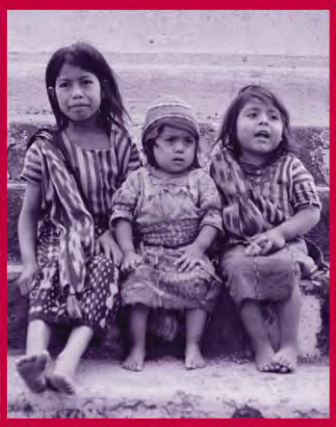
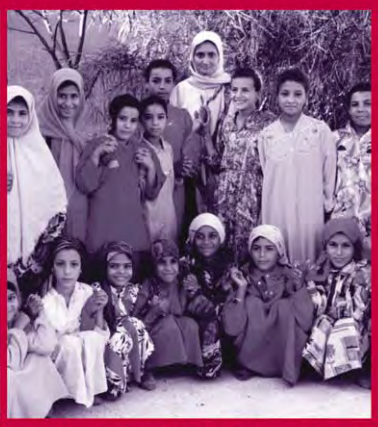
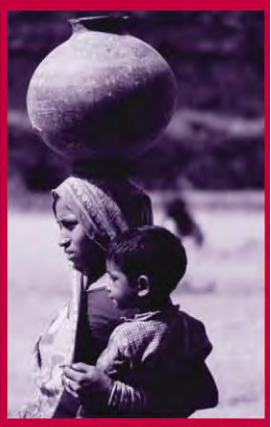
• STATE-OF-THE-ART FAMILY PLANNING AND REPRODUCTIVE HEALTH



SERVICES • STATE-OF-THE-ART FAMILY PLANNING AND REPRODUCTIV

Sustainable Adolescent Family Planning and Sexual and Reproductive Health Programs

The PROFAMILIA/Colombia and FEMAP/Mexico Models

CATALYST
consortium

USAID

PARTNERS:
Academy for Educational Development • Centre for Development and Population Activities • Meridian Group International • Pathfinder International • PROFAMILIA/Colombia

The CATALYST Consortium is a global reproductive health activity initiated in September 2000 by the Office of Population and Reproductive Health, Bureau for Global Health, U.S. Agency for International Development (USAID). The Consortium is a partnership of five organizations: the Academy for Educational Development (AED), Centre for Development and Population Activities (CEDPA), Meridian Group International, Inc., Pathfinder International and PROFAMILIA/Colombia.

CATALYST works in family planning and reproductive health through synergistic partnerships and state-of-the-art technical leadership. Its overall strategic objective is to increase the use of sustainable, quality family planning and reproductive health (FP/RH) services and healthy practices through clinical and non-clinical programs.

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LIST OF ACRONYMS

AMES (acronym in Spanish): Asociación Mexicana de Educación Sexual A.C. (Mexican Association of Sexual Education)

PAB (acronym in Spanish): Plan de Atención Básico (Basic Health plan)

CBD: Community-Based Distribution of Contraceptives

COFAV (acronym in Spanish): Centro de Orientación Familiar de Veracruz (Veracruz Family Counseling Center)

COFAX (acronym in Spanish): Centro de Orientación Familiar de Xalapa (Xalapa Family Counseling Center)

CORA (acronym in Spanish): Centro de Orientación a Adolescentes (Adolescent Counseling Center)

CYP: Couple Years of Protection

FEMAP (acronym in Spanish): Federación Mexicana de Salud y Desarrollo Comunitario A.C. (Mexican Federation of Community Health and Development)

EPS (acronym in Spanish): Empresa Promotora de Salud (Health Promoting Organization)

HIV/AIDS: Acquired Immunodeficiency Syndrome

IEC: Information, Education and Communication

IEP: Institutional Educational Project

IPPF/WHR: International Planned Parenthood Federation / Western Hemisphere Region

MEXFAM (acronym in Spanish): Fundación Mexicana para la Planeación Familiar (Mexican Foundation for Family Planning)

NDHS: National Demographic and Health Survey

PROFAMILIA (acronym in Spanish): Asociación Pro-Bienestar de la Familia Colombiana (Colombian Association for Family Welfare)

SADEC (acronym in Spanish): Salud y Desarrollo Comunitario (Community Health and Development)

SGSSS (acronym in Spanish): Sistema General de Seguridad Social en Salud (Social

Security Health System)

SRH: Sexual and Reproductive Health

TFR: Total Fertility Rate

NBI (acronym in Spanish): Indice de Necesidades Básicas Insatisfechas (Unmet Basic Needs Index)
USAID: United States Agency for International Development

VSC: Voluntary Surgical Contraception

WHO: World Health Organization

ACKNOWLEDGMENTS

The CATALYST Consortium partner, PROFAMILIA (Asociación Pro-Bienestar de la Familia Colombiana, Colombian Association for Family Welfare), identified two successful experiences in implementing highly sustainable youth programs—the PROFAMILIA Youth Center program and the community-based FEMAP for a Healthy Youth program implemented by FEMAP (Federacíon Mexicana de Salud y Desarrollo Comunitario A.C., Mexican Federation of Community Health and Development).

Gabriel Ojeda, Rodrigo Castro, German Lopez, and Marie-France Semmelbeck from PROFAMILIA and Enrique Suarez-Toriello and Jesus Servin from FEMAP collaborated in writing this report.

Maria Isabel Plata and Susana Moya from PROFAMILIA and Orlando Hernandez and Veronique Dupont from the CATALYST Consortium reviewed report drafts. Sally Salisbury from the CATALYST Consortium edited report drafts.

PROFAMILIA and FEMAP wish to extend their gratitude to USAID for funding through the Transition Project, which enabled these organizations to transform themselves from donor-dependent to independent institutions.

Special thanks to the reviewers, Alvaro Monroy and Barbara Janowitz, and to the clients, staff, and community leaders whom were interviewed for this report.

ORGANIZATION OF REPORT

There are four sections and two annexes in the report. The first section provides general background on the purpose and context of the report. The next two sections present the PROFAMILIA and FEMAP models. Each of these sections describes the national and the institutional context of the organization, the historical background of the model adolescent program, its programmatic framework and objectives, sustainability strategy, and financial and programmatic results. The final section presents lessons learned from both programs. Annexes provide detailed financial reports for both organizations.

EXECUTIVE SUMMARY

The objective of this report is to describe two adolescent family planning and sexual and reproductive health (FP/SRH) programs that have proven to be sustainable, successful, and of high quality. These models are the PROFAMILIA Youth Center program in Colombia and the FEMAP for a Healthy Youth program in Mexico

Many countries are working to provide young people with healthcare services that respond to their needs by having specially trained staff, reduced fees, outreach activities, and hours that are convenient. However, government programs are frequently unable to meet the increased demand for services, are insufficient in numbers, and have limited capacity. Increasingly, governments are turning to non-governmental organizations (NGOs) to implement adolescent FP/SRH services. Such NGOs are striving to become financially sustainable; however, this sustainability is difficult to achieve due to the limited ability of adolescents to pay for services. The programs presented here have different financial strategies for achieving sustainability. It is hoped that these models will help other organizations implement or plan locally funded adolescent FP/SRH programs.

Methodology Used in this Report

This report is a process documentation. That is, it focuses on what was implemented, how it was implemented, and the lessons learned throughout the implementation process. An essential element of the documentation was to describe the sustainability strategies used in program development and implementation, and the impact of those strategies on program and financial results.

While this report is not a research evaluation, the process documentation was conducted using the rigor and methodology characteristic of research. That is, the staff conducting the documentation made methodological decisions pertaining to sampling of experiences, instruments to be used, and data analysis objectives and procedures.

Although both adolescent programs are national programs, due to time and budget restrictions, visits were made to only three centers in each country. PROFAMILIA selected the largest of its program clinics—Bogota, Cali, and Medellín. These are also clinics where adolescent FP/SRH services are offered in separate youth centers. FEMAP selected programs representing different income-generating activities—SADEC (Salud y Desarrollo Comunitario, Community Health and Development) in Ciudad Juárez, COFAV (Centro de Orientación Familiar de Veracruz, Veracruz Family Counseling Center) in Veracruz, and COFAX (Centro de Orientación Familiar de Xalapa, Xalapa Family Counseling Center) in Xalapa.

Representatives of the CATALYST Consortium, PROFAMILIA, and FEMAP jointly developed the parameters of the process documentation. Two teams conducted the on-site surveys—a PROFAMILIA-led team visited FEMAP sites, and a FEMAP-led team visited PROFAMILIA sites. The teams also jointly analyzed the information obtained and wrote and finalized the report.

The definition of **sustainability** agreed upon for this report addresses three main components of sustainability that are interrelated—institutional, programmatic, and financial. In the context of FP/SRH, this definition of sustainability refers to an

institution's capacity to continue delivering quality services that meet defined norms and standards and are responsive to client and/or community needs, once donor(s) support has ended.

Results

Both PROFAMILIA and FEMAP demonstrated that they can cover all or a high percentage of the operational expenses of their youth programs without resorting to external financial support. In 2002, the PROFAMILIA Youth Center program reached an operational sustainability level of 79 percent nationwide. In 2002, after three years of operation, the FEMAP for a Healthy Youth program reached an operational sustainability level of 113 percent nationwide.

The PROFAMILIA and FEMAP sustainability strategies ensure the continuity of their programs. PROFAMILIA funds its adolescent programs with income generated through the sale of services and products to adolescents, at a price that is 20 percent lower than that paid by adults. The FEMAP for a Healthy Youth program receives its funding from income generated by activities independent of the adolescent program. This income is earmarked exclusively for the adolescent program.

Lessons Learned

- To be successful, the sustainability strategy should be developed in the context of the specific characteristics of the population served as the well as the organizational objectives and context of the sponsoring organization.

- When the financial strategy is based on resources contributed by adolescents, achieving 100 percent or greater sustainability is a very slow process

- The shorter the time to achieve sustainability, the more rapidly the organization will be able to scale up the program.

- Sustainability of an adolescent program is closely related to the managerial capability of the sponsoring organization.

- When the installed capacity is somewhat underused, market studies will identify other potential services that can be provided and determine if there is a demand for the new services by current or new users.

- When products are purchased to be sold or consumed locally, a thorough cost analysis considering volume and use of supplies should be done.

- Paying staff on a productivity basis is less costly and helps reduce operational expenses for clinics or activities that have a low volume of clients.

- Use of adolescent volunteers reduces costs.

- Adolescent FP/SRH programs should institutionalize a culture of payment; however, fees must be adjusted according to adolescents' ability to pay.

- To enhance and generate financial resources, organizations should:
    - Offer quality services
    - Sell adolescent educational services to schools, businesses, and communities.
    - Contract for services or supply contraceptives to adolescents through other private and public organizations.
    - Negotiate a fee-sharing arrangement with providers to whom adolescents are referred for other services.
- To promote a culture and business practices that are sustainability-driven, organizations should:
    - Strengthen their management and administration systems.
    - Establish a cost accounting system to track costs by cost centers (e.g. youth services/activities).
    - Implement productivity, expense, and quality standards.
    - Improve follow-up, supervision, and inventory control.
    - Establish policies that control the rationalization of expenditures.
    - Develop adequate planning systems.
    - Implement a Management Information System (MIS) that captures both programmatic and financial information and generates reports used for decision making.
    - Implement adequate training and refresher programs on adolescent heath for program managers, service providers, and volunteers.

Conclusion

The first steps in the pursuit of sustainability are usually slow. However, achieving sustainability is the most compelling proof of an organization's commitment with respect to its vision, mission, philosophy, and objectives, because, through these, the organization demonstrates its interest and desire to ensure the continuity of programs for young people.

INTRODUCTION

Adolescence is a time of tremendous opportunity and promise. To fulfill that promise, young people must be able to develop their full potential as educated, informed, and healthy citizens who are active and valued in their communities. Strategically and deliberately investing in the well being of young people can result in powerful positive individual and social behavior change. This is especially true with regard to FP/SRH issues, where ignorance and lack of services can result in devastating health consequences for young people. Health-seeking behaviors and patterns acquired during adolescence will affect the health and well being of not only these young people, but of their children.

- Almost 1.7 billion people are between the ages of 10 and 24.[1]
- 85 percent of these young people live in developing, emerging, or transition economies
- More than 40 percent of all teenage girls in the developing world will give birth before the age of 20.[2]
- Young women between the ages of 15 and 19 are two to four times more likely to die from pregnancy-related causes than women over the age of 20.[2]
- Of the 5 million new HIV infections each year, about 50 percent occur in individuals between the ages of 15 and 24.[2]

For more than a decade, the international community has been actively engaged in promoting and protecting the health of adolescents. Calls for action have emerged from various international forums, including the 1989 World Summit Conference, the 1990 World Summit for Children, the 1995 Fourth World Conference on Women, and the United Nations World Programme of Action for Youth to the Year 2000 and Beyond. In 1995, the World Health Organization, the United Nations Population Fund (UNFPA), and the United Nations Children's Fund jointly convened a Study Group on Programming for Adolescent Health. The resulting report, entitled "Action for Adolescent Health. Towards a Common Agenda" (www.who.int/child-adolescent-health/asrh.htm) highlighted the importance of investing in adolescent and youth health programs and urged governments to develop and strengthen initiatives serving this population group.

Many countries are working to provide young people with healthcare services that respond to their needs by having specially trained staff, reduced fees, outreach activities, and hours that are convenient. However, government programs are frequently unable to meet the increased demand for services, are insufficient in numbers, and have limited capacity. Increasingly, governments are turning to NGOs to implement adolescent FP/SRH services. Such NGO programs are striving to become financially sustainable; however, this sustainability is difficult to achieve due to limited ability of adolescents to pay for services.

To assist NGOs in developing sustainable adolescent FP/SRH programs, this report presents two models•the PROFAMILIA Youth Center program and the FEMAP for a Healthy Youth

[1] *Source*. United Nations 2001.
[2] *Source*. Population Reference Bureau. 2002. World Population Data Sheet, Washington, DC.

program. Although their financial strategies differ, both programs have proven to be sustainable, successful, and of high quality.

PROFAMILIA and FEMAP are private non-profit institutions, whose missions and objectives include developing FP/SRH programs for adolescents. Although they share similar missions and objectives, it is important to point out their legal, operational, and organizational differences before presenting their respective models (**Table 1**). These differences have implications for the implementation of their adolescent programs.

Table 1. Characteristics of PROFAMILIA and FEMAP

Characteristics	**PROFAMILIA**	**FEMAP**
Legal	National Civil Association	National Network of Civil Associations
Operational	Provides services directly to users	Provides services through its affiliates
Organizational	The central office establishes policies, procedures and norms.	Affiliates establish their own policies, procedures and norms. Their administrative and organizational structures are separate. Affiliation to FEMAP is subject to adherence to the federation's norms, policies and procedures.

Both organizations have demonstrated that they can cover all or a high percentage of the operational expenses of their youth programs without resorting to external financial support. In 2002, the PROFAMILIA Youth Center program reached an operational sustainability level of 79 percent nationwide. In 2002, after three years of operation, the FEMAP for a Healthy Youth program reached an operational sustainability level of 113 percent nationwide.

The PROFAMILIA and FEMAP sustainability strategies ensure the continuity of their programs. PROFAMILIA funds its adolescent programs with income generated through the sale of services and products to adolescents, at a price that is 20 percent lower than that paid by adults. The FEMAP for a Healthy Youth program receives its funding from income generated by activities independent of the adolescent program. This income is earmarked exclusively for the adolescent program.

The PROFAMILIA and FEMAP adolescent programs are presented here as models to other organizations that are implementing or planning to develop youth SRH programs, and have experienced or are facing reductions in international funding. These models are not intended to be replicated as such. Rather, they should be adapted to the national and organizational context of each organization, according to its programmatic and sustainability goals.

Methodology Used for Report

The reader must be careful to discern the difference between a process documentation, which is the scope of this activity, and evaluation or research, which is beyond the scope of this activity.

Process documentation tries to understand the steps carried out to implement an intervention to change an aspect of reality. Process documentation should look for common denominators across practical applications to derive general lessons learned about the best way to implement an intervention. Research, on the other hand, tries to understand a certain aspect of reality, which has not been addressed by a given intervention. The research itself does not transform the object of study. Research focuses on exploring research question and/or testing hypotheses. In social science, research may take place before an intervention occurs and it may help inform how the intervention should be designed. Finally, an evaluation focuses on a project, program or intervention and during a specific implementation period for that intervention, and it compares objectives and targets with achievements. There may be overlap between different studies.[3]

What is important for the purposes of the process documentation that the CATALYST Consortium conducted of the FEMAP and PROFAMILIA adolescent programs is the focus on what was implemented, how it was implemented, and the lessons learned throughout. An essential element of the process documentation describes what sustainability strategies were used in program development and implementation and the impact of those strategies on program and financial achievements. Although it focuses on documenting the "what" and "how," process documentation brings the rigor and methodology characteristic of research. That is, methodological decisions are made pertaining to sampling of experiences, instruments to be used, and data analysis objectives and procedures. A description of the process documentation (conducted between July 2002 and September 2003) as well as the specific case study methodology employed in this study follows.

- Two adolescent program models that have reached high levels of sustainability while meeting their objectives and goals were identified. These models belong to PROFAMILIA and FEMAP.

- A literature review on the topic of sustainability of youth programs was conducted prior to proceeding with the documentation. The review found that little information is available on models of successful and sustainable adolescent programs[4].

- Although both youth programs are national programs, due to time and budget restrictions, visits were made to only three centers in each country. The operational sustainability levels of the selected centers in each country were analyzed.

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[3] M. Rosario Ayllón Viaña. Una propuesta operativa para sistematizar: Aprendiendo desde la Práctica. Lima, Peru: Kallpa, 2002.

[4] The Focus end-of-program report (2001) concurs, concluding that "…information is lacking on the sustainability or costs of the programs and on sexual and reproductive health policies for youth." p. 34

- PROFAMILIA selected the largest of its program clinics—Bogota, Cali, and Medellín. These are also clinics where adolescent FP/SRH services are offered in separate youth centers.

- FEMAP selected programs representing different income-generating activities—SADEC in Ciudad Juárez, COFAV in Veracruz, and COFAX in Xalapa.

- Each organization described and analyzed the programmatic and financial characteristics of its adolescent program, including the program origin, objectives, target population served, service delivery approaches, thematic contents, education and communication (IEC) activities, relationship between the program and sexual education topics, quality of services (quality assurance and assessment), program planning and evaluation, sources of income (national and international), allocation of income with respect to expenses, and sustainability levels.

- A team comprising the CATALYST Consortium Senior Advisor for Sustainability and South-to-South and the PROFAMILIA Director of Research and Evaluation first visited FEMAP to discuss the objectives and the process of the documentation; agree on the operational definition of sustainability and the elements of sustainability; discuss sample size, and select the sites to be visited in Mexico and Colombia.

- Visits were conducted to three selected adolescent program sites in Mexico and to three adolescent clinics in Colombia to collect additional data and interview staff and program beneficiaries.

- Unstructured interviews were conducted with the directors, administrators and program staff at each center, as well as with service users and community members (if time allowed). Interviews were conducted by the following teams:
  - A team consisting of the PROFAMILIA Research and Evaluation Director and Director of Accounting, and the CATALYST Consortium Senior Advisor for Sustainability and South-to-South traveled to Mexico to conduct FEMAP interviews. The team was accompanied by the FEMAP Program Director.

  - A team consisting of the FEMAP Program Director and Project Coordinator traveled to Colombia to conduct the PROFAMILIA interviews. The team was accompanied by the PROFAMILIA Director of Accounting and the PROFAMILIA Research and Evaluation Director.

- Both teams worked together to analyze the information compiled during the site visits.

- Once the visits and the data collection were completed, the PROFAMILIA team drafted the PROFAMILIA section, and the FEMAP team drafted the FEMAP section. The final report was produced at a joint review meeting in Bogotá.

Definition of Terms

Sustainability. The concept of sustainability has evolved over the years and many different definitions exist. The definition of sustainability used by the CATALYST Consortium is not strictly limited to financial sustainability, although financial sustainability is an integral component. The CATALYST Consortium defines sustainability in a broader sense, and addresses three main components of sustainability that are interrelated—institutional, programmatic, and financial. In the context of FP/SRH, this definition of sustainability refers to an institution's capacity to continue delivering quality services that meet defined norms and standards and are responsive to client and/or community needs once donor(s) support has ended.

Institutional sustainability is defined as an organization's capacity with respect to its internal structure, its management systems, its culture, and its leadership. It includes the following elements:

- Leadership[5] demonstrated by the organization's assembly, board of directors, executive director, managers and, in general, the different officers, especially those involved in the decision-making process within the organization
- Strategic and programmatic planning processes
- Institutional culture related to the organization's mission, objectives and policies, with emphasis on a culture of sustainability
- Management systems to support different functions, including human resources, staff training, supervision, financial administration, accounting system, logistical process, and MIS (related to both programmatic and financial information as well as research and evaluation)
- Resource development, including obtaining international or national funding and local financial support for program development
- Institutional policy regarding the sale of services and products (does the institution charge fees for services and products)

Programmatic sustainability is defined as an organization's capacity to continue developing programs and/or providing quality services that are responsive to clients' needs and involve the community. It encompasses:

- Quality of services (quality assurance and assessment)
- Access to services (financial, geographic, and gender)
- Supply and demand of services (installed capacity to offer and provide services in response to potential or existing demand)
- Community and user participation in the development of services and programmatic activities
- Program philosophy and policies

[5] According to Adrián G. Cottin Belloso (Leadership in Action): leadership is the capability to see a problem, recognize it as such, propose a solution, and implement it without having to be motivated by others. Source: http://www.analitica.com

Financial sustainability is defined as an organization's capacity to develop strategies to generate resources that sustain organizational activities and contain and/or reduce costs. Financial sustainability implies:

- Cost studies and projections both for services and products
- Setting prices for services and products
- Generation of income through sales of services and products
- Funding alternatives for each program
- Investment and maintenance costs for each program
- Internal or cross-subsidies that benefit each program
- Internal financial controls for each program

Operational sustainability is a component of financial sustainability, and is defined as the relationship between locally generated income (including local donations) and total expenses necessary to deliver a specific number of services.

Operational expenses includes all expenses necessary for the provision of services, such as salaries, medical supplies, contraceptives, rent, maintenance, utilities etc. (Annexes A and B present PROFAMILIA and FEMAP operational expenses). Operational expenses do not include central administration expenses.

Cost-effectiveness. To provide a service at the lowest cost possible while maintaining a high level of quality

Non-profit. Organizations that do not seek or produce a profit nevertheless must operate like businesses and generate surpluses, which can be reinvested in their own programs to ensure continuity, while maintaining their social mission.

PROFAMILIA YOUTH CENTER PROGRAM

NATIONAL CONTEXT

The change in reproductive health behavior and wide acceptance of family planning (FP) in Colombia is considered a success story, not only in Latin America but worldwide. In the mid-1960s, the total fertility rate in Colombia was 7.0 children per woman, and the population growth rate was nearly 3.4 percent. By 2000, Colombia had reached a population of 42,500,000 inhabitants[6]; the total fertility rate had decreased to 2.8 children per woman, and the population growth to 1.7 percent. These important changes have been accompanied by a substantial increase in the use of contraceptive methods. In 2000, more than 76 percent of women of reproductive age, married or in union, used a FP method.

In 1969 the national government created the Maternal Child Care Working Group within the Ministry of Health. This new group was charged with implementing activities related to the protection of mother and child, including FP. Although this group continued its activities under different governments, the actual delivery of services has been very erratic due to volatile political trends and lack of decisive support of incumbent ministers. Hence, officially Colombia has never had an explicit population and FP policy. Nevertheless the 1991 Constitution specified that "couples have the right to decide freely and responsibly on the number of children they have, and must support and educate them while they are minors or disabled."

Likewise, the Constitution determined that "health care and environmental sanitation are public services, which fall under the responsibility of the State." All Colombians are guaranteed access to health services including educational, preventive, and curative services. In December 1993, the Congress passed Law 100, which reformed the health sector and guaranteed universal access to services, including FP/SRH services. The new law mandated that all individuals be covered by the social security system.

Initially, the approval of the social security system member was required before any care or services could be provided for a dependent. At the present time, this approval is no longer required and users need only present an identification card to obtain services. This new policy is a definite advantage for adolescents as they no longer need parental approval to receive needed health services.

By 2000, there were approximately 8,460,000 adolescents between the ages of 10 and 19, representing nearly 20 percent of Colombia's total population. **Table 2** presents the characteristics of Colombian adolescent women between the ages of 15 and 19.

[6] Colombia Demographic and Health Survey (CDHS), 2000. PROFAMILIA, Bogotá, October 2000

Table 2. Primary Socio-Demographic Indicators of 15–19 Year Old Adolescent Women in Colombia, 2000	
Indicators	
No education	0.6%
Incomplete primary education	21.1%
Complete secondary education	73%
Currently employed	22.6%
Lives in common-law marriage	12.7%
Married	1.6%
Separated	3.1%
General Fertility Rate (†)	85
Is or has been sexually active	40%
Has given birth or is pregnant with her first child	20%
Adolescent women who give birth at home	13%
Children under the care of their adolescent mothers	23%
Average intergenesic period among adolescent mothers	19.8 months
Adolescent women who knows the stage of the menstrual cycle and the fecundity period	38.1%
Use of methods among 15–19 year-old adolescent women, currently in union	57.2%
Adolescents who do not want to have more children	26.5%
Adolescents who have been raped	6.5%
Adolescents currently in union who report physical abuse from their partners	25%
Adolescents who know that HIV/AIDS can be prevented by condom use	66%
Adolescents who do not know about sexually transmitted infections	54.5%
Adolescents who are not covered by the Social Security Health Plan	47.1%
†Between 1978 and 2000, the fertility rate among women between the ages of 15 and 19 increased from 59 to 85 for every 1,000 women *Source*: CDHS 2000	

ADOLESCENT PROGRAMS IN COLOMBIA

Initiatives designed to meet adolescents' SRH needs emerged in Colombia at the end of the 1970s as a strategy to address the problem of early, unwanted pregnancies among youths. Programs were implemented by maternity hospitals or general hospitals in large cities, initiated by CAMFAM[7], and in some cases by NGOs. These institutions developed IEC programs locally, and some of them offered facility-based healthcare services related to pregnancy and sexually transmitted infections (STIs).

In the 1980s, CAMFAM in Bogotá, the Maternity Hospital Rafael Calvo de Cartagena, the Association of Basic Health Services in Manizales, the Hospital Universitario del Valle in Cali, and the Preventive Health Association in Bogotá, among others, initiated programs designed to promote health and provide comprehensive care to adolescents. Their activities centered on basic healthcare teams that developed educational and preventive activities for health promotion, training, assistance, and research.

[7] CAMFAM is an organization created by law. Its benefits include medical services and recreation for its members. Companies contribute funding for their employees.

One of the first initiatives that sought to go beyond the local action plan was the National Plan for Sexual Education headed by the Presidential Council for Youth, Women, and Families in 1990[8]. This plan included actions from the ministries of health and education, the Colombian Institute of Family Welfare, and benefited from the support of Comite Regional de Educación Sexual para America Latina y el Caribe (Regional Committee of Sexual Education for Latin America and the Caribbean), PROFAMILIA, the Restrepo Barco Foundation, and other non-governmental organizations. Educational strategies proposed by the National Plan for Sexual Education were later incorporated by the Ministry of Education into its National Sex Education Project. The healthcare strategies, including promotion and prevention activities, were absorbed by the new health system in 1993 as a result of the health sector reform.

In 1993, the Ministry of Education launched the National Sex Education Project and included it by law in the country's general education. The resolution emphasized the importance of sex education and became a mandatory requirement in the curricula of both primary and secondary schools. It was enforced through directives at national, departmental, and municipal government levels. Although the curriculum was established and guidelines provided, the impact of sex education through schools has been very limited, perhaps due to the lack of political will, lack of sufficient training of teachers, and lack of human and financial resources. According to the CDHS 2000 (**Table 2**), one out of five adolescents (15–19 years) are already mothers or are pregnant with their first child, only 38.1 percent of all women between the age of 15 and 19 know the point in the menstrual cycle when the risk of pregnancy is highest, and more than half of the adolescents do not know about STIs.

Under the new social security system[9], initiated in 1993 with Law 100, adolescent healthcare services and health promotion and disease prevention programs are regulated by the Ministry of Health. The services and programs are provided by institutions that are part of the social security system, including insurance companies, health promotion agencies, administrators of the subsidized plan, and service delivery institutions. In addition, civil society organizations such as PROFAMILIA continue to develop and implement programs for target groups within the adolescent population, as well as provide services to adolescents who are beneficiaries or affiliated with the new health system.

[8] Muñoz, Ana Lucía: Plan Nacional de Educación Sexual, in: Segundo Seminario Colombiano de Sexualidad en la Adolescencia: Riesgos – Logros – Oportunidades. Asociación Salud Con Prevención. Bogotá, 1993.
[9] CATALYST Consortium. PROFAMILIA's Role in Health Sector Reform in Colombia. Case Study. Bogotá, March 2003.

INSTITUTIONAL CONTEXT

The Asociación Pro-Bienestar de la Familia Colombiana (Colombian Association for Family Welfare), PROFAMILIA, is a private, nonprofit organization that was created on September 15, 1965 and became an International Planned Parenthood Federation affiliate in 1966. For 38 years, PROFAMILIA has implemented FP/SRH programs in urban and rural areas through 35 clinics and centers nationwide. PROFAMILIA provides services in the areas of clinical care, surgical care, laboratory examinations, promotion and prevention, and research and evaluation in the fields of demography, population, and biomedicine, all within a gender, rights, and sustainability framework. In addition, PROFAMILIA develops international initiatives and provides training and technical assistance to professionals and health institutions through South-to-South collaboration.

PROFAMILIA has become the largest private FP/SRH service provider in the developing world. This leadership position is based on the range and quality of the services PROFAMILIA provides, the geographic and population coverage of its health centers, the innovative and pioneering nature of its programs, and to its overall multiple contributions to SRH.

In 2003, PROFAMILIA owned 18 of its 35 clinics[10], including 45 operating rooms, more than 220 doctor's offices, and 85 hospital beds. Despite the wide geographic coverage, management is centralized with autonomy for certain processes at the local level. Finances, payroll, hiring of staff, and purchasing of supplies and materials needed both for the administration and for the provision of services are handled at the central level. Materials and supplies are subsequently distributed and delivered from the central warehouse to the different sites countrywide.

The current service portfolio of PROFAMILIA was developed within a historical process, which started with FP and expanded into a wide range of SRH services. This programmatic design, which covers a comprehensive range of SRH services, was achieved prior to the health sector reform and not as a result of it[11].

[10] PROFAMILIA assigns a cost for rent for all services. When the building is owned by PROFAMILIA, the cost for rent is calculated based on the commercial value of the asset and on the market price. It is estimated that a building must produce 0.8% of its market value in monthly rental income. The depreciation expense is deducted from the cost for rent charged to the clinic and is distributed among all services provided in that clinic.

[11] CATALYST Consortium. 2003. *PROFAMILIA's Role in Health Sector Reform in Colombia. Case Study*.

Table 3. Programmatic Development of PROFAMILIA

1965	PROFAMILIA is founded
1969	First radio promotion of FP
1971	Vasectomy program begins
1971	Rural distribution of contraceptives begins
1973	First laparoscopic tubal ligation
1976	Mobile surgical program begins
1979	Surgical training of Colombian physicians
1985	First male clinic opens
1986	Family Legal Counseling Program begins
1987	AIDS information campaign begins
1990	First Youth Center opens
1994	Emergency Contraception Program begins
1996	Menopausal program begins
2001	Sale and distribution of dedicated emergency contraception product begins
2003	Assisted Fertility Program begins

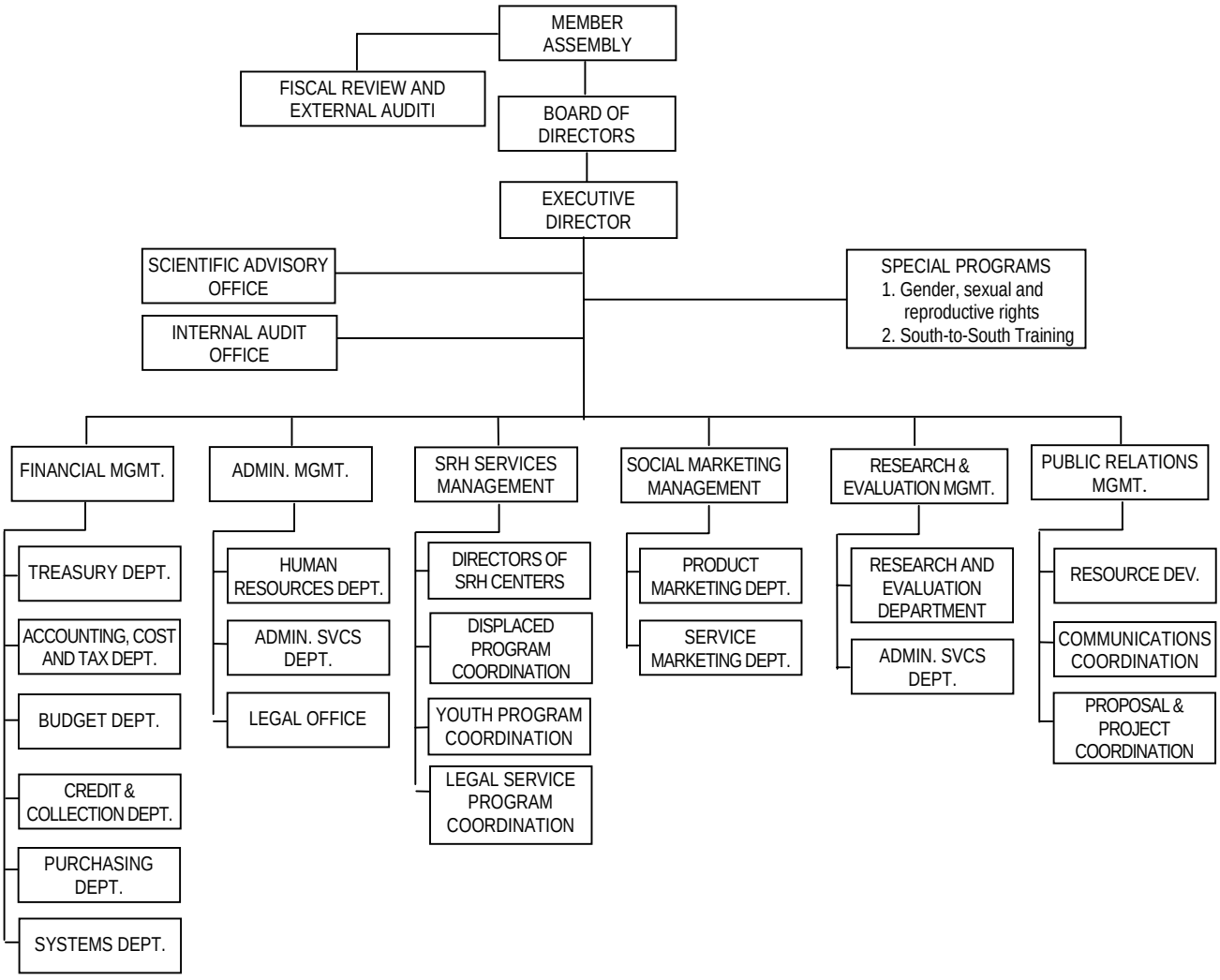
The PROFAMILIA Members Assembly and Board of Directors are the governing bodies of the organization (**Figure 1**), and both groups are composed of voluntary members. The Board of Directors has 11 members: seven women, one of whom is an adolescent representative, and four men. These Directors are appointed by the Members Assembly for fixed periods of time. The Assembly and Board of Directors are responsible for the organization's political and philosophical issues.

An Executive Director and six Management Teams provide administrative and logistical support for the planning, development, and evaluation of the various programs. The SRH Service Management and Social Marketing teams are responsible for service delivery program. The Youth Center program is part of the SRH Service Management Team.

The PROFAMILIA administrative structure facilitates the management and operation of the Youth Center program, as each of the management teams contributes the human, physical, and logistical resources, as well as the policies and information needed to support quality youth services.

Thus, for example, each management team reports specific statistics and financial information about the program monthly; selects, hires and trains staff; prepares educational and promotional material; establishes prices and margins for subsidies; and identifies adolescent-friendly reproductive health products for services.

Figure 1. PROFAMILIA Organizational Chart



In 2003 PROFAMILIA had 890 salaried employees and 600 contractors whose fees are based on productivity. Ongoing staff training ensures that they have the knowledge and skills needed to perform successfully on the job.

Professionals who work with adolescents such as general physicians, gynecologists, psychologists, teachers, certified nurses and nurse's aides are trained to use a gender and rights perspective to service delivery. Additionally, they learn how to build supportive relationships, and have counseling skills to work with adolescents. Thus, adolescents who use the program services can share their concerns with a "professional friend," who does not judge them for their behavior, but instead seeks to promote self-care and a healthy, enjoyable, and responsible sexuality[12].

[12] PROFAMILIA: Centros Para Jóvenes: Otra realidad de PROFAMILIA. Bogotá, 1993.

Institutional Sustainability

PROFAMILIA is a recognized role model in the area of sustainability. The organization has achieved sustainability through various means, including marketing of FP/SRH products (based on cost-effectiveness studies), sale of services to the public and private sectors, and implementation of strategies to decrease operational expenses and generate more income. From its founding, PROFAMILIA policy has been that clients who benefit from the services should contribute in some way towards supporting the organization. Indeed, the core of PROFAMILIA social mission is the belief that every client who visits a PROFAMILIA health center will receive the services s/he was seeking. Nevertheless, services are not offered free-of-charge. The philosophy behind this policy is the belief that users value most that for which they pay. This policy also ensures that users are not coerced into using contraception, but choose it voluntarily; encourages clients to demand quality services; and helps the organization generate resources to ensure its continued survival.

In the 1980s, PROFAMILIA conducted cost studies to determine the actual cost of each service and to establish prices. The results of the cost studies were used to identify potential areas for savings and to improve efficiency. PROFAMILIA also improved their MIS system in order to provide basic financial and programmatic data in a timely manner for informed and efficient administrative decision-making.

As the Health Sector Reform in Colombia was being implemented in 1993, PROFAMILIA began contracting with social security entities and delivering services to the affiliates of these institutions in order to replace its international funding with local funds. As a result, PROFAMILIA sustainability increased from 60 percent in 1990 to 80 percent in 2002, as illustrated in **Figure 2.**

Since its inception, PROFAMILIA has always operated to achieve financial sustainability, by combining management of FP and later SRH programs with an entrepreneurial spirit. For example, in 2001, PROFAMILIA began selling an emergency oral contraceptive to generate additional income as well as serve the needs of clients. The sale of this new product produced a financial surplus, as illustrated in **Figure 3**.

Figure 2. PROFAMILIA Financial Sustainability Trends at the Institutional Level, 1990•2002

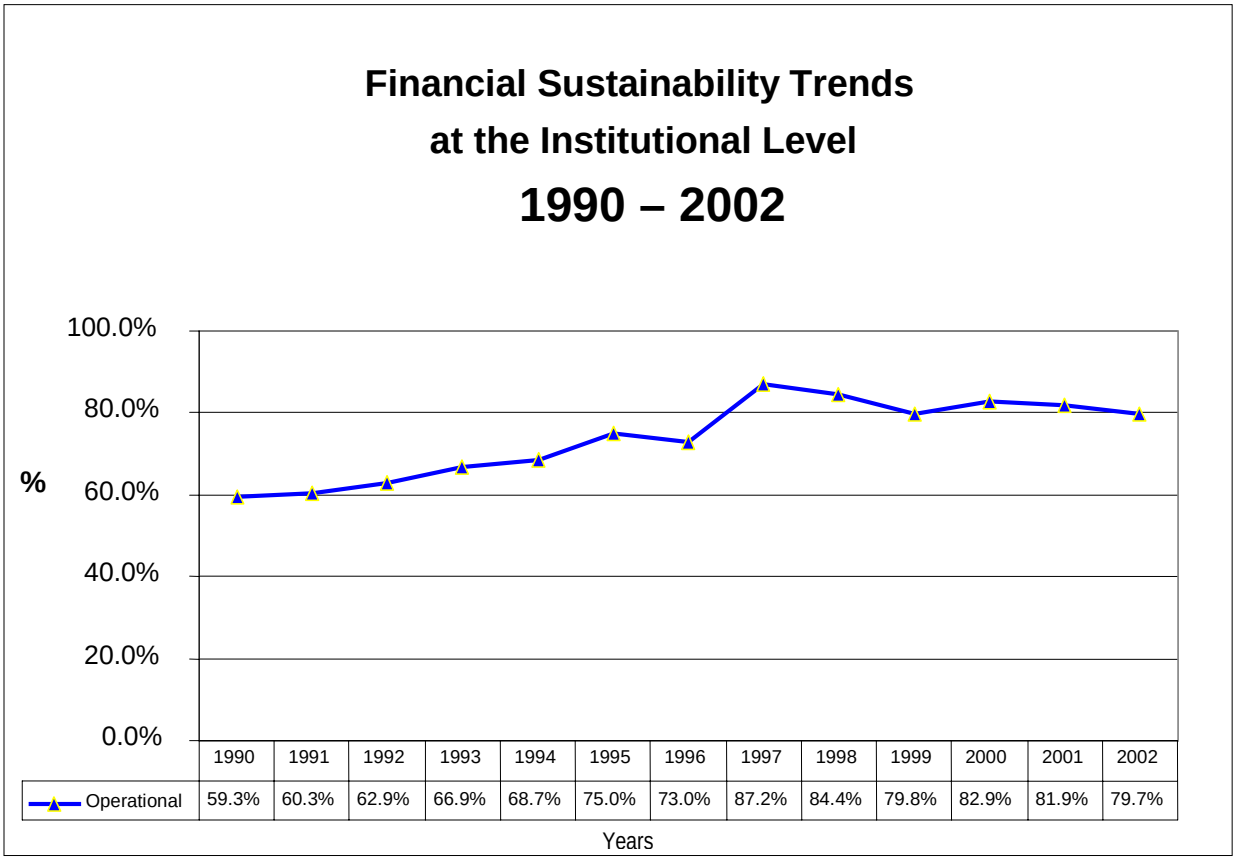


Figure 3: PROFAMILIA Institutional Financial Results, 1990 – 2002

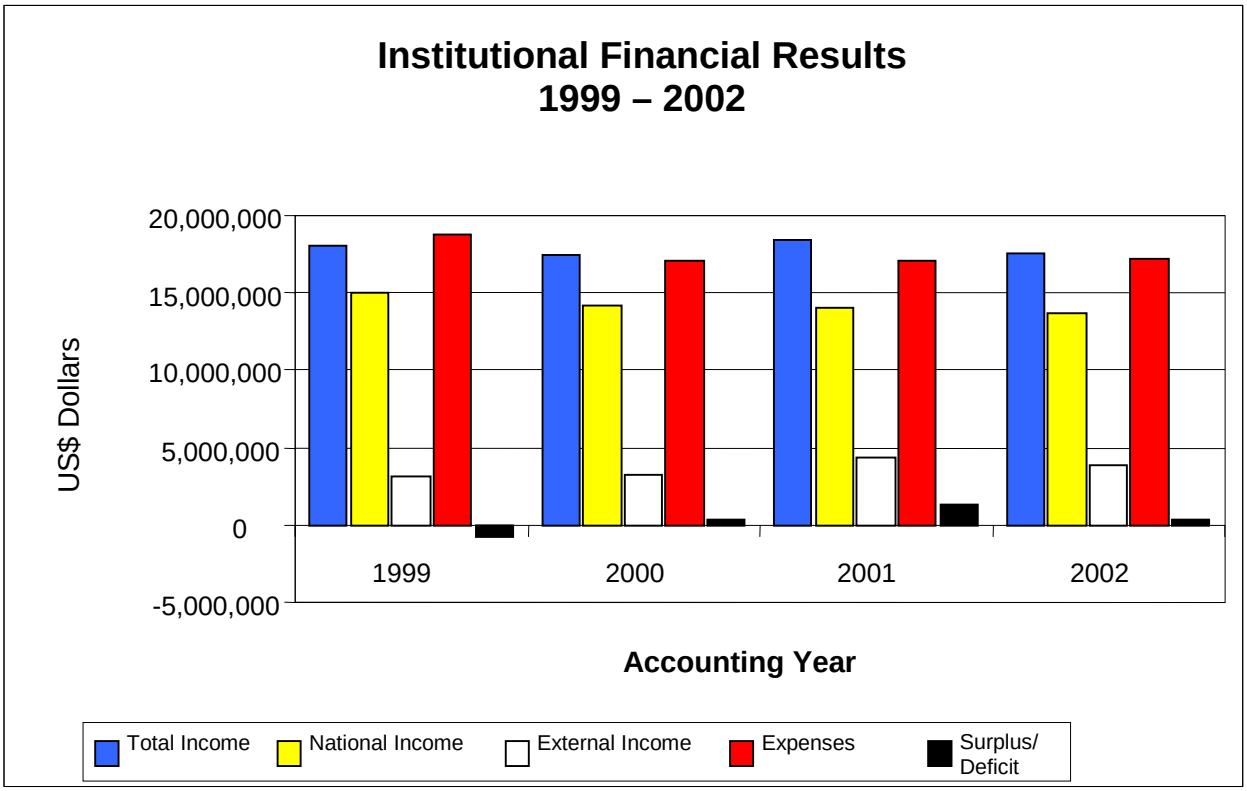


Figure 3 presents PROFAMILIA institutional financial results (income, expenses, and surplus/deficit) during the period 1999–2002. The 2001 surplus corresponds to the sale of a new dedicated emergency oral contraceptive product as well as to an increase in the number of FP/SRH services provided. Additionally, an endowment fund awarded by USAID to PROFAMILIA in 1997 also contributed to maintaining a constant income stream during that period.

PROFAMILIA ADOLESCENT PROGRAM

In 1985 PROFAMILIA began developing adolescent IEC and FP/SHR service delivery activities. From the onset of its adolescent program, PROFAMILIA benefited from the financial support of national and international institutions including the Antonio Restrepo Barco Foundation, Consejería para la Juventud, la Mujer y la Familia, the Moriah Foundation, the Planned Parenthood Federation of Canada, Marie Stopes International, the Public Welfare Foundation, International Planned Parenthood Federation/Western Hemisphere Region, USAID, and UNFPA. These donors contributed to the development of youth activities and awarded grants at various points in time.

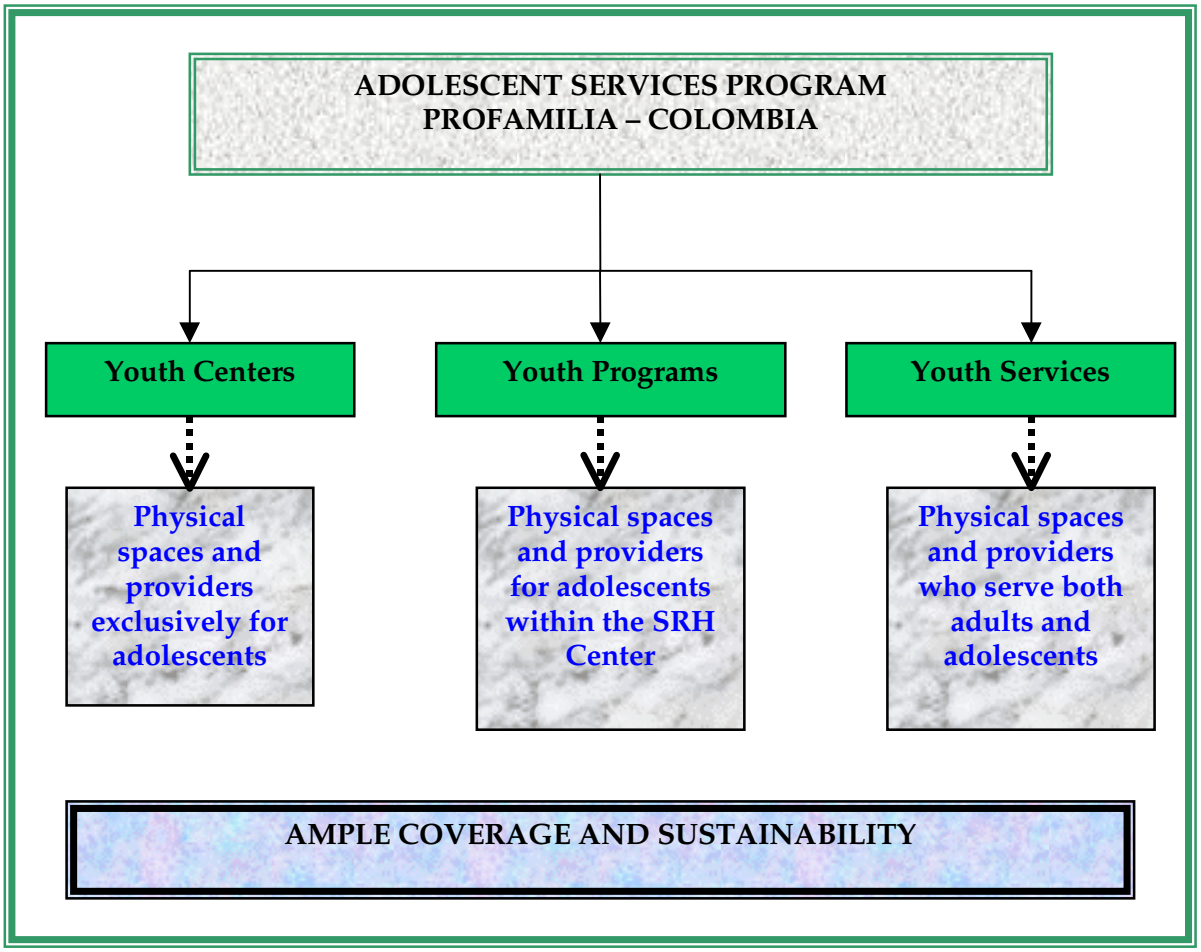
PROFAMILIA created the Youth Center Program in 1990 to provide adolescents between the ages of 10 and 19 with youth-friendly FP/SRH services. These services were delivered in dedicated spaces and staffed with professionals especially trained to serve adolescents and their partners, based on their needs and characteristics. In order to contain fixed costs, PROFAMILIA then expanded its Youth Center Program by adapting the physical facilities and hours of operation of the regular adult clinics to create space for the exclusive use of adolescents. PROFAMILIA considered the existing installed capacity, the demand for services, and the adolescents' capacity to pay in order to determine which model to implement in a given clinic. In addition, PROFAMILIA trained its medical, paramedical, and administrative staff so they could provide youth-friendly services that respected adolescents' rights and responded to their specific needs.

By 2003, the PROFAMILIA youth program had expanded its services to 35 centers nationwide, and developed the following three models of direct care to adolescents, as shown in **Figure 4**.

- *Youth Centers*, where services are provided only for adolescents, in dedicated settings
- *Youth Programs*, where spaces are reserved for adolescents within adult centers; and
- *Youth Services,* where adolescents share facilities and providers with the adult population.

Note: Also put the number of each of these models in the Figure. Thus, in the Youth Centers box put (3), in the Youth Programs box put (26) and in the Youth Services box put (6)

Figure 4. PROFAMILIA Youth Center Program



The Youth Center program seeks to:

- increase access and offer FP/SRH services adapted to the particular needs of adolescents;
- provide IEC and training in FP/SRH and human sexuality to youth, parents, teachers, and healthcare providers who work with adolescents;
- collaborate with national and international institutions on developing and conducting training programs for trainers and service providers in the fields of FP/SRH and sexuality for adolescents; and
- raise community awareness about adolescent SRH needs and adolescents' rights to live a healthy, enjoyable, and responsible sexuality.

Adolescents participate directly or indirectly in the PROFAMILIA Youth Center program sustainability strategy through the following initiatives:

- Representation on the PROFAMILIA Board of Directors through the membership of an adolescent woman
- Use of youth volunteer peer educators who participate in the design of printed IEC materials and organize and develop informational activities and campaigns in their schools and communities (The youth peer educators also conduct educational activities with specific populations such as displaced individuals, both adults and youth)
- The National Youth Event, an annual event at which young people speak up about their sexual and reproductive rights through a televised program with national coverage
- The National Youth Network, created to provide feedback on the results of the program in every city where it exists; the Network also provides a forum for other Latin American adolescents
- PROFAMILIA Youth website, maintained and updated by adolescents
- Suggestion boxes, used by service users to provide feedback on medical and counseling services received at PROFAMILIA Youth Centers

The youth peer educator activities represent a cost (at times marginal) to PROFAMILIA for training, follow-up, and creation and production of IEC material. However, there are no salary or transportation costs incurred because the peer educators are volunteers and work in their own communities and schools.

To conduct the National Youth Event, in which approximately 200,000 adolescents participate each year, youth peer educators seek resources in cash or in kind at the local level. PROFAMILIA is able to promote the use of adolescent services to a wide audience during the National Youth Event and through the work of the peer educators. Despite the costs involved, these local events realize cost savings because they decrease the resources needed for national level promotion. In addition, the face-to-face marketing strategy where young people talk about PROFAMILIA services helps position the organization and its youth services.

The Youth Center program has succeeded in reaching low- and middle-income adolescents, as well as marginalized adolescents, and youth living in rural areas, through teams of trained and committed professionals who do not judge or criticize adolescents. To reach out-of-school and/or hard-to-reach youth, the program uses youth peer educators. The Youth Center program has collaborated with the Colombia Ministries of Health and Education to promote sex education from pre-school to secondary school, as well as to conduct training of sex educators and medical and paramedical staff working with youth. Thus the Youth Center program has had an impact on adolescents FP/SRH policies and programs through activities implemented in educational settings.

Table 4 presents the characteristics of male and female users of the PROFAMILIA Youth Center program services in 2002.

Table 4. Profile Of Users Of Profamilia Youth Center Program, 2002	
Characteristics	
Average age (years)	17.8
Average number of children per adolescent mothers	1.3
Average years of schooling completed by users (years)	9.8
Users with incomplete primary education or less (%)	3.9%
Users with <2 minimum-wage salaries (%)	30.9%
Homes with <4 minimum-wage salaries (%)	74.9%
Homes with unmet basic needs [13] (%)	29.7%
Homes below the poverty line (%)	8.8%
Users covered by general system of Social Security in Health or other Social Security Institute (%)	42.4%
Users not covered (%)	43.5%

Programmatic Results

The PROFAMILIA Youth Center program provides both healthcare and IEC services. The staff plans and conducts courses, short courses, workshops, seminars, conferences, counseling, and orientation sessions for adolescents, parents, teachers, and staff from other institutions as well as from PROFAMILIA. These activities are carried out on site or at locations in the community, including schools, universities, clubs, and youth groups.

The PROFAMILIA management information system requires that all variables included in the system have the characteristics of validity, reliability and timeliness. Educational and promotional activities are not included within the MIS because these activities cannot comply with these requirements. The Research and Evaluation Team cannot determine with certainty, therefore, if and how training and IEC activities have led to behavior change. Service statistics presented in this report include only FP/SRH consultations and product sales.

The MIS disaggregates services statistics by type of center, program, service, and adolescent or adult users. In **Table 5** only the statistics of adolescent users are presented. Over-the-counter sales reflect only those sales made through the Youth Center program.

[13] UBNI: Unmet Basic Needs Index (made up of the following indicators: housing index, basic service index, crowding index, school absenteeism and economic dependency ratio).

Table 5. CUMULATIVE STATISTICS OF PROFAMILIA YOUTH CENTERS PROGRAM SERVICES, 1999–2002

SERVICES	1999	2000	2001	2002	TOTAL 1999–2002
TOTAL NEW FP	12,383	14,017	15,095	20,892	62,387
TOTAL Revisit FP (resupply, checkup visits)	10,638	10,606	9,280	5,035	35,559
TOTAL FP CONSULTATIONS	**23,021**	**24,623**	**24,375**	**25,927**	**97,946**
IUD Insertion	4,159	4,685	3,578	3,635	16,057
Norplant® Insertion	0	535	762	776	2,073
TOTAL SRH CONSULTATIONS	**21,174**	**22,446**	**17,152**	**16,763**	**77,535**
Surgical Procedures	147	298	403	560	1,408
Pap Smears	4,574	6,144	4,682	5,404	20,804
Pregnancy Tests	10,009	11,901	10,179	10,783	42,872
Ultrasounds	2,081	2,654	2,752	3,395	10,882
Routine laboratory tests	5,285	5,701	5,801	8,656	25,443
X-Rays	0	35	47	18	100
Vaccination	0	63	98	114	275
Surgeries	56	187	151	203	597
Pathology laboratory tests	62	79	67	133	341
OVER-THE-COUNTER SALES					
Contraceptive Pills	3,035	2,817	1,619	1,732	9,203
Condoms	18,237	9,466	5,199	5,069	37,971
Vaginal Contraceptive Tablets	4,511	1,663	2,005	1,258	9,437
Copper T380A IUD	3,443	2,808	2,108	1,586	9,945
Depo-Provera®	509	490	1,312	642	2,953
Cyclofen®	12,649	15,712	16,155	15,225	59,741
Postinor®	0	0	3,020	2,858	5,878
Speculae	2,553	2,103	2,649	1,771	9,076

Norplant® is the registered trademark of the Population Council for subdermal levonorgestrel implants.

Depo-Provera® is the registered trademark of the Upjohn Company for injectable medroxyprogesterone acetate

Cyclofen® is the registered trademark of TechSphere Aplicaciones Farmaceuticas

Postinor® is the registered trademark of Gedeon Richter LTD for levonorgestrel 750 mcg tablets.

As shown in **Table 5,** new FP consultations increased by 68 percent between 1999 and 2002. By contrast, between 2000 and 2002, SRH consultations decreased by nearly 25 percent due to a decrease in demand.

Overall, over-the-counter sales of contraceptive products decreased significantly between 1999 and 2002. PROFAMILIA has essentially withdrawn from the market of contraceptive pills and vaginal tablets, preserving only 4 percent and 26 percent

respectively of its total sales. PROFAMILIA has maintained a significant presence in the market of condoms sales, although it also registered a decrease in this line item"[14] due to high competition stimulated by the HIV/AIDS pandemic.

Table 6 shows adolescent services provided from 1999 through 2002 at the national level and at the Bogotá, Medellín, and Cali clinics.

Table 6. TOTAL SERVICES PROVIDED TO ADOLESCENTS BY PROFAMILIA, 1999 – 2002

SERVICES	1999	2000	2001	2002	Total
National Program					
Total Family Planning Consultations	23,021	24,623	24,375	25,927	97,946
Total SRH Consultations	21,174	24,446	17,152	16,763	77,535
Pap Smears	4,574	6,144	4,682	5,404	20,804
Pregnancy Tests	10,009	11,901	10,179	10,783	42,872
Ultrasounds	2,081	2,654	2,752	3,395	10,882
Bogotá					
Total Family Planning Consultations	7,099	7,842	8,842	9,190	32,973
Total SRH Consultations	3,329	3,870	3,281	3,198	13,678
Pap Smears	674	939	871	846	3,330
Pregnancy Tests	3,453	1,238	2,459	2,384	9,534
Ultrasounds	342	276	207	191	1,016
Cali					
Total Family Planning Consultations	3,353	3,189	3,192	2,817	12,551
Total SRH Consultations	1,477	1,738	1,673	1,790	6,678
Pap Smears	488	549	454	495	1,986
Pregnancy Tests	430	556	507	570	2,063
Ultrasounds	0	61	220	507	788
Medellín					
Total Family Planning Consultations	4,058	3,596	2,554	2,236	12,444
Total SRH Consultations	3,670	4,087	2,690	1,685	12,132
Pap Smears	868	1,017	607	738	3,230
Pregnancy Tests	17	448	326	372	1,163
Ultrasounds	0	0	25	133	158

Bogotá, Cali, and Medellín are the most populated cities in Colombia and therefore serve the greatest number of young people, as reflected in these service statistics. Of a total of 97,946 FP consultations offered to adolescents nationwide, 59.19 percent were provided in Bogotá, Cali, and Medellín. Likewise, of 77,535 SRH consultations provided nationwide, 41.9 percent were provided at these three health centers.

Programmatic results showed that the Bogotá Center serves a larger youth population than the centers of Medellín and Cali. Of the 57,968 FP consultations provided by the three centers, 56.8 percent were provided in Bogotá and, of the 32,488 SRH consultations, 42 percent were provided in Bogotá.

[14] CATALYST Consortium. PROFAMILIA's Role in Health Sector Reform in Colombia. Case Study. Bogotá, March 2003.

The Medellín Center presents the greatest fluctuations in the number of clinical services provided. The decrease between 2000 and 2002 is attributed to an administrative restructuring that affected the provision of services and led the clinic administrators to redesign its youth service delivery strategy. PROFAMILIA administrators decided to increase the range of services offered in order to generate income for the adolescent program and to motivate and attract new adolescent users. The new services offered are ultrasound, started at the end of 2001, and internal medicine, included in SRH consultations.

Because Bogotá, Cali, and Medellín serve the greatest number of adolescents, any changes in the number of services provided in these health centers substantially affects the local financing of their programs, as well as the national youth program financing.

Financial Results [15]

All financial data presented and analyzed in this section are based on PROFAMILIIA accounting records. More detailed financial information is presented in **Annex A**.

Initially, only token fees were charged for medical services. In 1990, the fee was US$0.86, the equivalent of less than 1 percent of the monthly minimum salary at that time, and less than the price of a movie theater ticket. The services were subsidized between 85 and 90 percent. Educational activities were offered at no charge. Personnel costs in the form of salaries for medical and administrative staff as well as counselors and educators represented a significant portion of the program budget.

As the program was extended to other cities and external support decreased, PROFAMILIA implemented strategies to reduce personnel costs. For example, medical doctors were contracted based on fees while educators hired to expand the reach of educational activities were contracted based on productivity. In other cases, agreements were signed with universities so that psychology students completing their coursework would do their practical training, as required by university curricula, as counselors with PROFAMILIA.

In addition, PROFAMILIA started to charge educational institutions fees for IEC activities based on their capacity to pay. Private colleges paid a fee that generated a small profit, while students attending public sector schools and colleges benefited from free workshops and talks. As external funding for the Youth Center program decreased, however, public institutions also started paying for IEC activities.

Another strategy to generate income was contracting with social security system health agencies to deliver SRH services on their behalf. PROFAMILIA also designs, reproduces, and sells printed and audiovisual IEC materials and sells contraceptive products to the adolescent clients of these agencies.

PROFAMILIA views the Youth Center program as a business and therefore ensures that the directors of the medical centers and the youth program coordinators are trained in administration, negotiation, and marketing skills. In addition, a different professional profile for new personnel was established in 1993 in the context of health sector reform.

[15] The program's financial sustainability is analyzed taking into account the program's self-generated resources also known as operational sustainability.

Even staff with several years of work experience with youth became more business-like in their attitudes and skills. This commitment to training and maintaining a business vision has resulted in an organizational commitment to sustainability.

PROFAMILIA contracts with the Colombian Government through partnerships with the education and health sectors in the following ways.

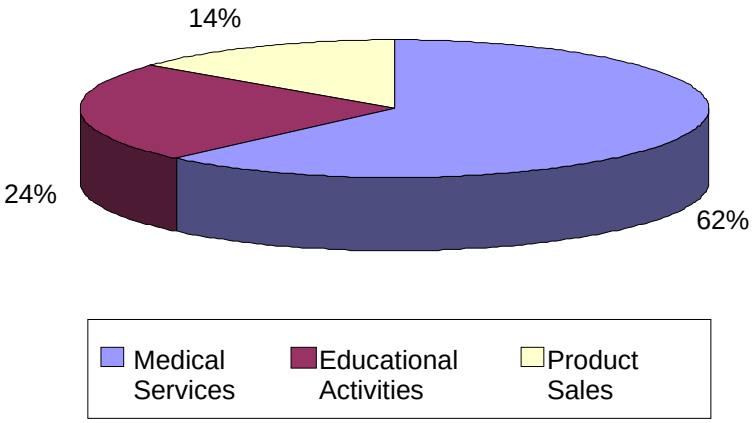
- In the educational sector, school regulations mandate that every educational institution in Colombia support healthy adolescent lifestyles, as outlined in the Institutional Educational Project. To assist educational institutions with meeting this objective, PROFAMILIA, upon request from these institutions, may contract directly with public and private schools, as well as with parents associations and universities, to provide IEC materials and FP/SRH training.
- As part of Law 100, the health sector's Basic Care Plan developed the Healthy Schools approach and implements SRH promotion and prevention activities. PROFAMILIA provides FP/SRH education and training for this initiative.

PROFAMILIA also generates income through the design, production, and sale of IEC materials such as videos, pamphlets, and booklets on SRH for youth. To generate a reasonable demand from educational and health institutions and from the adolescents themselves, PROFAMILIA designed and produced materials that comply with the sexual education curriculum taught in public and private schools. The materials are based on topics of interest to adolescents. Therefore, they respond to a specific need, are useful for educational work, and satisfy adolescents' needs for information. These materials, together with constant marketing, generate demand for materials and services.

Another strategy to increase local income consists of referring adolescents to services that they require but that PROFAMILIA does not provide, and by sharing the fees with the service provider. In Cali, for example, adolescents that need dental consultation are referred to a dental clinic and PROFAMILIA receives a percentage of the fee charged by the dentist.

At the end of the 1990s, PROFAMILIA made the decision to gradually increase user fees. In 2003, the fees charged for adolescent services were approximately 20 percent less than those for adults. For example, FP costs adolescents US$3.80, the equivalent of 3.2 percent of the minimum monthly salary, and 1.5 times the cost of a movie theater ticket. The organizational policy has been to charge the same service fees nationwide. The primary sources of income generated by the adolescent program at the national level are as illustrated in **Figure 5.**

Figure 5. Sources of Income Generated by the PROFAMILIA Youth Center Program at the National Level, 2002



In some cities the income generated by the adolescent program is still not sufficient to carry out activities and operations; in these instances, the program seeks external financial support, as shown in **Table 7**.

Table 7. PROFAMILIA Youth Centers Program Income, Expenses, and Operational Sustainability (US$)				
NATIONAL YOUTH PROGRAM TOTALS	**1999**	**2000**	**2001**	**2002**
External income	274,176	272,310	130,805	299,772
Locally-generated income	465,042	477,021	539,009	634,566
Expenses	638,531	638,630	650,878	799,935
Surplus or deficit	**100,687**	**110,701**	**18,936**	**134,403**
Operational Sustainability	72.8%	74.7%	82.8%	79.3%
BOGOTÁ				
External income	–	18,232	4,568	13,673
Locally-generated income	125,166	127,530	135,894	163,080
Expenses	91,507	96,115	96,631	119,851
Surplus or deficit	**33,659**	**49,647**	**43,831**	**56,902**
Operational Sustainability	136.8%	132.7%	140.6%	136.1%
CALI				
External income	32,273	27,862	3,263	2,876
Locally generated income	43,242	34,781	52,331	63,031
Expenses	78,113	70,356	68,443	72,619
Surplus or deficit	**(2,598)**	**(7,713)**	**(12,849)**	**(6,712)**
Operational Sustainability	55.4%	49.4%	76.5%	86.8%
MEDELLN				
External income	462	7,433	522	2,084
Locally-generated income	59,581	58,202	47,198	56,569
Expenses	51,498	79,098	75,299	84,333
Surplus or deficit	**8,545**	**(13,463)**	**(27,579)**	**(25,680)**
Operational Sustainability	115.7%	73.6%	62.7%	67.1%
OTHER CITIES				
External income	241,441	218,783	122,453	284,138
Locally-generated income	237,053	256,509	303,587	351,886
Expenses	417,412	393,061	410,505	523,132
Surplus or deficit	**61,082**	**82,231**	**15,535**	**109,892**
Operational Sustainability	56.8%	65.3%	74.0%	67.3%

The external income includes all international donations. Locally generated income is the income generated through the sales of products and services in the Youth Center program and includes income from service contracts with public and private organizations. From 1999 to 2002, the adolescent program has not received any local donation.

Financial data obtained from the Youth Center program at the national and local levels in Bogotá, Cali, and Medellín for the period 1999–2002 show that sustainability growth is a slow process. During this four-year period, sustainability of the adolescent program increased by 6.5 percent at the national level, or at an annual average growth of

1.6 percent. The slow growth is explained in part by the fact that the program generates income through the small service fees it charges adolescent users.

The Medellín Center requires further analysis. From an operational sustainability of 115.7 percent in 1999, it decreased to 67.1 percent in 2002. This drop, caused by a reduction in the delivery of services, led the clinic administrators to redesign the Center's strategy. They decided to increase the range of services offered to motivate and attract new users. Because demand was still low for the new services, PROFAMILIA hired more salaried professionals, which increased the Center's fixed costs. In 2003, the sustainability level reached 97.3 percent because PROFAMILIA is gradually replacing salaried staff with professionals paid based on productivity as is done in other centers.

The Cali program experienced significant growth, with an operational sustainability level that increased from 55.4 percent in 1999 to 86.8 percent in 2002. In 2003, the program continued to improve its operational sustainability. In the first eight months of 2003 it reached a sustainability level of 101.1 percent, attributable to an increased number of contracts with municipal and departmental public entities.

The Bogotá center (after 13 years in existence) had reached sustainability levels of 136.1 percent, in 2003, allowing it to continue operating without any international support.

In 2003 the youth centers of Cali, Medellin, and Bogotá reached more than 100% operational sustainability level, and their financial surpluses helped to cover expenses of youth centers with deficits. As shown in **Table 7**, the operational sustainability level of all the other centers combined reached 67.3 percent in 2002.

CONCLUSION

Over time and with their entrepreneurial spirit and vision, PROFAMILIA leaders have succeeded in creating a sustainability culture. This is reflected in organizational policies mandating that every program, including the Youth Center program,[16] take into consideration the following elements when designing and implementing an activity:

- Factors to consider to establish the program's sustainability level
- Strategies required to reach sustainability
- Identifying program activities that will or will not be sustainable
- Indicators to measure progress toward sustainability
- Activities to motivate and train program staff in order to raise their awareness and instill commitment to reach sustainability
- Quality standards that promote the growth of the program's sustainability

The PROFAMILIA Youth Center program has benefited from being part of a solid institution whose policies, norms, procedures, and resources (both physical and human) have contributed to helping the program reach high levels of sustainability.

[16] APLAFA, APROFE, PLAFAM, PROFAMILIA: Caja de Herramientas para Programas de Salud Sexual y Reproductiva para Adolescentes. South-to-South Collaboration Program in Population and Development. Bogotá, September 1999.

FEMAP FOR A HEALTHY YOUTH PROGRAM

NATIONAL CONTEXT

Mexico experienced an average annual population growth rate of 2 percent during the 1990s, increasing from 81.2 million inhabitants[17] in 1990 to 97.5 million[18] in 2000. This growth rate resulted from a reduction in the mortality rate, mostly due to a decrease in infant mortality; a minor birth rate increase; and negative social growth (migration). According to the census, more than 4 million Mexicans left the country during this period.

In 2000, Mexico had 42.6 million inhabitants 19 years old or younger—43.7 percent of the total population. Of those, 20.7 million were between the ages of 10 and 19. Thus, adolescents constituted 22.5 percent of the total population. These numbers demonstrate the unprecedented effort that is required to increase access to healthcare services for adolescents and their families, to create at least 500,000 new jobs per year, to build a similar number of houses, and to educate the more than 40 million people who were born during that period.

During the period between January 1999 and February 2000, a total of 2.5 million live births were reported, with 356,484 births, or 13 percent, being to women between the ages of 12 and 19[19].

Research conducted during 2000–2001 by FEMAP among 12 of its affiliates located in different regions of the country illustrates the problems faced by adolescents. The survey of 7,068 adolescents between the ages of 12 and 18 showed that 18.4 percent have experienced some type of domestic violence; 17.8 percent used drugs in the past year; 21.5 percent had practiced bulimia in the past year; 16.7 percent had experienced severe depression; 15.6 percent had attempted suicide at least once; and 22 percent had an active sexual life. Of those sexually active adolescents, 72 percent were at reproductive risk from unprotected sex. In addition, more than 50 percent of adolescents have problems with obesity or being overweight, putting them at high risk for developing cardiovascular diseases, diabetes, hypertension, and cerebral-vascular diseases as adults. The same research indicates that four out of ten adolescents do not have positive communication with their family and seven out of ten perceive that the community does not care about them or consider adolescents as a resource. Six out of ten are unable to plan and make decisions, and four out of ten have a negative vision of the future and think that their life does not have a purpose.

In view of the national statistics and its own research, FEMAP decided to devote more resources to establish and replicate efficient and sustainable adolescent programs. These programs were designed to address the specific needs of adolescents in order to produce positive behavior change.

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[17] XI Censo General de Población y Vivienda de 1990, México. Instituto de Nacional de Estadística, Geografía e Informática (INEGI), Mexico, 1991.

[18] XII Censo General de Población y Vivienda del 2000, México. Instituto de Nacional de Estadística, Geografía e Informática (INEGI), Mexico, 2001.

[19] Mexico DHS 2000

ADOLESCENT PROGRAMS IN MEXICO

Adolescent programs in Mexico began in 1978 when the Centro de Orientación a Adolescentes A.C. (Adolescent Counseling Center)[20] established the first center in the country to provide adolescent-friendly information, education, training, sex education, and FP services in Mexico City. The Asociación Mexicana de Educación Sexual A.C (Mexican Association of Sexual Education) was founded in 1979 and established a program dedicated to providing sexual education and training for male and female adolescents and for professionals working with adolescents.

In 1981, FEMAP established adolescent programs in Ciudad Juárez, Matamoros, Monterrey, Tijuana, and Celaya. These programs offered adolescent-friendly information, education, training, sex education, and family planning and healthcare services. In 1985, FEMAP expanded these services to its 20 affiliates, thus establishing the first national network for adolescent FP/SRH in Mexico—PROJUVE (Programa para Juventud).

At the end of the 1980s, and for the first time in the history of Mexico, the Ministry of Education of the State of Nuevo León introduced a sex education module in secondary school textbooks through an initiative of Pro-Superacion Familiar Neolonesa (a FEMAP affiliate). Building on that initiative, the Mexican Ministry of Public Education slowly began introducing the subject of sex education nationwide. Towards the mid-1990s, the Ministry of Health, through the General Family Planning Administration, established a national adolescent care network for FP information and services, with specialized staff at health centers and general hospitals. Unfortunately, the network began losing importance a few years after it was established. At the same time, Fundación Mexicana para la Planeación Familiar (the Mexican Foundation for Family Planning Foundation), MEXFAM, initiated an adolescent SRH program called Gente Jove (Young People). In 1999, FEMAP established a new initiative for adolescent care, FEMAP for a Healthy Youth, which currently is active in 11 cities around the country.

Development of national adolescent sex education and FP programs has been limited because governmental entities have not given them adequate importance and support. In addition, existing programs have very limited geographic coverage and few financial resources.

Civil society organizations have been more active than public sector organizations and are strong supporters of youth activities. Currently, the only national networks of adolescent programs in operation in Mexico are those conducted by FEMAP and MEXFAM.

[20] Centro de Orientación a Adolescentes. Prospective Cost-Effectiveness Study to Determine a Strategy of Expansion of Services to Young Adults in México City" was conducted by The Population Council in 1987.

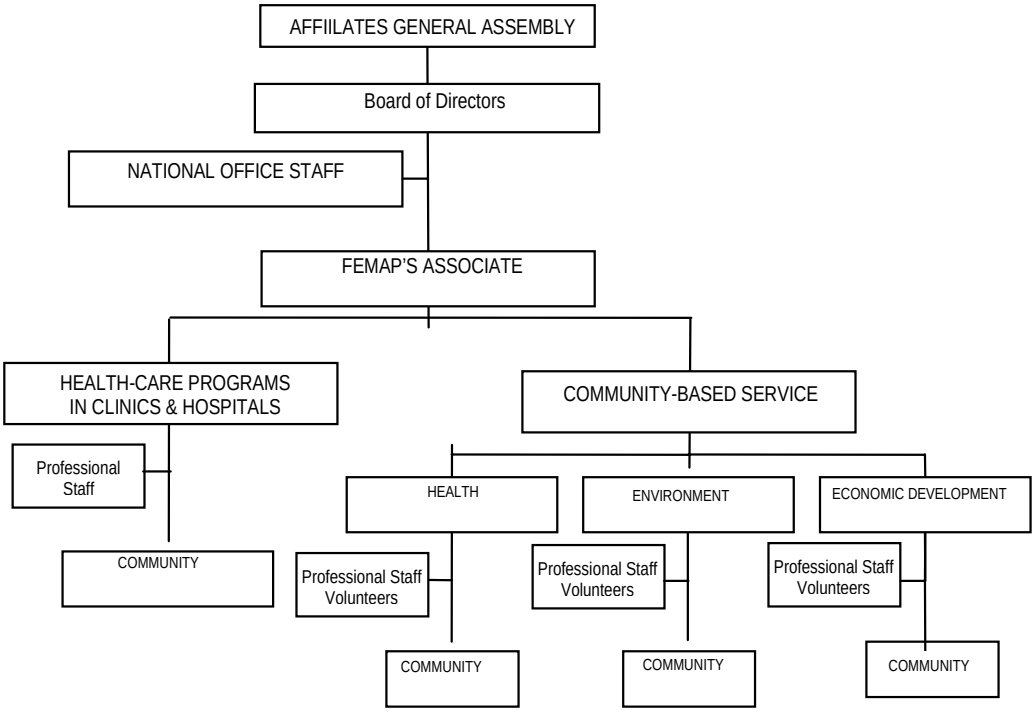
INSTITUTIONAL CONTEXT

The Federación Mexicana de Salud y Desarrollo Comunitario A.C. (Mexican Federation of Community Health and Development), FEMAP, is a national, nonprofit, civil society institution created in 1973. Its mission is to contribute to improved quality of life for Mexico's marginalized urban and rural population and to actively participate in building a more just, free, and equitable society. This mission is carried out through research, education, health service delivery, environmental improvements, and promotion of economic and social development among its target population. FEMAP is made up of a network of 44 affiliates that work in marginalized urban areas in 67 cities and in hundreds of rural communities in 21 Mexican states and in the Federal District (Mexico City). Its models of operation are based on education and promotion of voluntary and active involvement of the community. More than 7,900 volunteers, supported by 634 professionals in the fields of health and social sciences, management, and finances, implement the following information, education, and service delivery programs:

1) Community-Based Health Programs
    - Maternal and Child Health
    - FP/SRH
    - Prevention of
        - Chronic degenerative diseases
        - Cervical, uterine, and breast cancer
        - Sexually transmitted diseases, HIV/AIDS
        - Use and abuse of drugs, tobacco, and alcohol
2) Health Programs in Clinics and Hospitals
    - Primary and secondary healthcare services
    - Preventive medicine services
3) Environmental Health Programs
4) Economic Development Programs
    - Community banks
    - Micro-credit
5) Social Development Programs
    - Building human and social capital

Figure 6 presents the FEMAP organizational structure. The Affiliates' General Assembly constitutes the supreme ruling body that governs the norms, policies, procedures, and institutional regulations. The Assembly is responsible for carrying out the mission, objectives, and statutes of the organization. It comprises the presidents of the affiliate members. The Board of Directors is elected by the General Assembly and has nine members, including the Executive Director. The Board is responsible for managing FEMAP through the national office staff. Each affiliate has its own administrative and organizational structure and both professional staff and volunteers implement community-based service delivery programs according to the organizational mission. In order to become affiliates, prospective members must adopt and respect the organizational mission, objectives, norms, policies, regulations and procedures adopted by the Affiliates' General Assembly, and thus carry out the mandates approved by the Assembly.

Figure 6. FEMAP Organizational Structure



The national office comprises an executive management team and two coordination teams—one for operations and the other for administration and finances (see **Annex B**) The operations coordination team supports the affiliates through the FEMAP Pharmacies program, including purchasing, warehousing, and distribution; marketing; and training, technical and administrative assistance, including programmatic and evaluation reports, systems management, and social communication. The management and finances coordination team is responsible for general accounting, administrative and financial reports, and legal and fiscal matters and works closely with the operations coordination team.

Institutional Sustainability

FEMAP is widely recognized as a leader in Latin America due to its success in achieving financial sustainability without losing sight of its mission. The path chosen by FEMAP throughout its life, and especially since the 1993 USAID Transition Project, was one of building an organization that worked to improve its management capacity with the sole purpose of having the tools necessary to support implementation of its mission and social objectives. To this end, FEMAP developed alternatives for generating financial resources to enable self-financing of its community-based programs, thus ensuring their sustainability and continuity. In addition, FEMAP worked to change the organization's internal culture, so that the concept of sustainability would be understood, internalized, and serve as the focus of all organizational efforts.

FEMAP adopted the following principles to manage the institutional programs more effectively.

1) The future of a social organization can be planned and controlled by human action.

2) The management and administration teams can set realistic goals to meet their objectives successfully.

3) The management and administration teams can organize internal variables in order to achieve the best possible results for planned activities that are influenced by external environment variables.

4) The competence of the management and administration teams will be reflected in the quality of the decisions made on planning and control and as a result will determine the success of the organization.

In 1987, FEMAP experienced, without warning, a dramatic 44 percent cut to its total international funding. This revenue loss resulted in a reduction of FEMAP geographical coverage, especially in rural areas, because the community-based FP/SRH programs were almost totally dependent on international funding. As a result of this experience, FEMAP affiliates committed to an income-generating strategy that would ensure continuity of community-based programs. The strategy focused on building institutional capacity in order to sell FEMAP services and products. By 1990, FEMAP was able to reach the level of funding it enjoyed in 1987. This effort was strengthened in 1993 when FEMAP began to receive technical and financial assistance from the USAID Transition Project.

At the beginning of the 1990s, FEMAP designed a general strategy to generate more income by providing a wider range and greater volume of high-quality, affordable services. The first step of this strategy was to conduct a cost analysis of services and a study of the socio-economic profile of FEMAP service users, a market analysis of demand (real and potential), and an evaluation of the level of quality of care. The cost analysis included a break-even point analysis for each service provided by the institution, installed capacity, and productivity analysis, as well as sales projections.

As a result of these analyses, the organization was able to determine the actual cost of services; identify the components of those costs; and establish a series of strategies aimed at solving the problems identified, including high administrative costs, low productivity, excess staff, lack of pricing policies, excess expenditures in supplies, inadequate purchasing system, poor inventory control and, inadequate administrative and management capacity.

To achieve substantial improvements in productivity, FEMAP developed its management capacity by conducting workshops to transfer skills in administration and technology from the funding agencies to the national office, and from the national office to the affiliates. In addition, FEMAP established organizational standards for productivity, expenses, and consumption in order to control and reduce its costs

To recover costs, FEMAP established fee policies based on the actual cost of services. It was then necessary to change the attitudes of members of the Board of Directors who believed that services should be offered free or with subsidies to the communities served. Using the information gathered through the cost analysis and market survey, FEMAP developed a motivation and awareness campaign that convinced Board members of the need for fees in order to ensure sustainability of services. Thus, for the first time in its organizational history, FEMAP affiliates were able to set fees that considered both actual costs and the ability of the target population to pay.

The analysis of the use of installed capacity and productivity was used as a tool for staff allocation to streamline operations and for hiring practices. FEMAP established policies to pay staff based on productivity, thus substantially reducing the fixed organizational costs.

Using market studies and exit surveys, FEMAP initiated a service diversification process, as well as the development of new alternatives to generate income. For example, affiliate purchasing was centralized so that supplies could be bought in bulk at the least expensive price. This system decreased costs for the affiliates at the same time that it generated income for the national office.

A key element in this process was for FEMAP staff and affiliates to develop a business mentality. The approach chosen by FEMAP was to reallocate external donations from operating costs to potential income-generating initiatives, such as the following.

- Expansion of the infrastructure to deliver healthcare services (expansion of clinics and hospitals, laboratory equipment for clinical analysis, ultrasound and medical services)
- Implementation of new initiatives (pharmacies, centralized purchasing department)
- Development of management capacity

- Development of a MIS

The result of these efforts is illustrated by the following numbers. In 1992, 90 percent of total funds received by FEMAP was earmarked for operating expenses, including management and service delivery programs, and only 10 percent was earmarked for investments. In 1998, 93.6 percent of total income was earmarked for investments.

As a result of these efforts, FEMAP was able to reduce the cost of medical services while at the same time decreasing medical fees, thereby preserving affordability for the target population. This fact is shown by studies of the economic profile of FEMAP service users, conducted from 1993 to 2002.

Between 1992 and 2002, the annual volume of medical services provided by FEMAP and its affiliates increased more than tenfold. The profits generated by the medical services allow FEMAP and its affiliates to subsidize programs that cannot achieve sustainability (e.g., FP services and youth programs). The FEMAP medical service delivery system reached 100 percent operational sustainability. Fees paid by clients for medical services cover 100 percent or more of operating expenses.

At the community level, there was an increase in the number of individuals educated about FP/SRH; a decrease in cost by FP user per year; and a fourfold increase in couple years of protection.

In view of the increase in service volume resulting from the income-generating initiatives, FEMAP undertook a number of activities designed to maintain the quality of service delivery, including profile of service users, users' perceptions of quality of care, exit surveys, patient flow analysis, establishing complaint boxes, and service statistics analysis. The information obtained from these initiatives was used not only to improve the service delivery, but also to make the FEMAP corporate image synonymous with high quality at the lowest possible price.

Table 8 presents the trends in FEMAP operational sustainability from 1992 to 2002. Beginning at a sustainability level of 57 percent in 1992, in itself a remarkable achievement, FEMAP reached a 91 percent sustainability level by 2002.

Table 8. FEMAP Operational Sustainability Trends

YEAR	Operating Expenses in US$ Millions	Income Generated[21] In US$ Millions	Level of Operational Sustainability (%)
1992	4.48	2.56	57.0
1993	5.66	3.44	60.8
1994	5.06	2.98	58.9
1995	3.44	2.00	58.1
1996	4.63	2.95	63.7
1997	6.22	4.09	65.7
1998	6.10	4.54	74.4
1999	7.51	6.21	82.7
2000	8.50	7.12	83.8
2001	10.72	9.46	88.3
2002	11.35	10.31	90.8

The FEMAP achievements between 1993 and 1998 formed the basis for success of new initiatives launched in 1998, especially the FEMAP for a Healthy Youth program.

FEMAP ADOLESCENT PROGRAM

Adolescent programs have been a priority for FEMAP since its founding. A 1973 study conducted by the Ciudad Juárez affiliate revealed that a higher percentage of school dropout occurred after completion of the sixth grade. This finding led to inclusion of SRH topics in its educational initiatives. As new affiliates joined FEMAP, they too included adolescent programs in their service portfolios, leading to the first national network of adolescent programs, previously described.

Beginning in 1993, reduction in international funding forced FEMAP to integrate the adolescent programs with the community-based adult FP/SRH programs. In 1999, building on the institutional experience in adolescents programs, FEMAP initiated a new activity named FEMAP for a Healthy Youth. The main objective of this program was to develop a model for promoting and facilitating a comprehensive youth program. This report focuses on the sustainability strategy developed for that specific initiative.

The first program under FEMAP for a Healthy Youth was established in Ciudad Juárez with technical and financial support from the El Paso del Norte Health Foundation, an American foundation based in El Paso, Texas. Through this foundation, FEMAP was able to obtain funding from Family Planning International Assistance to expand the initiative to its affiliates in Cuahutémoc, Guadalajara, Mazatlán, Matamoros, Veracruz, Xalapa, Chamapa, Huixquilucan and Guerrero. It is important to mention that for the first time in its organizational history, and with the income generated through the

[21] The income generated excludes all international income and refers only to the income generated locally through patient fees and product sales.

financial strategies of the national office, FEMAP financed the implementation of the activity of the Saltillo affiliate.

FEMAP has found information, education, and training initiatives to be the most difficult programs to sustain financially over time. Throughout its history, these programs have suffered the most as a result of budget cuts, while adult FP/SRH programs have achieved 100 percent sustainability. To rescue and strengthen its information, education, and training program for adolescents, considered by FEMAP to be the pillars of supporting services, the organization developed the FEMAP for a Healthy Youth program. It was designed to become financially sustainable in three years or less.

The FEMAP adolescent care program has the following separate, but linked, components.

- FEMAP for a Healthy Youth. This program is implemented at the affiliate-level by social workers and volunteers. Information, education, and training topics include FP/SRH, prevention of STDs and HIV/AIDS, prevention of use and abuse of drugs, tobacco and alcohol, prevention of risk behaviors, and building human capital through the promotion of assets development. In addition, this program provides FP services to adolescents and refers them to health services.
- Community-based FP/SRH program. This program provides information and education, including several of the topics mentioned above, and provides FP services and referrals to FEMAP medical services for adults and adolescents. On average, 34 percent of active clients in community-based programs are individuals aged 19 and younger.
- Clinical Programs. Individuals between the ages of 12 and 19 account for 18 percent of total medical services provided in FP/SRH through FEMAP clinics and hospitals. These services include medical consultations, prenatal follow-up, perinatal care, postnatal care, FP, cervical and uterine cancer screening, and a comprehensive care clinic for pregnant adolescents.

Profile of FEMAP Adolescent Program Users

Table 9 presents the socio-economic profile of adolescents using FEMAP services nationwide.

Table 9. Socio-Economic Profile of Adolescents Using FEMAP Services	
Characteristics	
Average age	14.7 years
Age range	10–19 years
Percentage of males	52.2%
Percentage of females	48.7%
Single	91.6%
Married	6%
Other marital status	2.4%
Average educational level	8.1 years of school
Schooling range	6.5 to 9.7 years of school
Currently studying	61.8%
Currently working	38.2%
Average monthly income of those currently working	US$162.07
Range of monthly income of those employed	US$123.55 to US $210.59
Equivalent in minimum-wage salaries [22]	1.13 salaries
Poverty line in minimum-wage salaries	3 minimum-wage salaries
Average number of persons per household	5.4 people
Range of persons per household	4.75 to 6.05 inhabitants

FEMAP Adolescent Services at the National Level

Table 10 summarizes services received by adolescents nationwide within the three program components previously described (FEMAP for a Healthy Youth, Community Based Programs, and Clinical Programs). From January 1, 2000 through December 31, 2002, FEMAP provided 563,715 services to adolescents: 60.2 percent were health services, 27.8 percent were FP services, and 12 percent were SRH services. During that same period, the total volume of services provided to adolescents increased by 40.9% and the total number of adolescent FP users increased by 62.2 percent.

[22] In México the current minimum wage is $4.10/day.

Table 10. FEMAP Adolescent Services 2000–2002†				
Adolescent Services	**2000**	**2001**	**2002**	**Total**
FP Users, Healthy Youth program‡	6,258	9,427	11,812	27,497
FP Users, Community‡	30,876	39,003	48,813	118,692
FP User through, Clinics‡	2,707	3,080	4,048	12,542
Medical Consultations	81,729	82,992	102,408	267,129
Prenatal Care	11,554	12,181	14,856	38,591
Deliveries	2,358	2,486	2,803	7,647
Postnatal Follow-up	5,423	6,467	7,148	19,038
Pap Smear	739	1,025	1,359	3,123
Lab Exams	13,524	13,935	25,867	53,326
X-rays and Ultrasounds	5,436	6,204	7,197	18,837
Total FP Users	**39,841**	**51,510**	**64,673**	**158,731**
Total Services	**160,604**	**176,800**	**226,311**	**563,715**

†*Source*. FEMAP MIS

‡ Healthy Youth users refer to adolescents treated through FEMAP for a Healthy Youth. Community users refer to adolescent treated by community-based FP/SRH programs. Clinic users are adolescents treated at FEMAP clinics and hospitals.

FEMAP for a Healthy Youth—Building Developmental Assets

The philosophy underlying the FEMAP for a Healthy Youth Program builds on the concept of developmental assets, as conceived by the Search Institute[23]. Developmental assets are defined as the useful or valuable qualities of those individuals who contribute towards helping children and adolescents grow in a healthy manner, become responsible for themselves and for their environment, and become interested in a common good.

Search Institute research beginning in 1989 identified a total of 40 assets—20 external and 20 internal. External assets are the positive experiences young people receive from the world around them and are grouped into four categories: support, empowerment, boundaries and expectations, and constructive use of time. Internal assets identify those characteristics and behaviors that reflect positive internal growth and development of young people. They are also grouped into four categories: commitment to learning, positive values, social competencies, and positive identity. Taken together, these developmental assets highlight the important role played by families, teachers, school, the community, civil society organizations, religious congregations, and other sectors of society, as well as children and adolescents themselves, in raising healthy young people.

[23] Search Institute, The Banks Building, 615 First Avenue, NE, Minneapolis, Minnesota 55413, USA. www.search-institute.org/

Their research shows that when development assets are managed in a comprehensive and joint manner, they constitute a powerful means to model attitudes and behaviors for children and adolescents. It has also shown that the greater the number of development assets experienced by young people, the more likely they are to adopt and become involved in positive behaviors, and that the fewer the number of assets present, the greater the possibility youth will engage in risky behaviors.

Program Justification

If society as a whole commits to investing more in the elements that children and adolescents require during their growth and development process, it is more likely that they will be healthy, reach their potential, and become individuals who contribute in a positive way to their families, communities, workplaces, and society at large.

Based on this hypothesis, the FEMAP for a Healthy Youth Program promotes a model that promotes coordinating and joining efforts of society as a whole to establish and safeguard a common vision aimed at daily and permanent developmental asset building. The goal of this vision is to rebuild the social fabric and develop human capital.

Developmental assets grow out of two types of applied research:

- Prevention, which focuses on protective factors that inhibit high-risk behaviors (use and abuse of drugs, tobacco and alcohol, violence, reproductive risk, unwanted pregnancies, dropping out of school, etc.) and
- Resiliency, which identifies factors that increase the ability of children or young people to rebound in the face of adversity.

Requirements for Program Implementation

The program implementation requires development of:

- An information, education, and training program involving all social actors, including adolescents;
- An extensive program of social mobilization and community participation;
- A common vision to facilitate uniting and coordinating joint efforts; and.
- A series of community-based activities to facilitate building developmental assets for children and adolescents in communities covered by the organization.

Implementation is also complemented by specific information, education, and service delivery programs aimed at preventing and/or treating high-risk behaviors, including unwanted pregnancy, abortion, STDs, and HIV/AIDS.

FEMAP for a Healthy Youth Program Objectives

The program objectives included creating a network of volunteer adolescent promoters; implementing an information, education, and training program; and establishing an adolescent SRH program. To accomplish these objectives, the program uses social mobilization to promote and build developmental assets for children and adolescents, promote behavior change to prevent risk behaviors, and develop adolescents' capability to overcome adversity. The program also provides tools to help adolescents become

responsible for their reproductive health, promotes responsible sexuality, and provides health education.

The program aimed to achieve financial sustainability and thus maintain its continuity using its own resources by the fourth year of operation (2003). The sustainability strategy focused on building a reserve fund to develop income-generating or "productive" initiatives"[24] and/or establish new productive initiatives to generate surpluses to strengthen service delivery and/or expand their coverage.

FEMAP For A Healthy Youth Program Sustainability Strategy

The productive initiative strategy was planned to generate financial resources independent of the program. These resources would then be used exclusively for funding FEMAP for a Healthy Youth program. Examples of these productive initiatives include buying specialized equipment in order to offer new services, selling drugs and pharmaceuticals, and social marketing of contraceptives. This financial sustainability strategy is essentially a cross-subsidy scheme explained in more detail in the section below.

The strategy was developed as a three-year funding scheme (**Table 11**) that covered 100 percent of operating expenses during the first year, 33 percent during the second year, and 0 percent during the third year. The scheme also funded productive initiatives at the same level during all three years.

Table 11. FEMAP for a Healthy Youth Program Productive Initiative Three-Year Funding Scheme

Year	Year 1	Year 2	Year 3	Total
Operating Funds[25]	US$15,000	US$5,000	US$0.00	US$20,000
Productive Initiative Funds	US$9,000	US$9,000	US$9,000	US$27,000
Total	**US$24,000**	**US$14,000**	**US$9,000**	**US$47,000**

It is important to note that FEMAP for a Health Youth was initiated with a very low operating budget (US$15,000), sufficient to cover only minimum essential requirements.

Productive initiatives selected by the three affiliates that were surveyed for this report were as follows.

- Ultrasound and X-ray services, (Xalapa)
- Investment in pharmacy inventory to generate greater sales of drugs and pharmaceutical products (Veracruz)
- Social marketing of contraceptive methods (Juárez and Xalapa).

[24] For FEMAP, a productive initiative is an economic activity that has the potential to produce sufficient income to sustain the activity operating expenses starting in the third year of the activity and that is sustained financially 100 percent in the fourth year.
[25] Operating fund refers to the funds needed for operational expenses.

Thus, for example, the affiliate that chose to invest resources to increase its pharmacy inventory by US$9,000 dollars every year for three years, and whose sales produce a minimum monthly profit of 10 percent, has the potential of generating additional resources of US$64,800, having invested only US$27,000, at the end of the three years.

Table 12 presents this example, which assumes a monthly sale of 100 percent of drugs and products purchased with those funds:

Table 12. FEMAP for a Healthy Youth Program Productive Initiative Funding Scheme Assuming 100 Percent of Drugs and Products Sold

	Year 1	Year 2	Year 3	Total
Investment in Pharmacy Inventory	US$9,000	US$9,000	US$9,000	US$27,000
Total Inventory Available	US$9,000	US$18,000	US$27,000	US$27,000
Total Income by Sales per Year	US$118,800	US$237,600	US$356,400	US$712,800
Total Sales and Operating Costs per Year	US$108,600	US$216,000	US$324,000	US$648,600
Annual Net Profit	**US$10,200**	**US$21,600**	**US$32,400**	**US$64,200**

In summary, this strategy was designed to produce sufficient income to sustain and expand the affiliate's adolescent program during the three years of funding, build an investment fund, and invest in a larger inventory and/or establish new productive initiatives.

Programmatic Results

Although it is important to have successful financial strategies, it is equally important to meet the programmatic objectives. **Table 13** summarizes the primary community-based activities conducted by the FEMAP for a Healthy Youth program at the national level and by the three affiliates surveyed for this report from 2000 through 2002.

Table 13. FEMAP for A Healthy Youth Program Community-Based Activities†				
Programmatic Activities	**2000**	**2001**	**2002**	**TOTAL**
Training Teachers	293	366	1,186	1,845
Training Promoters	935	1,108	1,497	3,540
Training Parents	1,052	696	2,407	4,155
Training Subtotal	***2,280***	***2,170***	***5,090***	***9,540***
Number of Volunteers	776	908	1,097	1,097‡
Attendants at Community Chats	2,361	6,176	18,828	27,365
Attendants at School Chats	762	1,497	4,856	7,115
One-on-One Information	18,288	30,509	71,340	120,137
Adolescent Information, Education, and Training Subtotal	***21,351***	***38,182***	***95,024***	***154,557***
FP Users	6,258	9,427	11,812	27,497
Total	**30,665**	**50,687**	**113,023**	**194,375**

†*Source*: FEMAP MIS

‡This is not a cumulative number.

Nationwide, during the period from 1 January 2000 through 31 December 2003, the program trained 6,000 parents and teachers. In addition, FEMAP established and trained a network of 1,097 volunteer adolescent promoters to provide information, education, and training to 154,557 adolescents, and to reach a total of 27,497 FP users. Of these FP users, 83 percent used condoms, 15 percent used hormonal contraceptives, and 2 percent used injectable contraceptives. **Table 13** shows an increase in coverage of adolescents during the first three years of the program, thus meeting expectations with respect to the growth of the program. During this period, training of volunteer staff, parents and teachers increased by 346 percent; the information, education, and training program coverage increased by 4.5 times; and the number of FP users increased by 88.8 percent.

Table 14 summarizes activities conducted by the affiliates in Ciudad Juárez, Veracruz, and Xalapa during the period between 1 January 2000 and 31 December 2002.

Table 14. FEMAP for a Healthy Youth Programmatic Results In Ciudad Juárez, Veracruz, And Xalapa†

Programmatic Activities	**Xalapa**			**Veracruz**			**Juárez**			**Total**
Years	**2000**	**2001**	**2002**	**2000**	**2001**	**2002**	**2000**	**2001**	**2002**	
Training Teachers Promoters Parents	 52 106 183	 94 110 95	 272 148 436	 67 299 243	 54 208 162	 238 287 678	 87 302 372	 105 342 177	 299 363 773	 1268 2065 3097
Training Total	**341**	**299**	**856**	**609**	**424**	**1203**	**761**	**624**	**1435**	**6424**
Number of Volunteers	138	171	179	196	194	271	273	295	348	798‡
Community Chats School Chats One-on-One	501 53 1436	1298 97 5133	4133 216 16290	580 54 2344	1307 131 4739	4996 223 18368	847 80 32219	1692 194 7148	5696 359 27231	21050 1887 85908
Information, Education, Training Total	**1990**	**6528**	**20639**	**2978**	**6177**	**23587**	**4146**	**9034**	**33286**	**108845**
Method Users†‡	628	1210	1703	746	1801	2425	2899	3329	4975	19716
Total	**3097**	**8208**	**23377**	**4529**	**8596**	**27486**	**8079**	**13282**	**40044**	**135798**

†*Source*: FEMAP MIS

‡This is not a cumulative number

†‡Method Users: active users of contraceptive methods

In these three cities, the program trained 4,365 parents and teachers, established and trained a network of 798 volunteer adolescent promoters, provided information, education, and training to 108,845 adolescents, and established 19,716 FP users. Of these FP users, 85 percent used condoms and 15 percent used oral hormonal contraceptives. **Table 14** shows an increase in coverage of adolescents during the first three years, thus meeting expectations with respect to growth and increase in coverage. During this period, training of volunteer staff, parents and teachers increased by 104%percent[26]; information, education, and training program coverage increased seven times, and the number of FP users increased by 113 percent. It is also important to point out that, thanks to this project, adolescents in these cities gained greater access to health care and to RH services provided by FEMAP clinics and hospitals. From 1 January 2000 through 31 December 2002, health service provision increased by 34.6 percent and RH service provision increased by 28.3 percent.

[26] The percent increase is calculated by comparing the training totals of 2002 for Xalapa, Veracruz and Juárez or 3494 to the totals of 2000 or 1711. The same is done to calculate the percentage increase for the IEC program coverage and the number of contraceptive users.

Financial Results

Table 15 illustrates the sustainability of the FEMAP for a Healthy Youth program at the Ciudad Juarez, Veracruz, and Xalapa affiliates, the aggregate of the program implemented by other affiliates, and the program as a whole. Sustainability is analyzed in terms of percentage, comparing the total income generated by the activity and the total expenses. All financial data comes from FEMAP accounting and financial records.

Table 15. FEMAP for a Healthy Youth Program Income, Expenses, and Operational Sustainability (Expressed in US$)

JUÁREZ	**2000**	**2001**	**2002**
External Income	$14,842.10	$8,631.60	$0.00
Self-Generated Income	$45,409.50	$39,624.00	$79,825.60
Expenses	$24,381.30	$21,680.10	$38,121.40
Surplus/(Deficit)	$21,028.20	$17,943.90	$41,704.30
Operational Sustainability	***125.4%***	***182.8%***	***209.4%***

VERACRUZ	**2000**	**2001**	**2002**
External Income	$23,747.40	$14,842.10	$7,961.20
Self-Generated Income	$23,857.60	$34,076.70	$34,983.90
Expenses	$33,870.20	$32,930.00	$34,115.30
Surplus/(Deficit)	($10,012.60)	$1,146.10	$868.60
Operational Sustainability	***70.4%***	***103.5%***	***102.5%***

XALAPA	**2000**	**2001**	**2002**
External Income	$23,747.40	$14,842.10	$7,961.20
Self-Generated Income	$27,296.90	$34,706.90	$27,018.10
Expenses	$33,223.80	$27,965.00	$28,567.20
Surplus/(Deficit)	($5,926.90)	$6,741.80	($1,549.10)
Operational Sustainability	***82.2%***	***124.1%***	***94.6%***

REST OF THE COUNTRY	**2000**	**2001**	**2002**
External Income	$70,926.30	$81,473.70	$54,806.00
Self-Generated Income	$439,595.40	$520,792.40	$556,939.00
Expenses	$432,995.70	$488,559.10	$514,655.60
Surplus/(Deficit)	$6,599.60	$32,233.30	$42,283.40
Operational Sustainability	***101.5%***	***106.6%***	***108.2%***

NATIONAL TOTAL	**2000**	**2001**	**2002**
External Income	$133,263.09	$119,789.50	$70,728.33
Self-Generated Income	$521,317.30	$629,199.30	$698,766.60
Expenses	$524,471.00	$571,134.10	$615,459.40
Surplus/(Deficit)	($3,153.70)	$58,065.20	$83,307.10
Operational Sustainability	***99.4%***	***110.2%***	***113.5%***

As shown in **Table 15**, the Juárez and Veracruz affiliates attained operational sustainability between the second and third year after having initiated the project. The Xalapa affiliate attained sustainability in the second year, experienced a decrease in the

third year, and regained sustainability in 2003. These figures demonstrate that all the affiliates were able to reach 100% sustainability by the second year, sooner than expected.

By 2003, the FEMAP for a Healthy Youth program no longer received financial support from its national offices and was operating with income generated through existing productive initiatives.

It is important to remind the reader that external income is not part of operational sustainability as per the definition in the Introduction. FEMAP uses external income to invest in infrastructure, equipment, etc. rather than for operational expenses.

CONCLUSION

The programmatic and financial results presented above demonstrate that it is possible to achieve sustainability of an adolescent FP/SRH program in a short period of time. This accomplishment resulted from the management capacity and commitment of the affiliates to ensure the continuity of adolescent programs. The results also reflect the reach of organizations when they develop and implement income-generating strategies that challenge paradigms and, as a result, expand the range of possibilities to attain sustainability.

LESSONS LEARNED

The different strategies for generating income developed by PROFAMILIA and FEMAP demonstrate that it is possible to implement sustainable adolescent programs. Programs targeted at adolescents, among others, can be funded with self-generated income or through cost recovery by charging fees for services, as is the case of PROFAMILIA; or through resources generated by activities other than the adolescent program itself (cross-subsidy), as is the case of FEMAP.

- To be successful, the sustainability strategy should be in developed in the context of the specific characteristics of the population served as the well as the organizational objectives and context of the sponsoring organization. FEMAP affiliates develop income-generating strategies, or productive initiatives, targeted to a population other than adolescents to obtain the necessary resources to sustain the FEMAP for a Healthy Youth program. PROFAMILIA youth clinics are financed directly by adolescent users, through the fees charged for the services provided and through the sale of products purchased and consumed and through the sale of educational activities to public and private institutions. These different strategies emerged in response to the specific characteristics of the population served by each organization.

  - When the financial strategy is based on resources contributed by adolescents, achieving 100 percent or greater sustainability is a very slow process. For example, the PROFAMILIA clinic in Bogotá initiated the adolescent program in June 1990 and did not become self-sufficient until 1999.

  - The shorter the time to achieve sustainability, the more rapidly the organization will be able to scale up the program. On average, the productive initiatives implemented by the FEMAP affiliates to cross-subsidize the FEMAP for a Healthy Youth program achieved operational sustainability in a period of only two years, sooner than expected. This success enables the program to establish new adolescent FP/SRH programs or expand existing programs.

  - Sustainability of an adolescent program is closely related to the managerial capability of the sponsoring organization. Both PROFAMILIA and FEMAP are organizations that have in place good management systems, including planning, evaluation, cost accounting, MIS, and quality assurance. All organizational programs incorporate a sustainability strategy or component.

  - When the installed capacity is somewhat underused, market studies will identify other potential services that can be provided and determine if there is a demand for the new services by current or new users. One of the strategies implemented by PROFAMIILIA to improve its operational sustainability was to optimize the use of its installed capacity to provide services for adolescents.

  - When products are purchased to be sold or consumed locally, a thorough cost analysis considering volume and use of supplies should be done. Costs can be reduced substantially if the high volume of products and supplies justifies buying in bulk in order to obtain lower prices and discounts. Both FEMAP and

PROFAMILIA have adopted this strategy to reduce cost of contraceptives and other products for their programs.

- Paying staff on a productivity basis is less costly and helps reduce operational expenses for clinics or activities that have a low volume of clients. Salaried professionals represent a fixed cost, because the professional gets paid even if no client is seen or treated, while the payment of fees based on productivity (by client seen) represents a variable cost. Both PROFAMILIA and FEMAP established personnel policies to reduce labor (salaries and fees) costs, which typically are the highest operating costs in service delivery. Both organizations ensure that retention of salaried staff is justified, for example, because of high volume of clients in large clinics, but rely on professionals paid by client seen (productivity) for specialized or new or low volume services.

- Use of adolescent volunteers reduces costs. PROFAMILIA and FEMAP rely on young volunteer promoters as a strategy for reducing costs and expanding coverage for their educational activities and promotion of adolescents' services. However, rotation of volunteers and cost associated with training of new volunteers remains an issue.

- Adolescent FP/SRH programs should institutionalize a culture of payment; however, fees must be adjusted according to adolescents' ability to pay. PROFAMILIA enhanced the operational sustainability of adolescent programs by institutionalizing a culture of payment in its program. It is fundamental to avoid service delivery at no cost to users, as this generates a culture of non-payment. However, it is important to adjust fees according to adolescents' payment capabilities.

- To enhance and generate financial resources, organizations should:
  - Offer quality services
  - Sell adolescent educational services to schools, businesses, and communities.
  - Contract for services or supply contraceptives to adolescents through other private and public organizations.
  - Negotiate a fee-sharing arrangement with providers to whom adolescents are referred for other services.

- To promote a culture and business practices that are sustainability-driven, organizations should:
  - Strengthen their management and administration systems.
  - Establish a cost accounting system to track costs by cost centers (e.g. youth services/activities).
  - Implement productivity, expense, and quality standards.
  - Improve follow-up, supervision, and inventory control.
  - Establish policies that control the rationalization of expenditures.

As seen in this report, the first steps in the pursuit of sustainability are usually slow. However, the experience and lessons learned during the process may enable new activities to reach sustainability in less time, hence the importance of sharing the experiences of PROFAMILIA and FEMAP with other interested organizations Achieving sustainability is the most compelling proof of an organization's commitment with respect

to its vision, mission, philosophy and objectives, because, through these, the organization demonstrates its interest and desire to ensure the continuity of programs for young people.

ANNEX A

Annex A.1
PROFAMILIA NATIONAL CUMULATIVE STATEMENT OF INCOME AND EXPENSES
ADOLESCENT PROGRAMS
January 1 to December 31, 2002

TYPE OF TRANSACTION	NATIONAL	BOGOTÁ PROGRAM	CALI PROGRAM	MEDELLIN PROGRAM	PROGRAM IN OTHER CENTERS
	(Expressed in US Dollars)				
	US$	US$	US$	US$	US$
International Contracts and/or Donations	299,772	13,673	2,876	2,084	281,138
INTERNATIONAL INCOME	**299,772**	**13,673**	**2,876**	**2,084**	**281,138**
Medical Services (Paid for by youth)	394,406	94,672	46,023	36,685	21,028
Medical Services (Paid for by other users)	–	–	–	–	–
Educational Activities and Other INCOME	149,073	37,810	7,670	5,044	98,548
Contraceptive Sales	148,615	51,525	9,338	24,637	63,114
Sales of Other Products	9,505	1,626	500	459	6,920
Returns and Sales Discounts	(9,838)	(667)	(125)	–	(9,046)
Cost of Contraceptive Sales	(55,110)	(21,427)	(333)	(10,130)	(23,220)
Cost of Other Product Sales	(2,084)	(459)	(42)	(125)	(1,459)
Gross Margin on Product Sales	91,086	30,598	9,338	14,841	36,310
SELF-GENERATED INCOME	**634,566**	**163,080**	**63,031**	**56,569**	**351,886**
TOTAL INCOME	**934,339**	**176,754**	**65,907**	**58,654**	**633,024**
Salaries	221,025	27,889	25,304	29,515	138,318
Social Benefits and Loans	148,823	16,550	15,174	33,642	83,458
Informational/Promotional Material	32,224	4,085	1,626	1,709	24,804
Advertising and Publicity	104,635	6,462	3,794	2,209	92,170
Professional Fees	103,509	19,093	12,256	5,920	66,241
Public Services	15,132	3,043	1,626	1,084	9,380
Rentals	30,932	11,089	5,878	2,293	11,672
Insurance, Surveillance, Freight and Other Services	17,675	4,377	792	542	11,964
Sporting Goods	–	–	–	–	–
Recreational and Cultural Activities	–	–	–	–	–
Office, Bank and Other Expenses	49,900	9,546	2,043	2,710	35,601
Travel and Transportation Expenses	34,100	2,460	500	792	30,348
Refreshments for Trainings	–	–	–	–	–
Medications and Clinical Material	33,183	13,590	3,252	3,377	12,965
Name Tags and Printing of Business Cards	–	–	–	–	–
Maintenance and Repairs	8,796	1,667	375	542	6,211
Purchase of Fixed Assets	–	–	–	–	–
Investment in Productive Initiatives	–	–	–	–	–
TOTAL COSTS AND EXPENSES	**799,935**	**119,851**	**72,619**	**84,333**	**523,132**
INSTITUTIONAL SURPLUS (DEFICIT)	**134,404**	**56,903**	**(6,712)**	**(25,679)**	**109,892**
Minus: International Donations and Contracts	(299,772)	(13,673)	(2,876)	(2,084)	(281,138)
OPERATIONAL SURPLUS (DEFICIT)	**(165,369)**	**43,230**	**(9,588)**	**(27,764)**	**(171,247)**
OPERATIONAL SUSTAINABILITY	**79.3%**	**136.1%**	**86.8%**	**67.1%**	**67.3%**

Annex A.2
PROFAMILIA NATIONAL CUMULATIVE STATEMENT OF INCOME AND EXPENSES
ADOLESCENT PROGRAMS
January 1 to December 31, 2001

TYPE OF TRANSACTION	NATIONAL	BOGOTÁ PROGRAM	CALI PROGRAM	MEDELLIN PROGRAM	PROGRAM IN OTHER CENTERS
	(Expressed in US Dollars)				
	US$	**US$**	**US$**	**US$**	**US$**
International Contracts and/or Donations	130,805	4,568	3,263	522	122,453
INTERNATIONAL INCOME	**130,805**	**4,568**	**3,263**	**522**	**122,453**
Medical Services (Paid for by youth)	337,125	82,520	40,107	30,972	183,527
Medical Services (Paid for by other users)	–	–	–	–	–
Educational Activities and Other INCOME	130,022	30,450	7,265	5,568	86,739
Contraceptive Sales	112,361	40,325	8,439	19,401	44,196
Sales of Other Products	9,831	1,958	305	305	7,265
Returns and Sales Discounts	(2,784)	(392)	(174)	–	(2,219)
Cost of Contraceptive Sales	(44,457)	(18,227)	(3,480)	(8,874)	(13,877)
Cost of Other Product Sales	(3.089)	(740)	(131)	(174)	(2.045)
Gross Margin on Product Sales	71,862	22,925	4,959	10,658	33,321
SELF–GENERATED INCOME	**539,009**	**135,894**	**52,331**	**47,198**	**303,587**
TOTAL INCOME	**669,813**	**140,462**	**55,593**	**47,720**	**426,039**
Salaries	219,240	20,358	23,882	33,930	141,071
Social Benefits and Loans	149,205	19,053	14,790	20,924	94,439
Informational/Promotional Material	24,795	3,437	1,262	1,218	18,879
Advertising and Publicity	11,006	–	2,523	348	8,135
Professional Fees	63,423	22,707	9,962	2,871	27,884
Public Services	12,606	2,105	2,236	870	7,395
Rentals	27,061	3,828	1,131	3,828	18,274
Insurance, Surveillance, Freight and Other Services	19,227	4,176	1,740	1,131	12,180
Sporting Goods	–	–	–	–	–
Recreational and Cultural Activities	–	–	–	–	–
Office, Bank and Other Expenses	47,285	6,351	4,437	3,219	33,278
Travel and Transportation Expenses	35.905	696	348	1.088	33.773
Refreshments for Trainings	–	–	–	–	–
Medication and Clinical Material	29,293	10,701	2,828	4,916	10,849
Name Tags and Printing of Business Cards	–	–	–	–	–
Maintenance and Repairs	11,832	3,219	3,306	957	4,350
Purchase of Fixed Assets	–	–	–	–	–
Investment in Productive Initiatives	–	–	–	–	–
TOTAL COSTS AND EXPENSES	**650,878**	**96,631**	**68,443**	**75,299**	**410,505**
INSTITUTIONAL SURPLUS (DEFICIT)	**18,936**	**43,831**	**(12,850)**	**(27,579)**	**15,534**
Minus: International Donations and Contracts	(130,805)	(4,568)	(3,263)	(522)	(122,453)
OPERATIONAL SURPLUS (DEFICIT)	**(111,869)**	**39,263**	**(16,112)**	**(28,101)**	**(106,919)**
OPERATIONAL SUSTAINABILITY	**82.8%**	**140.6%**	**76.5%**	**62.7%**	**74.0%**

Annex A.3
PROFAMILIA NATIONAL STATEMENT OF INCOME AND EXPENSES
ADOLESCENT PROGRAMS
January 1 to December 31, 2000

TYPE OF TRANSACTION	NATIONAL	BOGOTÁ PROGRAM	CALI PROGRAM	MEDELLIN PROGRAM	PROGRAM IN OTHER CENTERS
	(Expressed in US Dollars)				
	US$	US$	US$	US$	US$
International Contracts and/or Donations	272,310	18,232	27,862	7,433	218,783
INTERNATIONAL INCOME	**272,310**	**18,232**	**27,862**	**7,433**	**218,783**
Medical Services (Paid for by youth)	295,871	71,619	21,925	39,128	163,199
Medical Services (Paid for by other users)	-	-	-	-	-
Educational Activities and Other INCOME	136,459	38,988	8,742	11,874	76,854
Contraceptive Sales	76,013	28,470	6,825	13,510	27,208
Sales of Other Products	10,238	1,870	467	421	7,480
Returns and Sales Discounts	(1,683)	(374)	(140)	-	(1,169)
Cost of Contraceptive Sales	(35,763)	(12,482)	(2,852)	(6,545)	(13,884)
Cost of Other Product Sales	(4,114)	(561)	(187)	(187)	(3,179)
Gross Margin on Product Sales	44,691	16,923	4,114	7,199	16,455
SELF-GENERATED INCOME	**477,020.8**	**127,529.7**	**34,780.8**	**58,201.8**	**256,508.5**
TOTAL INCOME	**749,330**	**145,762**	**62,643**	**65,635**	**475,291**
Salaries	207,189	24,262	23,327	33,004	126,595
Social Benefits and Loans	132,251	16,128	14,679	22,439	79,005
Informational/Promotional Material	29,265	888	3,459	47	24,870
Advertising and Publicity	37,913	3,740	1,215	1,917	31,041
Professional Fees	51,797	15,988	8,181	841	26,787
Public Services	11,407	2,244	1,028	1,122	7,012
Rentals	21,691	3,740	2,898	3,459	11,594
Insurance, Surveillance, Freight and Other Services	15,100	5,937	3,646	982	4,535
Sporting Goods	-	-	-	-	-
Recreational and Cultural Activities	-	-	-	-	-
Office, Bank and Other Expenses	62,409	8,789	8,882	5,423	39,315
Travel and Transportation Expenses	31,976	1,730	748	1,309	28,189
Refreshments for Trainings	-	-	-	-	-
Medication and Clinical Material	26,132	9,864	1,917	7,386	6,966
Name Tags and Printing of Business Cards	-	-	-	-	-
Maintenance and Repairs	11,500	2,805	374	1,169	7,153
Purchase of Fixed Assets	-	-	-	-	-
Investment in Productive Initiatives	-	-	-	-	-
TOTAL COSTS AND EXPENSES	**638,630**	**96,115**	**70,356**	**79,098**	**393,061**
INSTITUTIONAL SURPLUS (DEFICIT)	**110,700**	**49,647**	**(7,713)**	**(13,464)**	**82,230**
Minus: International Donations and Contracts	(272,310)	(18,232)	(27,862)	(7,433)	(218,783)
OPERATIONAL SURPLUS (DEFICIT)	**(161,609)**	**31,415**	**(35,576)**	**(20,897)**	**(136,552)**
OPERATIONAL SUSTAINABILITY	**74.7%**	**132.7%**	**49.4%**	**73.6%**	**65.3%**

Annex A.4
PROFAMILIA NATIONAL STATEMENT OF INCOME AND EXPENSES
ADOLESCENT PROGRAMS
January 1 to December 31, 1999

TYPE OF TRANSACTION	NATIONAL	BOGOTÁ PROGRAM	CALI PROGRAM	MEDELLIN PROGRAM	PROGRAM IN OTHER CENTERS
	(Expressed in US Dollars)				
	US$	US$	US$	US$	US$
International Contracts and/or Donations	274,176	–	32,273	462	241,441
INTERNATIONAL INCOME	**274,176**	**–**	**32,273**	**462**	**241,441**
Medical Services (Paid for by youth)	275,735	75,053	21,996	38,220	140,465
Medical Services (Paid for by other users)	–	–	–	–	–
Educational Activities and Other INCOME	140,639	29,271	15,126	16,685	79,557
Contraceptive Sales	71,820	29,617	8,602	7,621	25,980
Sales of Other Products	13,452	4,734	1,270	924	6,524
Returns and Sales Discounts	(1,039)	(346)	(58)	–	(635)
Cost of Contraceptive Sales	(30,310)	(12,239)	(3,233)	(3,695)	(11,143)
Cost of Other Product Sales	(5,254)	(924)	(462)	(173)	(3,695)
Gross Margin on Product Sales	48,669	20,842	6,120	4,676	17,031
SELF-GENERATED INCOME	**465,042**	**125,166**	**43,242**	**59,581**	**237,053**
TOTAL INCOME	**739,218**	**125,166**	**75,515**	**60,043**	**478,494**
Salaries	218,174	22,401	21,592	19,225	154,956
Social Benefits and Loans	141,909	13,336	15,068	11,027	102,477
Informational/Promotional Material	21,304	2,771	1,790	3,349	13,394
Advertising and Publicity	1,963	58	–	1,097	808
Professional Fees	61,602	20,322	9,757	173	31,349
Public Services	15,126	2,713	2,367	1,443	8,602
Rentals	29,617	5,023	7,794	4,215	12,586
Insurance, Surveillance, Freight and Other Services	13,741	2,829	5,600	924	4,388
Sporting Goods	–	–	–	–	–
Recreational and Cultural Activities	–	–	–	–	–
Office, Bank and Other Expenses	74,476	11,316	11,316	4,503	47,341
Travel and Transportation Expenses	32,562	1,386	1,732	1,905	27,539
Refreshments for Trainings	–	–	–	–	–
Medication and Clinical Material	15,357	5,138	346	2,656	7,217
Name Tags and Printing of Business Cards	–	–	–	–	–
Maintenance and Repairs	12,701	4,215	751	981	6,755
Purchase of Fixed Assets	–	–	–	–	–
Investment in Productive Initiatives	–	–	–	–	–
TOTAL COSTS AND EXPENSES	**638,531**	**91,507**	**78,113**	**51,498**	**417,412**
INSTITUTIONAL SURPLUS (DEFICIT)	**100,687**	**33,659**	**(2,598)**	**8,545**	**61,082**
Minus: International Donations and Contracts	(274,176)	–	(32,273)	(462)	(241,441)
OPERATIONAL SURPLUS (DEFICIT)	**(173,489)**	**33,659**	**(34,871)**	**8,083**	**(180,359)**
OPERATIONAL SUSTAINABILITY	**72.8%**	**136.8%**	**55.4%**	**115.7%**	**56.8%**

ANNEX B

Annex B.1
STATEMENT OF INCOME AND EXPENSES FEMAP 2002

STATEMENT OF INCOME AND EXPENSES
ADOLESCENT PROGRAMS
January 1 to December 31, 2002

(Expressed in US Dollars Exchange Rate $ 9.50)

Line Item	TYPE OF TRANSACTION	National Total $US	FEMAP C. JUAREZ PROGRAM $US	FEMAP VERACRUZ PROGRAM $US	FEMAP XALAPA PROGRAM $US	FEMAP Other Affiliates $US
1	Contracts and/or Donations	70,728	–	7,961	7,961	54,806
2	**INTERNATIONAL INCOME**	**70,728**	**–**	**7,961**	**7,961**	**54,806**
3	Medical Services (Paid for by youths)	54,863	–	–	–	54,863
4	Medical Services (Paid for by other users)	468,116	–	14,916	27,366	425,836
5	Educational and other services	–	–	–	–	–
6	Contraceptive Sales	339,653	177,390	8,027	28,346	125,889
7	Other Product Sales	104,304	–	68,481	–	35,823
8	Returns & Discounts in Sales	–	–	–	–	–
9	Cost of Contraceptive Sales	(184,181)	(97,565)	(3,582)	(17,145)	(65,890)
10	Cost of Other Product Sales	(83,990)	–	(52,858)	(11,550)	(19,582)
11	Gross Margin on Product Sales	175,786	79,826	20,068	(348)	(76,240)
12	**SELF-GENERATED**	**175,786**	**79,826**	**34,984**	**27,018**	**556,939**
13	**TOTAL REVENUE**	**769,495**	**79,826**	**42,945**	**34,979**	**611,745**
14	Salaries	359,683	23,939	16,679	13,174	305,892
15	Social Benefits and Loans	92,905	7,543	5,984	3,485	75,893
16	Informational/Promotional Material	11,305	281	1,092	369	9,563
17	Advertising & Publicity	7,761	311	346	246	6,859
18	Professional Fees	–	–	–	–	–
19	Public Services	22,840	317	306	358	21,859
20	Rentals	15,111	–	669	583	13,859
21	Insurance, Surveillance, Freight & Other Services	–	–	–	–	–
22	Sporting Goods	8,631	277	146	350	7,859
23	Recreational & Cultural Activities	11,579	553	336	834	9,856
24	Office, Bank & Other Expenses	7,559	333	422	451	6,352
25	Travel & Transportation Exp.	25,109	639	639	2,773	21,058
26	Refreshments for Trainings	6,517	243	257	378	5,639
27	Medications & Clinical Material	–	–	–	–	–
28	Name Tags & Printing of Business Cards	1,022	–	51	76	895
29	Maintenance & Repairs	4,692	180	2,089	392	2,032
30	Purchase of Fixed Assets	2,590	–	–	–	2,590
31	Investing in Productive Initiative	38,157	3,507	5,100	5,100	24,450
32	**TOTAL COSTS & EXPENSES**	**615,459**	**38,121**	**34,115**	**28,567**	**514,656**
33	**INSTITUTIONAL SURPLUS (DEFICIT)**	**154,035**	**41,704**	**8,830**	**6,412**	**97,089**
34	**Minus: International Donations and Contracts**	**(70,728)**	**-**	**(7,961)**	**(7,961)**	**(54,806)**
35	**OPERATIONAL SURPLUS (DEFICIT)**	**83,307**	**41,704**	**869**	**(1,549)**	**42,283**
36	**INCOME SUSTAINABILITY**	**90.8%**	**100.**	**81.5**	**77.2**	**91.0**
37	**OPERATIONAL SUTAINABILITY**	**113.5%**	**209.**	**102.5**	**94.6**	**108.2**

Annex B.2
STATEMENT OF INCOMES AND EXPENDITURES – FEMAP 2001

STATEMENT OF INCOMES AND EXPENDITURES – FEMAP
ADOLESCENT PROGRAMS
January 1 to December 31, 2001

(Expressed in US Dollars Exchange Rate $ 9.50)

Line Item	TYPE OF TRANSACTION	FEMAP/Mexico				
		National Total	C. JUAREZ PROGRAM	VERACRUZ PROGRAM	XALAPA PROGRAM	Other Affiliates
		$US	$US	$US	$US	$US
1	International Contracts and/or Donations	119,789	8,632	14,842	14,842	81,474
2	**INTERNATIONAL INCOME**	**119,789**	**8,632**	**14,842**	**14,842**	**81,474**
3	Medical Services (Paid for by youths)	48,579	–	–	–	48,579
4	Medical Services (Paid for by other users)	460,440	–	16,382	38,167	405,890
5	Educational Activities & Other INCOME	–	–	–	–	–
6	Contraceptive Sales	204,987	88,053	8,220	21,367	87,346
7	Sales of Other Products	107,822	–	67,932	–	39,890
8	Returns & Sales Discounts	–	–	–	–	–
9	Cost of Contraceptive Sales	(105,699)	(48,429)	(3,779)	(13,231)	(40,260)
10	Cost of Other Product Sales	(86,930)	–	(54,680)	(11,597)	(20,653)
11	Gross Margin on Product Sales	120,180	39,624	17,694	(3,461)	66,323
12	**SELF-GENERATED INCOME**	**629,199**	**39,624**	**34,076**	**34,707**	**520,792**
13	**TOTAL INCOME**	**748,989**	**48,256**	**48,918**	**49,549**	**602,266**
14	Salaries	344,189	15,165	19,252	13,880	295,892
15	Social Benefits and Loans	76,293	2,178	6,244	4,309	63,563
16	Informational/Promotional Material	14,548	–	153	536	13,859
17	Advertising & Publicity	5,625	–	–	–	5,625
18	Professional Fees	–	–	–	–	–
19	Public Services	13,253	224	325	318	12,385
20	Rentals	13,868	–	1,311	498	12,058
21	Insurance, Surveillance, Freight & Other Services	–	–	–	–	–
22	Sporting Goods	11,549	137	211	343	10,859
23	Recreational & Cultural Activities	10,658	61	297	443	9,857
24	Office, Bank & Other Expenses	8,328	182	287	–	7,859
25	Travel & Transportation Exp.	30,115	158	632	3,430	25,895
26	Refreshments for Trainings	10,362	68	189	247	9,857
27	Medications & Clinical Material	–	–	–	–	–
28	Name Tags & Printing of Business Cards	1,235	–	–	–	1,235
29	Maintenance & Repairs	2,833	–	521	453	1,859
30	Purchase of Fixed Assets	2,859	–	–	–	2,859
31	Investment in Productive Initiatives	25,419	3,507	3,507	3,507	14,897
32	**TOTAL COSTS & EXPENSES**	**571,134**	**21,680**	**32,930**	**27,965**	**488,559**
33	**INSTITUTIONAL SURPLUS (DEFICIT)**	**177,855**	**26,575**	**15,988**	**21,584**	**113,707**
34	**Minus: International Donations and Contracts**	**(119,789)**	**(8,632)**	**(14,842)**	**(14,842)**	**(81.**
35	**OPERATIONAL SURPLUS (DEFICIT)**	**58,065**	**17,944**	**1,146**	**6.**	**32,233**
36	**INCOME SUSTAINABILITY**	**84.**	**82.**	**69.**	**70.**	**86.**
37	**OPERATIONAL SUSTAINABILITY**	**110.**	**182.**	**103.**	**124.**	**106.**

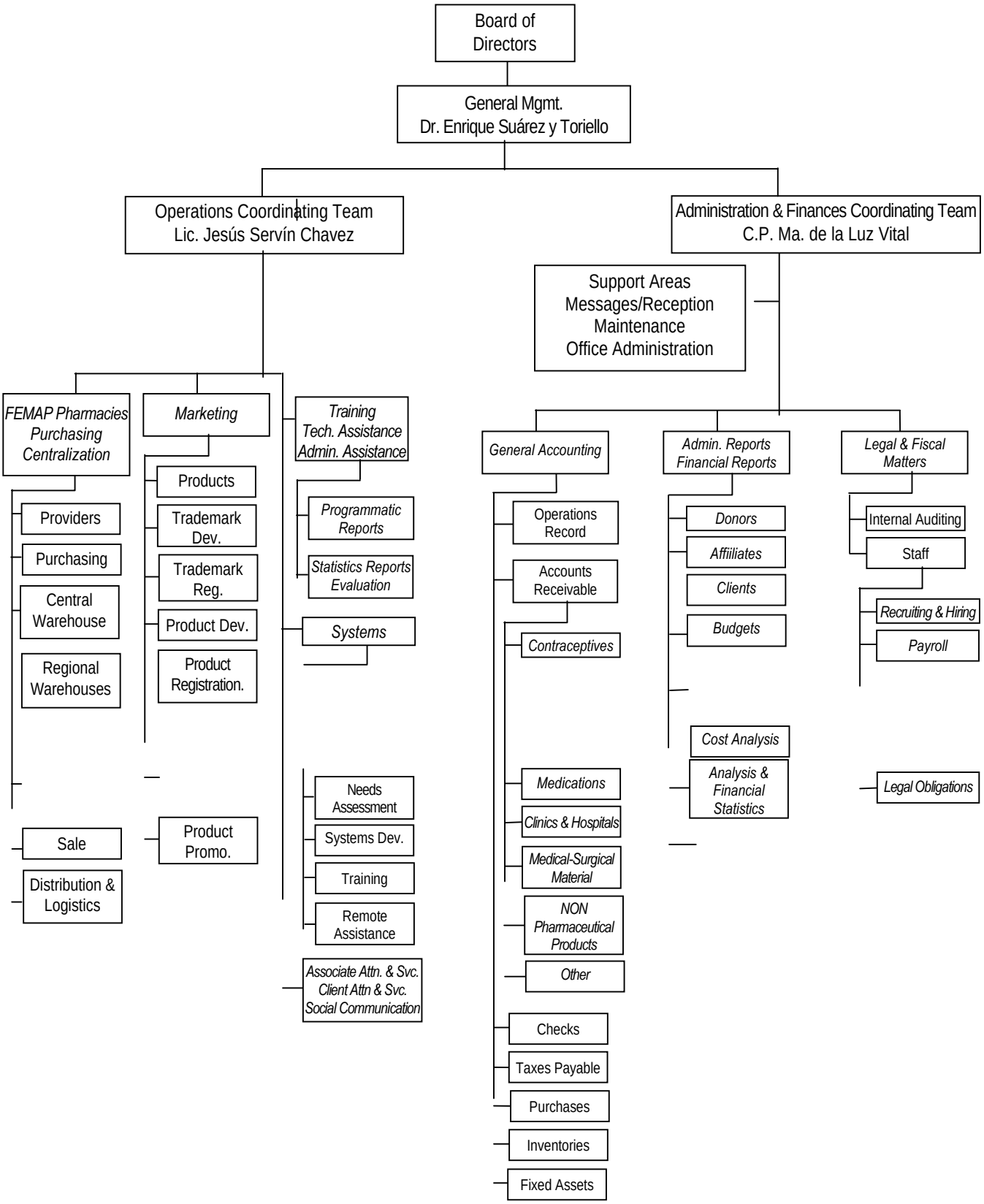
Annex B.3
STATEMENT OF INCOME AND EXPENSES – FEMAP 2000

STATEMENT OF INCOME AND EXPENSES – FEMAP
ADOLESCENT PROGRAMS
January 1 to December 31, 2000

(Expressed in US Dollars Exchange Rate $ 9.50)

		FEMAP/Mexico				
Line Item	**TYPE OF TRANSACTION**	**National Total $US**	**C. JUAREZ PROGRAM $US**	**VERACRUZ PROGRAM $US**	**XALAPA PROGRAM $US**	**Other Affiliates $US**
1	International Contracts and/or Donations	133,263	14,842	23,747	23,747	70,926
2	**INTERNATIONAL INCOME**	**133,263**	**14,842**	**23,747**	**23,747**	**70,926**
3	Medical Services (Paid for by youths)	28,284	–	–	–	28,284
4	Medical Services (Paid for by other users)	420,468	–	10,876	29,966	379,626
5	Educational Activities & Other INCOME	–	–	–	–	–
6	Contraceptive Sales	132,718	70,057	-	14,102	48,560
7	Sales of Other Products	112,197	–	66,307	–	45,890
8	Returns & Sales Discounts	–	–	–	–	–
9	Cost of Contraceptive Sales	(83,470)	(39,489)	-	(8,090)	(35,890)
10	Cost of Other Product Sales	(88,881)	-	(53,325)	(8,681)	(26,875)
11	Gross Margin on Product Sales	72,565	30,567	12,982	(2,669)	31,685
12	**SELF-GENERATED INCOME**	**521,317**	**30,567**	**23,858**	**27,297**	**439,595**
13	**TOTAL INCOME**	**654,580**	**45,410**	**47,605**	**51,044**	**510,522**
14	Salaries	292,247	18,568	16,930	13,090	243,658
15	Social Benefits and Loans	87,661	2,653	5,926	3,403	75,680
16	Informational/Promotional Material	20,216	164	2,684	789	16,578
17	Advertising & Publicity	9,260	–	105	632	8,523
18	Professional Fees	–	–	–	–	–
19	Public Services	7,435	167	275	378	6,615
20	Rentals	10,888	–	1,350	585	8,953
21	Insurance, Surveillance, Freight & Other Services	–	–	–	–	–
22	Sporting Goods	8,696	126	211	1,500	6,859
23	Recreational & Cultural Activities	9,670	200	526	1,089	7,854
24	Office, Bank & Other Expenses	6,870	66	884	1,023	4,897
25	Travel & Transportation Exp.	25,841	371	1,211	5,302	18,958
26	Refreshments for Trainings	12,043	247	474	463	10,859
27	Medications & Clinical Material	–	–	–	–	–
28	Name Tags & Printing of Business Cards	2,271	–	277	414	1,580
29	Maintenance & Repairs	4,601	37	589	195	3,780
30	Purchase of Fixed Assets	16,086	–	647	2,580	12,859
31	Investment in Productive Initiatives	10,686	1,781	1,781	1,781	5,343
32	**TOTAL COSTS & EXPENSES**	**524,471**	**24,381**	**33,870**	**33,224**	**432,996**
33	**INSTITUTIONAL SURPLUS (DEFICIT)**	**130,109**	**21,028**	**13,735**	**17,820**	**77,526**
34	**Minus: International Donations and Contracts**	**(133,264)**	**(14,842)**	**(23,747)**	**(23,747)**	**(70,926)**
35	**OPERATIONAL SURPLUS (DEFICIT)**	**(3,154)**	**6,186**	**(10,013)**	**(5,927)**	**6,600**
36	**INCOME SUSTAINABILITY**	**79.6%**	**67.3%**	**50.1%**	**53.5%**	**86.1%**
37	**OPERATIONAL SUSTAINABILITY**	**99.4%**	**125.4%**	**70.4%**	**82.2%**	**101.5%**

ANNEX B 4: FEMAP OPERATIONAL ORGANIZATIONAL CHART



CATALYST
consortium

Catalyst Consortium
1201 Connecticut Avenue, NW, Suite 500
Washington, DC 20036
T. 202.775.1977
F. 202.775.1988
www.rhcatalyst.org

Partners:
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