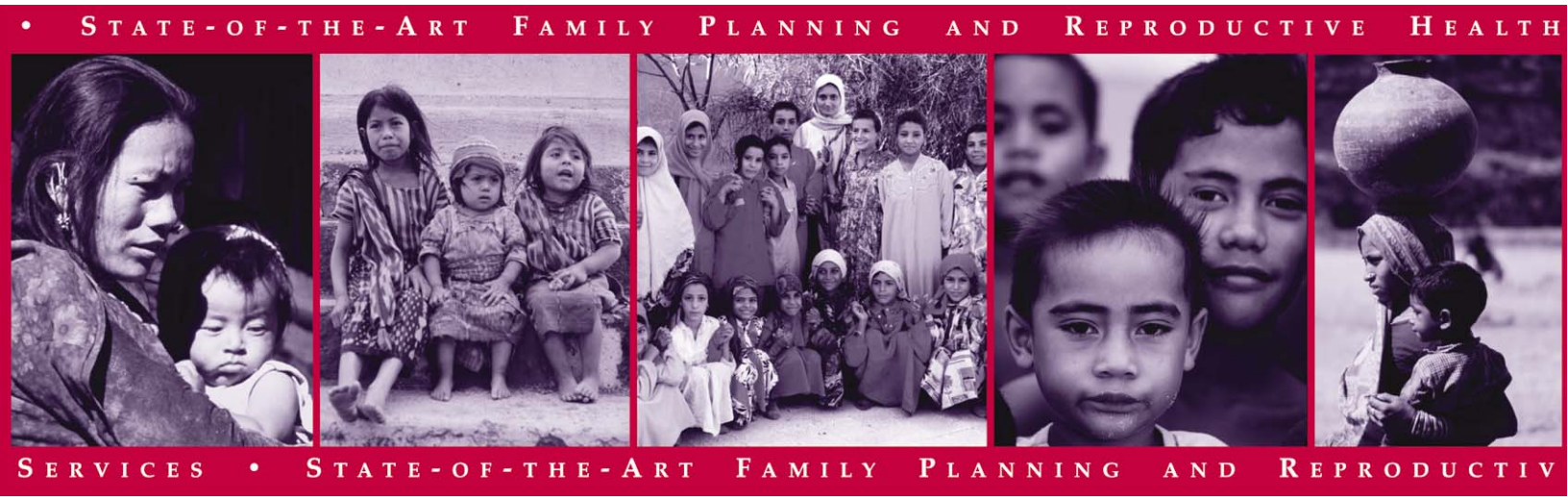

PROFAMILIA'S ROLE IN HEALTH SECTOR REFORM IN COLOMBIA

CASE STUDY SUMMARY

Bogotá, March 2003

CATALYST consortium

USAID

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

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CASE STUDY SUMMARY

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Iván Jaramillo Pérez
Consultant

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Acknowledgments

The present case study was financed by the CATALYST Consortium, a global health initiative funded by the United States Agency for International Development (USAID). The CATALYST Consortium assists USAID Missions and Offices in delivering on the Cairo Agenda through synergistic partnerships and state-of-the-art technical leadership in sexual and reproductive health.

The case study was prepared by Ivan Jaramillo in collaboration with PROFAMILIA/Colombia. PROFAMILIA/Colombia South-to-South Program promotes the exchange of knowledge, experience and information among developing countries to ensure sustainable institutional development and access to quality sexual and reproductive health for all women, men and adolescents. The structural framework of the South-to-South technical collaboration between the CATALYST Consortium and PROFAMILIA focuses on finding long-term financial, programmatic and institutional solutions through continuous exchange between organizations.

The author would like to give special thanks to the following individuals who collaborated on editing and revising the drafts: Maria Isabel Plata and Gabriel Ojeda from PROFAMILIA, and Marie-France Semmelbeck and Orlando Hernández from the CATALYST Consortium. We also want to thank Nancy Pielemeir, Activity Director, and Tania Dmytraczenko, Health Economist at Abt Associates, Inc., for collaborating with the CATALYST Consortium in the review of this document.

PROFAMILIA/Colombia also wishes to extend its gratitude to the USAID Transition project, which, between 1992 and 1996, enabled it to make all of the necessary programmatic and institutional adjustments and take advantage of the opportunities presented under the Law 100, and make the shift from a donor dependent institution to an independent one. An additional endowment provided by USAID in 1996 has been instrumental in maintaining the upkeep of many of the PROFAMILIA/Colombia facilities once USAID direct assistance ended.

Finally, the author would like to thank the interviewees of the client profile survey.

About the Case Study

The purpose of the present case study is to disseminate information about the changes that were required on the part of the NGO PROFAMILIA/Colombia, so that it could continue to provide sexual and reproductive health services to the poorest population in the country during the process of health sector reform. Currently, the institution has reached the point of self-financing in almost all of its work. It hopes to effectively communicate lessons learned so that these may be adapted by other NGOs working in the context of health sector reform in Latin America and in other regions.

The case study is organized in two parts. The first part covers health sector reform in Colombia, and highlights the role NGOs played both before and after the reform. The second part discusses how PROFAMILIA/Colombia has been impacted by and has adapted to the health sector reform. The author used a new methodology, which is based on a proposal developed by the Inter-American Institute for Social Development (INDES) at the Inter-American Development Bank (IDB)[1], and which uses dialogues with internal and external actors to illustrate how the process developed. Three instruments were used to compile the information necessary for this work: semistructured interviews, a diagnostic and participatory strategic design workshop, and a review of documents.

The present case study may be used as a social management tool by NGOs in Latin America and other regions. The collaborating author, Mr. Jaramillo, intentionally limits his comments to allow room for the interviewees to speak, highlighting the responses he considers important. Furthermore, he occasionally and objectively helps analyze problematic situations in the interviews on particular topics where there is no full agreement between the internal and external actors including for example, the role played by the national government, the weight given to international aid, or the contribution of internal efforts to the success of PROFAMILIA. The author also presents decisions, and systematizes the expectations quantified in the participatory workshop, while allowing the reader to form his/her own conclusions.

Using a different methodology, in the first part of the case study, Mr. Jaramillo introduces the Colombian context, the reform and its impact, using statistical data from the National Planning Department (DNP) and PROFAMILIA/Colombia, as well as previous studies conducted by the author on health sector reform. In the second part, he synthesizes the lessons learned by PROFAMILIA/Colombia.

[1] Varela Claudia, Development of Case Studies and Study Cases on Social Management, Methodological Guidelines, Project INDES / IDB – IDRC, September 2001.

Abbreviations

ARS (acronym in Spanish)	Administrator of the Subsidized Plan
CA	Cooperating agency
CNSSS (acronym in Spanish)	National Council on Health Social Security
CPS	Client profile survey
DANE (acronym in Spanish)	National Statistics Department
DHS	National demographic and health survey
DLS (acronym in Spanish)	Local health departments
DNP (acronym in Spanish)	National Planning Department
EPS (acronym in Spanish)	Health promoting organization
FOSYGA (acronym in Spanish)	National Health Solidarity and Guarantee Fund
IDB	Inter-American Development Bank
IEC	Information, education and communication
ILO	International Labor Organization
IPPF	International Planned Parenthood Federation
IPS (acronym in Spanish)	Service provider institution
KAPS	Knowledge, attitudes and practices in health
NGO	Nongovernmental organization
PAB (acronym in Spanish)	Basic Health Plan
PAC (acronym in Spanish)	Complementary Health Plan
PAHO	Pan American Health Organization
POS (acronym in Spanish)	Mandatory Health Plan
PROFAMILIA	Colombian Family Planning Association
SILOS (acronym in Spanish)	Local health systems
SRH	Sexual and reproductive health
SSI	Social Security Institute
SWOT	Strengths, weaknesses, opportunities, threats
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UPC (acronym in Spanish)	Capitation payment unit
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

In the following case study, the NGO PROFAMILIA/Colombia, documents its role in the health sector reform process in Colombia. The case study discusses the impact of the reform on the institution and its clients, and how the institution adapted to the framework of that reform. The case study is organized in two parts. In the first part, the author describes the health sector reform process, and highlights the role the NGO sector played both before and after the reform. In the second part of the case study, the author describes how the health sector reform impacted PROFAMILIA/Colombia, and how the private NGO adapted successfully to an increasingly competitive environment, while continuing providing services to the poorest segments of the population.

The health sector reform in Colombia was enacted through Law 100 in 1993. Its main objective was to provide universal coverage for health services including sexual and reproductive health services. Under the health sector reform, health services are guaranteed and financed through three programs: the contributive program financed completely through mandatory employee-employer contributions; the social security program subsidized by the government; and the complementary health program which covers only the wealthiest segment of the population.

In Colombia, family planning (FP) and sexual and reproductive health (SRH) services were already available prior to the reform, but the reform modified the way in which the services were offered, provided and financed. Law 100 offered PROFAMILIA potential advantages for creating economic alternatives to international funding. It should be noted that an external donor, USAID, provided considerable financial support to PROFAMILIA through grants and an endowment to support the transition. PROFAMILIA expanded its portfolio of services from family planning to include a wider range of sexual and reproductive health services[2]. PROFAMILIA purchased the equipment needed for the diversification of services for example ultrasounds, etc.

By selling a wider range of services as well as charging new clients, PROFAMILIA was able to replace international donations with local funds. Between 1990 and 2000, the use of sexual and reproductive health services increased significantly in the areas of general medicine (47%), gynecological and prenatal services (21% and 19% respectively); and other services (146%). A new service for men, urology consultations, was introduced that provided 20,000 visits per year in 2000. The volume of contraceptive methods sold mainly to public and private service provider institutions increased by more than 400%.

For PROFAMILIA/Colombia, the combination of a specialization in family planning and diversification into various sexual and reproductive health services was a key factor in guaranteeing the institution's competitiveness and its capacity to adapt to changing market conditions. PROFAMILIA had to learn skills in marketing, sales, contracting, invoicing and billing. Over the years PROFAMILIA had developed its own infrastructure and expanded to the national scale, and thus was recognized as a

[2] Refer to Annex 2 for a complete list of health services offered at PROFAMILIA/Colombia

national leader among sexual and reproductive health service providers. This gave PROFAMILIA a comparative advantage for competing with other providers, and has allowed it to continue to offer low costs services. It is important to note that PROFAMILIA was able to make all of these changes while continuing to serve the same, or even poorer populations than it had been serving prior to the reform. PROFAMILIA's staff is optimistic about the future despite the country's turbulent environment. Managers focus on creating an internal balance by enhancing PROFAMILIA's strengths, addressing problems, and by taking advantage of every opportunity that arises in the new environment.

I. THE COLOMBIAN CONTEXT

Geo-economic Data about the Republic of Colombia [3]

The local currency is the Colombian *peso.* The devaluation system is flexible in relation to the US dollar. Colombia's socioeconomic indicators include the following: the inflation rate reached 6.99% in 2002; the unemployment rate in December 2002 was 15.6%; the underemployment reached 34.5%; the Gross Domestic Product was (US)$83 million in 2002 (or the equivalent of $1,900 per inhabitant); the value of exports was (US)$11 million in 2000; the net balance of international reserves reached (US)$10 million in November 2001.

Socio-demographic Data [4]

Colombia is considered a young country: 44.6% of the 42,299,301 inhabitants are under 19 years of age and 63% of the population is under 30 years of age.

The population's educational level continues to rise. The illiteracy rate was 6.8% in 2000, yet has decreased in recent years as the proportion of people with high school and university level education has increased.

According to the National Planning Department (DNP, Acronym in Spanish), the percentage of the population with unmet basic needs is 37.53%. The availability of basic services is generally better than it was in 1995. The 2000 Demographic Health Survey (DHS) found that the most important changes occurred in the area of electrical services where 95% of homes now have electricity, and have access to clean water where 78% of homes have running water. The increased access to these services is particularly noticeable in rural areas.

Fertility and Family Planning

The 2000 DHS found that the total fertility rate is 2.6 children per woman. In the main municipalities, the total fertility rate is 2.3, and in rural areas it increases to 3.8 children per woman. The average family size, or the average number of children born alive to women between 15-49 years of age, is 3.7 for all women and 4.1 for women in union.

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[3] Map of Colombia from the Web site: www.ippfwhr.org with the cities where PROFAMILIA has sexual and reproductive health centers.

[4] Ojeda, Gabriel and Ordóñez Myriam, PROFAMILIA, DHS, Bogotá 2000.

In Colombia, all women of reproductive age, regardless of their civil status, are familiar with at least one contraceptive method. Currently, contraceptive methods use is increasing with 77% of women in union using a family planning method. Contraceptive prevalence increases to 84% among women who are not in union, but who are sexually active. These results place Colombia, along with Brazil, in the lead in terms of contraceptive prevalence in Latin America.

Among women in union, female sterilization is the most frequently used method (27%), followed by the IUD and the pill (12%). Between 1995 and 2000, there was a significant increase in the use of condoms and injectable methods among women in union. The use of natural or traditional methods remained constant.

In Colombia, 6% of women who are married or in union are considered to have an unmet need for family planning. The majority of these women want to limit the number of children they have but are not practicing any form of contraception. Less than half (48%) of pregnancies that occurred in the last five years were wanted pregnancies, at the time the women learned they were pregnant. Twenty nine percent were wanted later on, and 23% were unwanted. If all of the unwanted pregnancies had been prevented, the total fertility rate in Colombia would have fallen to 1.8, as opposed to the 2.6 found in the DHS survey.

II. HEALTH SECTOR REFORM IN COLOMBIA

Trends in Health Sector Reform in Latin America [5]

The National Health System promoted by the Pan American Health Organization (PAHO) during the 1960s and 1970s and implemented in most Latin American countries, supported a centralized management system. Responsibility for governance, auditing, administrative and operational functions of health service provisions were delegated to the municipal levels of the public and the private sectors.

[5] Jaramillo Pérez, Iván, Macro tendencies in Reform in Latin America, CLD-OPS, Caracas 2000

Characteristics of the Previous National Health System

The Colombian National Health System, created in 1973 and regulated in 1975, was characterized by the following:

1. Centralization of managerial, financial and auditing functions in the Ministry of Health (MOH).
2. Decentralization of personnel administration and of some health institutions at the local level.
3. Non-interference by the departments and municipalities in the managerial and operational functions.
4. Concentration of the technical management of services in regional units, dependent on the Ministry of Health.
   Hospitals worked without any administrative autonomy, and depended completely on the Ministry of Health
5. Limited financial development, with high levels of inequity and inefficiency: 50% of subsidies were concentrated in segments of the population that were not poor, and 80% of expenses in levels II and III.

Source: Londoño, Beatriz, Jaramillo, Iván and Uribe, Juan Pablo. Decentralization and Reform in Health Services: Colombia's Case. Human Development Department LCSHD Paper Series No.65. The World Bank, Latin America and the Caribbean Regional Office. March 2001.

During the last fifteen years, the health sector reform in Latin America -generally referred to as *Modernization of the State*- was carried out with the objective of creating smaller and more efficient States. The State would thereby become capable of managing its scarce resources in a more efficient and equitable manner. Focusing on the common good and on individual subsidies to the poorest populations.

To respond to these objectives in the external context of the economic opening and integration into the globalization process, two strategies for internal reorganization were developed: decentralization and privatization. In Argentina, Brazil, Colombia, Bolivia and Chile, decentralization of the health sector has implied transferring functions and financial resources to the municipalities and to the intermediate levels of the public administration.

In Colombia, the process of decentralizing the health sector began with decree 77 in 1987, Law 10 in 1990, and later on, Law 60 in 1993. With the health sector reform, the Social Security Health System (SSHS) was initiated in December 1993, when Law 100 was passed. Both processes, decentralization and privatization, were required by the Constitutional Reform of 1991 and terms of reference were established. In particular, articles 48 and 49, which characterized Colombia as a decentralized country, authorized the end of the monopolies in public and social services and introduced public-private competition in the provision of services. Furthermore, the concept of "public assistance-offered" subsidies was replaced by a system based on subsidies by demand.

Principal Aspects of Health Sector Reform in Colombia[6]

The main purpose of the 1991 Constitution, and Law 100 from 1993, is to provide universal coverage for health services to be guaranteed and financed through three plans. The contributive plan, financed completely through mandatory employee-employer contributions, covers 70% of the Colombian population according to preliminary estimates; the social security plan, with subsidies by fiscal demand and parafiscal solidarity, covers 30% of the population by 2001. The wealthiest 10% of the population purchases a Complementary Health Plan (PAC), governed by market laws. In 1993 when Law 100 was enacted, health social security plans covered only 18% of the population; today coverage is close to 70%. The table below describes the fundamental principles of health sector reform in Colombia.

Fundamental Principles of Health Sector Reform in Colombia

- ✓ ***Universal***–Insurance coverage for all Colombians through a unique benefits plan (equity).
- ✓ ***Integral***– Sufficient and complete protection of individuals' needs (promotion, prevention, treatment and rehabilitation) and in the public health interest.
- ✓ ***Decentralization and Participation*** – Greater responsibility to the local and departmental levels in terms of managing and financing health services.
- ✓ ***Coordination*** – Need to reach a sustainable balance between the different actors (EPS insurers, IPS service providers, users and regulators).
- ✓ ***Mandatory*** – No Colombian can refuse to participate in the insurance and solidarity system.
- ✓ ***Solidarity*** – Subsidies to the poorest and most vulnerable populations from the healthiest populations and those with the greatest ability to pay for services.
- ✓ ***Independent choice*** – For citizens, as well as the insurance organizations (EPS) and the health service providers (IPS).
- ✓ ***Gradual*** – Recognize the difficulty to reach a complete and immediate functioning of all of the new system's mechanisms.
- ✓ ***Efficiency and Quality*** – expected as a final result of the dynamics of regulated competition.

Table prepared by: Londoño, Beatriz, Jaramillo, Iván and Uribe, Juan Pablo. Decentralization and Reform in Health Services: The Colombian Case, Human Development Department LCSHD Paper Series No.65. The World Bank, Latin America and the Caribbean Regional Office. March 2001.

The Mandatory Health Plan

The Mandatory Health Plan (POS, acronym in Spanish) covers personal/individual services, including operations, procedures and products (including medications) at all

[6] Jaramillo Pérez, Iván, The Future of Health in Colombia, Fescol - Corona, Bogotá 1999.

stages of health/sickness (promotion, prevention, treatment and rehabilitation) and at all levels of complexity.[7] Its content, at the level of both procedures/services and medications, is reviewed and adapted periodically by the National Council on Health Social Security (CNSSS, acronym in Spanish). At the same time, CNSSS analyzes the adequacy of the Capitation Payment Unit (UPC, acronym in Spanish), which is the annual value of the mandatory plan paid to the Health Promoting Organization (EPS, acronym in Spanish) per individual affiliated, in order to balance the cost of insurance policy and premiums paid. All of the EPS offer the same integral and mandatory plan, and all members pay an equal proportion of their income.

The EPS and the Administrator of the Subsidized Plan (ARS, acronym in Spanish) that manage the contributive and the subsidized social security health plans respectively, must then offer a Mandatory Health Plan (POS) that includes basic quality health services and meets the technological and physical structure standards determined by the national institution responsible for monitoring health and by the social security. This plan includes family planning and general sexual and reproductive health services and cannot exclude treatment for preexisting diseases. The EPS and ARS can provide services covered by the POS to their affiliated clients through their own hospital infrastructure or through direct contracts with Service Provider Institutions (IPS, Acronym in Spanish). Law 100 gives incentives to the EPS and ARS to provide services through contracts with the IPS. Instead of the traditional form of payment per activity or procedure, which is known to stimulate unnecessary activities and costs, a system of payment per capitation for outpatient services and integral payments per diagnosis for hospitalization and surgery is in place. The mechanisms and contract rates are regulated by the CNSSS, as shown in Annex 1, Organizational Chart of the General Social Security Health System.

The Provision and Promotion of Preventive Health Services

In addition to the Mandatory Health Plan (POS), law 100 also established the Basic Health Plan (PAB, acronym in Spanish), a preventive and promotional plan mostly under the responsibility of the Ministry of Health and regional health directions, which includes all services in the interest of public health, as for example, immunization programs, environmental sanitation and monitoring vector-borne diseases. The PAB also includes some family planning and general sexual and reproductive health services. The government is responsible for the PAB through the Ministry of Health, which defines and develops the terms of the plan, and through the departmental and municipal governments for its actual implementation.

Through resolution 4288 of 1996, the Ministry of Health defined the PAB, which includes educational and informational activities for health promotion and prevention of diseases:

[7] The POS excludes, for example, plastic surgery procedures considered to be purely for esthetic purposes, infertility treatments, certain prosthesis and diverse medications that are not considered essential.

- Health promotion
    - Sexual and Reproductive Health (SRH)
    - Prevention of gender violence
    - Integral child and adolescent health

- Prevention and early detection
    - Family Planning (FP) for men and women of reproductive age
    - Prenatal care
    - Safe Birth
    - Cytology for women between the ages 25 and 65
    - Breast exam for women over 35

The Colombian reform is conscious that the universality of medical insurance – and even more so when it is accompanied by competition and demand subsidies- can create curative services and unnecessary procedures to the detriment of the prevention of diseases and health promotion. Law 100, supported by Law 60 of 1993 that guarantees part of the financing, developed three prevention strategies to neutralize the tendencies to strengthen the curative services.

First: With the separation of public and private sector health services, an opening is created for the PAB.

Second: The promotion of a strategy for resource allocation and payment by capitation forces the insurance companies and service providers to obtain profits by stimulating prevention and promotion activities to avoid expenditures associated with curative and rehabilitation activities.

Third: Creating a special fund of a parafiscal nature, similar to the National Health Solidarity and Guarantee Fund (FOSYGA), which favors the Health Promoting Organization (EPS) for the development of special programs for the prevention of diseases and health promotion. The programs financed through this account benefit clients affiliated with the EPS, and have a collateral impact on public health programs[8].

The "Regulated Competition System" and the "Independent Choice System"

The Colombian system, in contrast to that of the United States and Chile, does not establish prices for each type of plan. The independent choice system in Colombia is based exclusively on the prestige, quality, opportunity and geographic location that are offered to the users. Users can choose between different insurance administrators (EPS), the Administrators of the Subsidized Plan (ARS) and the different Service Provider Institutions (IPS).

[8] See Annex 1, Organizational Chart of the General Social Security Health System

Mandatory Compensation and Solidarity Mechanisms

Considering that the independent choice system could become a well-financed system for the wealthy and a bankrupt system for the poor, a mechanism that guarantees compensation was established. EPS have to work with the members from the highest socioeconomic stratum to transfer the surplus they generate to organizations whose members are from the lowest socioeconomic stratum.

Solidarity and Guarantee Fund

To make a viable competitive system that works in prevention and compensation as well as in solidarity, the National Health Solidarity and Guarantee Fund (FOSYGA, acronym in Spanish) was created to manage some of the sector's financial accounts, as shown in Annex 1, Organizational Chart of the General Social Security Health System.

III. PROFAMILIA'S ROLE BEFORE THE REFORM

Through the years, PROFAMILIA/Colombia has become the largest private family planning and sexual and reproductive health service provider in the developing world. PROFAMILIA/Colombia owes this leadership position to the magnitude and quality of its diverse services, its geographic and population coverage and to the pioneering nature of its activities and multiple contributions to sexual and reproductive health.

Three Main Reasons for PROFAMILIA/Colombia Success[9]

[9] Source: Gómez, Fernando and Seltzner, Judith. Family Planning and Population Programs in Colombia 1965 to 1997, Number. 97-114-062, May 1998. Prepared for the US Agency for International Development.

In 2002, PROFAMILIA owned eighteen of the thirty-five clinics it operated. These clinics counted more than 45 operating rooms, 220 medical offices and 85 hospital beds. Despite the broad geographical coverage, PROFAMILIA's management is centralized, with local autonomy for certain processes. The central level manages finance and payroll, hires personnel and, for economies of scale, purchases supplies and products that are necessary for both the administrative work and the provision of services of all the clinics nationwide. PROFAMILIA employs 1,534 people countrywide.

PROFAMILIA's current portfolio of services developed through a historic process, which began with family planning, and expanded to include a wide range of sexual and reproductive health services. This programmatic design, which includes not only family planning but also integral sexual and reproductive health care, was achieved before the reform—not as a consequence of it. The health reform only modified the way in which the services were offered, provided and financed. PROFAMILIA's adaptation to the demands of the reform, however, was facilitated precisely because of the expansion of the programmatic package developed during the previous twenty years.

PROFAMILIA's Programmatic Development

1965	PROFAMILIA is founded
1969	First promotion of family planning in Latin America on the radio
1971	Vasectomy program begins
1971	Distribution of contraceptives in rural areas begins
1973	First tubal ligation by laparoscopy
1976	Mobile surgical program begins
1979	Surgical training of Colombian doctors
1985	First clinic for men opens
1986	Program offering legal counsel to families begins
1987	AIDS Information campaign
1990	First youth center opens
1994	Emergency contraception program begins
1996	Menopause program begins
2001	Distribution and sale of a dedicated emergency contraception product begins
2002	Assisted fertility program begins

IV. IMPACT OF THE HEALTH SECTOR REFORM ON PROFAMILIA

From 1973 to 1996, PROFAMILIA benefited from generous donations from USAID, as shown in Annex 3. These donations were used to support PROFAMILIA programs, remodel clinics, and purchase new equipment in order to expand beyond family planning. Additionally, USAID donated contraceptives to the PROFAMILIA clinics and helped fund the demographic and health surveys.

As a result of Law 100, PROFAMILIA replaced international funds with local income

generated by contracting services out to municipalities in the public and private sectors. However, this created problems in financial management and, as a result, the institution had to learn how to manage a new category of "financial risk." In the programmatic area, on the other hand, the organization was well prepared, and without losing its family planning specialty, it offered a wide range of sexual and reproductive health services. Also, the selling price of products benefited from the organization's low production costs. Furthermore, in the new environment, the many years of educational work carried out by PROFAMILIA, added to its cumulative field experience allowed it to continue to sell its services and charge new clients for service fees.

Without intending to, PROFAMILIA/Colombia was preparing for the health sector reform since the creation of the organization. Its development agenda always required adopting an entrepreneurial spirit, first in family planning and later in sexual and reproductive health. As some of PROFAMILIA's directors have put it, although NGO do not work with a "for-profit mentality," this does not mean that they should work with a "for-loss mentality."

The consulting team, coordinated by Rafael Toro[10] found that to adapt to the new environment that emerged in 1993, and to strengthen its position in the market, PROFAMILIA had to take the following steps:

- Create a group to study Law 100
- Train personnel in Law 100
- Establish a group to sell services within the Marketing Department
- Make additional investments in the clinics
- Conduct a market study
- Initiate an administrative restructuring

How did PROFAMILIA prepare itself institutionally for the health sector reform?

✓ Realizing that part of the Colombian reform could be based on the reform already carried out in Chile, the Manager of Sexual and Reproductive Health Services was sent to study the Chilean model.
✓ Funding from the USAID Transition project enabled PROFAMILIA to increase the investment in hardware and software. PROFAMILIA also initiated the process of updating its accounting and billing/accounts receivable systems, as well as its systems for the provision and monitoring of programs and services, in anticipation of expanding the marketing of services.
✓ Taking advantage of the existing capacity was prioritized. Low prices were maintained, which was in large part compensated for by the high volume of sales. The institutional focus was also maintained, allowing the users to exercise their sexual and reproductive rights.

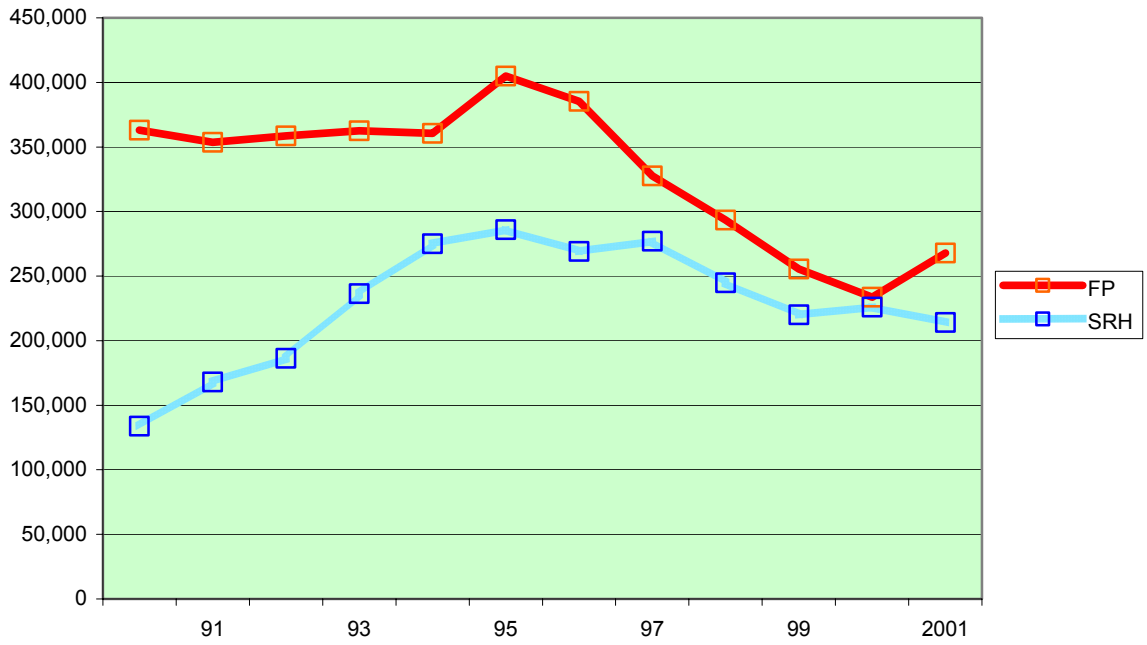
[10] Toro, Rafael, Ob. Cit. Page 56.

- ✓ Training activities were carried out for the personnel, so that the institution could easily participate in the reform process. First, the personnel was informed about the institutions created under the reform and what new elements it included, and then they were trained in how to contract the EPS and ARS.
- ✓ A market study was conducted to better understand PROFAMILIA's position in the new market environment with the IPS and EPS, and to understand how PROFAMILIA was recognized in the market as a service provider institution.

The Competition

Law 100 incorporated sexual and reproductive health into the Mandatory Health Plan (POS) managed by the health insurance companies, and the Basic Health Plan (PAB) managed by the municipalities and department. This meant a stimulus for the competition as well as for PROFAMILIA/Colombia. In other words, PROFAMILIA lost the de facto family planning and reproductive health monopoly that it had gained prior to the reform, as shown in the following graph *Distribution of FP and SRH Visits at PROFAMILIA from 1990 to 2001.*

Distribution of FP and SRH Visits at PROFAMILIA from 1990 to 2001



However, the newfound competition often offered low quality services. For example, competitors operated clinics pejoratively called "garages." Not only PROFAMILIA/Colombia, but the entire health sector was alarmed, to the point where

the Health Ministry had to issue a decree that required health organizations to comply with certain essential technical standards in order to provide various health services. These requirements were mandatory for all service providers, and PROFAMILIA had to comply with them as well. In some cases, these requirements were very stringent and PROFAMILIA found that its network of services used successfully for 35 years, had to adapt in many ways to the new norms. Additional funding for capital expenditures was required to adapt to Law 100.

Impact of the Health Sector Reform on Programs

The following are among the most important observable changes between 1990 and 2000 in terms of the volume of services:

- The annual volume of family planning visits suffered a decline during the second half of the last decade, as illustrated by the Graph *Distribution of FP and SRH Visits at PROFAMILIA from 1990 to 2001*, on the previous page. The volume of regular check-ups decreased by 48%, as other service providers captured part of PROFAMILIA's FP market share as well as the natural increase in the demand for these services.

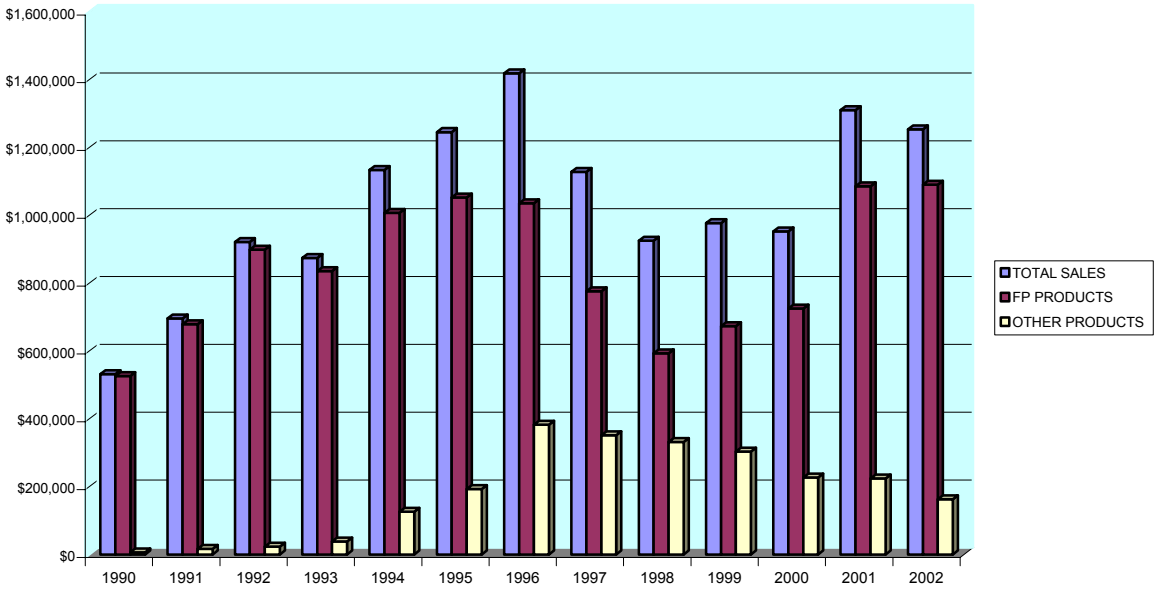
- PROFAMILIA's SRH services increased significantly, especially in general medicine (by 47%) and other services (by 146%)[11]. The gynecological and prenatal services increased by 21% and 19% respectively, exceeding the natural demand.

- Nearly 20,000 urology consultations for men were provided annually.

- The social marketing profits made with the sales of products, as summarized in the graph below, have given PROFAMILIA funds to cross subsidize needed FP services. Family planning products include the IUDs, Condoms, Injectables, and Emergency Contraceptive Pills. Other products include pregnancy tests kit, speculums, and Pap smear kits.

[11] Refer to Annex 2 for a complete list of health services offered at PROFAMILIA/Colombia

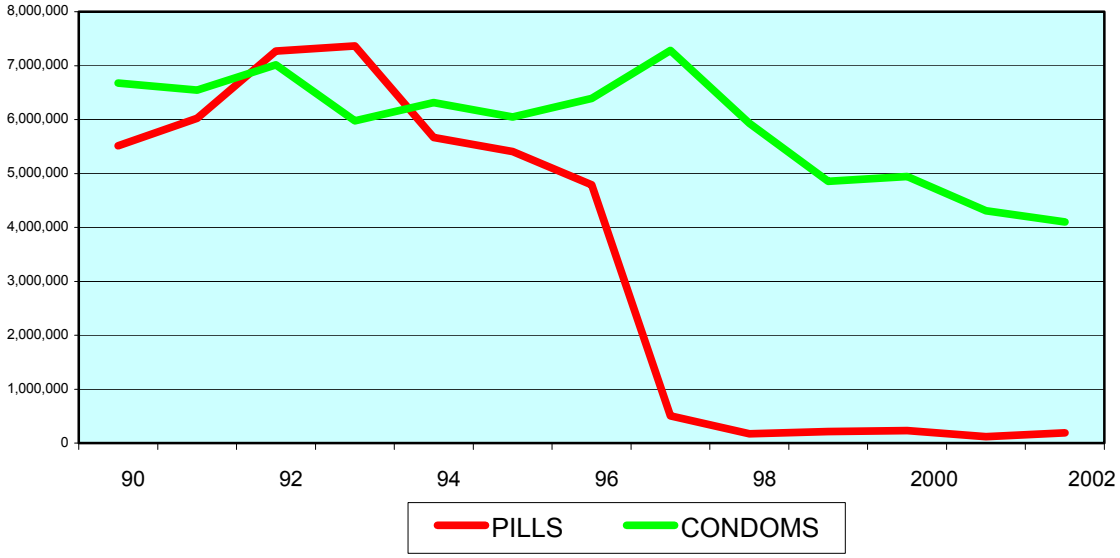
Social Marketing Sales, PROFAMILIA 1990-2002



- In terms of social marketing of products, PROFAMILIA has practically completely withdrawn from the market of oral contraceptives (as illustrated in the graph *Total Sales of Contraceptive Pills and Condoms from 1990 and* 2001) and vaginal tablets, maintaining only 4% and 26% of its former sales volume. These products have become widely and easily available from other SRH providers in Colombia.

- PROFAMILIA maintains an important presence in the condom market, although condom sales have also decreased 23% during that same period (*Graph, Total Sales of Contraceptive Pills and Condoms from 1990* 2001).

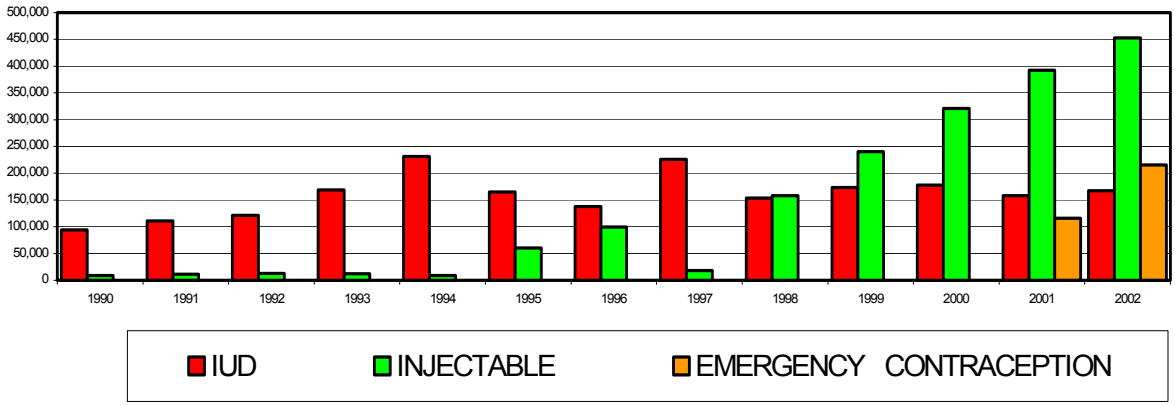
Total Sales of Contraceptive Pills and Condoms PROFAMILIA 1990-2002



- There has been a significant increase (400%) in the sales of IUDs and new products such as injectables, pregnancy tests, specula, and a dedicated product for emergency contraception, as shown in the graph *Total Sales of IUDs, Injectables, and ECP at PROFAMILIA from 1990 to 2001* on the next page. These products are sold mainly to service provider institutions both in the public and private sectors.

Total Sales of IUDs, Injectables, and Emergency Contraception

PROFAMILIA Contraceptive Sales 1990-2002



- Educational programs cost PROFAMILIA approximately one and a half million dollars or more per year. These funds could be used for other purposes, but PROFAMILIA considers it key to allocate funds to information and training. This investment, made over several years, has become the most successful mechanism for generating a demand for PROFAMILIA's services.

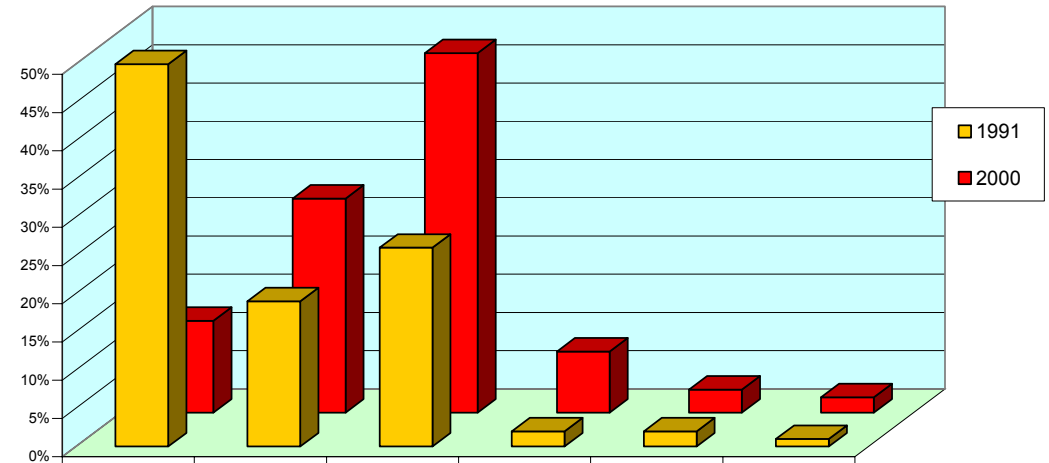
Changes in the Financial Structure – Expenses

In 1991, the cost of family planning services represented 78% of PROFAMILIA's total expenses. In 2000, the cost of FP and SRH services had fallen to 74% of PROFAMILIA's expenses, illustrating a shift in the last decade from predominantly family planning (31%) to sexual and reproductive health (43%).

Changes in the Financial Structure – Income

In addition to FP services, SRH services have become PROFAMILIA's primary source of income. In 1991, sexual and reproductive health services represented 26% of the total income generated, and in 2000, they represented 47%, as illustrated in the graph *PROFAMILIA Income Sources in 1991 and 2000*. These services created a surplus that is used to cross-subsidize FP services.

PROFAMILIA Income Sources in 1991 and 2000



	International	FP Product and Service Sales	SRH Product and Service Sales	Financial	Local donations	Other
1991	50%	19%	26%	2%	2%	1%
2000	12%	28%	47%	8%	3%	2%

Changes in the Administrative Structure

In order to adapt to the new environment, PROFAMILIA's managerial and administrative structure underwent significant changes between 1991 and 2000, characterized by the decentralization of functions, the generation of new managerial substructures, and the shift of responsibilities from simply "managing donations" to "managing to generate resources". In 1996, the organizational structure was reorganized, as shown in the two organizational charts on pages 24 and 25. The most significant changes occurred in the following areas.

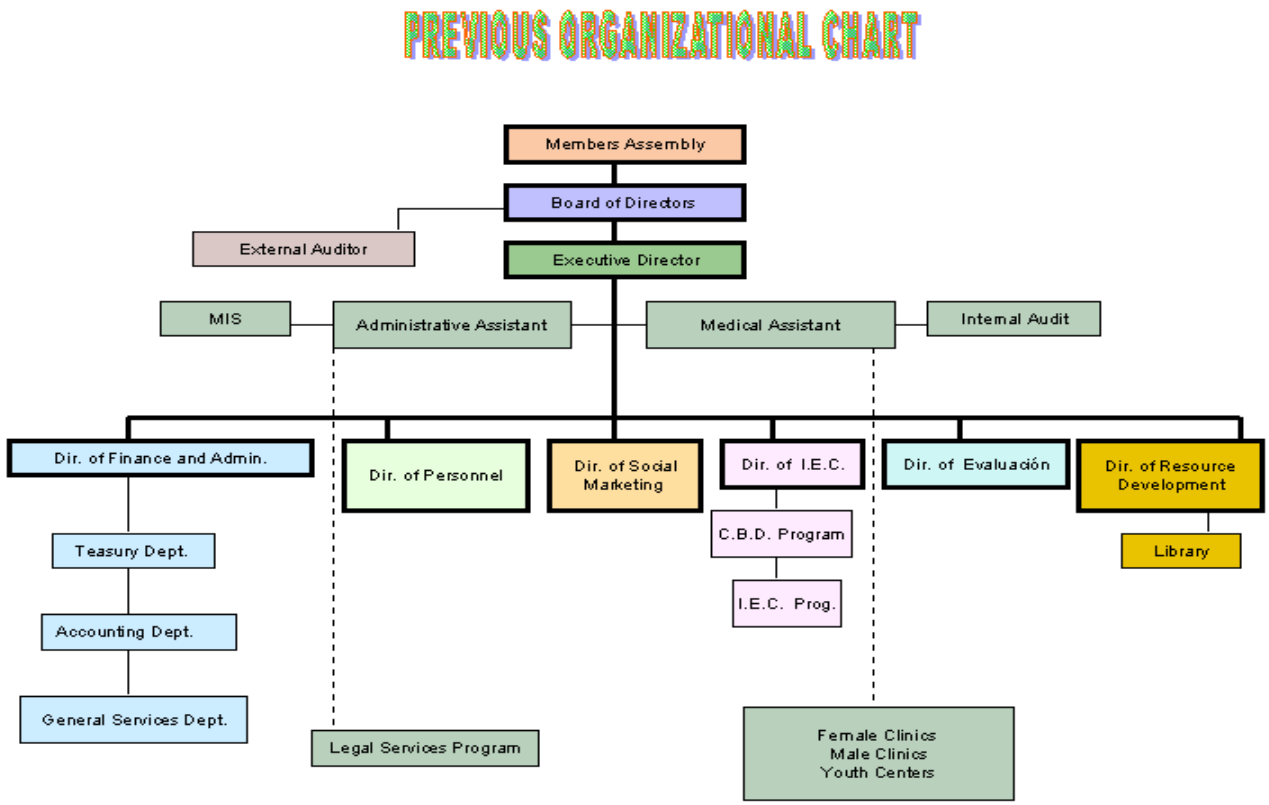
First, although the Office of the Executive Director kept its name, it increasingly focused on general management, delegating the administrative functions of planning, organizing, coordinating and evaluating, as well as the specific monitoring of diverse areas, to the expanded subordinate structure. The Office of the Executive Director manages special programs, as well as internal auditing.

The Department of Administration and Finance was split into two units with different names, and was decentralized. The Finance Department is now responsible for developing contracting systems; determining costs and prices; managing accounting, treasury, credit and accounts receivable. The Department of Administration, which includes the Human Resources Department, strengthens the management of the human talent in the organization and manages all of the administrative services.

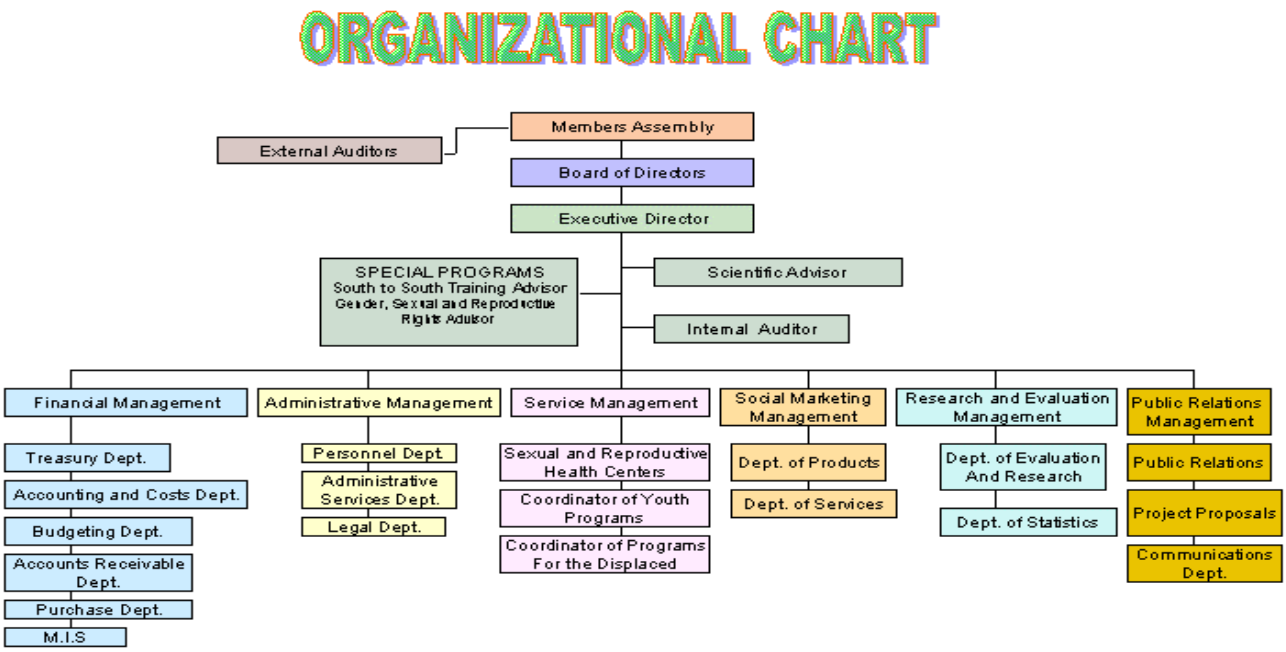
One of the great innovations includes the decentralization and creation of the Department of Sexual and Reproductive Health Services, whose functions were immersed in the other structures, and which manages diversified services in addition to family planning. This unit must generate resources to compensate for the decrease in international donations. The SRH Services Department assumes the responsibility for the 35 clinics throughout the country, as well as for the youth centers and rural programs.

The Department of Research and Evaluation did not undergo significant changes, but was raised to the level of direction. The Department of Social Marketing acquired a new dimension as Department of Marketing, responsible not only for the introduction and development of new products, but also for the launch and modification of the marketing strategy for services. The sudden expansion of the inter-institutional relations led to the creation of a Public Relations Department.

Previous Organizational Chart



Current Organizational Chart



Changes in the Profile of the SRH Regional Clinic Managers

When PROFAMILIA began expanding throughout the country in 1965, it understood that families wanted to know more about family planning, and that they wanted to be advised by someone with strong professional and ethical qualities. This person had to be recognized in the community as an authority by medical colleagues, the government and the Church to be able to introduce FP methods, which were, at the time, still controversial. The likelihood of those FP methods and SRH services to be accepted by the communities depended greatly on the authority of that person in the medical field.

Therefore, the strategy was that in each city the most eminent doctors, gynecologists and obstetricians would manage the regional clinics in order to establish professional trust, especially among women who visited the clinic. During the initial expansion, PROFAMILIA had plenty of external aid, and the availability of financial resources was not an issue. Therefore, the directors needed to have great professional skills, technical and scientific prestige, and of course honesty, but not necessarily a great entrepreneurial spirit.

Fortunately, since the beginning of the 1990s, the number of doctors and nurses with graduate degrees in hospital administration and health management grew. Therefore, despite the difficult changes, it was relatively easy to recruit directors with health administration backgrounds, and replace former part-time administrators with directors

who dedicated themselves full-time to their work at PROFAMILIA. At the same time, many of the regional directors were retiring, after thirty years of work with the organization.

Today the regional clinic directors have graduate degrees in business or health management. They manage the clinic, sell services and products, and expand services contracts with the health insurers. In general, they oversee and support the clinic as a business unit.

Changes in the Profile of PROFAMILIA Service Users

In light of the transformations PROFAMILIA was undergoing in the 1990's, it remained all the more important for the NGO to evaluate constantly the socioeconomic level of its clients so that it would know which segments of the population it was reaching, and also to what degree it was adapting to the new environment. To this end, the CATALYST Consortium and PROFAMILIA planned and implemented a study in 25 of its centers to identify the socioeconomic profile of PROFAMILIA clients, and analyze how the profile had evolved; compare the client profile to the country's general population; define the clients' level of knowledge about their rights in the context of the health reform; establish who among clients is covered by the subsidized plan, and who is covered by the contributive plan; and establish their perception of the quality of all the services offered. Some of these findings are summarized in the table below.

PROFAMILIA Service Users Socioeconomic Characteristics

	DHS 95	CPS 95	DHS 00	CPS 02	% DIF. CPS 02-95
USER SPOUSE UNEMPLOYED		2.3	8.2	3.4	+ 47.8
HOUSEHOLDS WITH < 4 MINIMUM WAGE SALARIES		65.4		73.8	+ 2.8
CRITICAL LEVEL OF OVERCROWDING	5.7	2.4	4.7	4.0	+66.7
HOUSEHOLDS WITH PRECARIOUS FLOOR MATERIALS	5.2	3.8	5.0	5.2	+36.8
HOUSEHOLDS WITH UNMET BASIC NEEDS	34.7	27.2	22.4	28.7	+5.5

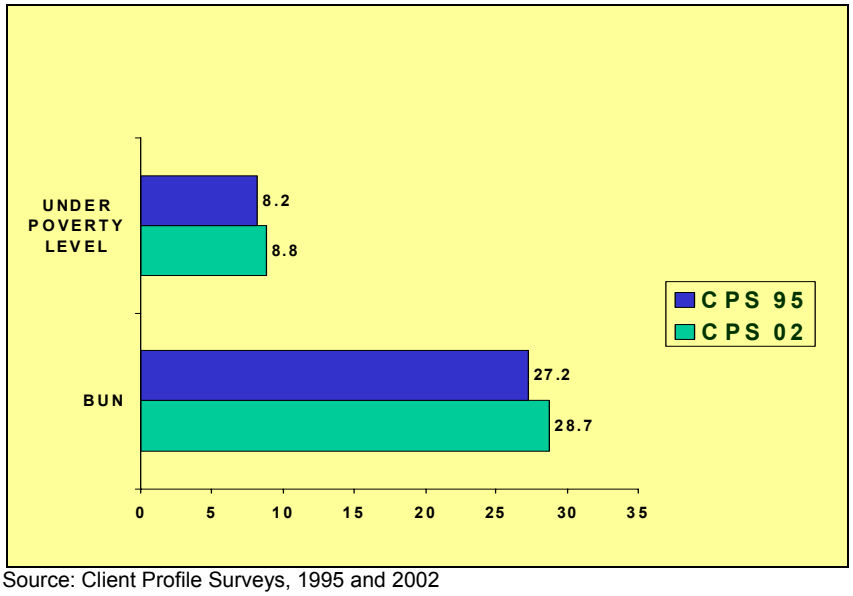
Source: DHS 1995 and 2000, and Client Profile Surveys, 1995 and 2002

The socioeconomic PROFAMILIA client profile study demonstrated that working on sustainability did not conflict with PROFAMILIA/Colombia's mission. On the contrary, PROFAMILIA/Colombia was able to continue serving the low-income population.

PROFAMILIA users are primarily young adults. However, 8% of the institutional clients are adolescents, 18.7% are older than 39 years of age, and one in every three clients is not affiliated with the social security system. In comparing the organization's studies of 1995 and 2002, the general economic characteristics of PROFAMILIA clients changed during that period. In 2002, PROFAMILIA's clients had a lesser capacity to pay for services than they did in 1995, as shown in the graph *PROFAMILIA Service Users Socioeconomic Characteristics*.

Whereas overcrowding in homes decreased from 5.7% to 4.7% in the general population between the two National Demographic and Health Surveys, it increased from 2.4% to 4% among PROFAMILIA clients. Also, the percentage of unmet basic needs was 6.3% higher among PROFAMILIA users (28.7% according to CPS, 2002) than the national average (22.4% according to DHS 2000). In other words, based on findings from the client profile surveys (CPS), PROFAMILIA clients' quality of life not only has worsened during the past seven years, as illustrated in the graph below, but also has remained below the national average.

Households with Unmet Basic Needs and Under Poverty Level, PROFAMILIA



Source: Client Profile Surveys, 1995 and 2002

The client profile surveys also revealed that PROFAMILIA clients have a *good* or *very good* perceptions of the services offered at PROFAMILIA, and recognize the organization more for its family planning services than for its urology consultations. The services that clients use most are family planning; followed by gynecology, cytology, general medicine, ultrasound scanning, clinical laboratory, pediatrics and urology.

V. CURRENT SITUATION AND FUTURE CHALLENGES

PROFAMILIA's technical and management team met in December 2001 to carry out a workshop that examined PROFAMILIA's current situation and future challenges in relation to the health sector reform and the decrease in international donations. The workshop's specific objectives were to conduct an assessment –based on the results from a SWOT analysis- and define PROFAMILIA/Colombia's preservation, development and adaptation strategies within the country's changing environment.

Results from the SWOT analysis revealed that out of a total of 193 surveyed staff, 33% emphasized the organization's internal strengths (e.g. transparency in decision-making; good general management and financial management practices; competent human resources and technological resources; diversification of SRH services; and the national and international recognition of PROFAMILIA as a leader among SRH service providers), while only 20% focused on its weaknesses (e.g. lack of staff trainings in new technologies as well as staff knowledge in Law 100 and other topics such as gender and rights; weaknesses in marketing of services to the mass media, and difficulty to integrate a credit culture in the services provided; lack of uniformity in pricing policy and lack of standardization in administrative practices among PROFAMILIA clinics; limited physical and technological infrastructures and need for expansion in low income and marginal areas) .

One could deduce that PROFAMILIA's staff has a high self-esteem, and is primarily aware of the organization's internal strengths. While PROFAMILIA's weaknesses are also recognized, they are not given significant weight.

The SWOT analysis also revealed that the fear of external threats (29% of staff surveyed) is greater than the belief that PROFAMILIA/Colombia could benefit from opportunities in the environment (18% of staff surveyed). In spite of the confidence in PROFAMILIA's internal strengths, the staff expressed fearful and defensive sentiments toward the country's environment in particular in regards to the fiscal crisis, the economic recession, and the sociopolitical conflict. The fiscal crisis has led to a financial crisis at the departmental and municipal levels, and has caused increasingly longer delays in direct payments to PROFAMILIA and to the Administrators of the Subsidized Plan (ARS), forcing PROFAMILIA/Colombia to increase the amount of its working capital on hand to cover these temporary internal deficits. Also, the decrease in international donations has had an additional psychological impact on PROFAMILIA staff.

PROFAMILIA staff is well aware of the importance to protect the institution's strengths while working on resolving its deficiencies. Despite Colombia's turbulent environment, an optimistic perception of the future is prevalent among PROFAMILIA staff that prefers taking advantage of the opportunities offered in the new environment, rather than protecting the institution. The defensive attitude surfaces only when facing threats.

VI. LESSONS LEARNED FROM PROFAMILIA IN TERM OF THE REFORM

The combination of a specialization in family planning and the diversification of sexual and reproductive health services have been key factors in guaranteeing PROFAMILIA's competitiveness and its capacity to adapt to changing market conditions.

1. Lessons learned from PROFAMILIA's History

- Since its inception, PROFAMILIA worked to achieve self-sufficiency, although it could not achieve it during its process of expansion. This did not, however, prevent PROFAMILIA from seeking for ways to generate its own resources, through local donations and the sale of products and services.
- PROFAMILIA always considered itself a "business."
- PROFAMILIA never implemented a general policy of providing free products and services, opting instead for policies of partial subsidy of products and services. This philosophy of never providing services and products for free helped PROFAMILIA and its clients face the process of self-sufficiency that the reform required.
- PROFAMILIA has demonstrated honesty, transparency and efficiency in managing international donations, which enabled it to maintain ties with international donors and agencies, even during the transition to self-sufficiency.
- Developing its own infrastructure and expanding on a national scale has established PROFAMILIA as a strong NGO, as opposed to a transitory one. It has also given PROFAMILIA a comparative advantage in competing with other providers, and has allowed it to maintain low production costs.
- Unintentionally, the educational and community work that PROFAMILIA carried out before the health sector reform turned out to be the best marketing strategy for the sale of PROFAMILIA services and products. The fruits of this work would be reaped later on, as a consequence of the reform.
- The prestige and image that PROFAMILIA created during 37 years of service have been, without a doubt, the best guarantee of its endurance and adaptation, even in a competitive environment where it is necessary to act like a business to survive institutionally and to achieve self-sufficiency.
- PROFAMILIA political neutrality has been an important condition to survive in a country in conflict, and paradoxically has granted PROFAMILIA a technical and moral authority to influence the design of "social policies."

2. Lessons learned during the Preparatory Stages of the Reform

- PROFAMILIA prepared for the reform conceptually, visiting and studying other countries and their processes, and evaluating the impact the reform could have on its mission.
- PROFAMILIA knew when to opportunely influence the health sector reform. First, it supported the introduction of a special article in the 1991 Constitution that states that "the couple has the right to decide freely and responsibly how

many children to have and will have to sustain and educate them when they are small or disabled"; and later PROFAMILIA's professional staff advised the Health Ministry on the regulation of Law 100 in 1993, by influencing the design of the Norms and Attention Guidelines for the Development of Specific Protection Steps, Early Detection and Care for Diseases of Public Health Interest (Resolution 412 of February 25, 2000). In both cases, it was possible to institutionalize FP and SRH as rights.

- PROFAMILIA had to refine its knowledge about the cost of each product/service to be able to adequately set prices and offer products/services without suffering a loss or with precise subsidies.
- With USAID funding, PROFAMILIA developed a management information system and invested in hardware and software, both of which were indispensable prerequisites for PROFAMILIA to adapt to the health reform. Information technology was necessary in the areas of accounting, costs, operations, marketing and monitoring of services.
- Educating and training personnel was necessary to be able to respond opportunely to the reform's challenges.

3. Lessons Learned during the health sector reform

- To adapt to the health sector reform, PROFAMILIA had to learn skills in marketing, sales, contracting, invoicing and billing.
- PROFAMILIA had to budget for working capital funds to cover operational expenses in the event of a temporary deficit and the USAID Endowment fund provided PROFAMILIA with an additional safety net.
- PROFAMILIA knew how to reach the communities, but did not know how to reach the institutions that could buy services. Therefore, it had to learn how to market its products to the insurance companies as well as to the municipal and departmental governments. In order to be able to negotiate with mayors, local health directors and insurance companies, a training course was initiated for managerial staff as well as for the national sales teams in business negotiation, discount offers, dealing with manuals of price lists, ranges of services, mandatory health plan, and basic health plan
- Managing donations requires relatively simple structures, but generating resources requires more complex structures. PROFAMILIA had to differentiate functions that were previously grouped together, and had to create specialized departments under the executive director.
- Provision, marketing and sale of products and services imply a specialized dependence on social marketing.
- In order to compete and recover its losses in external sources of funding, PROFAMILIA had to reduce costs and reorganize its personnel structure by reducing it by 20%.
- In order to sell services to informed and demanding buyers, it was necessary to develop systems for quality control. Quality is necessary to compete with other SRH providers and to retain clients. Auditing is necessary to comply with contractual terms, and also to be able to charge for products and services.

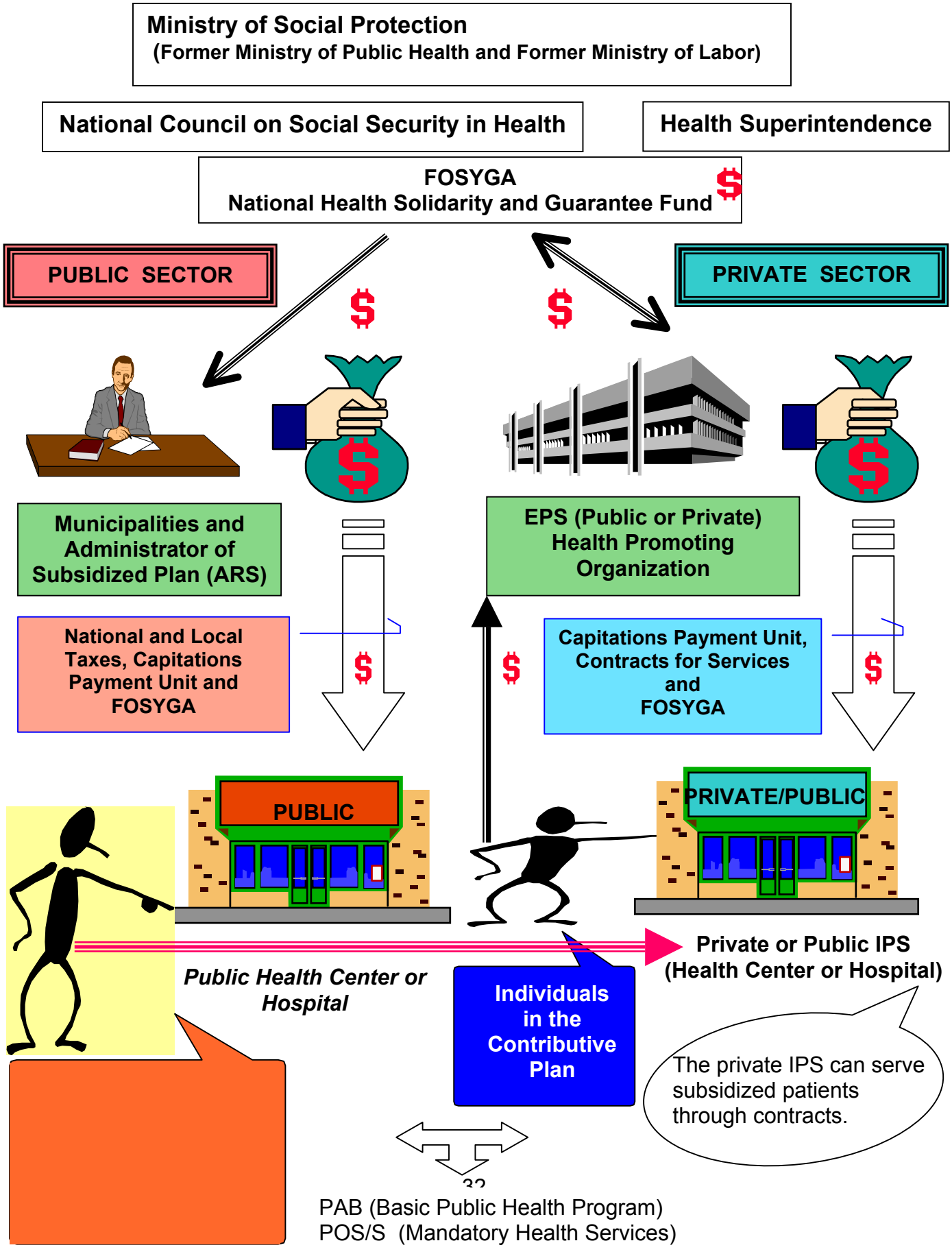
4. Lessons learned in Programmatic Matters

- PROFAMILIA knew how to take advantage of the great and spontaneous demand for family planning services, and later gradually introduced a range of other sexual and reproductive health services through education. Family planning opened the front door to the communities, but it was the diversification of SRH services that guaranteed PROFAMILIA's long-term survival.
- It can be concluded that specialization in family planning offered PROFAMILIA a competitive advantage, but diversification of services provided the stability and the ability to adapt to the changes in the market.

5. Lessons learned in Financial Matters

- If PROFAMILIA had not developed alternative sources of income, it would have had to reduce its income and size by approximately 38%, when USAID Transition project ended in 1996.
- The Social Security Reform made it possible for PROFAMILIA to sell family planning services that were previously provided to users below the costs of production at remunerative prices, generating now up to 50% more income for each sale. Currently, these services are almost completely self-financed.
- Sexual and reproductive health services, which were provided through the diversification policy, have represented the most important source of income for PROFAMILIA, and have compensated for the decrease in external donations. The percentage that these sales represent in the income structure increased by 80% above their initial level at the start of the decade. In addition, they create a surplus that compensates for the subsidy, however small, and which family planning still receives.
- It has been demonstrated that as a result of the reform, it was possible for PROFAMILIA to generate various types of incomes, such as local donations and other non-operational funds, from the improved use of its infrastructure and technological and human resources. Additionally PROFAMILIA also showed that it was possible to generate income from financial investments by reinvesting the interest earned on the investments in institutional strengthening activities.
- Although PROFAMILIA had to expand its administrative structure, it was able to maintain its administrative expenses at 11% of total expenses. However, it had to strengthen its institutional development by investing in its infrastructure.

Annex 1. Organizational Chart of the General Social Security Health System



Annex 2. PROFAMILIA's Clinical and Surgical Services

Family Planning services
IUD
Oral contraceptives
Injectables
Implants
Condoms
Vaginal Tablets
Periodic Abstinence
Emergency Contraception
Female Voluntary Surgical Contraception
Male Voluntary Surgical Contraception

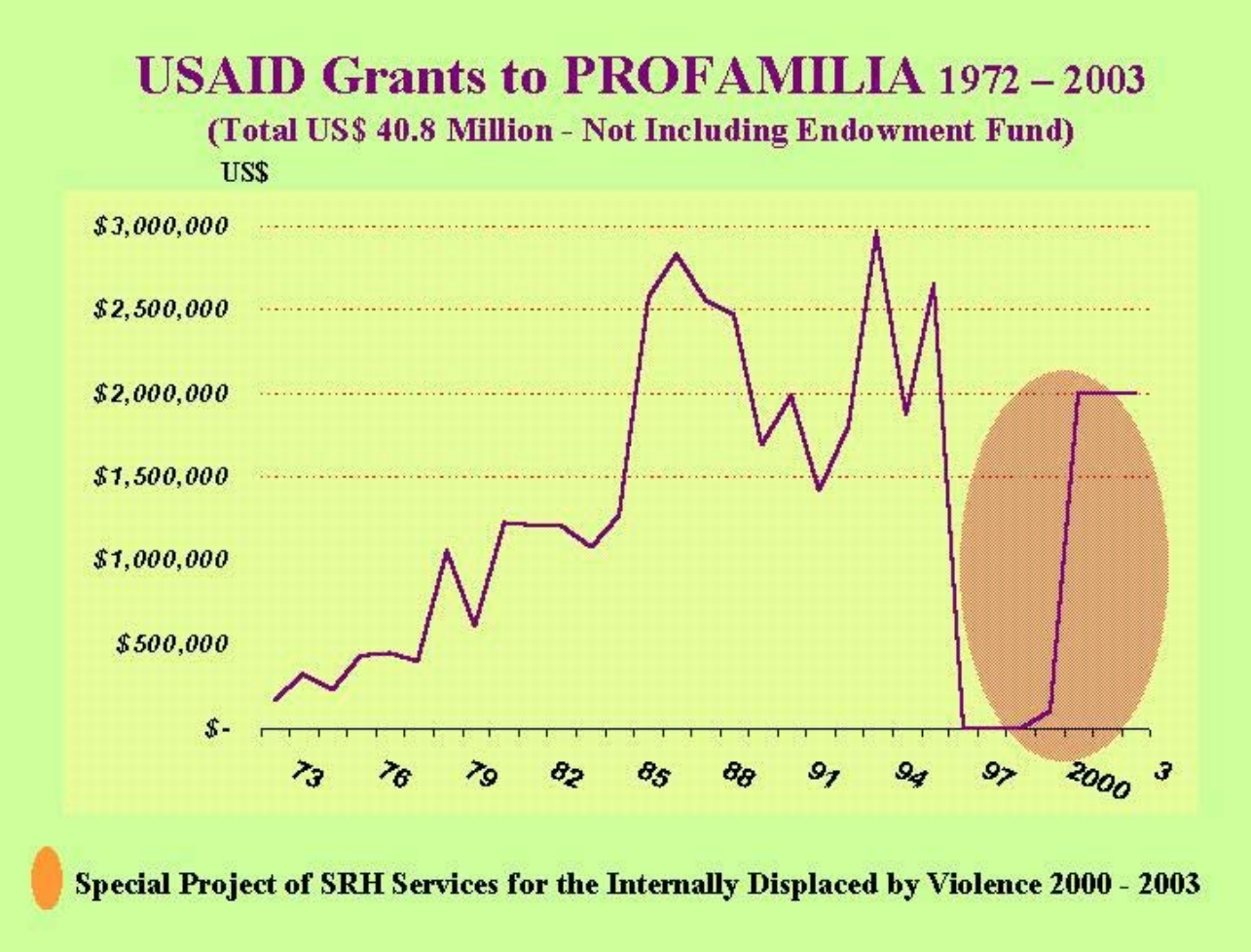
Sexual and Reproductive Services
Gynecological Care
Menopause Consultation
Urology Consultation
Infertility Consultation
STI Consultation
Pre-natal Care
Ultrasounds
Mammography
Other Radiology Procedures
Cryosurgeries

Other Services
Immunization
General Health
Internal Medicine
Pediatric Consultation
Psychological Consultation

Pathology and Laboratory

Pregnancy Test
HIV Test
Pap Smear Test
Surgical Pathology
Clinical Pathology
Other Tests

Annex 3. USAID Grants to PROFAMILIA



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