. Multiplicadores Recapacitados No. Multiplicadores reportando actividades No. Beneficiarios directos No. Beneficiarios Indirectos No. De Padres/Madres/tutores en jornadas No. Miembros Juntas de Vecinos en Jornadas Materiales Reproducidos y distribuidos No. De Jornadas de retroalimentación Multip. No. Acividades Educativas: charlas, encuentros cara a cara, Visitas Domiciliariasde los Multiplicadores con sus Beneficiarios	Tres capacitaciones para 90 Multiplicadores Recapacitación para 100 Multiplicadores Total de 150 Multiplicadores en 7 Barrios 3,000 Beneficiarios directos 22,000 Beneficiarios Indirectos 30 Jornadas con 800 Padres/Madres/tutores y 800 Miembros de Juntas de vecinos Reproducción y distribución de Materiales de IEC 16 Jornadas de Retroalimentación a Multiplic. sobre SSR, Drogadicción, Teatro, Comunición Interpersonal e Intrafamiliar, Prevención de Violencia 14,400 Actividades Multiplicadores-Beneficiarios	**51%**
RED COMUNITARIA SSR RD$1,358,207.82	Provisión de información y de la variedad de Métodos anticonceptivos de probada eficacia y calidad a la población a través de una red de Trabajadoras Comunitarias, Barberos, Operadoras de Salones de Belleza y otros voluntarios comunitarios de ADOPLAFAM	400.000 Ciclos de Gestágenos Orales 320,000 Condones 800 DIU 7,000 Inyectables Através de : Operadoras de Salones de Belleza Barberos Voluntarios Médicos Asociados	No. De ciclos de Gestagenos distribuidos No. De condones distribuidos No. De DIU colocados No. De Inyectables distribuidos	840, 180 Ciclos de Gestágenos Orales 2,611,635 Condones 2,266 Dispositivos Intrauterinos DIU 14,054 Inyectables 4,890 Tabletas Vaginales 90,855 APP´S (Año Protección Pareja)	**107%**
CUPONES RD$3,925,172.25	Identificación de personas en condiciones de pobreza crítica con necesidades insatisfechas de servicios de Salud Sexual y Reproductiva e Infantil, quienes, previo proceso de depuración, recibirán cupones que le permitan el acceso y uso de los servicios de salud y diagnóstico ofrecidos por el Centrc de ADOPLAFAM.	17,000 Clientes con cupones: Identificados por la Red Comunitaria 100% totalmente gratuitos y 50% pagados a la mitad 70% de clientes con Cupones al inicio del proyecto y reducción al 25% para el último año y continuado por ADOPLAFAM	No. De formularios aplicados No. De Personas Beneficiarias Identificadas No. De Personas referidas de centros hospitalarios No. De cupones distribuidos por año	17,099 Cupones ejecutados en consultas y Diagnóstico 60% de pagos de consultas en efectivo 40% de consultas cubiertas por cupones	**54%**
SUSTENTABILIDAD INSTITUCIONAL	Persigue el desarrollo institucional y seguimientc al Plan Estratégico de Sustentabilidad elaborado, por ADOPLAFAM, através de asistencia tecnica del equipo de CMS.	Sustentbilidad por el Centro Diagnóstico SSR Centro de Adiestramiento 70% de Sustentabilidad al finalizar el período Soporte al Programa para adolescentes y Población pobre Generación de Ingresos Reportes Trimestrales Revisión de Planes anuales	Funcionamiento de un Centro Diagnóstico de SSR Funcionamiento de un Centro de Adiestramiento Gestiones para identificar y captar nuevos donantes Gestión y negociación de contratos venta de servicios Asistencia Tecnica para optar por fondos patrimin. Ingresos por renta de espacios físicos. Incremento de visión empresarial de ADOPLAFAM.	Sustentbilidad por el Centro Diagnóstico SSR No se desarrolló el Centro de Adiestramiento por baja demanda del mercado 60% de Sustentabilidad financiera institucional Redución del espacio dedicado a oficinas para renta de espacios disponibles a otras instituciones Inversiones a plazo fijo para generar ingresos Alianzas para servicios, contratos, nuevos proyectos y venta de métodos anticonceptivos Revisión y reprogramación de Planes Anuales	
AUDITORIA RD$104,000.00					**100%**

METAS Y LOGROS PROYECTO SUSTENTABILIDAD USAID-ADOPLAFAM-JULIO 2001-JUNIO 2004-B

El proyecto está enmarcado en el RI 2.2.1 de la estrategia global de USAID:Mejorada la sustentabilidad de las ONG para continuar la provisión de servicios ala población pobre y a adolescentes.
PRESP. RD$15,725,264.00
EJEC. RD$10,829,056.00
72%

COMPONENTES DEL ACUERDO	DEFINICIÓN OPERACIONAL	METAS ESTABLECIDAS POR ADOPLAFAM EN UNIDAD DE AÑC	INDICADORES CORRESPONDIENTES A LAS METAS	LOGROS ACUMULADOS AL 30 DE JUNIO DEL 2004
CENTRO DIAGNÓSTICO SSR **PRESUP. RD$7,177572.11** **EJEC. RD$4,619,257.00** **55%** **CUPONES** **PRESUP. RD$3,925,172.00** **EJEC. RD$2,554,406.00** **CUPONES + CENTRO = 66% DEL TOTAL GASTOS.**	Aferta de servicios de salud materna e infantil, prevención y atención de enfermedades transmisibles, salud sexual y reproductiva, medicina general y cardiologia. Oferta de servicios de laboratorio automatizados, sonografia, colposcopia y RayosX	10,941 Consultas 25,000 Pruebas de Laboratorio y otras Beneficios al 3er año subsidio cruzado para intervenciones sociales de ADOPLAFAM	No. De Familias Censadas No. De Cupones No. De consultas Cantidad de Médotos anticonceptivos No. De Eqiopos e Instrumentos No. De exámenmes de laboratorio por día No. De sonografía No. De Radiografías Centro funcionando No. De material Educativo de promoción	18,118 Consultas 33,503 Pruebas Diagnósticas Electrocardiografias Corposcopias Programa Calidad servicos PRIME Rayos X
EDUCACIÓN Y ORIENTACIÓN SSR PARA ADOELESCENTES **PRESUP. RD$3,160,311.82** **EJEC. RD$2,095,022.00** **51%**	Programa de capacitación y seguimiento para Adolescentes Multiplicadores que orientan a sus Beneficiarios directos e Indirectos en el retardo de las primera relación sexual, prevención de embarazos y de la ITS/VIH/SIDA , derechos sexuales y reproductivos, autoestima, valores y toma de decisiones prevención de violencia y participación comunitaria.	150 adolescentes multiplicadores capacitados en SSR/ITS/VIH/SIDA 3,000 Beneficiarios directos Padres/Madres/tutires/Líderes que apoyan las actividades del programa Reproducción y distribución de Materiales de IEC Jornadas de retroalimentación Multiplicadores Visitas dominicillarlas a Beneficiarios, Padres y Lideres comunitarios.	No. De Multiplicadores capacitados No. Multiplicadores Recapacitados No. Multiplicadores reportando actividades No. Beneficiarios directos No. Beneficiarios Indirectos No. De Padres/Madres/tutores en jornadas No. Miembros Juntas de Vecinos en Jornadas Materiales Reproducidos y distribuidos No. De Jornadas de retroalimentación Multip. No. Acividades Educativas: charlas, encuentros cara a cara, Visitas Domiciliariasde los Multiplicadores con sus Beneficiarios	Tres capacitaciones para 90 Multiplicadores Recapacitación para 100 Multiplicadores Total de 150 Multiplicadores en 7 Barrios 3,000 Beneficiarios directos 22,000 Beneficiarios Indirectos 30 Jornadas con 800 Padres/Madres/tutores y 800 Miembros de Juntas de vecinos Reproducción y distribución de Materiales de IEC 16 Jornadas de Retroalimentación a Multiplic. sobre SSR, Drogadicción, Teatro, Comunición Interpersonal e Intrafamiliar, Prevención de Violencia 14,400 Actividades Multiplicadores-Beneficiarios
RED COMUNITARIA SSR **PRESUP. RD$1,358,207.82** **EJEC. RD$1,456,371.00** **107%**	Provisión de información y de la variedad de Métodos anticonceptivos de probada eficacia y calidad a la población a través de una red de Trabajadoras Comunitarias, Barberos, Operadoras de Salones de Belleza y otros voluntarios comunitarios de ADOPLAFAM	400.000 Ciclos de Gestágenos Orales 320,000 Condones 800 DIU 7,000 Inyectables Através de : Operadoras de Salones de Belleza Barberos Voluntarios Médicos Asociados	No. De ciclos de Gestagenos distribuidos No. De condones distribuidos No. De DIU colocados No. De Inyectables distribuidos	840, 180 Ciclos de Gestágenos Orales 2,611,635 Condones 2,266 Dispositivos Intrauterinos DIU 14,054 Inyectables 4,890 Tabletas Vaginales 90,855 APP´S (Año Protección Pareja)
CUPONES **PRESUP, RD$3,925,172.25** **EJEC. RD$2,554,406.00** **54%**	Identificación de personas en condiciones de pobreza crítica con necesidades insatisfechas de servicios de Salud Sexual y Reproductiva e Infantil, quienes, previo proceso de depuración, recibirán cupones que le permitan el acceso y uso de los servicios de salud y diagnóstico ofrecidos por el Centro de ADOPLAFAM.	17,000 Clientes con cupones: Identificados por la Red Comunitaria 100% totalmente gratuitos y 50% pagados a la mitad 70% de clientes con Cupones al inicio del proyecto y reducción al 25% para el último año y continuado por ADOPLAFAM	No. De formularios aplicados No. De Personas Beneficiarias Identificadas No. De Personas referidas de centros hospitalarios No. De cupones distribuidos por año	17,099 Cupones ejecutados en consultas y Diagnóstico 60% de pagos de consultas en efectivo 40% de consultas cubiertas por cupones
SUSTENTABILIDAD INSTITUCIONAL	Persigue el desarrollo institucional y seguimiento al Plan Estratégico de Sustentabilidad elaborado, por ADOPLAFAM, através de asistencia tecnica del equipo de CMS.	Sustentbilidad por el Centro Diagnóstico SSR Centro de Adiestramiento 70% de Sustentabilidad al finalizar el período Soporte al Programa para adolescentes y Población pobre Generación de Ingresos Reportes Trimestrales Revisión de Planes anuales	Funcionamiento de un Centro Diagnóstico de SSR Funcionamiento de un Centro de Adiestramiento Gestiones para identificar y captar nuevos donantes Gestión y negociación de contratos venta de servicios Asistencia Tecnica para optar por fondos patrimin. Ingresos por renta de espacios físicos. Incremento de visión empresarial de ADOPLAFAM.	Sustentbilidad por el Centro Diagnóstico SSR No se desarrolló el Centro de Adiestramiento por baja demanda del mercado 60% de Sustentabilidad financiera institucional Redución del espacio dedicado a oficinas para renta de espacios disponibles a otras instituciones Inversiones a plazo fijo para generar ingresos Alianzas para servicios, contratos, nuevos proyectos y venta de métodos anticonceptivos Revisión y reprogramación de Planes Anuales
AUDITORIA **RD$104,000.00**				

METAS Y LOGROS PROYECTO SUSTENTABILIDAD USAID-ADOPLAFAM-JULIO 2001-JUNIO 2004-C

El proyecto está enmarcado en el RI 2.2.1 de la estrategia global de USAID:Mejorada la sustentabilidad de las ONG para continuar la provisión de servicios ala población pobre y a adolescentes.
PRESP. RD$15,725,264.00
EJEC. RD$10,829,056.00
72%

COMPONENTES DEL ACUERDO	DEFINICIÓN OPERACIONAL	METAS ESTABLECIDAS POR ADOPLAFAM EN UNIDAD DE AÑO	INDICADORES CORRESPONDIENTES A LAS METAS	LOGROS ACUMULADOS AL 30 DE JUNIO DEL 2004
CENTRO DIAGNÓSTICO SSR **PRESUP. RD$7,177572.11** **EJEC. RD$4,619,257.00** **CUPONES** **PRESUP. RD$3,925,172.00** **EJEC. RD$2,554,406.00** **CUPONES + CENTRO = 66% DEL TOTAL GASTOS.**	Aferta de servicios de salud materna e infantil, prevención y atención de enfermedades transmisibles, salud sexual y reproductiva, medicina general y cardiologia. Oferta de servicios de laboratorio automatizados, sonografia, colposcopia y RayosX	10,941 Consultas 25,000 Pruebas de Laboratorio y otras Beneficios al 3er año subsidio cruzado para intervenciones sociales de ADOPLAFAM	No. De Familias Censadas No. De Cupones No. De consultas Cantidad de Médotos anticonceptivos No. De Eqiopos e Instrumentos No. De exámenmes de laboratorio por día No. De sonografía No. De Radiografías Centro funcionando No. De material Educativo de promoción	18,118 Consultas 33,503 Pruebas Diagnósticas Electrocardiografias Corposcopias Programa Calidad servicos PRIME Rayos X
EDUCACIÓN Y ORIENTACIÓN SSR PARA ADOELESCENTES **PRESUP. RD$3,160,311.82** **EJEC. RD$2,095,022.00** **19%**	Programa de capacitación y seguimiento para Adolescentes Multiplicadores que orientan a sus Beneficiarios directos e Indirectos en el retardo de las primera relación sexual, prevención de embarazos y de la ITS/VIH/SIDA , derechos sexuales y reproductivos, autoestima, valores y toma de decisiones prevención de violencia y participación comunitaria.	150 adolescentes multiplicadores capacitados en SSR/ITS/VIH/SIDA 3,000 Beneficiarios directos Padres/Madres/tutires/Líderes que apoyan las actividades del programa Reproducción y distribución de Materiales de IEC Jornadas de retroalimentación Multiplicadores Visitas dominicillarlas a Beneficiarios, Padres y Lideres comunitarios.	No. De Multiplicadores capacitados No. Multiplicadores Recapacitados No. Multiplicadores reportando actividades No. Beneficiarios directos No. Beneficiarios Indirectos No. De Padres/Madres/tutores en jornadas No. Miembros Juntas de Vecinos en Jornadas Materiales Reproducidos y distribuidos No. De Jornadas de retroalimentación Multip. No. Acividades Educativas: charlas, encuentros cara a cara, Visitas Domiciliariasde los Multiplicadores con sus Beneficiarios	Tres capacitaciones para 90 Multiplicadores Recapacitación para 100 Multiplicadores Total de 150 Multiplicadores en 7 Barrios 3,000 Beneficiarios directos 22,000 Beneficiarios Indirectos 30 Jornadas con 800 Padres/Madres/tutores y 800 Miembros de Juntas de vecinos Reproducción y distribución de Materiales de IEC 16 Jornadas de Retroalimentación a Multiplic. sobre SSR, Drogadicción, Teatro, Comunición Interpersonal e Intrafamiliar, Prevención de Violencia 14,400 Actividades Multiplicadores-Beneficiarios
RED COMUNITARIA SSR **PRESUP. RD$1,358,207.82** **EJEC. RD$1,456,371.00** **13%**	Provisión de información y de la variedad de Métodos anticonceptivos de probada eficacia y calidad a la población a través de una red de Trabajadoras Comunitarias, Barberos, Operadoras de Salones de Belleza y otros voluntarios comunitarios de ADOPLAFAM	400.000 Ciclos de Gestágenos Orales 320,000 Condones 800 DIU 7,000 Inyectables Através de : Operadoras de Salones de Belleza Barberos Voluntarios Médicos Asociados	No. De ciclos de Gestagenos distribuidos No. De condones distribuidos No. De DIU colocados No. De Inyectables distribuidos	840, 180 Ciclos de Gestágenos Orales 2,611,635 Condones 2,266 Dispositivos Intrauterinos DIU 14,054 Inyectables 4,890 Tabletas Vaginales 90,855 APP´S (Año Protección Pareja)
CUPONES **PRESUP, RD$3,925,172.25** **EJEC. RD$2,554,406.00** **23%**	Identificación de personas en condiciones de pobreza crítica con necesidades insatisfechas de servicios de Salud Sexual y Reproductiva e Infantil, quienes, previo proceso de depuración, recibirán cupones que le permitan el acceso y uso de los servicios de salud y diagnóstico ofrecidos por el Centro de ADOPLAFAM.	17,000 Clientes con cupones: Identificados por la Red Comunitaria 100% totalmente gratuitos y 50% pagados a la mitad 70% de clientes con Cupones al inicio del proyecto y reducción al 25% para el último año y continuado por ADOPLAFAM	No. De formularios aplicados No. De Personas Beneficiarias Identificadas No. De Personas referidas de centros hospitalarios No. De cupones distribuidos por año	17,099 Cupones ejecutados en consultas y Diagnóstico 60% de pagos de consultas en efectivo 40% de consultas cubiertas por cupones
SUSTENTABILIDAD INSTITUCIONAL	Persigue el desarrollo institucional y seguimiento al Plan Estratégico de Sustentabilidad elaborado, por ADOPLAFAM, através de asistencia tecnica del equipo de CMS.	Sustentbilidad por el Centro Diagnóstico SSR Centro de Adiestramiento 70% de Sustentabilidad al finalizar el período Soporte al Programa para adolescentes y Población pobre Generación de Ingresos Reportes Trimestrales Revisión de Planes anuales	Funcionamiento de un Centro Diagnóstico de SSR Funcionamiento de un Centro de Adiestramiento Gestiones para identificar y captar nuevos donantes Gestión y negociación de contratos venta de servicios Asistencia Tecnica para optar por fondos patrimin. Ingresos por renta de espacios físicos. Incremento de visión empresarial de ADOPLAFAM.	Sustentbilidad por el Centro Diagnóstico SSR No se desarrolló el Centro de Adiestramiento por baja demanda del mercado 60% de Sustentabilidad financiera instituciona Redución del espacio dedicado a oficinas para renta de espacios disponibles a otras instituciones Inversiones a plazo fijo para generar ingresos Alianzas para servicios, contratos, nuevos proyectos y venta de métodos anticonceptivos Revisión y reprogramación de Planes Anuales
AUDITORIA **RD$104,000.00**				

MUDE

Overall, MUDE is well on its way to successful achievement of project goals by EOP. MUDE has likely achieved more project results than suggested by the following evaluation graphics. For example, although this was apparently not captured by the indicators, MUDE increased its geographical penetration and grew its voluntary network from roughly 260 promoters in 2001 to 450 as of October 2004, an impressive achievement, especially noting ADOPLAFAM declines in this capital base over the same period (likely related to ADOPLAFAM's choice to invest in building the diagnostic center).

MUDE began the project with 26 percent sustainability (according to the project indicator) and achieved a 68-percent level as of October 2004. This should be seen as strong performance, especially under the projects constraints addressed earlier. The graphics on the following pages deepen the presentation of MUDE's application of the grant to activities (compared to quarterly and annual reports). MUDE has performed remarkably within the constraints identified in the report. The organization's major concern is sustainability of SP/CD under the HSR and scenarios of transition within the SR section.

PRIME's assistance is highly regarded in training volunteers, in strengthening the network, and where client service questionnaires were developed and continue to guide decisions and improvements in QA/QC.

Compared to the other two NGOs, MUDE's business model has been affected most by shortcomings in business planning TA. The suggestion to implement horizontal strategies (an approach where different products are identified for sale to an already-captured market) was intended for revenue generation—in this case beauty supplies—and was not appropriate (see also the 1999 study by Cuellar, et. al, evaluating the Development Associates contract at EOP).

The micro-finance component is a fine example of MUDE's business model. However, as Benton and Monroy state, "[b]ecause high margins and significant sales volume are necessary to generate income, a cross-subsidy scheme may not succeed in a small, low-income country." (17). As positioned in the project, cross-subsidy under the same roof is a distraction to some extent with MUDE's focus on health objectives.

Micro-finance would flourish outside of its current institutional environment, where MUDE's social goals could be leveraged to impressive levels in a 10-year time frame. Reaching a US$ 20 million credit portfolio is a realistic 10-year goal.

Mujeres en Desarrollo Dominicana, Inc.
Reproductive Health Program 2004

Grant Objectives

(Taken from USAID Grant Agreement 517-G-00-01-00117-00)

1. Better access to quality reproductive health services for 75,000 rural poor women reproductive age.

- 1.1 Increase the size of the volunteer network by identifying and training 116 additional volunteers
- 1.2 Reinforce coupon and referral system
- 1.3 Introduce wholesalers and distribution units for health products in rural areas

2. Increased availability of health products and services in rural areas.

- 2.1 Identification and introduction of new services and products to diversify the supply and increase the organization's presence in the rural market.

3. Increased demand for contraceptives and related services.

- 3.1 Implementation of a social marketing campaign for reproductive health services to increase the demand for contraceptives and related services.

4. Increased institutional capacity to sustain health programs.

- 4.1 Construction of a health fund.
- 4.2 Increase efficiency by introducing new strategies.
- 4.3 Training to improve the technical capacity of project staff and volunteer network.
- 4.4 Establishment of a price structure based on cost analysis and profit margins.
- 4.5 Introduction of control tools to ensure quality services.

Program Activites

- * Volunteers added to network by a recruitment and selection process
  * Volunteers trained in a variety of topics through seminars, courses, talks, group dynamics and supporting materials
  * Network coordination occurred regularly
  - ◆9 ◆7
- * Inter-Institutional agreements reached
  * Coupons and referrals distributed
  - ◆11 ◆12 ◆13
- * Feasibility study realized to identify areas of instalation of wholesalers
  * Distribution units established through volunteer promoter network
  - ◆7 ◆10 ◆6
- * Inter-institutional agreements reached, ex. with PSI for the sale of Pante condoms.
  * Studies realized to identify demand for health products and services
  - ◆3 ◆2 ◆10
- * Comunity Coordinators trained in social marketing
  * Marketing studies realized for identified products
  * Social marketing tactics employed
  - ◆9 ◆7
- * Plans elaborated to ensure the successful use of cross-subsidization funds
  * Financial projections elaborated
  * Fund SUMMA created to support future health programs
  - ◆3 ◆4
- * Physical and operational improvementes made to warehouses and production centers
  * Bakery production expanded in size and products
  * Personel trained in the use of new equipment
  * Product quality surveys and evaluations realized
  * Staff and volunteers trained in client service and quality management
  * System of growth indicators established and used regularly
  * Internal management mechanisms established
  - ◆14 ◆3 ◆1 ◆5
- * Staff trained in eficiency and quality control
  * Volunteers trained in business management, quality service and effective social marketing
  - ◆9 ◆14
- * Production process and costs analyzed
  * Production plans adjusted regularly
  - ◆12 ◆3 ◆5
- * Internal control standards established
  * Quality surveys applied regularly
  - ◆14 ◆5

Each volunteer is responsible for a certain number of families in their community. Volunteers learn about guidance and counseling, family planning, reproductive health, and community building.

Coupons and referrals were redeemed for additional health services at partnering institutions.

The study revealed a need to refocus efforts towards other distribution methods.

Products studied include shampoo and conditioner, analgesics, menthol, and honey soap.

Marketing tactics included product branding, the distribucion of promotional materials and community events.

To date, the SUMMA health fund totals US$21,410. Cross-subsidization is possible thorugh credit, bakery and contraceptive sales.

The bakeries now offer five different producs to local markets.
Growth indicators include income from sales, sales volumes, costs, and percentage of market share.

Internal management mechanisms are centered on production processes, distribution mechanisms, and administration procedures.

Project staff and volunteers now have the capacity to monitor quality, capture local markets, and manage production processes.

Plans are adjusted taking into account market shifts, cost of production and demand projections.

Internal controls include inventory management, production supervision and distribution mechanisms.

◆ Indicators	Results
Organization Sustainability Indicators	
1. Percentage of organizational financial sustainability	2001 > 19% 2004 > 50%
2. Donor Diversity: number of projects approved by international and local agencies between 2001-2004	28 projects awarded
3. Net income of the institution, by component	--Bakeries > 4,033,675 --Contraceptive Sales > 1,855,934 --Credit > 2,639,555
4. Total of Health Fund	US$21, 410
5. Percentage of Profitability by component	--Bakeries > 25% --Credit > 22%
Program Outcome Indicators	
6. Number of health services beneficiaries	150,010 Total, includes: Health Operatives Referrals Family counseling Comunity Promotion Contraceptives
7. Number of new volunteer promoters	233 Total Number volutneers 2001 > 217 Number volunteers 2004 > 450
8. Number of youth beneficiaries	2,799
9. Total number of people trained and types trainings offered	18,531 6 Major Components
10. Numbers and types of contraceptive methods distributed	Condoms > 1,4636,80 Depoprovera > 2,268 Oral > 142, 080 AQV > 700 Norplant/ DUI > 381
11. Number of APPs	Condoms > 97,578 Depoprovera > 567 Oral > 9,742 AQV > 70 Norplant/ DUI > 109
12. Average cost of APPs	RD$221 (Sept. 2002 est.)
13. Numbers of coupons distributed	1,081
14. Percentage of beneficiaries responding positively in surveys about quality of services received	--Formal surveys 70% --Informal surveys 100%

Profamilia

Profamilia, as shown by the evaluation graphic that follows, has addressed project goals largely successfully and appears likely to complete them by EOP. The NGO built two clinics under the project, increasing the number of clinics to seven. This was very wise, both for USAID and for Profamilia. Certainly, changes in the product arena where Profamilia plays a major role have affected project performance in those areas (see the sections on social marketing). Nonetheless, Profamilia has struggled and performed well in this arena. The organization has also successfully planned to penetrate the HMO level of the HSR, where this should prove to be an important threshold in Profamilia's growth.

Profamilia had already achieved 71 percent sustainability at project start-up; as of October 2004, its sustainability level had increased to 89 percent. It is well known that successive improvements become more difficult to achieve as sustainability levels climb. Profamilia has indeed set the standard for sustainability; however, this view should acknowledge that MUDE and ADOPLAFAM are not integrated backward into the clinic platform, a key factor that determines ability of an enterprise to generate revenue.

What distinguishes Profamilia from the rest is that the NGO successfully pursued a brick and mortar clinic base, and from that “backward integrated” position in the health sector was always mindful of the SP/CD factors as important components of the overall model. Revenue is more reliably earned under an enterprise strategy of clinic ownership.

While Profamilia did not request much in the way of CMS business planning TA, it is nonetheless worthwhile to review Profamilia’s business planning approach. Profamilia does not accept many offers for partnership, as staff is limited and previous experience has taught the organization to be prudent. Once Profamilia commits to a task, however, its staff's staunch commitment to the success of their tends to overcomes obstacles and prevail.

One of Profamilia’s imprimaturs is that within its global business model, Profamilia knows how to phase the critical elements of a project through leveraging factors along the critical path until all the pieces of the puzzle are complete and everyone is ready to play. Some description of project related achievements outside the logical framework are perhaps worth mentioning.

La Sierra (LS)

La Sierra is formed by 22 community groups in the surrounding areas; Profamilia successful manages the only aqueduct in the zone. The clinic concept began when the president of the Federation met Profamilia’s president during the 1990s in a meeting in North Santiago. The Federation president asked Profamilia’s Director of Competitive Strategy to work with him in RH/FP. Profamilia began meetings, the federation made an offer, and Profamilia formed a joint venture in the space to be built by the Federation. Prior to its completion, Profamilia rented a clinic space and paid a nurse. Profamilia’s hospital in Santiago has long played a supporting role and continues to send a team each week to attend the higher level medical load.

Profamilia was attracted by the clarity of needs presented by a unified community and recognized that 25 percent of the LS population was traveling four hours round trip for RH services—75 percent of the population's RH needs went unattended. Profamilia's investment was to be equipment, start-up costs, and staff. The business model is based on the integration of the community working to capture clients/patients through pre-paid services for sonograms, primary medicine, and so on. As a component of Profamilia's Regional model, LS is a feeder. The model uses offsets of marketing by the feeder against the Santiago hospital's marginal costs in service delivery. A doctor from the Santiago hospital only charges for medical service at marginal cost, where normally procedures start at RD$150 in pediatrics, GYN, pap smear, etc. Sonograms cost RD$225. It is worth noting that over time, the LS business formula is proving successful. Yet each of Profamilia's business formulas applied to the seven clinics is an independent business formula; this tailoring of business formulas to each profit center is complex insofar as it is a "bottom up" model, appropriately built and adapted to accommodate the unique features impacting each clinic.

San Francisco de Macorís en Duarte

This clinic started in 1998/99 through an offer negotiated between a Profamilia social promoter and the Rotary Club (CR). CR had a shell intended to be a clinic and asked that Profamilia to form a private/public partnership with PFCR, as SESPAS offered the clinic shell. Because the shell was assigned to CR and SESPAS would contribute doctors, Profamilia presented and negotiated their contribution as "everything else." Profamilia already had the workplan in place; at that time, Profamilia did not have the equipment, but had a clear business plan and was able to respond to unanticipated events (such as the change in government). Profamilia continues to be known for taking care of business and for not letting partners down.

Sabana Perdida (SP)

Sabana Perdida began when Magaly Caram interrupted a meeting one day and said, "I am buying a clinic and it is a very good price." Profamilia had already undertaken a market study for health services in Santo Domingo and Santiago de los Caballeros under the previous USAID contract. These studies had recommended a hospital in Santo Domingo and feeder clinics within nearby urban populations. Profamilia's reaction to the study was to reject these financial requirements because they were outside Profamilia's reality and, as such, the project was not feasible as planned.

Sensitive to these limiting parameters, Profamilia knew exactly what buying this clinic out of bankruptcy offered. It was not an emotional or capricious reaction upon learning about the clinic's availability; on the contrary, the organization had been preparing itself for two years. Profamilia already had a track record of community health projects in the SP neighborhood, which this reinforced the numbers that made good sense.

Profamilia discovered the SP opportunity was immediately following the presentation of its "Strategic Plan 2001-2005" to USAID; together with the workplan for the same period. These plans considered a clinic in the East of Santo Domingo for which very serious

planning had preceded their commitment. Yet Profamilia knew they could not implement the scale of medical centers suggested in the study, so instead, they modified their business model to scan the environment for opportunities on a smaller, “clinic level” scale.

The owner of the failed clinic in SP negotiated with Profamilia at the same time they launched a very rapid update for the earlier market study. Profamilia deepened the market study to include opinion leaders (it was done so thoroughly that statistical tests were not necessary).

During the three-month period of the purchase, it is difficult to convey the levels of simultaneous multi-tasking that occurred; for example: providing an on-time availability of land title, history, legal issues, civil engineering structural analysis—and bringing Profamilia’s Board of Directors along each step of the way. At that time, Profamilia had built a budget tied to the USAID grant agreement for operating expenses. The purchase price, however, was arranged with Profamilia equity.

Review of SP reveals a buffet of opportunities that would evaluate the experience positively, including community leadership through ACOPRO, outreach by clinic staff (doctors, nurses, psychologists, etc.) with visits into the surrounding neighborhoods, and many other intimate connections in the community. Profamilia has successfully launched youth programs from the SP base—partly supported by the overall warmth and approachability of the clinic and the community.

While successful clinics delivering health services can achieve project goals and objectives for many different reasons, one piece of SP’s success is Profamilia’s commitment to the personal style of management by the clinic director. Profamilia reports through observing a level of social interaction among vertical levels of staff across their functions and between staff and clients, and a flow of decisions and medical services with easy communication between clients and staff.

USAID has helped Profamilia to achieve many important results through the project. And Profamilia takes its grant responsibilities seriously as per their successful achievement of those same goals.

PROFAMILIA, INC.

Resumen Indicadores, y su cumplimiento, compromisos contractuales de la Institución con el USAID RFA No. 517 - 01 - 007
Para el Período Julio 1, 2001 a Junio 30, 2004

Plan Estratégico USAID

IR2.2 Sustainable, effective reproductive health/family planning services provided by public and private sectors

2.2.1 Improved NGO sustainability to continue provision of quality services for the poor and adolescents

2.2.3 Improved RH policy environment

Metas componentes de PROFAMILIA dentro del RFA No. 517 – 01 - 007		Definición Operacional Indicadores	LOGROS
Indicadores	**Resultados Esperados (EOP's)**		
1 Adolescentes, Multiplicadores Voluntarios (MV's), entrenados/as, trabajando en educación sexual con sus pares	240	Adolescentes y Jóvenes de cada barrio, seleccionados y entrenados, ejecutando acciones de IEC, consejería, referimiento y distribución anticonceptivos con sus pares	240
2 Adolescentes, Beneficiarios Directos (BD's), servidos con acciones de educación sexual y salud reproductiva así como referimientos a centros de atención clínica	9,600	Adolescentes y Jóvenes "enrolados" por los MV's recibiendo acompañamiento directo y sistématico (por lo menos habiendo participado en 4 jornada educativa, referimientos y distribución anticonceptivos).	7,582
3 Adolescentes, Beneficiarios Indirectos (BI's), contactados mediante acciones de IEC sobre educación sexual y salud reproductiva	23,400	Adolescentes y Jóvenes que han participado en algun tipo de charla educativa y/o orientación dadas por los MV's en los barrios seleccionados.	40,232
4 Líderes comunitarios, maestros/as y padres de los/as MV's y comunidades de intervención, sensibilizados e informados sobre educación sexual y SS&R	1,740	Adultos/as, padres de los MV's, líderes y técnicos/as de los barrios de influencia del proyecto, trabajados/as directamente por el proyecto con acciones de información, sensibilización y educación.	2,496
5 Años Protección Pareja (APP's) provistos a través de los componentes clínicos y el componente comunitario para adolescentes	39,490	Años Protección Pareja resultante de los anticonceptivos distribuidos/ejecutados directamente mediante los componentes del proyecto.	21,070
6 Consultas de planificación familiar, salud sexual y reproductiva y materno-infantil ofertadas en los componentes clínicos	63,035	Consultas de evaluación para anticoncepción, de ginecología, papanicolaou, control obstétrico e infantil, y vacunación, dadas en los componentes del proyecto.	49,614
7 Otras consultas y servicios de diversificación ofertadas en los componentes clínicos	97,845	Consultas de medicina general, pruebas laboratorio, medios diagnóstico y servicios odontologicos, dados en los componentes del proyecto.	84,881

Plan Estratégico USAID

IR2.2 Sustainable, effective reproductive health/family

Metas componentes de PROFAMILIA dentro del RFA No. 517 – 01 - 007

Indicadores	Resultados Esperados (EOP's)	Definición Operacional Indicadores	LOGROS
8 Servicios pre-pagados (cupones) para población, adulta y adolescente, en pobreza crítica, distribuidos y ejecutados	27,535	Total de servicios ejecutados (otorgados) vía cupones, a población pobre e indigente, adulta y adoslescente.	28,043
9 Nivel de sustentabilidad financiera institucional alcanzado	90%	Total de gastos de operación de la institución (excluidos los gastos de inversión, los proyectos con financiamiento especiales y los gastos de depreciación)/el total de ingresos generados	90%
10 Cantidad aproximada de condones entregados a ONG's que trabajan con VIH/SIDA	2,200,000	Condones a ser vendidos exclusivamente a otras ONG's, trabajando en PF y VIH/SIDA.	618,349
11 Número de establecimientos [de PROFAMILIA] que proveen servicios de SS&R para adolescentes y jóvenes	***3***	***Clínicas de PROFAMILIA ofreciendo atención especializada para adolescentes entre 12 y 19 años de edad.***	***3***
12 % de clientes adolescentes atendidos/total de clientes atendidos en los centros de servicios.	***18%***	***Adolescentes que reciben [en un período] atención especializada/total de clientes atentidos en cada centro de PROFAMILIA.***	***18%***
13 % de clientes pobres atendidos en los centros propios/total de personas atendidas (en dichos centros).	***5%***	***Personas atendidas con algún servicio mediante el sistema de cupón o prepagado/total de clientes atentidos en cada centro de PROFAMILIA.***	***3%***

Notas:

(1) Los datos de los indicadores 1, 2, 3, 4, 5, 6, 7, 8, 10 y 11 son hasta el 30 de Junio del 2004.

(2) Los datos de los indicadores 9, 12 y 13 son hasta Diciembre 31, 2003 ya que son obtenidos anualmente dentro del período fiscal de PROFAMILIA.

VI. Management and Human Resources

Proper assessment of management and deployment of human resource assets and staff capabilities is a demanding task that requires a scope of work in organizational diagnosis. The evaluation frameworks built by the NGOs and the organizational development consultant permitted a working knowledge of staff from all levels of the organizations and was a useful way to understand how each functions (particularly within the central corporate offices).

All of the NGOs share some common managerial and organizational themes. All three NGOs are highly professional organizations, from the CEOs the staff. Perhaps it is leadership setting an example for staff, yet the valence of behavioral themes suggests a cultural level driving this as well, one with a long social history and shared values. The result is cohesive organizations where bureaucracy is minimized and decision-makers are willing to allow emerging needs to guide their efforts. Observing staff adjust flexibly over the course of the day makes evident their ability to adapt to an often unpredictable environment. These observations hold true for all NGOs, and speaks very well for USAID's long term partnership with them.

The following section describes organizational issues for each of the three NGOs.

ADOPLAFAM

ADOPLAFAM has both benefited and suffered more than the others during the project. The long-term benefits and wisdom of investing just under 70 percent of project funds to finally achieve actual ownership should not be underestimated; neither should the shrinking of its voluntary social network from perhaps 1,500 to 600 during the same period (substantial effort is already underway to rebuild). ADOPLAFAM applied a very strict interpretation of the sustainability indicator to its operations, with less than ideal consequences.

ADOPLAFAM is viewed by many as the most centrally managed of the three NGOs. Yet where ADOPLAFAM's CEO is the founder—ADOPLAFAM is largely the result of his vision—nonetheless, leadership is shared to a higher degree among more of the staff than is the case with the other NGOs. In addition, ADOPLAFAM is perhaps more organically deployed of the three; this is appropriate given their commitment to build and operate the diagnostic center.

The emergence of the diagnostic center required an available pool of high level resources for the launch and "beta" period of operation. Not unlike the fire department, the best example of organization of required resources immediately available to deploy in life threatening situations, ADOPLAFAM could not anticipate what would be needed, nor when. It would appear that the "beta" period, interrupted by the crisis, is now under control. It is also likely that a transition is now underway that will thoughtfully return direct reports to the CEO to a more predictable agenda, one that will include more attention to rebuilding voluntary social networks.

ADOPLAFAM demonstrated the deepest use of delegated authority among the widest number of staff producing the evaluation framework. It was also one where the staff insisted on building it according to "their" criteria versus direction from the OD consultant. Their ownership and fluid distribution of tasks revealed the highest application of teamwork of the three NGOs as well.

The notion of centralized leadership then, at least as observed during 10 days from start to finish for the evaluation framework, is least seen in ADOPLAFAM compared to the other NGOs. Perhaps a perception of centralization is better reflected by ADOPLAFAM's application of SP/CD models, where in this case, the CEO weighs-in heavily.

The CEO travels frequently and sometimes for periods longer than one month. Leadership acting in his absence is distributed among four direct reports. The CEO has delegated "acting" authority to each during these extended absences over the life of the project. His ability to do this would suggest more widespread reliance on others than is thought.

ADOPLAFAM's human resource base in its central office decreased roughly from 25 in 2001 to 17 in 2004. Also over the same period ADOPLAFAM decreased costs and generated revenue by splitting its central office, renting the larger section to an institutional tenant, and moved to a smaller space within the same property. Now as it transitions toward balancing the diagnostic center with its countrywide SP/CD capabilities, human resources are better able to direct attention and support that task.

ADOPLAFAM's organization chart (see Annex F) is based on functions; however, its organic capability for mobilizing around emerging needs is not revealed as shown.

MUDE

MUDE's management and organizational dynamics have matured over the LOP. MUDE grew its SP/CD penetration both in numbers of promoters/trainers (260 to 450), and expanded its geographical coverage. MUDE's deployment of human resource assets is more disbursed into regions instead of centralized at the corporate office. This ability to expand and deploy more deeply into the regions is especially valuable and remarkable given the difficult situation over the LOP with respect to the crisis. MUDE, with USAID's support, managed this very well.

MUDE's corporate office is well led by its CEO and direct reports to her are extremely capable and highly motivated. MUDE utilizes its BOD actively and effectively; this serves as a very important boundary-spanning tool for linking MUDE, as needed, with important Dominican networks. MUDE has wisely used Peace Corps Volunteers, an important factor leveraging staff during the crisis.

MUDE has shown excellent results recruiting high level professional talent, extraordinary talent. Such was the case for the planning directors, the Peace Corps Volunteer who moved on as Peace Corps staff, and the new director. The evaluation framework was built by the new planning director, a Dominican-American with a Master's degree in Planning. The long-term professional staff is also exceptionally talented and capable in their function—MUDE has distinguished itself in acquiring such talent.

As shown in MUDE's organization charts (2002 and 2004), microfinance is taking up more space and prominence over the period. This is not surprising, since cross-subsidization was

encouraged. The microfinance component has been a success; however, it would be wise to consider the potential for this split mission to compromise MUDE's health goals at some point, as well as the anticipated profit from the microfinance component not being fully realized.

Profamilia

Profamilia uses a relatively flat organization structure where the human resource assets are largely operating under the four major divisions. Substantial delegation of authority is required for this and it functions well. Testimony to this is the CEO's availability and freedom to manage the environment (with heavy demands on her schedule) as she is known to do. Yet underlying this delegation is her monitoring of strategic results—online/real-time before key results are reported. The CEO is a solid leader and manager, with uncanny instincts for business. One commonly-held observation, that the CEO style is centralized, should take note of the CEO's reliance and partnership with the director of project strategy. This is a very important factor to build into a more balanced view of Profamilia's management dynamics "at the top."

Profamilia uses a classic mix of pre-determined functions with solid procedures and slack resources at the top able to react when unanticipated things happen. The organization structure and staff capabilities are well balanced for this mix.

Because Profamilia operates on a larger scale, it can decrease demands seen in other NGOs to multi-task and job-band, relying on a larger staff. It would seem that Profamilia has reached its health threshold, causing an economy of scale at this point of clinic growth under the USAID project. USAID has played a major role in this by wisely facilitating Profamilia's growth from five to seven clinics.

Profamilia's self confidence was demonstrated by the organization's lack of interest in the business planning TA, and by the development of their own client satisfaction instruments for QA/QC instead of relying on PRIME, where PRIME excelled at building these instruments. Profamilia has achieved a very high level of management competence and successful implementation of its strategy.

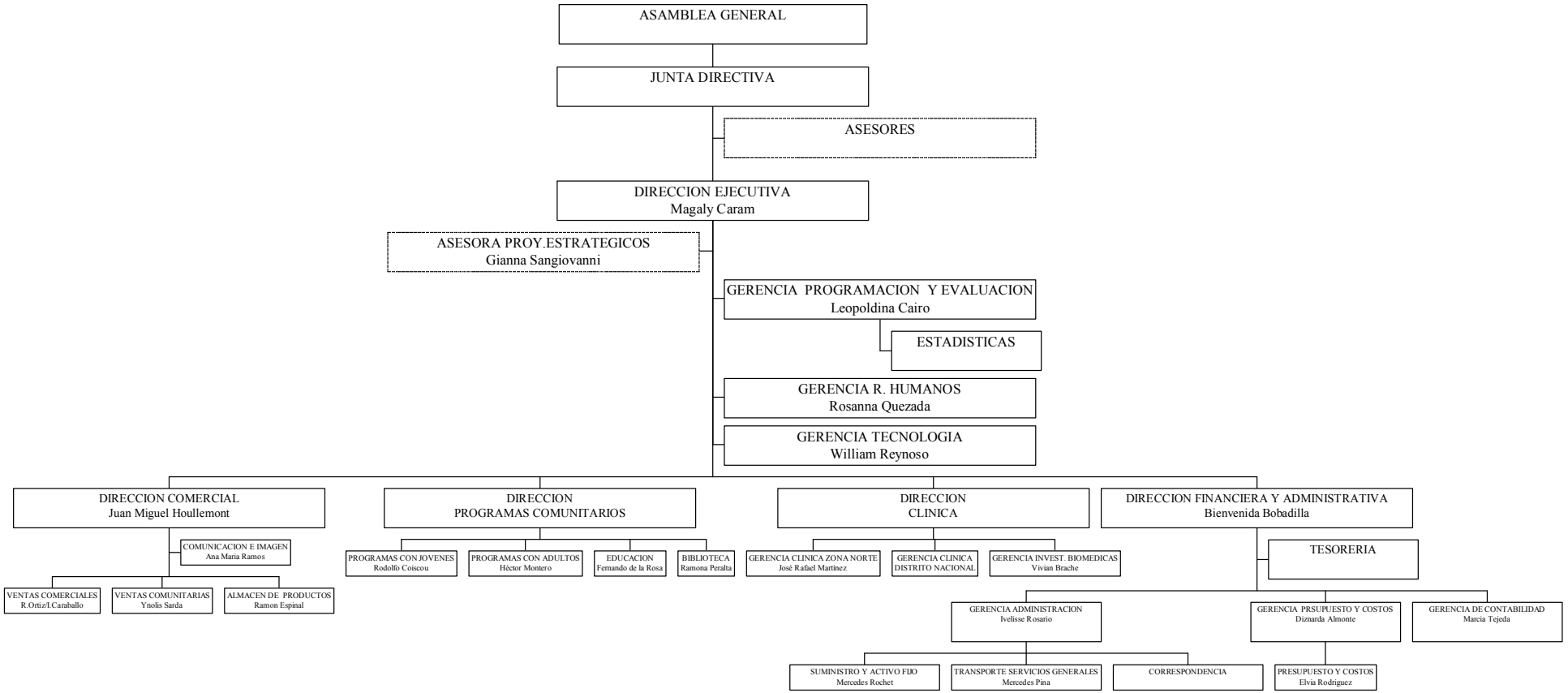
Overall, the management, professionalism, and deployment of human resources of the three NGOs is commendable. With respect to the Dominican Republic, this would hold true throughout the public or private sector.

Annex F. NGO Organization Charts

ADOPLAFAM Organization Chart
MUDE Organization Chart (2002 and 2004)

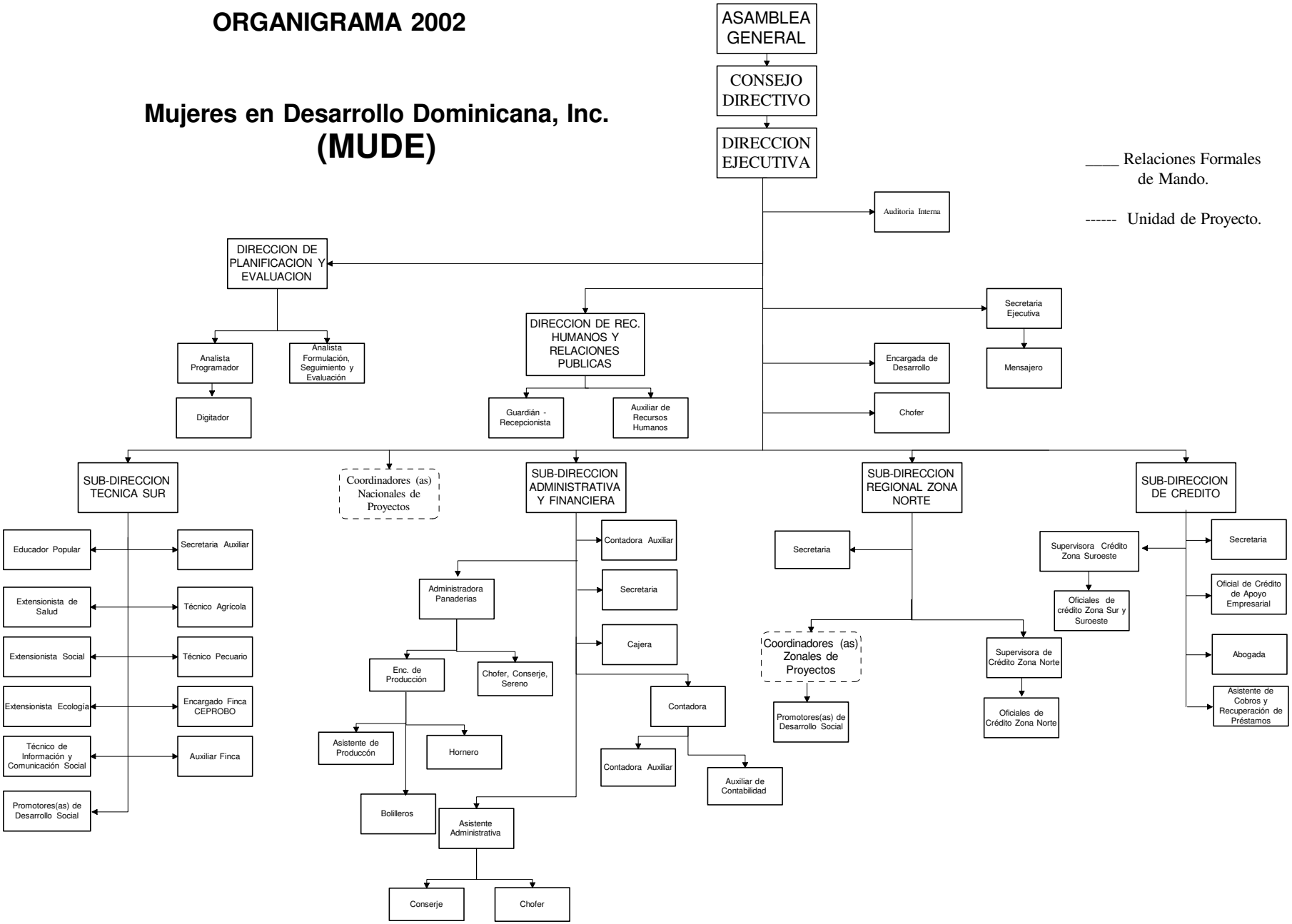
ASOCIACION DOMINICANA PROBIENESTAR DE LA FAMILIA, INC.

Estructura Organizacional a julio 2003

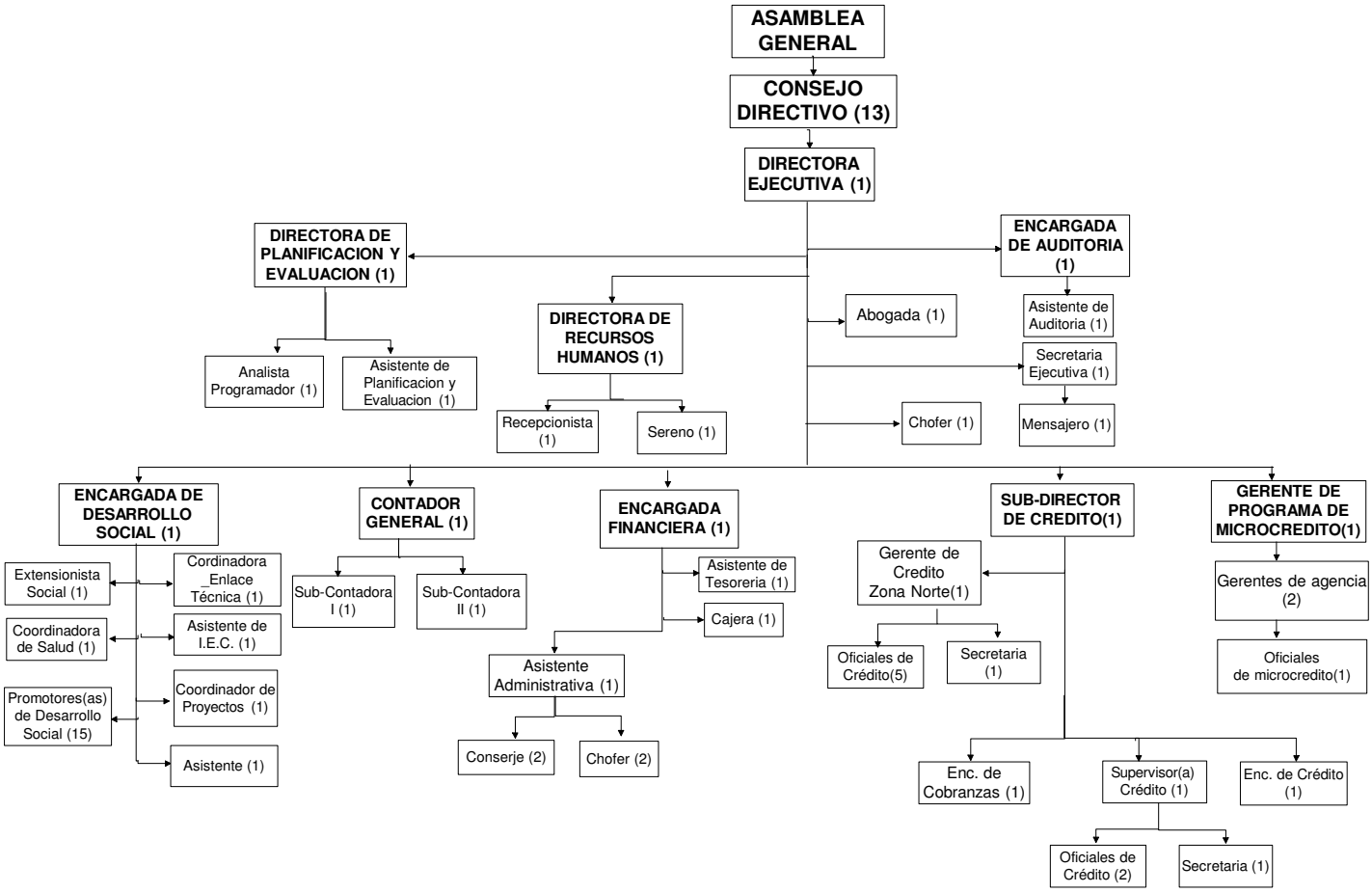


ORGANIGRAMA 2002

Mujeres en Desarrollo Dominicana, Inc.
(MUDE)



Enero 2002



ORGANIGRAMA- 2004

Mujeres en Desarrollo Dominicana, Inc. MUDE

Annex G. Financial Analysis, Spanish Version (F. Vásquez)

INFORME FINAL
ANALISIS FINANCIERO DEL PROYECTO DE SUSTENTABILIDAD

Franklin Vásquez, Consultor
Initiatives/USAID

Santo Domingo, R.D.
10 de Octubre del 2004

INDICE

ESTRATEGIA DE LAS ONG´S EN SALUD REPRODUCTIVA/PLANIFICACION FAMILIAR
INFORME DE ANALISIS FINANCIERO

INTRODUCCION

Este reporte forma parte del Reporte Final que Initiatives debe presentar a la USAID como resultado de la evaluación que le fuera contratada. Dicha evaluación consistió en identificar los avances logrados por el Proyecto de Sustentatibilidad mediante el cual tres ONG´s recibieron asistencia técnica y soporte financiero. Las ONG´s que recibieron asistencia técnica fueron: a) La Asociación Dominicana Pro-Bienestar de la Familia, Inc. –PROFAMILIA-, b) Mujeres en Desarrollo Dominicana, Inc. (MUDE) y c) La Asociación Dominicana para la Planificación Familiar, Inc. (ADOPLAFAM).

La evaluación tiene tres ámbitos específicos: 1) Evaluar el Desarrollo Organizacional de las ONG´s; b) Realizar un análisis financiero del Proyecto y 3) Evaluar el Mercadeo de Servicios de las ONG´s.

El presente reporte abarca específicamente el análisis de la situación financiera, enfocando la evaluación del comportamiento de los ingresos, la evolución de los gastos, el rol de los donantes, el papel del Proyecto de Sustentabilidad, así como el análisis de los indicadores financieros que se definieron en el proyecto.

RECONOCIMIENTOS

Este reporte fue elaborado gracias a la colaboración de las ONG´s analizadas, y del personal que en ellas labora. En PROFAMALIA debemos agradecer especialmente a la Señora Magaly Caram, Directora Ejecutiva de la entidad, así como a la Lic. Bienvenida Bobadilla, Subdirectora Financiera y Administrativa, y a la Señora Gianna Sangiovanni, Asesora de Proyectos Estratégicos. Su disposición a suministrarnos toda la información solicitada, y el tiempo que dedicaron a responder cada una de las preguntas que realizamos, fue particularmente valiosa.

En MUDE nuestros agradecimientos para su Directora Ejecutiva, Lic. Rosa Rita Álvarez, quien puso todo el empeño en que obtuviéramos las informaciones necesarias. Su equipo de trabajo conformado por la Lic. Graciela Castillo y por el Lic. Juan Méndez fue más que necesario para lograr nuestros objetivos.

En el caso de ADOPLAFAM se destaca la incorporación de una parte importante del equipo de trabajo de la institución en este proceso. De manera particular, nuestros agradecimientos al Dr. Ramón Portes, quien mostró bastante entusiasmo y motivación por darnos el apoyo requerido. Gracias adicionales en ADOPLAFAM para el Lic. Jesús Emilio Corletto, Auditor Interno y Encargado de Sostenibilidad y para la Lic. Marta Irenes de Salas, Gerente Financiera, por sus valiosas y sinceras contribuciones.

También, queremos reconocer la contribución brindada por la Señora María de Moya, Ex – Coordinadora del Proyecto de Comercial Market Strategies (CMS), sin la cual no hubiéramos podido contar con datos, informaciones e ideas tan precisas.

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De manera particular, queremos reconocer al equipo de trabajo que participó en esta evaluación. A María Mamlouk, nuestra TeamLeader, cuyos conocimientos y experiencia fue suficiente para impulsar al equipo a obtener los resultados deseados; a Betty Ravenholt, nuestra especialista en Marketing Services, siempre dispuesta a discutir las ideas y a contribuir en beneficio de la evaluación; y a David Schrier, experto en Desarrollo Organizacional, quien siempre quiso ir un poco más allá de los objetivos planteados, tratando de aportar elementos nuevos al proceso. A todos ellos les agradezco por permitirnos ser parte de este gran equipo.

Finalmente, a Initiatives, en la persona de la Señorita Jaime Jarvis, quien desde lejos estuvo apoyando y dando la asistencia debida a cada uno de los consultores.

Por último, espero que este reporte refleje la situación encontrada en cada una de las instituciones, y que los hallazgos, conclusiones y recomendaciones contribuyan al fortalecimiento institucional de las tres ONG´s analizadas.

PROGRAMA CON ONG´S

El Plan Estratégico de desarrollo sostenible propuesto por la USAID/República Dominicana para los próximos cinco (5) años comprende tres objetivos estratégicos. Estos objetivos estratégicos son: “Las Oportunidades de Crecimiento Sostenido han Incrementado para los Pobres”, “Más Participación, Representación y Logros Cuantitativos en Democracia” y “Mejoramiento Sostenido en la Salud de la Población Vulnerable en la República Dominicana”. El Plan Estratégico empezó en Octubre 2001 y termina en Septiembre 2007.

En virtud de la implementación de la estrategia, y en función del objetivo de “Mejoramiento Sostenido en la Salud de los Grupos Vulnerables de la Población”, USAID/República Dominicana otorgó asistencia técnica y soporte financiero a tres ONG´s especializadas en Salud Sexual y Reproductiva, para la ejecución de Proyectos de Sustentabilidad que le permitieran a estas instituciones, reducir su dependencia de los fondos de la USAID, así como desarrollar alianzas estratégicas tanto con el sector público como con el sector privado, a fin de cumplir con su misión social.

En función de lo anterior, se establecieron metas específicas durante el período 2001-2005, así como indicadores de sustentabilidad que debían ser logrados.

Adicionalmente, las tres ONG´s recibieron asistencia técnica del Proyecto Commercial Market Services (CMS), el cual apoyó en áreas consideradas como vitales para mejorar el desarrollo organizacional de estas entidades.

Una de las áreas que se consideran vitales en el Proyecto de Sustentabilidad de las NGO´s, es el mejoramiento del Indice de Sustentabilidad Financiera, el cual se definió como "la capacidad de la institución de generar sus propios ingresos a fin de poder cubrir los diferentes costos en que incurre para poder cumplir con su misión social".
Se entiende, también, que uno de los objetivos de impulsar la sustentatibilidad financiera de las ONG´s es reducir su dependencia de los fondos de donantes, así como eficientizar las operaciones técnicas, administrativas y financieras de estas instituciones.

En virtud de lo anterior, la USAID/República Dominicana está interesada en conocer los avances que se han logrado en el ámbito de los Programas de las ONG´s, y de esta manera identificar los caminos en cuanto a la asistencia técnica a estas entidades en el futuro. En ese sentido, el análisis financiero fue dirigido a:

1. Evaluar la posición financiera de cada una de las tres ONG´s que están recibiendo recursos de USAID; describir todas las fuentes de ingresos incluyendo apoyo de otros donantes; calcular el porcentaje de ingresos procedentes por las ONG´s a partir de la venta de servicios (Por ejemplo, ingresos por servicios dividido por el total de costos operacionales) y presentar los cambios en los ingresos por servicios de los últimos cinco años[1].

2. Revisar las decisiones de la institución con respecto a la utilización de los aportes de USAID en el proceso de mejoramiento de la posición financiera.

3. Comentar los cambios en los sistemas y procedimientos de administración financiera que han sido implementados con la asistencia técnica de USAID.

4. Describir los costos y los centros de negocios de cada ONG, y las proyecciones de gastos e ingresos para los próximos cinco años[2].

5. Impacto de la crisis macroeconómica y de la devaluación del peso sobre la generación de ingresos corrientes por parte de las ONG´s.

6. Estimar los costos de inversión asociados con las estrategias de desarrollo recomendadas para las ONG´s, incluyendo costos asociados con expansión de servicios a mujeres pobres y adolescentes[3].

[1].- Se trabajó con los datos financieros disponibles.
[2].- En el caso de las tres ONG´s, se realizaron las proyecciones que la información suministrada nos permitió.
[3].- Aún cuando se realizaron recomendaciones asociadas a la expansión de los servicios, la estimación de costos de inversión no se consideró útil ya que todo dependería de la cobertura de expansión, del tipo de cobertura, del área de trabajo, y de la disponibilidad de recursos para tales fines.

ASOCIACION DOMINICANA PRO-BIENESTAR DE LA FAMILIA, INC. (PROFAMILIA)

Descripción General

La Asociación Dominicana Pro-Bienestar de la Familia, Inc. –PROFAMILIA-, es una institución sin fines de lucro, fundada en el año 1966, por un grupo de profesionales de distinta índole, con la participación activa de la Iglesia Evangélica Dominicana. Está incorporada mediante el Decreto del Poder Ejecutivo No. 271, de fecha 31 de agosto del 1966.

PROFAMILIA es una institución pionera en servicios de salud y planificación familiar, tanto a niveles clínicos como comunitarios. Igualmente, la institución se destaca por trabajar con adolescentes y jóvenes, en las áreas de salud sexual y reproductiva y educación para la prevención del VIH/SIDA.

La institución es parte de la Federación Internacional de Planificación Familiar (IPPF), de quien recibe anualmente asistencia técnica y económica. No obstante, PROFAMILIA recibe apoyo financiero y asistencia técnica de otros organismos e institucionales internacionales, así como del Gobierno dominicano.

Sus acciones las ejecuta mediante tres (3) programas específicos: a) Programa Clínico, b) Programa Comercial y c) Programa Comunitario y Social. Adicionalmente, tiene los denominados Proyectos Especiales, los cuales implementa en función de las necesidades y demandas particulares que se presentan.

El Programa Clínico atiende las necesidades y demandas de la población, en cada uno de los centros que existen. Actualmente, existen unos seis (6) centros clínicos, ubicados en diferentes provincias y barrios de la ciudad de Santo Domingo, y los cuales ofrecen servicios integrales de salud. Adicionalmente, PROFAMILIA opera un Centro de Salud Integral para Jóvenes, una Unidad de Apoyo Emocional, y una Unidad de Investigaciones Biomédicas.

La oferta de servicios de PROFAMILIA está dirigida a los grupos vulnerables de la población, a sectores de bajos ingresos, y a grupos poblacionales que viven por debajo de la línea de pobreza.

PROFAMILIA ofrece diferentes productos y servicios, tales como venta de anticonceptivos, condones, servicios médicos integrales, entre otros. A través de los años, esta institución ha logrado consolidar una fuerte estructura operativa y de servicios, que la ha colocado como líder en el área de Salud Sexual y Reproductiva y en Planificación Familiar, y mantiene una imagen y un posicionamiento importante a nivel de la sociedad.

Además, a lo interno, la institución ha logrado construir una sólida estructura administrativa y financiera, contando con un conjunto de sistemas, procesos y procedimientos, que le ha permitido alcanzar un elevado nivel de desarrollo organizacional. Un porcentaje importante de los avances logrados en PROFAMILIA han sido el resultado de la ejecución de proyectos apoyados por USAID.

Análisis Financiero

Desde su creación, PROFAMILIA ha recibido un fuerte apoyo de organismos internacionales, y de otras instituciones, públicas y privadas, nacionales e internacionales. Este apoyo, en su generalidad, le ha permitido cumplir con su misión y su función social, y expandir su oferta de servicios a través de los años.

Sin embargo, debido a las limitaciones de recursos que se observan a nivel internacional para apoyar determinados programas de carácter social, así como en virtud de las carencias del país como consecuencia de las recurrentes crisis económicas, las instituciones como PROFAMILIA han tenido que reevaluar su desempeño financiero y su desenvolvimiento organizacional. Es así que, la institución, con el apoyo de la USAID, definió un Proyecto de Sustentabilidad cuyo propósito fundamental era mejorar la posición económica de la entidad y, a partir de ahí, reducir la dependencia que tenía de las donaciones internacionales. El proyecto se ejecutaría en el Período 2001-2005.

Adicionalmente, PROFAMILIA estuvo recibiendo asistencia técnica del Proyecto Comercial Market Strategies (CMS) durante los primeros años del Proyecto de Sustentabilidad. CMS apoyó en las áreas de Fortalecimiento Institucional, en la medición de los indicadores de sustentabilidad, así como en el área de mercadeo social.

Un dato importante es que PROFAMILIA ha internalizado el concepto de sustentabilidad, y prueba de ello es que dentro de las estrategias definidas en el Plan Estratégico 2004-2006 se estableció: “Mantener y profundizar los avances logrados hasta la fecha en términos de la sostenibilidad financiera, incorporando acciones que mejoren la tasa (de retorno) de los proyectos y programas”.

Históricamente, los ingresos de PROFAMILIA han provenido de dos fuentes principales: a) Ingresos Producidos Localmente, y b) Aportes de Donantes. Dentro de los ingresos generados se destaca: i) la venta de productos y servicios, ii) las cuotas de los pacientes, iii) los intereses por inversiones, iv) los misceláneos[4], etc.

Las donaciones, por su lado, provienen de diferentes instituciones internacionales y de distintos países. En este caso, se destaca la subvención que anualmente realiza la IPPF, así como el aporte de la USAID. También, organismos internacionales, universidades e instituciones privadas se enumeran dentro de las entidades que apoyan financieramente el trabajo realizado por PROFAMILIA. Asimismo, el Gobierno dominicano mantiene una subvención anual a esta institución.

Como se mencionó anteriormente, PROFAMILIA opera tres programas básicos: el Programa Clínico, el Programa Comercial y el Programa Comunitario y Social. Existen, además, los denominados Proyectos Especiales los cuales, por sus características, no constituyen una fuente importante de recursos.

[4].- Los ingresos misceláneos constituyen un porcentaje importante de los ingresos generados localmente, sin embargo, no se identifica claramente.

Cada uno de estos programas, a su vez, se ejecuta mediante centros de negocios, las cuales son unidades concebidas para que, en el corto o mediano plazo, sean sustentables financieramente.

En el análisis de los datos, se pudo comprobar que el Programa Clínico constituye la fuente principal de ingresos de la institución[5], seguido del Programa Comercial y del Programa Comunitario. Los dos primeros han sido sustentables financieramente en los últimos años, en tanto que el Programa Comunitario continúa mejorando su nivel de sustentabilidad, aún cuando todavía se presenta como deficitario.

Evolución de Ingresos

En cuanto a la evolución de los ingresos, es notable la expansión lograda por PROFAMILIA en cuanto a los recursos generados localmente. En efecto, la tasa promedio anual de crecimiento de los ingresos fue de 23.0%, pasando de tener RD$100.0 millones de ingresos en el 2002 a RD$151.4 millones en este año 2004[6]. En el año 2003, los ingresos tuvieron una expansión de un 24.0% con relación al año 2002 (Ver Tabla Anexa No. 1).

Como se puede ver en la Tabla Anexa No. 1, la venta de productos y la cuota de pacientes ha constituido históricamente más del 80.0% de los ingresos generados localmente. Adicionalmente, la partida definida como misceláneos aporta cerca del 10% de los ingresos anuales de la institución. Cabe indicar en este punto, que la partida "misceláneos" debería ser especificada, ya que los ingresos por este concepto constituyen una parte importante del total.

El incremento en los ingresos que ha tenido PROFAMILIA en los últimos años, ha requerido un esfuerzo mayor, toda vez que la crisis macroeconómica ha afectado negativamente a los sectores vulnerables y de menores ingresos, que es la población que comúnmente atiende la institución, lo que se ha traducido en una reducción en la capacidad de compra de dicha población.

De mantenerse la tasa de crecimiento de los ingresos de PROFAMILIA (cerca de un 23% promedio anual), durante los próximos cinco (5), la institución podría alcanzar un Total de Ingresos para el 2010 de aproximadamente RD$420.3 millones[7].

Ingresos por Donaciones

Desde su creación, PROFAMILIA ha recibido importantes donaciones de instituciones y organismos internacionales, las cuales han apoyado el proceso de expansión de la institución, permitiéndole esto ampliar su cobertura de servicios y también cumplir con su misión institucional. En efecto, como se evidencia en la Tabla No. 1, PROFAMILIA ha logrado ingresos totales por donaciones y/o subvenciones, ascendentes a RD$133.8 millones en los últimos tres

[5].- Dentro de los Ingresos Generados Localmente.
[6] .- Los valores del año 2004 fueron proyectados a partir de la ejecución Enero-Junio de ese mismo año.
[7].- Esta proyección se realiza bajo el supuesto de que las condiciones que dieron origen a los ingresos del período anterior se mantendrán. En particular, se entiende que las ventas de productos y servicios tendrán un ritmo de expansión similar al que han tenido hasta ahora, que se realizarán inversiones en niveles parecidos a lo ejecutado en años anteriores, que la demanda de los productos y servicios se mantendrá, que los precios, en promedio, no se alterarán, y que la institución mantendrá su capacidad de gestión operativa.

años[8], para un promedio anual de RD$44.6 millones. La tasa de expansión de los ingresos por donaciones fue de 24.1% durante el período 2002-2004.

Dentro del total de ingresos por donaciones, se destaca que la IPPF y la USAID aportan cerca del 65% anualmente de los recursos que recibe PROFAMILIA por este concepto. Por su parte, USAID ha mantenido una contribución cercana a un 30% promedio anual con relación al total de donantes. Otros donantes importantes de PROFAMILIA han sido: Population Council, Organización Mundial de la Salud (OMS), Embajada de Japón, Naciones Unidas y el Gobierno Dominicano, quien otorga una subvención a esta institución[9].

Por sus características, las donaciones y subvenciones fluctúan de año a año, ya que la mayoría de éstas se otorgan para la ejecución de programas y proyectos específicos, con un tiempo estimado de finalización. Sin embargo, por lo que se observa, PROFAMILIA mantiene un ritmo de captación de donaciones bastante alto, observándose que, aún cuando en algunos casos, determinados donantes se retiran[10], otros se incorporan de manera rápida, lo que indica que existen en esa institución amplias capacidades de gestión e identificación de fuentes de recursos.

En cuanto a la participación de USAID dentro del total de ingresos de PROFAMILIA, se puede observar que, en promedio, ésta ha venido disminuyendo en los últimos años. En efecto, mientras en el año 2002 los aportes realizados por USAID a esta institución constituían un 7.4% del total, en el 2004 se reduce a 7.3%. No obstante, en el 2003 se evidenció una expansión con relación al año anterior, llegando a ser de 8.4%.

TABLA NO. 1
PROFAMILIA
PARTICIPACION DE USAID EN RELACION AL TOTAL DE DONANTES
2002-2004

CATEGORIA DE INGRESOS	2002	%P**	2003	%P**	2004	%P**
APORTES DE LA USAID*	10.046.142	**7,4**	14.318.685	**8,4**	14.938.535	**7,3**
APORTES USAID/TOTAL DONANTES* **		**29,1**		**30,8**		**28,3**
APORTES DE DONANTES****	34.564.743	25,6	46.443.548	27,2	52.862.647	25,9
INGRESOS GENERADOS*****	100.403.410	74,4	124.509.350	72,8	151.475.246	74,1
TOTAL DE INGRESOS******	134.968.153	100,0	170.952.898	100,0	204.337.893	100,0

FUENTE: Elaborado en base a informaciones de la Subdirección Financiera de PROFAMILIA.

(*) Constituye el total de donaciones que recibe PROFAMILIA de USAID, incluyendo los aportes del Proyecto de Sustentabilidad.

(**) El porcentaje calculado de los aportes de USAID a PROFAMILIA es con relación al Total de Ingresos.

(***) Este porcentaje define los que representan los aportes de la USAID con relación a los aportes totales de donaciones.

(****) Incluye a todos los donantes que tiene PROFAMILIA.

(*****) Se refiere a los ingresos generados a través de la venta de productos y servicios de la institución.

(******) Es la suma de los aportes de donantes más los ingresos generados.

[8].- Se refiere al Período 2002-2004.
[9].- Para ver más información sobre los Ingresos por Donaciones de PROFAMILIA, ver Tabla Anexa No. 2.
[10].- Ya sea por finalización de contratos o por terminación de determinados proyectos.

Se puede resumir en que el aporte en recursos que recibe PROFAMILIA de USAID es relativamente moderado, y que se ha reducido el nivel de dependencia para fines de su desempeño operativo[11].

Evolución de Gastos

En los últimos años, los gastos de PROFAMILIA han mostrado una tendencia a la disminución, tal como se puede observar en la Tabla Anexa No. 2. En efecto, mientras que en el 2003, la expansión del gasto fue de un 35.1% con relación al año inmediatamente anterior, en el 2004 se estima que crecerá sólo en un 34.4%. En promedio, el gasto de esta institución ha crecido a un ritmo anual de un 30.1%, lo que puede observarse como adecuado en función del incremento de los costos de operación y de funcionamiento que experimentaron la mayoría de las instituciones en el país como consecuencia de la crisis económica.

Sin embargo, es notable que en PROFAMILIA los gastos están dominados por dos renglones principales: los gastos de personal y los honorarios por servicios. De manera conjunta, estos dos renglones representan alrededor de un 65% del total de gastos. En el caso de los gastos de personal, se estima que al finalizar el 2004, éstos constituyan el 33.2% del total.

De todas maneras, se entiende que el ritmo de expansión de los gastos de la institución se ha reducido, lo que le ha permitido, entre otras cosas, mejorar sus indicadores de sustentabilidad. Se espera que, hacia futuro, esta tendencia continúe.

No obstante, es preciso indicar, que si se aspira a mejorar los indicadores de sostenibilidad, es conveniente revisar los renglones de gastos con miras a su disminución, al tiempo que se identifican nuevas fuentes de ingresos, y se diversifican los productos y servicios que se ofertan.

Indice de Sustentabilidad

Los datos muestran que PROFAMILIA ha mejorado significativamente su nivel de sustentabilidad financiera, al pasar de un 71.0% que tenía en el año 2000, a un 89.0% en el 2004. Como se observa, la institución logró subir unos 18 puntos en su indicador de sustentabilidad. Esto también indica que la institución logró aumentar los ingresos en una proporción mayor a los gastos o, dicho de otra manera, que PROFAMILIA puede cubrir el 89% de los recursos que eroga con los ingresos que genera la propia institución.

Es importante decir, sin embargo, que a medida que esta entidad se acerca a la meta del 100% de sustentabilidad, los esfuerzos por aumentar los ingresos, y por controlar los costos, deben ser mayores, ya que, en este punto, se supone que la institución está agotando sus fuentes de ingresos, y que sus capacidades están siendo utilizadas al máximo[12].

[11].- Esto no quiere decir que los fondos que aporta la USAID a PROFAMILIA no sean necesarios.

[12].- Esto podría convertirse en una hipótesis que pudiera ser comprobada o rechazada, a partir de un análisis organizacional de PROFAMILIA.

Contribución Proyecto USAID a la Sustentabilidad Institucional

Resulta claro que, aún cuando no hay una medida del nivel de contribución que tuvo el Proyecto de Sustentabilidad en la generación de ingresos y, particularmente, en la mejora de los indicadores de sustentabilidad, se entiende que los aportes realizados por la USAID fueron importantes en este proceso.

De manera específica, es claro que los objetivos alcanzados en materia de servicios y oferta de productos que se establecieron a partir del Proyecto de Sustentabilidad, no se hubieran alcanzado sin la asistencia técnica de la USAID. Adicionalmente, los esfuerzos del proyecto en eficientizar los procesos de PROFAMILIA, al tiempo de contribuir al fortalecimiento institucional, a la mejora de los procedimientos internos, así como al mercadeo de los servicios, no se hubieran traducido en resultados concretos si no hubiera existido el proyecto.

Hallazgos

En resumen, el análisis financiero, y del funcionamiento del sistema administrativo de PROFAMILIA, permitió los siguientes hallazgos:

- PROFAMILIA ha logrado consolidar una estructura institucional con elevadas capacidades de gestión de recursos y de administración gerencial.

- La institución ha desarrollado una mentalidad empresarial, sin afectar su misión social.
- La ejecución de los proyectos y programas de PROFAMILA se administran como unidades o centros de negocios.

- PROFAMILIA ha mejorado significativamente su nivel de sustentabilidad financiera, a partir del Proyecto de Sustentabilidad.

- La diversificación en la cantidad de productos y servicios que ofrece la institución es uno de los puntos fuertes de la institución.

- Históricamente, PROFAMILIA ha contado con el apoyo de donantes para la ejecución de sus programas. En los últimos años, sin embargo, ha reducido su nivel de dependencia de fondos externos.

- Se percibe que, en términos de generación de recursos, la institución cerca de su techo. Esto implica que la generación de nuevos recursos debe estar basada en la ampliación de sus capacidades[13].

[13].- Ver Conclusiones y Recomendaciones al final del reporte.

MUJERES EN DESARROLLO DOMINICANA, INC. (MUDE)

Descripción General

Mujeres en Desarrollo Dominicana, Inc. (MUDE) es una institución sin fines de lucro, creada en el 1979 para responder a las necesidades de las mujeres de menores ingresos de la población. MUDE es una institución multisectorial y de desarrollo integral, y opera mediante tres áreas básicas: Microcrédito, Programas Sociales y Panaderías. Estos programas, a su vez, constituyen las principales fuentes de ingresos de la institución, aunque algunos de ellos son más sustentables que otros.

Mediante el programa de microcrédito, MUDE otorga pequeños préstamos a mujeres de recursos limitados de la zona rural y en determinadas zonas urbanas, teniendo hasta el momento una fuerte influencia en los lugares donde opera.

Dentro de los programas sociales que ejecuta MUDE, se destaca el programa de salud el cual está enfocado a la planificación familiar y a la salud sexual y reproductiva de las mujeres de los barrios marginados de la capital y del área rural.

Adicionalmente, MUDE incursionó en la industria de la harina, estableciendo dos panaderías (Duvergé y Santiago Rodríguez), lo cual ha resultado provechoso en términos de generación de ingresos, ya que le ha permitido mejorar sus niveles de sustentabilidad.

Esta institución recibe también importantes aportes de donantes externos, destacándose el apoyo que le brinda USAID a los diferentes programas que se ejecutan. De hecho, USAID no sólo ha colaborado con MUDE en el ámbito de la salud, sino que también le ha otorgado fondos para la ampliación de las panaderías, y para el área de microcrédito, por lo que para esta institución USAID es un aliado estratégico.

En cuanto al Proyecto de Sustentabilidad, MUDE fue una de las instituciones que recibió fondos y asistencia técnica para la ejecución de este proyecto. Y como parte del proceso de evaluación, se obtuvieron informaciones sobre los avances que ha tenido el proyecto, así como el impacto logrado en materia de sustentabilidad financiera.

Análisis Financiero

El análisis financiero de MUDE consistió en determinar la evolución de los ingresos, así como medir los niveles que ha alcanzado el gasto en el período bajo estudio. De manera particular, se analizan las diferentes fuentes de ingresos de la institución y la contribución que los donantes realizan y que le permiten a la institución cumplir con la función social para la que fue creada.

Evolución de los Ingresos

MUDE tiene cuatro fuentes de obtención de recursos, las cuales son: a) Intereses por préstamos, b) Ventas de productos de panadería, c) Venta de métodos y d) Donaciones. En efecto, y según se observa en la Tabla No. 2, los ingresos totales de la institución crecieron, en promedio, cerca

de un 35.0% en el período 2001-2003. Sin embargo, conviene decir que esta elevada expansión de los ingresos se explica, principalmente, por el crecimiento de las donaciones, las cuales casi se duplican en el 2003 con respecto al 2002, creciendo en un 70.2% en ese lapso de tiempo.

Por su parte, los ingresos internos aumentaron en un 32.0%, lo que se explica por el aumento en la venta de métodos y en la mejora en las ventas de las panaderías. De su lado, los ingresos por Intereses de Préstamos crecieron en un 21.7% en el período 2000-2003.

Aún cuando la serie temporal de dos años que se presenta aquí, es insuficiente como para realizar estimaciones sobre el comportamiento futuro de la variable ingresos, y si suponemos que las condiciones nacionales e internacionales estarán inalterables durante los próximos cinco años, podríamos esperar un ritmo de expansión anual de los ingresos cercano al 30%. Esta estimación contempla también que los donantes seguirán siendo atraídos por los proyectos presentados por MUDE, y que habrá estabilidad económica en el país.

TABLA No. 2
MUDE
COMPORTAMIENTO DE LOS INGRESOS, SEGÚN FUENTES
2001-2003

INGRESOS POR FUENTES	2001	%P	2002	%P	2003	%P
Intereses/Préstamos	6.627.565	21,3	7.379.292	21,3	8.983.470	16,3
T. de C.			11,3		21,7	
Panaderías	2.210.041	7,1	2.204.837	6,4	3.221.963	5,9
T. de C.			- 0,2		46,1	
Venta de Métodos	398.541	1,3	770.708	2,2	1.462.458	2,7
T. de C.			93,4		89,8	
INGRESOS PROPIOS	**9.236.147**	**29,7**	**10.354.837**	**29,9**	**13.667.891**	**24,8**
T. de C.			12,1		32,0	
Donaciones	21.834.701	70,3	24.306.478	70,1	41.374.272	75,2
T. de C.			11,3		70,2	
TOTAL DE INGRESOS	**31.070.848**	**100,0**	**34.661.315**	**100,0**	**55.042.163**	**100,0**
T. de C.			**11,6**		**58,8**	

Fuente: Elaborado en base a Informaciones ofrecidas por MUDE.

Ingresos por Donaciones

Es notable la alta dependencia que tiene MUDE de la cooperación internacional la cual, al 2003, representó el 75.2% del total de ingresos de la institución. Por otro lado, sin embargo, se muestra que esta institución tiene una elevada capacidad de gestión de recursos externos. Aún cuando las donaciones comúnmente presentan variaciones de año a año, en el caso de MUDE la tendencia ha sido a crecer de manera sostenida.

Al relacionar los recursos de donación aportados por la USAID como porcentaje del total de donaciones recibidas por MUDE, se observa que para el año 2003, este organismo internacional aportó el 31.0% de los fondos recibidos por esta ONG. De hecho, los aportes de la USAID a MUDE se han producido en casi todas las áreas en las cuales opera esta última institución.

Análisis de Gastos

La revisión de las informaciones sobre los gastos de MUDE muestra que esta institución disminuyó sus erogaciones (costos y gastos), en el 2002, en un 20.2%. Sin embargo, en el 2003 la expansión de esta variable fue de aproximadamente un 60% con relación al año anterior, lo que arroja un crecimiento promedio anual de un 20% durante el período 2001-2002[14].

La expansión de los costos y gastos para el año 2003 tiene su explicación en el aumento generalizado de los precios de los factores producción que se produjo, como consecuencia de la crisis macroeconómica. Esto afectó no sólo a MUDE, sino a la mayoría de las instituciones de este tipo.

Como se evidencia en la Tabla Anexa No. 4, dentro de los gastos totales de la institución el componente de Gastos de Personal, anualmente consume alrededor del 43.7% del total de Gastos Administrativos, seguido de los Gastos Operativos y de las Reservas para Cuentas Incobrables.

Índice de Sustentabilidad

MUDE ha experimentado una mejoría significativa en sus indicadores de sustentabilidad. A pesar de la alta dependencia de fondos externos que mantiene esta institución, es notable el esfuerzo que se realiza para controlar los costos de operación, y también por elevar los ingresos mediante los diferentes productos y servicios que se ofertan, en un momento en que las instituciones han sido severamente afectadas por la crisis económica.

Según las estimaciones realizadas, MUDE pasó de tener un índice de sustentabilidad financiera de 26% en el año 2000, a lograr un nivel de sustentabilidad de un 68.0%, incrementando en 42 puntos este importante indicador.

Hacia futuro, se espera que con los esfuerzos que actualmente se realizan, y básicamente con el apoyo de la USAID, a través del Proyecto de Sustentabilidad, se alcancen mejores resultados. No obstante, es de esperar también que los gastos mantengan un ritmo de expansión bajo y que los ingresos, especialmente los generados por la propia institución, puedan expandirse a una tasa elevada y sostenida.

Hallazgos[15]

En resumen, después del análisis financiero de MUDE, y de la revisión de sus esquemas y sistemas administrativos, a continuación se presentan los principales hallazgos:

- MUDE ha desarrollado una adecuada imagen corporativa y un importante posicionamiento en la sociedad dominicana, lo cual contribuye a sus procesos de gestión de recursos.

[14].- Los datos con relación al año 2004, no pudieron ser obtenidos.
[15].- Las Conclusiones y Recomendaciones pueden verse en la parte final de este reporte.

- La institución ha mejorado significativamente su nivel de sustentabilidad financiera en el período 2000-2004.

- MUDE ha desarrollado importantes capacidades de gestión de recursos, de fuentes locales e internacionales, lo que le ha permitido mantener determinados programas sociales.

- MUDE tiene una fuerte presencia en determinadas zonas rurales, sobre todo a través del Programa de Microcrédito y con la presencia de panaderías en dos provincias del país.

- MUDE basa la generación de sus ingresos en tres instrumentos principales: Microcrédito, Panaderías y Programas Sociales.

- Históricamente, la cooperación internacional ha sido una fuente importante de recursos para MUDE.

- Las panaderías tienen su principal fuente de ingresos en el Desayuno Escolar, el cual se ofrece mediante el Convenio suscrito con la Secretaría de Estado de Educación. Esto las hace vulnerable frente a decisiones estatales, lo cual implica un riesgo de inversión.

- MUDE carece de un centro y/o unidad de costos que le permita tener control sobre los mismos.

- MUDE precisa de capital de inversión para la implementación de nuevos programas y servicios.

- La preocupación por la sustentabilidad financiera de MUDE, se incrementa a partir del proyecto que apoya USAID.

ASOCIACIÓN DOMINICANA PARA LA PLANIFICACIÓN FAMILIAR, INC. (ADOPLAFAM)

Descripción General

La Asociación Dominicana de Planificación Familiar, Inc. (ADOPLAFAM) es una entidad sin fines de lucro, amparada en el Ley 520 del año 1920 e incorporada mediante el Decreto del Poder Ejecutivo No. 415-87 del 6 de agosto del 1987. Su objetivo fundamental es mejorar la calidad de vida de la madre y del niño por medio del fortalecimiento de la atención primaria y la planificación familiar.

ADOPLAFAM desarrolla programas de salud sexual y reproductiva, así como salud ambiental con énfasis en saneamiento, uso adecuado del agua y de sistemas sanitarios, y atiende a grupos vulnerables de la población, los cuales viven por debajo de la línea de pobreza, y residen en zonas marginadas de la Ciudad de Santo Domingo y del interior del país.

Desde sus inicios, y por sus características, esta institución ha venido desarrollando sus actividades con el apoyo económico y la asistencia técnica de diversas instituciones, públicas y privadas, nacionales e internacionales, las cuales, en determinado momento, se han identificado con la misión social de ADOPLAFAM. En ese marco, una de las instituciones que mayor cooperación ha brindado a esta entidad es USAID, la cual entiende que los objetivos de ADOPLAFAM son coincidentes con la estrategia diseñada por este organismo cooperante.

A partir del año 2001, sin embargo, y en función de la nueva estrategia de USAID, se entendió como importante continuar el apoyo a esta institución, pero mediante un Proyecto de Sustentatibilidad el cual tenía como propósito fundamental propiciar que ADOPLAFAM pueda ofrecer servicios de calidad en Salud Sexual y Reproductiva, Planificación Familiar y prevención de ITS/VID/SIDA, a la población por debajo de la línea de pobreza y que ha sido definida como población vulnerable, bajo el concepto sustentabilidad financiera.

Adicionalmente, el proyecto[16] persigue desarrollar en la institución, capacidades y habilidades de hacer negocios, en el marco de su misión, que le permita financiar sus gastos fijos y ofrecer subsidios cruzados para programas comunitarios que no son sustentables. Paralelamente, se espera que con el aumento de sustentabilidad esta entidad disminuya su dependencia de los recursos de donaciones.

En virtud de lo anterior, USAID está interesada en medir la posición financiera actual de la institución, así como determinar en qué medida la asistencia técnica ofrecida contribuyó a mejorar esta situación financiera. Asimismo, USAID quiere determinar el nivel de sustentabilidad de las ONG´s que forman parte del proyecto, y también evaluar los niveles de dependencia que mantiene la institución con relación a los donantes internacionales.

Análisis Financiero

El análisis y la revisión de la situación financiera de ADOPLAFAM se realizó conjuntamente con los directivos de la institución y con los responsables del área administrativa y financiera. Asimismo, diversos documentos nos fueron suministrados, a la vez que recibimos los datos solicitados[17].

Como resultado del Proyecto de Sustentabilidad que apoya la USAID y que también contó con la asistencia técnica del Proyecto Commercial Market Strategies (CMS), ADOPLAFAM incorporó a sus estrategias de trabajo el concepto de sustentabilidad financiera, lo cual se lograría, por un lado, aumentando los ingresos y, por otro lado, reduciendo los gastos y ejerciendo control sobre los costos.

[16].- Se tiene previsto que este proyecto finalice en Junio del 2005.
[17].- La revisión de las informaciones financieras nos permitió identificar algunas deficiencias en su composición.

Evolución de los Ingresos

ADOPLAFAM logra sus ingresos mediante dos (2) instrumentos específicos: a) Ingresos por Venta de Productos y Servicios y b) Ingresos por Donaciones.

Durante el período 2001-2004, esta institución tuvo una expansión promedio de sus ingresos de un reducido 3.03%. En efecto, y como se evidencia en la Tabla Anexa No. 5, los ingresos de ADOPLAFAM se redujeron en un 16.81% durante el año 2004 con relación al año inmediatamente anterior, lo que en alguna medida afectó los indicadores de sustentabilidad.

Tomando en consideración las informaciones suministradas, y bajo el supuesto de que las condiciones económicas se mantendrán como hasta ahora, la expansión futura de los ingresos de ADOPLAFAM va a ser reducida. Es por ello que esta institución debe abocarse a un proceso de revisión e identificación de nuevas fuentes de ingresos, al tiempo que también debe diversificar la cantidad de productos y servicios que ofrece.

De hecho, los principales ingresos de esta institución provienen de la venta de anticonceptivos, de los servicios que ofrece en el Centro Diagnóstico, y de las donaciones que recibe. Mantener esta situación aumenta el riesgo de disminución de sus ingresos, y de reducción de su nivel de sustentabilidad.

Ingresos por Donaciones

Históricamente, ADOPLAFAM ha mantenido una fuente dependencia de los recursos de donación, aunque también esto le ha permitido cumplir con su misión social y expandir su cobertura hacia grupos sociales vulnerables.

Durante el período 2001-2004, las donaciones representaron, en promedio, alrededor del 60.0% de los ingresos institucionales. Dentro de estos se destaca, fundamentalmente, los aportes recibidos de USAID, los cuales llegaron a representar, en el año 2003, más del 50.0% del total de donaciones (Ver Tabla Anexa No. 6).

Hacia futuro, y a partir del Proyecto de Sustentabilidad, se espera que ADOPLAFAM implemente nuevas estrategias para generar nuevos ingresos, y de esta manera reducir su alta dependencia de los recursos internacionales.

No obstante, este deberá ser un proceso ordenado para no afectar las capacidades operativas internas, ni los avances que se han logrado en materia de fortalecimiento y desarrollo organizacional.

Análisis de Gastos

Una buena noticia en el caso de los gastos institucionales de ADOPLAFAM es que en el período 2001-2004 éste renglón tuvo, en promedio, una expansión negativa de 13.64%. Según las informaciones obtenidas, este comportamiento se debió a la política de disminución de costos

implementada por la institución, en respuesta a la crisis económica y a la búsqueda de la sustentabilidad.

Sin embargo, se advierte que la disminución indiscriminada de costos de la institución, y más específicamente la reducción en los gastos de personal, está afectando sensiblemente la capacidad operativa y de gestión de ADOPLAFAM.

Índice de Sustentabilidad

El índice de sustentabilidad financiera de ADOPLAFAM mejoró significativamente en el período bajo estudio, al pasar de ser un 19% en el 2000, a alcanzar un 59% en el 2004[18].

Conviene señalar, sin embargo, que en la revisión de los datos financieros de esta institución, y el cálculo del indicador de sustentabilidad financiera, pudimos encontrar cierta inconsistencia con el dato mencionado anteriormente, lo que se supone puede haber ocurrido debido a la base de datos a partir de la cual se generaron las informaciones[19].

Sería recomendable que, a los fines de compatibilizar las informaciones, se realice un análisis profundo de la base de datos financiera de ADOPLAFAM, lo cual también puede ayudar a mejorar la gestión administrativa.

Un elemento importante a destacar en cuanto a la mejora en el índice de sustentabilidad, es que la implementación del Proyecto de Sustentabilidad apoyado por USAID ha generado una nueva dinámica a lo interno de las instituciones, toda vez que existe una alta preocupación por lograr los objetivos de autosustentabilidad.

Hallazgos[20]

De manera resumida, a continuación se presentan los hallazgos encontrados en el proceso de análisis financiero y de revisión de los procesos administrativos de ADOPLAFAM.

- ADOPLAFAM ha mejorado su nivel de sustentabilidad al pasar de un 26% en el 2000, a un 68% en el 2004.

- ADOPLAFAM ha creado un nicho de mercado con un gran potencial de crecimiento.

- Los productos y servicios ofrecidos por ADOPLAFAM, y los cuales le permiten generar los ingresos que se necesita, son compatibles con la misión social que ha definido la institución.

- ADOPLAFAM ha logrado un posicionamiento a nivel del mercado en el cual se desenvuelve, lo que le permitiría expandirse y crecer en el futuro.

[18].- Datos suministrados por Ex – Coordinadora de CMS.
[19].- ADOPLAFAM señala no tener centro de costos que le permita dar un seguimiento a las estadísticas relacionadas con este renglón.
[20].- Ver Conclusiones y Recomendaciones en la última parte de este reporte.

- ADOPLAFAM ha desarrollado importantes capacidades de gestión de recursos, sobre todo a nivel de la cooperación internacional. Sin embargo, esto ha generado una alta dependencia de las donaciones internacionales.

- ADOPLAFAM, en busca de la sustentabilidad financiera, ha realizado cambios internos que han reducido su capacidad operativa, afectando los procesos de supervisión y de generación de nuevos ingresos.

- Los ingresos de ADOPLAFAM dependen, fundamentalmente, de la venta de pocos productos, y de la operación de un solo centro, lo que la hace vulnerable frente a cualquier eventualidad, tal como una crisis económica o un proceso de inestabilidad política y social en el país.

- Se evidencian serias deficiencias en los procesos de gestión administrativa y financiera, así como en los sistemas informáticos que se utilizan para la generación de la información financiera y contable.

- La disminución de gastos, vía la reducción de personal, está influenciando negativamente en la institución.

- ADOPLAFAM carece de un centro o unidad de costos, que le permita tener control sobre los elementos que inciden en la formación de dichos costos.

- La generación de recursos vía la inversión en certificados financieros limita la creación y puesta en marcha de otros programas y proyectos que pudieran ser mejores fuentes de ingresos.

ANALISIS COMPARATIVO DE LAS ONG´s

La revisión de los indicadores de sustentabilidad definidos y obtenidos por las tres ONG´s analizadas, arroja informaciones interesantes. En efecto, según se muestra en la Tabla No. 3, las tres ONG´s lograron aumentar el índice de sustentatibilidad financiera, ya que, en promedio, alcanzaron un incremento de 33.3 puntos.

Sin embargo, los datos comparados destacan que el mayor incremento en el índice de sustentabilidad fue logrado por MUDE que pasó de tener un bajo 26% en el 2000 a un 68% en el 2004.

TABLA No. 3
EVOLUCION INDICE DE SUSTENTABILIDAD
2000-2004

INSTITUCION	2000*	2004**	VARIACION ABSOLUTA
PROFAMILIA	71	89	18
MUDE	26	68	42
ADOPLAFAM	19	59	40

Fuente: Elaborado en base a datos ofrecidos por el Proyecto de CMS.
(*) Los datos del año 2000 corresponden al mes de Octubre.
(**) Los datos del 2004 corresponden al mes de junio.

Por su parte, ADOPLAFAM también tuvo un incremento significativo en cuanto a la sustentabilidad financiera, ya que de 19% que tenía en el 2000, logró aumentar hasta un 59% en el 2000.

Paradójicamente, PROFAMILA es la que experimentó un menor nivel de expansión en lo concerniente al indicador de sustentabilidad, ya que sólo pudo lograr aumentar unos 18 puntos. Sin embargo, cuando se analiz la estructura internas de las tres ONG´s estudiadas, se evidencia que PROFAMILIA tiene una mayor diversificación de sus fuentes de ingresos, además de que ha logrado consolidar programas, proyectos y servicios que, en su mayoría, son autosustentables. Adicionalmente, PROFAMILIA cuenta con una estructura administrativa y financiera sólida, con sistemas internos ágiles, al tiempo que ha logrado elevar la capacidad de gestión de recursos.

Otro elemento a destacar en el caso de PROFAMILIA, es que se evidencia que la institución está llegando a su techo[21] en cuanto la generación de recursos, por lo que un incremento en un punto porcentual en el indicador de sustentabilidad, va a implicar mayores costos marginales. Esto supone, entonces, que la generación futura de recursos, deberá basarse en la identificación de nuevas fuentes de ingresos, en la diversificación en la oferta de productos, en la ampliación en la cobertura de atención a clientes, y en la expansión de los servicios hacia sectores con mayor capacidad de compra.

IMPACTO DE LA CRISIS MACROECONOMICA Y LA DEVALUACION DEL PESO SOBRE LOS INGRESOS GENERADOS POR LAS ONG´S

La crisis macroeconómica y la devaluación del peso ocurrida en los últimos dos años, afectó sensiblemente a la mayoría de las instituciones dominicanas. En el caso de las ONG´s, el impacto de la crisis fue particularmente severo, ya que no sólo les afectó en la gestión interna, sino que también tuvo su repercusión en los sectores vulnerables que son atendidos por estas instituciones. De manera particular, la crisis económica afectó a las ONG´s a través de:

[21]._ Para fines del análisis financiero, hemos definido como “techo de generación a recursos” como el tope de capacidad instalada para la generación de nuevos ingresos. Esto implica que si se quiere aumentar los ingresos, será necesario identificar nuevas fuentes de ingreso, nuevos proyectos, nuevos donantes, nuevos servicios y/o nuevos programas.

- Incremento de los costos vía el aumento de los precios de factores de producción que utiliza la institución (Específicamente energía eléctrica, transporte, medicamentos, reactivos)

- Reducción del poder adquisitivo de los grupos vulnerables que son atendidos por la institución.

- Mantenimiento de los precios de los productos de salud relativamente bajo, por la escasez de demanda.

- Incremento de la población viviendo en condiciones de pobreza y excluidas de la seguridad social, la cual demanda servicios gratuitos. Datos de organismos internacionales informan que la cantidad de pobres en el período 2000-2004 aumento en un millón en el país.

- Reducción de la tasa de crecimiento del producto interno bruto (PIB).

- Incremento del desempleo. De acuerdo con los datos del Banco Central de la República Dominicana, la tasa de desempleo pasó de ser un 16% de la población económicamente activa en el año 2002, a ser de 9% en el año 2003.

HALLAZGOS GENERALES

El análisis financiero y de los sistemas administrativos de las ONG´s, también permitió observar hallazgos que son comunes a las tres instituciones analizadas. En ese sentido, se evidenció lo siguiente:

- A través de los años, la cooperación internacional ha sido una fuente importante de recursos de las ONG´s.

- El desarrollo de las ONG´s se ha sustentado en los aportes que ha hecho la cooperación internacional.

- La cooperación internacional y, específicamente, las donaciones de USAID, han apoyado programas dirigidos a grupos vulnerables, con bajos niveles de ingresos y escasas posibilidades de acceder a servicios de salud y pagar por dicho servicios.

- La sustentabilidad es un tema recurrente en los últimos años en las ONG´s, lo cual parece ser un resultado del Proyecto de Sustentabilidad que apoya USAID.

- A pesar de los avances en términos de mejora en los niveles de sustentabilidad, las ONG´s, determinados programas y proyectos administrados y ejecutados por estas instituciones, mantienen una fuente dependencia de los recursos de donantes.

- El apoyo del Proyecto Commercial Market Strategies (CMS) fue vital en el proceso de establecimiento y mejoramiento de los indicadores de sustentabilidad de las NGO´s.

- La asistencia técnica de CMS, que en principio estaba dirigida a mejorar la sustentabilidad de las ONG´s mediante diferentes acciones, debió dirigirse al fortalecimiento institucional, pues se comprobó que algunas de estas instituciones tenían debilidades estructurales que había que corregir previo a iniciar procesos de cambio tendentes a mejorar la sustentabilidad financiera.

- Las tres ONG´s han mejorado sustancialmente sus niveles de sustentabilidad financiera, reduciendo su dependencia de la cooperación internacional y de donantes.

- En el proceso de revisión y análisis de los datos financieros de las algunas de las ONG´s, se evidenciaron ciertas inconsistencias en cuanto al cálculo de los indicadores, ya que, también en determinados casos, no fue posible tener informaciones sobre los costos de los productos y servicios de salud que ofrecen.

- MUDE y ADOPLAFAM carecen de centros y/o unidades de costos que les permita tener un control sobre el costo promedio de cada uno de los productos y servicios que ofrecen. Esto, obviamente, afecta la estimación de los indicadores de sustentabilidad.

CONCLUSIONES Y RECOMEDACIONES

- Aún cuando el concepto de sustentabilidad se ha arraigado en las ONG´s durante el período del proyecto, es importante continuar realizando esfuerzos en ese sentido.

- La entrada en vigencia y operación de la Ley de Seguridad Social, y el proceso de Reforma del Sector Salud, es obvio que afectarán, de una manera u otra, a las ONG´s, sobre todo en lo relacionado con la oferta de productos y servicios que actualmente realizan. Es por ello que se recomienda que éstas instituciones se aboquen a estudios profundos sobre las implicaciones, positivas y negativas, que la mencionada ley está teniendo sobre estas entidades. Al mismo tiempo, se recomienda identificar mecanismos y estrategias para adecuarse a las nuevas reglas que establece la ley, así como aprovechar las oportunidades que la misma encierra.

- Es obvio que en el mercado de productos y servicios de salud, ha comenzado un proceso de transformación cuyo principal objetivo es mejorar la eficiencia del sistema y que una mayor cantidad de personas, sobre todo a nivel de los grupos vulnerables de la población, accedan a los diferentes productos y servicios que se ofrecen. Esto también está implicando que las instituciones de servicios de salud (Clínicas, Hospitales, etc.) se transformen y se hagan más competitivas. Es por ello que se recomienda que las ONG´s realicen estudios profundos sobre sus posibilidades de ser competitivas y de tener una mayor participación en el mercado de productos y servicios de salud.

  Al mismo tiempo, es recomendable que las ONG´s realicen estudios específicos sobre el mercado en el cual ofrecen sus servicios, para evaluar las posibilidades de expansión,

crecimiento, diversificación, ampliación de cobertura, y de incremento de precios que existen. Esto permitirá, también, la evaluar las posibilidades de ofrecer servicios a sectores menores vulnerables de la población, aunque manteniendo la misión social que tienen.

- Por años, USAID ha venido apoyando la labor de las ONG´s en República Dominicana, sobre todo a nivel de los servicios de salud sexual y reproductiva, y de prevención de enfermedades infecto contagiosas y del VIH, entre otras. Esto le ha permitido a las ONG´s, no sólo alcanzar metas cuantitativas, sino cumplir con una labor social en un país en donde el número de personas viviendo en condiciones de pobreza es cada vez mayor. Por ejemplo, según datos de organismos internacionales, en el período 2000-2004, la cantidad de pobres en el país aumentó en un millón. A su vez, y específicamente a partir del Proyecto de Sustentabilidad que se inició en el año 2001 con el apoyo de USAID, las ONG´s vieron la necesidad de hacer compatible su misión social con el aumento de sus capacidades para generar nuevos ingresos, y de esta manera reducir su dependencia de los recursos de donación.

  Colocados en este punto, entendemos recomendable que USAID mantenga niveles de apoyo importante para las ONG´s, ya que dicho apoyo se convertirá en aumento de servicios de salud para los sectores vulnerables y de menores ingresos que viven en zonas marginadas del país.

- No obstante, se recomienda que, en lo adelante, la entrega de recursos y/o de asistencia técnica de USAID a OnG´S, se realice a través de mecanismos que garanticen la obtención de determinados resultados financieros (aumento de ingresos y control de costos[22]), la evaluación del cumplimiento de ciertas metas financieras, y la atención y cobertura de servicios a grupos específicos.

  Esto requerirá, adicionalmente, un proceso de *acompañamiento* mucho más cercano que el que se realizó bajo el Proyecto de Sustentabilidad, de forma que se le de seguimiento a los procesos de cambio a nivel financiero, administrativo y operativo de las ONG´s.

- Hacia futuro, las ONG´s tendrán que transformarse y, en virtud de ello, desarrollar sus actividades a partir de varios ejes estratégicos:

  - Desarrollar una clara visión de negocios, entendiendo que la institución es sin fines de lucro, pero también, *sin fines de perdida*.

  - Iniciar un proceso de diversificación de actividades de generación de ingresos, para identificar y entrar en nuevos nichos de mercado, sobre todo en aquellos con potencial de crecimiento y con mayores capacidades de pago.

  - Establecer alianzas estratégicas a nivel local con empresas privadas y otras organizaciones de la sociedad, aún cuando éstas no se desenvuelvan en el sector salud

[22].- Aquí insistimos en el control de los costos, no en su disminución, ya que esto último pudiera afectar en cierta medida las capacidades operativas de las ONG´s.

ni atiendan grupos vulnerables, pero que sí representan oportunidades de nuevos *negocios sociales*.

- Ampliar y diversificar la oferta de productos y servicios, introduciendo aquellos que puedan ser ofertados a sectores con mayores capacidades de pago.

- Administrar como centros de negocios todos los programas, proyectos y áreas institucionales, aún cuando algunas de estas, por sus características, se entienda que no son autosustentables.

- Se recomienda, también, que USAID continúe apoyando el fortalecimiento institucional de las ONG´s, entendiendo que éstas tienen debilidades que debe superar, y potencialidades que deben desarrollar, en el ámbito de la generación de ingresos.

- En el caso de PROFAMILIA, se recomienda a USAID apoyar un Programa de *Consolidación Institucional*, mediante los siguientes enfoques:

  - Sustentabilidad financiera en un 100 porciento.
  - Diversificación de productos y servicios bajo el concepto de incrementar los ingresos marginales y controlar los costos marginales.

  - Identificación y penetración a nuevos nichos de mercado.

  - Inicio de transformación positiva como entidad prestadora de servicios de salud.

  - Aumentar el uso del *Overhead Institucional* como mecanismo de generación de ingresos, mediante la administración de nuevos proyectos.

- Se recomienda que la estrategia futura de USAID para el apoyo a las ONG´s, tome en consideración dos elementos básicos:

  - Que las ONG´s pasan por procesos de desarrollo diferentes y que se encuentran en estadios diferentes de expansión y crecimiento.

  - Que deben existir objetivos de corto plazo, de mediano plazo y de largo plazo.

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TABLA ANEXA No. G-1

PROFAMILIA

COMPORTAMIENTO DE LOS INGRESOS

Período 2002-2004

INGRESOS GENERADOS	2002	%P	2003	%P	2004 (Enero-Junio)	2004 (Proyectado)*	%P
Venta de productos	36,768,621	36.6	49,546,536	39.8	28,066,613	56,133,226	37.1
Cuota de pacientes	35,822,562	35.7	40,510,932	32.5	39,872,319	79,744,638	52.6
Intereses por inversión	4,424,660	4.4	6,088,839	4.9	2,040,354	4,080,708	2.7
Programa de Recaudación de Fondos	658,272	0.7	2,621,328	2.1		-	-
Utilización de préstamos	10,979,630	10.9	5,440,790	4.4	-	-	-
Misceláneos	11,749,665	11.7	20,300,925	16.3	5,758,337	11,516,674	7.6
				-		-	-
INGRESOS TOTALES	**100,403,410**	**100.0**	**124,509,350**	**100.0**	**75,737,623**	**151,475,246**	100.0
TASA DE CRECIMIENTO ANUAL			**24.0**			**21.7**	

Fuente: Elaborado en base a informaciones suministradas por la Subdirección Financiera de PROFAMILIA.

(*) Proyectado a Diciembre.

TABLA ANEXA No. G-2

PROFAMILIA

INGRESOS PROYECTADOS

Período 2005-2009

INGRESOS GENERADOS	2005	2007	2008	2009	2010
Venta de productos	69,043,868	84,923,958	104,456,468	128,481,455	158,032,190
Cuota de pacientes	98,085,905	120,645,663	148,394,165	182,524,823	224,505,533
Intereses por inversión	5,019,271	6,173,703	7,593,655	9,340,195	11,488,440
Programa de Recaudación de Fondos		-	-	-	-
Utilización de préstamos		-	-	-	-
Misceláneos	11,516,674	14,165,509	17,423,576	21,430,999	26,360,128
			-	-	-
INGRESOS TOTALES	**183,665,718**	**225,908,833**	**277,867,864**	**341,777,473**	420,386,292

Fuente: Elaborado en base a informaciones suministradas por la Subdirección Financiera de PROFAMILIA.

(*) Proyectado a Diciembre.

Tabla No. G-3

PROFAMILIA

COMPORTAMIENTO DE LOS INGRESOS PROVENIENTES DE DONANTES Y/O SUBVENCIONES

PERIODO 2002-2004

DONANTES	2002	%P	2003	%P	2004*	%P
IPPF Subvención Regular y Especiales	9,285,587	26.9	15,689,401	33.8	24,435,863	46.2
Agencia Internacional para el Desarrollo (USAID)	10,046,142	29.1	14,318,685	30.8	14,938,535	28.3
Population Council	2,472,614	7.2	904,580	1.9	-	-
OXFAM	46,610	0.1	1,719,095	3.7	431,246	0.8
CONRAD	1,147,532	3.3	1,225,518	2.6	1,215,499	2.3
Organización Mundial de la Salud	-	-	144,230	0.3	1,493,590	2.8
Universidad de Columbia	3,523,117	10.2	3,328,561	7.2	1,467,350	2.8
Embajada de Japón	1,570,880	4.5	2,934,000	6.3	-	-
Naciones Unidas	309,213	0.9	2,263,638	4.9	3,112,673	5.9
Gobierno Dominicano	2,997,671	8.7	2,560,390	5.5	3,050,000	5.8
SEE/BID					2,530,000	4.8
Otros Ingresos	3,165,377	9.2	1,355,450	2.9	187,891	0.4
INGRESOS TOTALES DE DONANTES	**34,564,743**	**100.0**	**46,443,548**	**100.0**	**52,862,647**	**100.0**
TASA DE CRECIMIENTO ANUAL			**34.4**		**13.8**	

Fuente: Elaborado en base a informaciones suministradas por la Subdirección Financiera de PROFAMILIA.

(*) Los valores de ese año corresponden a lo presupuestado, a excepción de los ingresos provenientes de la Universidad de Columbia y de Otros Ingresos, que son valores ejecutados durante el período Enero-Junio 2004, pero que no estaban en Presupuesto.

Tabla No. G-3
PROFAMILIA
NIVEL DE PARTICIPACION DE LOS FONDOS USAID EN EL TOTAL DE INGRESOS
PERIODO 2002-2004

CATEGORIA DE INGRESOS	2002	%P**	2003	%P**	2004	%P**
APORTES DE LA USAID*	10,046,142	**7.4**	14,318,685	**8.4**	14,938,535	**7.3**
APORTES USAID/TOTAL APORTES DE DONANTES* **		**29.1**		**30.8**		**28.3**
APORTES DE DONANTES****	34,564,743	25.6	46,443,548	27.2	52,862,647	25.9
INGRESOS GENERADOS*****	100,403,410	74.4	124,509,350	72.8	151,475,246	74.1
TOTAL DE INGRESOS******	134,968,153	100.0	170,952,898	100.0	204,337,893	100.0

FUENTE: Elaborado en base a informaciones de la Subdirección Financiera de PROFAMILIA.

(*) Constituye el total de donaciones que recibe PROFAMILIA de USAID, incluyendo los aportes del Proyecto de Sustentabilidad.

(**) El porcentaje calculado de los aportes de USAID a PROFAMILIA es con relación al Total de Ingresos.

(***) Este porcentaje define los que representan los aportes de la USAID con relación a los aportes totales de donaciones.

(****) Incluye a todos los donantes que tiene PROFAMILIA.

(*****) Se refiere a los ingresos generados a través de la venta de productos y servicios de la institución.

(******) Es la suma de los aportes de donantes más los ingresos generados.

TABLA No. G-3

MUDE

COMPORTAMIENTO DE LOS INGRESOS, SEGÚN FUENTES

PERIODO 2002-2004

INGRESOS POR FUENTES	2001	%P	2002	%P	2003	%P
Intereses/Préstamos	6,627,565	21.3	7,379,292	21.3	8,983,470	16.3
T. de C.			11.3		21.7	
Panaderías	2,210,041	7.1	2,204,837	6.4	3,221,963	5.9
T. de C.			- 0.2		46.1	
Venta de Métodos	398,541	1.3	770,708	2.2	1,462,458	2.7
T. de C.			93.4		89.8	
INGRESOS PROPIOS	**9,236,147**	**29.7**	**10,354,837**	**29.9**	**13,667,891**	**24.8**
T. de C.			12.1		32.0	
Donaciones	21,834,701	70.3	24,306,478	70.1	41,374,272	75.2
T. de C.			11.3		70.2	
TOTAL DE INGRESOS	**31,070,848**	**100.0**	**34,661,315**	100.0	**55,042,163**	100.0
T. de C.			**11.6**		**58.8**	

Fuente: Elaborado en base a informaciones de MUDE.

TABLA ANEXA No. G-4

PROFAMILIA

COMPORTAMIENTO DE LOS GASTOS GENERALES, SEGÚN RENGLONES

RENGLONES	2001	2002*	2003*	2004**
Costo de personal	30,816,840	34,822,447	44,701,401	60,085,552
Transporte y viáticos	2,297,900	1,694,406	3,172,600	4,264,462
Mantenimiento de Vehículos	439,014	640,546	739,396	993,862
Material gastable	1,201,647	1,455,705	2,138,650	2,874,674
Comunicaciones	1,157,619	1,433,761	1,688,634	2,269,784
Activos fijos	1,928,145	5,989,186	9,535,457	12,817,119
Publicidad y propaganda	3,054,843	964,323	2,391,534	3,214,589
Honorarios por servicios	20,686,975	22,258,043	26,829,363	36,062,787
Suministros médicos	3,120,090	6,458,676	9,814,273	13,191,891
Combustible	477,050	478,201	583,125	783,810
Gastos administrativos	7,552,710	9,145,000	13,096,541	17,603,764
Gastos de embarque		60,580	16,925	22,750
Costos de anticonceptivos	2,250,941			-
Mantenimiento de equipos	571,523	1,041,905	1,336,561	1,796,543
Reparaciones y mejoras	3,222,321	7,841,062	7,349,980	9,879,503
Reuniones y hospitalidad	334,416	598,136	1,365,168	1,834,996
Seguros	594,958	597,695	1,313,784	1,765,928
Gastos aduanales	74,110			-
Gastos financieros		562,520	2,189,516	2,943,046
Capacitación y adiestramiento	926,440	1,822,601	2,649,956	3,561,948
Libros y revistas	11,715	37,495	203,041	272,918
Gastos de pacientes		783,372	1,054,778	1,417,784
Otros	1,528,767	853,656	2,270,574	3,052,000
TOTALES	**82,248,024**	**99,539,316**	**134,441,257**	**180,709,708**
TASA DE CRECIMIENTO ANUAL		**21.0**	**35.1**	**34.4**

Fuente: Elaborado en base a informaciones suministradas por la Subdirección Financiera.

(*) Los datos correspondientes a los años 2002 y 2003 fueron tomados de las Auditorias.

(**) Datos proyectados en base valores de la ejecución presupuestaria Enero-Junio 2004.

TABLA No. G-5
MUDE
EVOLUCION DE LOS GASTOS, SEGÚN RENGLON Y AÑOS
2001-2003

RENGLON	2001	2002	2003
Costos y Gastos			
	32,397	583,800	941,050
Costos de Métodos	1,165,149	1,423,840	1,890,142
Costos de Panaderías	11,090,664	5,419,808	17,543,498
Costos de Infraestructura			
Total Costos	**12,288,210**	**7,427,448**	**20,374,690**
Gastos Generales y Administrativos			
Gastos de Personal	11,376,583	9,969,375	9,770,211
Otros Gastos de Personal	-	-	-
Incentivos a Oficiales de Crédito	77,350	40,229	45,300
Equipo de Transporte	1,717,312	1,956,366	1,661,482
Gastos Operativos	5,163,061	3,550,478	4,587,552
Gastos de Local y Equipos	889,627	858,357	841,882
Reuniones y Eventos	41,009	23,087	16,568
Dsarrollo de Programas	1,984,485	1,105,983	4,002,202
Reserva/Cuentas Inconbrables	2,705,373	1,716,373	1,716,781
Gastos Miscelaneos	384,416	915,566	520,035
Gastos Legales	-	19,814	64,512
Gastos Financieros	-	1,662,796	1,977,878
Total Gastos	**24,339,216**	**21,818,424**	**25,204,403**
TOTAL COSTOS Y GASTOS	**36,627,426**	**29,245,872**	**45,579,093**

Fuente: MUDE.