



## Memorandum

Date January 2, 1981

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Program Evaluation Branch  
Family Planning Evaluation Division, BE

Subject Foreign Trip Report (AID/RSSA): Guatemala, August 18-30, October 6 and 10, 1980

To William H. Foege, M.D.  
Director, Centers for Disease Control (CDC)  
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## SUMMARY

The purpose of this consultation was to assist in the integration of contraceptive supplies into the Ministry of Health logistics system. Currently, the Ministry of Health receives contraceptive supplies through APROFAM's direct distribution program (DDP). The effect of more than a year of government restrictive policies is apparent in the DDP's distribution statistics. In 19 out of 22 departments, distribution of contraceptives decreased in the first half of 1979. In fact, in three departments, no distribution at all occurred. In 1981, the Drogueria Nacional (DN) will take over the distribution of contraceptives in 11 departments. However, the DN is limited by problems in transportation, warehouse space, and budget (See FPED/CDC Foreign Trip Report: Guatemala, dated March 3, 1980). Because of inflation as well as increases in patient visits, the medicine budget decreased from 27¢ per patient visit in 1975 to 21¢ per patient visit available for medicine in 1979--a decrease of 21 percent. This may prove to be a problem in the purchase of contraceptives such as Depo-Provera which AID cannot supply to the Ministry of Health. Transportation delays, both from the central level to area headquarters, as well as from area headquarters to local level, are common. Under a tri-partite agreement, AID

will provide \$180,000 for vehicles, transportation expenses, per diem, and warehousing over a two year period--1981-1982. The implementation of this program was discussed during the consultation. Six trucks and five drivers will be required to implement the distribution program. However, a supervisor for the DN's distribution program should be hired as soon as possible. Other recommendations to improve the distribution system included: an improved requisition form, the channeling of requisitions through the area chief's office, and a system for prioritizing medicine purchases.

I. PLACES, DATES, AND PURPOSE OF TRAVEL

Guatemala, August 18-30, 1980, at the request of USAID/Guatemala and AID/DS/POP/FPSD, to assess the integration of contraceptive supplies into the Ministry of Health logistics system. This consultation was provided by Mark W. Oberle, M.D., M.P.H., of the Program Evaluation Branch, FPED/BE/CDC. Brief follow-up visits were conducted on October 6 and October 10 in conjunction with a consultation to El Salvador by Dr. Oberle and Richard Monteith, Program Analyst. This travel was in accordance with the Resource Support Services Agreement (RSSA) between the Office of Population, AID, and CDC/BE/FPED.

II. PRINCIPAL CONTACTS

A. USAID/Guatemala

1. Mr. Eliseo Carrasco, Director
2. Mr. Thomas Stukel, Acting Deputy Director
3. Mr. Scott Edmonds, Health and Population Officer
4. Mr. Neal Woodruff, Assistant Health and Population Officer
5. Mr. Carlos Andrino, Project Assistant

B. Ministry of Health

1. Dr. Angel Paz Cojulun, Director General
2. Dr. Leonel Barrios Santos, Subdirector General
3. Mr. Enrique Prado Spiegeler, Coordinator, Drogueria Nacional (DN)
4. Mr. Rene Mendez, Administrator, DN
5. Mr. Enrique Pinar, Chief of Personnel, DN
6. Mr. Salomon Gonzalez, Warehouse Chief, DN
7. Dr. Victor Manuel Gamboa, Chief, Escuintla Health Area

C. Asociacion Pro-Bienestar de la Familia (APROFAM)

1. Dr. Roberto Santiso, Executive Director
2. Mr. Rolando Sanchez, Director, Direct Distribution Program
3. Mr. Victor Hugo Fernandez, Administrator

### III. INTEGRATION OF CONTRACEPTIVE SUPPLIES INTO MINISTRY OF HEALTH LOGISTICS SYSTEM

#### A. Background

The Integrated Family Planning Services agreement signed by AID, the Ministry of Health (MOH), and APROFAM, has two components. Under the medical supervision program, AID provides funds for transportation and per diem for visits to health posts by medical supervisors. Under the supplies program, AID will provide \$180,000 for vehicles, transportation expenses, per diem, and warehousing to the MOH over a two year period--1981-1982. In 1981 the MOH will assume responsibility for contraceptive distribution to health posts and health centers in 11 departments. APROFAM will continue supplying contraceptives in the other 11 departments. If this phase is judged successful, the MOH will assume responsibility for contraceptive distribution in the rest of the country in 1982.

Much of the responsibility for supply distribution will reside with the Drogueria Nacional (DN), although close cooperation with the MOH's operational arm, the Direccion General (DG) will be essential.

In addition to the above grant, other funds probably will be available in early 1981 from a loan/grant--The Community-based Health and Nutrition Systems Improvement Project. This project provides funds for a regional warehouse in Totonicapan, 2 warehouse administrators, 2 drivers, and 3 diesel pick-up trucks. Although this project is designed to supply the departments of Totonicapan, Solola, and San Marcos, it would reduce the pressure on the DN's central warehouse.

During an earlier consultation, a number of problems in the DN's operations were described (see FPED/CDC Foreign Trip Report: Guatemala, dated March 3, 1980). Among these problems were the following:

1. The budget for medicine purchases is inadequate and has not increased sufficiently to compensate for inflation and expanding health facilities.
2. The same fixed value of medical supplies is allotted each year to each health center (\$3,200/year) and health post (\$800/year), no matter what the size and characteristics of the populations served in their catchment area.
3. Supply delivery is frequently delayed by lack of transport.
4. Stockouts and/or low inventory levels frequently occur at the medicine warehouse.

5. The medicine warehouse is small and physically separated from the system's 2 other warehouses.

During this consultation, the first three problem areas were examined in greater detail. In addition, a proposal for an improved medicine distribution system was designed, and the current status of APROFAM's Direct Distribution Program was reviewed.

B. Follow-up of APROFAM's Direct Distribution Program

Until June 1979, the Direct Distribution Program (DDP) of APROFAM had supplied contraceptives to 569 health centers and health posts (see FPED/CDC Foreign Trip Report: Guatemala, dated December 20, 1979). Subsequently the Minister of Health prohibited distribution in facilities without a physician. On April 18, 1980, AID and the MOH signed the Integrated Family Planning Services grant, facilitating supervision of services in these facilities. However, it was not until August 14, 1980 that the Director General signed a letter formally authorizing full resumption of family planning services in MOH facilities.

The effect of more than a year of restrictive policies is apparent in the DDP's distribution statistics (Table 1). Only 56,403 cycles of oral contraceptives were distributed to MOH facilities in the first half of 1980, compared to 308,677 in all of 1979--a decrease of 63% on an annual basis.

Distribution has been uneven throughout the country. In three departments--Jutiapa, Escuintla, and Santa Rosa--distribution rates have approached 1979 levels (Table 2).

But in all other departments distribution decreased. In fact, in three departments--Quetzaltenango, San Marcos, and Peten--no distribution at all occurred. By comparison, 33,420 cycles of oral contraceptives were delivered to MOH facilities in these three departments in 1979. If anything, these comparisons understate the dramatic decrease, because the DDP was effectively hobbled in the last half of 1979 as well as in 1980.

C. The Medicine Budget, Drogueria Nacional

In the coming year, the MOH will continue to receive condoms and Norinyl free, probably through APROFAM. However, Neogynon, Depo-Provera and other commodities manufactured outside the U.S. may have to be purchased by the MOH. Although it would be desirable to maintain the current variety of commodities, the MOH may not be willing to commit its own funds. At the moment the budget for curative medicines is inadequate to meet patient demands, and the situation over the last 5 years has worsened. The following analysis attempts to document the nature of the budgetary dilemma.

The DN's drug budget has more than doubled in the last five years--from \$525,000 in 1975 to \$1,077,500 in 1980. However, the number of health posts and health centers have also increased. In 1973 there were 227 health posts and 80 health centers. In August 1980, the DN supplied 541 health posts and 153 type B health centers, with more to open by year's end. An increase in the cost of medicine and the number of patient visits also puts added pressure on the DN's budget. To try to adjust for the effect of inflation, we calculated an inflation index based on the most popular pharmaceuticals distributed by the DN. Unfortunately, the DN leadership is new, and no recorded analysis of purchases and prices was available. Thus, no one at the DN could confidently provide statistics on drug supplies. Since the warehouse supervisor initiates the purchase order for most drugs, we analyzed invoices for the 11 drugs he felt were most popular in order to obtain a crude approximation of price changes. These 11 drugs represent 16% of all drug purchases in 1975. Between 1975 and 1979, the price of these 11 drugs increased by 4.1% per year when each drug's contribution to inflation was weighted by the volume of purchases in 1975, the base year (Table 3). Although this is the standard method of calculating an inflation rate, the result is deceptively low, because in 1979 the DN purchased a large proportion of expensive drugs such as Ampicillin. If the price change is adjusted by 1979's mix of medicines rather than 1975's, the inflation rate would be 8.8%. Both methods of calculating the inflation rate for medicines produce results that are lower than Guatemala's official general rate of inflation in the same period--10.4%.

Accepting the limitations of this estimate, we attempted to adjust the drug budget for both the increase in patient visits and the increase in drug prices. The funds available for drug purchases just barely kept pace with patient visits (Table 4). In 1975 there was \$0.27 in the medicine budget per patient visit in health centers and health posts. In 1979, \$0.26 per visit was available for drug purchases. However, when inflation is taken into account, the MOH appears to have lost ground. Expressed in 1975 dollars, there was only \$0.21 per patient visit available for medicine in 1979--a decrease of 21%. The limitations of these data were discussed with MOH personnel, and Mr. Mendez of the DN agreed to conduct a more extensive analysis in September. This analysis had not been performed by the time of our follow-up visit. Although the DN has requested \$2 million for drug purchases in 1981, a real increase in medicines available per patient visit may not occur because: 1) Increases of drug prices are anticipated. 2) Additional health posts are planned. 3) The health promoter programs may increase demand for medications. The hesitancy of MOH officials to purchase contraceptives should be viewed in light of these constraints.

Nevertheless, the DN's drug purchasing procedures can be improved. At the moment, the warehouse chief initiates a purchase order based on prior drawdown of stock. There is no system of priorities based on medical need coordinated with the DG. As a result, important medications are frequently lacking. For example, in visits to 5 health centers and health posts in Escuintla and Zacapa, none had stocks of adult aspirin supplied by the DN. Aspirin has been out of stock since January. Only one of these five clinics had stocks of procaine penicillin, a popular injectable medication. On the other hand, one health center director complained that he had accumulated 8 gallons of piperazine solution without requesting it. He rarely sees cases of ascariasis. On the other hand, infection with Necator americanus is common, but pyrantel pamoate and mebendazole, the drugs of choice, are frequently unavailable.

Back in Guatemala City, records of the DN demonstrated that aspirin purchases have not increased recently (Table 5). In 1975 the DN purchased 3 million adult aspirin tablets. In 1979 the DN also purchased 3 million tablets. Meanwhile, the DN has septupled the purchase of cold tablets--at a cost of \$63,350 in 1979. The cold tablets contain aspirin, caffeine and an antihistamine and cost twenty times as much as aspirin. In 1979 the DN also spent \$13,500 on kapectate, despite the fact that a study in Guatemala City's Roosevelt Hospital failed to demonstrate the efficacy of this drug.\* Expectorants also were a large budget item--\$30,240 in 1979. Altogether, cold tablets, expectorants, and kapectate comprised 11% of the DN's 1979 drug budget. Although these drugs may have a place in clinical practice, they may deserve a lower priority in purchasing.

Initially, the concept of prioritizing drug purchases met with some skepticism. However, after discussing the problem with Dr. Barrios and Mr. Mendez, two approaches to help establish priorities were devised. First, a simple quantitative task to assign each drug to one of 3 priority levels has been designed by Dr. Michael Bernhart of Georgia State University. This exercise takes into account the prevalence and mortality rate of the disease for which each drug is used and the substitutability of the drug. Area chiefs under the direction of the DG would use this exercise as an aid in establishing priorities. A simpler, less quantitative exercise is planned for November. Each health center or health post would receive a questionnaire (see Attachment). The physician or nurse in charge would list the ten most important drugs for that clinic in order of priority, taking into account the above factors, but

\*Portnoy BL, DuPont HL, Pruitt D, Abdo JA, Rodriguez, JT: Antidiarrheal agents in the treatment of acute diarrhea in children. JAMA 226:1525-1528, 1973.

and in a quantitative fashion. This survey would provide less precise information, but would provide an opportunity for clinicians to assist MDG officials in establishing priorities. Dr. Higgins and Mr. Mendes agreed to cooperate on such a survey in early November.

#### 2. Allocation to Health Facilities

Since the founding of the DN eight years ago, each Type B health center has had an annual drug budget of \$3,200 and each health post a budget of \$400. This has resulted in clear inequities. One health post in Guatemala had \$0.12 available per patient visit in 1969. Another post in the same department had \$1.07 per patient visit available. Dr. Higgins suggested that a new method of allocation would be desirable, but was uncertain which factors--population, patient visits, or alternative sources of care--should be included to provide more equitable allocation. He did suggest that if a new allocation formula were instituted that no facility should suffer a cut in funding. Instead, facilities with the greatest demonstrated needs would receive the greatest increase in funding when and if budgetary increases occurred.

#### 3. Delivery Delays

Delivery delays occurred during the consultation in August, but not all delays are attributable to shortages of vehicles. Currently the DN uses its own small pickups to ship medicines, supplies, and equipment to facilities close to the capital. The Guatemalan Air Force still supplies isolated posts in the Peten and Ixcán areas on a sporadic basis. The majority of the country is supplied by the DN transportation section. When trucks are available, supplies are shipped to the area level. The area chiefs supply their own posts and posts if local vehicles are available, but more frequently the area chief sends a cable requesting each facility to call on the area level. Frequently, the local nurse will pay for expedited services. Delays of one week from area to local level are especially common.

During the August consultation, the transportation section did not provide a truck as scheduled, and deliveries for 2 health areas were delayed. Stacking cartons exacerbated the warehouse's already difficult space problem. In the same week an officer of FAG informed the DN of space available for a shipment to Ixcán. The space was not filled on four hours' notice.

The primary shipping document for each facility is based on an order form filled out by the physician or nurse responsible for the facility. These forms use WHO/DC trip report Guatemala, dated March 1969 and at least 8 years old, and require many deletions and additions. The forms are either sent directly to the DN or via

the district or area level. In three departments--Jutiapa, Santa Rosa, and Sacatapequez--the forms are collated at the area level before forwarding to the DN. Occasionally, a clinic will fail to submit its request in time and will subsequently require an "emergency" shipment. The DG is currently planning to require forms to pass through the area chief's office to assure that all forms will arrive on time.

Some complaints of delays are actually a problem of perceptions. Some clinic personnel feel that medicine shipments should arrive precisely at the beginning of every quarter. This is a physical impossibility for DN personnel. However, regular shipments at staggered, three-month intervals should be the goal. Once an improved distribution system is instituted, local clinic personnel should be apprised of the expected date of each quarterly shipment so that clinic activities can be programmed around this date.

F. Improvements in Medicine Distribution

An improved distribution system for the DN should provide the following: transportation from Guatemala City to area levels, transportation from area to local level, and capacity for an anticipated increase in the volume of medicines required by new health facilities and promoters. Mr. Edmonds projects an increase of one-third in medicine supplies to cover promoter projects.

The budget available for logistics improvements is illustrated in Table 6. The MOH will essentially provide personnel, and AID will provide funds for vehicles, per diem, and transportation expenses. However, the most important decision in designing this system has yet to be made. Although Dr. Barrios felt that contraceptives should be fully integrated with other medicines and should not be charged for, a final decision on charging for contraceptives had not been made. If the MOH decides to charge, closer control of distribution will be required, and contraceptives will have to be packaged separately from other medicines. The current proposal was designed under the assumption that contraceptives, like other commodities, would be free to the patient. Transportation from Guatemala City to area level would be carried out by 2 diesel trucks. These would have a capacity of 8 tons each (or one 5-ton truck and one 10-ton truck). These vehicles would deliver quarterly shipments to the area chiefs' headquarters as is done currently. The difference is that the vehicles and drivers would be assigned to the DN.

From area headquarters to health centers and health posts, a fleet of four pick-up trucks would supplement the area chief's vehicles. In other words, these pick-ups would follow the larger trucks from department to department and deliver locally. The pick-ups should be 4-wheel drive vehicles, preferably of 2000-pound capacity.

Currently, APROFAM's DDP has a goal of 5 contacts per day. However, the DN vehicles would have to carry a greater load--approximately 650 pounds per health center and 250 pounds per health post. Ultimately, the vehicles might be based regionally. In fact, in 1981 it is assumed that the 3 additional vehicles assigned to the regional warehouse in Totonicapan will handle distribution in that region. MOH officials would like to purchase vehicles as soon as possible but as of our follow-up visit, no vehicles had been ordered.

An additional important step for the program is to identify a program supervisor. A supervisor is needed to establish routing and procedures, as well as to coordinate with the area chiefs. Although this person, as well as other distribution personnel, would be located in the DN, funds are not available to hire a supervisor until January 1981. Given this limitation, the current date for beginning MOH distribution is March 1981.

In summary, the new system would require a supervisor, 5-6 drivers for the 6 vehicles, and possibly 5 drivers' assistants.

G. Other Unresolved Issues

1. Selection of the initial 11 departments--The 11 departments to be supplied by the MOH logistics system had not been decided as of our visit. However, the loan coordinating committee agreed that these departments would be located in western Guatemala.
2. Source of contraceptive supplies--Supplies of condoms and Norinyl 1+50 are assured, but the MOH has not decided whether or how to obtain Neogynon, Depo-Provera or foams not available from U.S. manufacturers.
3. Inventory--According to the project grant agreement APROFAM is supposed to conduct an inventory of contraceptives in MOH facilities. Since access to many facilities has been barred, APROFAM and the MOH have not coordinated an inventory plan.
4. Evaluation--The project grant agreement requires an evaluation of the MOH's logistics system. On the basis of this evaluation, the coordinating committee would decide the nature of the final transfer of the DDP to the MOH in 1980. The timing and criteria of the evaluation have not been decided, nor have the evaluators been identified. Individual members of the coordinating committee were reluctant to discuss evaluation until other important issues had been resolved.

IV. Recommendations

- A. The Drogueria Nacional's (DN) medicine requisition forms should be updated.
- B. Requisitions should be channeled through at least the district chief's office rather than directly to the DN.
- C. Medicines should be classified by priority so that DN personnel can maintain adequate inventories of high priority drugs. A structured task for area chiefs and a questionnaire survey of health center and health post personnel were discussed as a means of obtaining input from the field.
- D. As the Ministry of Health takes over responsibility for contraceptive distribution, suppliers of Neogynon, Depo-Provera and other methods not supplied by AID should be identified.
- E. A supervisor for the DN's distribution program should be hired as soon as possible. Once the MOH decides on whether to charge for contraceptives, the distribution supervisor should plan with the area chiefs the utilization of the vehicles and personnel provided by the project grant agreement.
- F. Six trucks (two 8-ton diesels and four 2,000-pound pick-ups) and 5-6 drivers will be required to implement the distribution program.

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TABLE 1

Contraceptives Distributed to the Guatemala Ministry of Health  
By the Direct Distribution Program, by Year

	<u>June-Dec.</u> <u>1976</u>	<u>1977</u>	<u>Jan.-Dec.</u> <u>1978</u>	<u>1979</u>	<u>Jan.-June</u> <u>1980</u>
Orals (Cycles)	173,905	198,583	367,137	308,677	56,403
Condoms (Units)	49,464	112,638	385,416	243,174	41,574
Vaginal Tablets (Tubes)	4,903	6,135	2,862	4,712	1,474
Depo-Provera (Doses)	2,415	9,270	10,229	1,705	2
C-Film (Envelopes)	157	-	-	3	-
Creams, Foams, Jellies (Tubes)	7,013	6,663	3,997	1,147	3
IUD's	955	2,401	890	1,203	70
Diaphragms	-	-	-	72	-

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TABLE 2

Contraceptives Distributed to the Guatemala Ministry of Health  
by the Direct Distribution Program, by Department  
January - June 1980

	<u>Orals</u>	<u>Condoms (Dozens)</u>	<u>Neo-Sampoon</u>	<u>Creams</u>	<u>I.U.D.</u>	<u>Depo-Provera</u>
Baja Verapaz	750	84	10	-	-	-
Sacatepequez	2,260	144	30	-	-	-
Alta Verapaz	1,860	120	10	-	10	-
Retalhuleu	270	-	-	-	-	-
Quiche	1,800	60	40	-	-	-
Solola	160	12	40	-	-	-
Progreso	2,155	96	160	-	-	-
Zacapa	3,845	197 1/2	110	-	-	-
Jutiapa	5,420	480	200	-	-	-
Totonicapan	1,200	84	20	-	-	-
Suchitepequez	3,600	-	20	-	-	-
Izabal	6,940	108	45	-	25	-
Jalapa	2,200	120	-	-	-	-
Escuintla	3,850	497	215	-	-	-
Guatemala	8,582	444	211	-	35	-
Buehuetenango	2,040	168	60	-	-	-
Santa Rosa	6,860	516	153	-	-	2
Chiquimula	1,450	70	80	-	-	-
Chimaltenango	1,161	264	70	3	-	-
Quetzaltenango	-	-	-	-	-	-
San Marcos	-	-	-	-	-	-
Peten	-	-	-	-	-	-
<b>Total</b>	<b>56,403</b>	<b>3,464 1/2</b>	<b>1,474</b>	<b>3</b>	<b>70</b>	<b>2</b>

TABLE 3

Price Changes for 11 Drugs  
National Pharmacy, Guatemala  
1975-1979

	<u>Prices*</u>		<u>Change</u>
	<u>1975</u>	<u>1979</u>	<u>1975-1979</u>
Adult Aspirin**	2.88	3.27	+13.5%
Pediatric Aspirin**	2.88	3.36	+16.7%
Procaine Penicillin**	30.00	38.40	+28.0%
Vitamins**	6.20	8.20	+32.3%
Prenatal Vitamins**	19.00	8.20	-56.8%
Ampicillin**	67.00	118.00	+76.1%
Dipidex**	74.80	100.70	+34.6%
Cold Tablets** ****	(5.18)	18.10	+248.9%
Kaopentate***	6.60	4.50	-31.8%
Expectorant***	4.20	4.32	+2.9%
Piperazine***	6.25	6.17	-1.3%

Average Annual Change = 8.0%

Inflation Index\*\*\*\*\* = 4.1%

\*Prices are the average price in dollars for each year, weighted by the volume of each purchase.

\*\*Price per 1,000 tablets, capsules or vials.

\*\*\*Price per gallon.

\*\*\*\*Cold tablets were not purchased in 1975. Quoted price is for 1976.

\*\*\*\*\*The inflation index (4.1%) is the annual rate of inflation, weighted by the distribution of pharmaceuticals purchased in the base year, 1975. Although this is the standard method of calculating an inflation rate, the result is deceptively low because in 1979 the DN purchased a larger proportion of expensive drugs such as Ampicillin. If the price change is adjusted by 1979's mix of drugs rather than 1975's, the inflation rate would be 8.8%. This is still less than the general rate of inflation in Guatemala (10.4%).

TABLE 4

Funds for Medicines (per Patient Visit)  
Guatemala 1975-1979\*

	<u>Drug Budget Per Visit (\$)</u>	<u>Drug Budget Per Visit (Adjusted for Inflation)**</u>
1975	0.27	0.27
1976	0.26	0.25
1977	0.18	0.16
1978	0.24	0.21
1979***	0.26	0.21

\*Visits include all outpatient consultations to health posts and Type A and B Health Centers.

\*\*The medicine budget was adjusted by a conservative inflation index of 4.1% per year (Table 3). The drug budget per patient visit decreased from \$0.27 in 1975 to \$0.21 in 1979, a decrease of 21%.

\*\*\*Patient visits for 1979 were based on preliminary data.

TABLE 5

Volume and Value of Drug Purchases  
National Pharmacy, Guatemala 1975-1979

	<u>1975</u>		<u>1979</u>	
	<u>Quantity</u>	<u>Value (\$)</u>	<u>Quantity</u>	<u>Value (\$)</u>
Ampicillin	60	4,020	580	68,440
Cold Tablets	550	2,850	3,500	63,350
Expectorant	1	4,200	7	30,240
Piperazine	2	12,500	3	18,510
Kaopectate	1	6,600	3	13,500
Procaine Penicillin	70	2,100	323	12,380
Pediatric Aspirin	3,000	8,640	3,500	11,760
Adult Aspirin	3,000	8,640	3,000	9,810
Dipidex	115	8,600	70	7,050
Vitamins	3,000	18,800	850	6,970
Prenatal Vitamins	260	4,940	800	6,560

\*Quantity is in 1,000's of tablets, capsules or vials, except for kaopectate, piperazine and expectorant.

Note: In 1979, 11% of the medicine budget was expended for kaopectate, expectorant and cold remedies.

TABLE 6

Integrated Family Planning Services Agreement  
Supplies Program - Illustrative Budget

	<u>1981</u>	<u>1982</u>	<u>Total</u>
AID Funds			
Vehicles	80,000	-	80,000
Per diem	5,000	10,000	15,000
Transportation	20,400	41,332	61,732
Storage Capacity	<u>23,268</u>	<u>-</u>	<u>23,268</u>
Subtotal	128,668	51,332	180,000
MOH Funds			
Personnel	<u>31,000</u>	<u>31,000</u>	<u>62,000</u>
Total	159,668	82,332	242,000

Attachment 1

Draft Questionnaire for Establishing Medicine Purchasing Priorities

Fecha \_\_\_\_\_

Puesto o Centro de Salud \_\_\_\_\_

Departamento \_\_\_\_\_

Persona que llena el cuestionario \_\_\_\_\_

(1-2)

Cheque una cajilla : Medico

EPS

(3)

Enfermera

Auxiliar

<u>Prioridad</u>	<u>Codigo de la medicina</u>
#1	_____ (4-6)
#2	_____ (7-9)
#3	_____ (10-12)
#4	_____ (13-15)
#5	_____ (16-18)
#6	_____ (19-21)
#7	_____ (22-24)
#8	_____ (25-27)
#9	_____ (28-30)
#10	_____ (31-35)

Instrucciones: Este cuestionario debe ser llenado por la persona bajo cuya responsabilidad funciona permanentemente la clínica, es decir que para centros de salud sera el médico director y para puestos de salud sin médico permanente sera la enfermera, EPS o auxiliar de enfermeria a cargo.

- 1) Revisando la lista de medicinas adjunta, decida cuales son las diez medicinas mas importantes para su puesto o centro de salud, independientemente de si estan o no, actualmente disponibles. Tome en cuenta la severidad y prevalencia en su comunidad de la enfermedad que trata cada medicina. Es decir, un medicamento que trata una enfermedad grave y común debe de tener una prioridad alta.
- 2) Escriba el código de las medicinas seleccionadas en los espacios indicados, en orden de importancia. Es decir, escriba el código de la medicina mas esencial en el primer espacio y el de la segunda medicina en el segundo espacio.
- 3) Envíe este cuestionario junto con el pedido de las medicinas el próximo trimestre.