



## Memorandum

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Subject Foreign Trip Report (AID/RSSA): Honduras, February 8-18, 1982--Evaluation of  
the Asociación Hondureña de Planificación de Familia Community-Based  
Distribution (CBD) Program

To

William H. Foege, M.D.  
Director, Centers for Disease Control  
Through: Horace G. Ogden  
Director, CHPE *HGO*

## SUMMARY

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## SUMMARY

At the request of the Asociación Hondureña de Planificación de Familia (AHPF) and USAID/Honduras, we provided followup technical assistance in the evaluation of the AHPF Community-Based Distribution (CBD) Program. In addition, assistance was provided to the USAID Mission in preparing the Contraceptive Procurement Tables for the 1984 Annual Budget Submission.

During the third quarter of 1981, 26,847 active users were reported to have been served by the program. This represents an increase of 13 percent over the number of active users served in the second quarter. However, as explained in this report, this increase in the number of active users may be artificial, since the number of active users for the first quarter were over-reported and subsequently under-reported the second quarter. When third quarter performance is compared with that of the first quarter, it can be seen that the number of active users served by the program has not increased since the program was reorganized.

The goal of the program is to have 1,240 distribution posts operational by year's end. At the end of the third quarter, 705 posts were operational compared with 437 in January 1981. Thus, over a period of 9 months, 269 new distribution posts were established, an increase of 62 percent. However, since the total number of active users has not substantially changed, the number of active users per distribution post has decreased. As described in this report, the maintenance of previous users has been neglected during the expansion phase of the program.

Previous consultation reports (CDC Foreign Trip Reports: Honduras, dated May 27 and October 22, 1981) documented the slow progress of the program during the initiation phase in the first half of 1981. In this report, we identified continuing performance problems that have to be corrected if the program is to increase its effectiveness in terms of active users as well as increase its geographic coverage. For example, an excessive amount of time is devoted to data collection leaving very little time, if any, for promotional and educational activities in the community. We have made recommendations for streamlining data reporting procedures so that additional time can be devoted to maintaining previous users active in the program as well as bringing new users in the program. Another problem area identified was that some distributors did not have adequate training on the use of oral contraceptives, and appropriate educational materials for users were not available. We have taken action in providing AHPF, via USAID/Honduras, Spanish language material to be used as a guide in developing instructions on the use of all methods of contraception. We also noted during our field trips that there is little or no coordination between the promoters and distributors in scheduling supervision and community education promotion activities. However, once data collection procedures are streamlined, there should be time available for these activities.

Although the CBD program has not performed to expectations, preliminary results of the Contraceptive Prevalence Survey conducted in 1981, show that approximately 22 percent of married women in Honduras that use oral contraceptives use the CBD program as their source of pills. The actual figure may even be higher, since the CBD program has distribution posts established in Ministry of Health facilities, and some women in the survey probably reported their source of oral contraceptives as a MOH clinic rather than the CBD program.

We also assisted the Mission in preparing the 1984 Contraceptive Procurement Tables. After our return to Atlanta, these tables were reviewed with Mr. Tony Boni, AID/S&T/POP/FPSD. It should be noted that we recommend that 603,600 cycles of Noriday that AID has scheduled for shipment to the Ministry of Health between July 1982 and June 1983, be cancelled because of oversupply of this method. If the Mission approves the tables, a cable should be sent to AID/S&T/POP/FPSD indicating their approval.

Finally, we recommend that FPED/CDC consultants evaluate the progress of the CBD program when a report on the program for the second quarter of CY 1982 is available. This should be in July if our recommendations on data collection are adopted.

#### I. PLACES, DATES, AND PURPOSE OF TRAVEL

Honduras, February 8-18, 1982, at the request of the Asociación Hondureña de Planificación de Familia (AHPF), USAID/Honduras, and AID/S&T/POP/FPSD, to evaluate the AHPF/CBD program. In addition, assistance was provided to the Mission in preparing the Contraceptive Procurement Tables for the 1984 Annual Budget Submission. This consultation was provided by Richard S. Monteith,

M.P.H., Program Evaluation Branch, and Carlos Huezo, M.D., Epidemiologic Studies Branch, Family Planning Evaluation Division (FPED), Center for Health Promotion and Education (CHPE), CDC. This travel was in accordance with the Resource Support Services Agreement (RSSA) between the Office of Population, AID, and FPED/CHPE/CDC.

## II. PRINCIPAL CONTACTS

### A. USAID/Honduras

1. Mr. Ron Witherell, Chief, Human Resources Division (HRD)
2. Mr. John Massey, Chief, Health, Population and Nutrition, HRD
3. Dr. Barry Smith, HRD
4. Ms. Cynthia Guisti, Program Office

### B. Asociación Hondureña de Planificación de Familia (AHPF)

1. Sr. Alejandro Flores, Executive Director
2. Sr. German Cerrato, Administrator
3. Sra. Nelly Elizabeth Fúnez, Regional Supervisor, Community-Based Distribution Program (CBD)
4. Sr. Roberto Flores, Regional Supervisor, CBD
5. Sr. Melvin Walterio Tome, Regional Supervisor, CBD

### C. Other

1. Mr. Michael Thomas, Triton, Commercial Retail Sales (CRS) Project, Project Director
2. Dr. Danilo Velasquez, Chief, Maternal and Child Health Division, Ministry of Health
3. Dr. Gabriel Ojeda, Consultant, Asociación Pro-Bienestar de la Familia Colombiana (PROFAMILIA)

## III. EVALUATION OF THE COMMUNITY-BASED DISTRIBUTION PROGRAM

### A. Data Collection and Reporting

#### (1) Contraceptives Sold to Users

The most popular method in the program in terms of sales and Couple Years of Protection (CYP) are by far oral contraceptives, and the most popular brand of orals is Norinyl/Noriday (Table 1). Ovral is the least sold oral contraceptive, but this is due to its limited availability and cost to users, which is three times greater than the cost of Noriday, e.g., US \$0.75 versus US \$0.25. Because Ovral is available to the program only in limited quantities, some distribution posts run out of Ovral between resupply visits. Thus, some users must interrupt their use of this method or use alternative methods until quantities of Ovral become available again. Since it is unlikely that larger quantities of Ovral will be made available to the AHPF as well as to the CBD program insuring continuity of use, we recommend that the AHPF consider the complete exclusion of Ovral from the CBD program and emphasize Norminest as an alternative to Noriday in the event of secondary effects. Exclusion of Ovral may also result in increased sales of both Noriday and Norminest, since some women may be buying Ovral only because they consider it to be a superior product to Noriday and Norminest because of its higher cost.

Funds collected from the sale of contraceptives increased by 16 percent from the second to the third quarter (Table 2). Forty-six percent of the money was deposited in AHPF's general account and the remainder was paid to the distributors as commission.

(2) Active Users

The number of contraceptives sold to users is converted into CYP, which serves as a surrogate for the number of active users. Unfortunately, sales data for the fourth quarter of CY 1981 were not available at the time of our consultation. Therefore, our evaluation of the program in terms of active users was limited to the first 9 months of the year.

During the third quarter of 1981, 26,847 active users were reported to have been served by the program (Table 3). This represents an increase of 13 percent over the number of active users served in the second quarter (see CDC Foreign Trip Report: Honduras, dated October 22, 1981). Nevertheless, when third quarter performance is compared with that of the first quarter, it can be seen that the number of active users served by the program has not increased since the program was reorganized. Reasons related to the slow progress of the program were documented in CDC Foreign Trip Reports: Honduras, dated May 27 and October 22, 1981.

An explanation for the apparent decline in active users from the first quarter to the second quarter for Regions I and II is that data for the second quarter for some distribution posts included only the months of May and June; the month of April was included in the first quarter report. Thus, the number of active users for the first quarter were over-reported and subsequently under-reported for the second quarter.

Preliminary results of the Contraceptive Prevalence Survey (CPS), conducted in 1981, show that approximately 11 percent of married women age 15-49 in Honduras use oral contraceptives. The results also show that, although the CBD program has not performed to expectations, it is the source of oral contraceptives for 22 percent of oral contraceptive users in the country. This would result in between 2 and 3 percent of women using the CBD program as their source of pills. The actual figure may be higher, since the CBD program has distribution posts established in Ministry of Health (MOH) facilities, and some women in the survey probably reported their source of oral contraceptives as a MOH clinic rather than the CBD program. Geographically, 21.4 percent and 23.9 percent of urban and rural oral contraceptive users, respectively, obtain their oral contraceptives from the CBD program. Thus, in both urban and rural areas, the CBD program is the source of oral contraception for at least 1 of every 5 users.

(3) New Acceptors

Table 4 shows that 48 percent more new acceptors were incorporated into the CBD program during the third quarter than were incorporated in the second quarter. This is explained by the fact that during the second quarter program, efforts were directed primarily at supervising and resupplying existing distribution posts while during the third quarter attention was given to establishing new posts. The data in Table 4 also show that the greatest increase in new acceptors occurred in Region II. The data in this table as

well as Table 3 suggest, however, that while Region II is experiencing success in recruiting new users, it is less successful in maintaining users in the program as they have had an increase of 1,424 new users but an increase of only 766 active users. In fact, in all three regions, the increase in active users in the third quarter is substantially less than the number of new acceptors in that quarter, indicating discontinuation of previous users of the program.

(4) Discussion and Recommendations

The slow progress of the program in increasing the number of active users served by the program is, in part, associated with the user and supply data system. During our evaluation we observed that the amount of time that promoters take to collect data from the distribution posts is excessive, leaving very little time, if any, for promotional and educational activities in the community. During our field visits, we observed in Regions I and II that promoters spent practically all their time, 3 to 4 hours, in data collection and updating forms and no time on community education and promotion. For posts that serve a large number of active users, e.g., 200 or more users, data collection and updating can take more than 1 day.

The majority of the promoter's time is spent on reviewing and updating the distributor's tickler file. This file is a collection of individual cards which are maintained for each user. The cards are to be filed by date of next visit to facilitate the identification of users who failed to keep their next appointment and to plan followup visits. In reality, the majority of the distributors do not keep this file up-to-date nor do they visit users who have failed to keep their appointment. Because the promoters spend the majority of their time in the distribution posts updating the tickler files, they do not visit these women either. We strongly recommend that the use of the tickler file be discontinued for the following reasons:

- (1) The time required to update the file.
- (2) The ineffectiveness of followup visits in encouraging women to return to the program. (The principal reasons for desertion are not amenable to followup visits, e.g., pregnancy, user has moved, and user has switched to a method not available through the CBD program).
- (3) Form DC-1, which is used to record the visits of users, can be used to identify women who have failed to keep their appointment, if program officials insist on continuing with followup visits.

During our consultation we met Dr. Gabriel Ojeda, Director, Evaluation and Research Division, Asociación Pro-Bienestar de la Familia Colombiana (PROFAMILIA), who was providing technical assistance to the AHPF. The purpose of his consultation was to review data collection and reporting by all divisions of AHPF, and to make recommendations to streamline these functions. After reviewing the CBD program forms and reports, he recommended that only contraceptives (units) sold to users be reported. We concur and recommend that the AHPF consider adopting his recommendations.

The fourth quarter report for 1981 on the CBD program was unavailable at the time of our consultation. In fact, data collection for this quarter did not begin until January 1982. During our evaluation visit in September 1981, we recommended that data collection procedures be changed in such a way that data for a given quarter be collected during the same quarter. Although our recommendation was accepted, the mechanics were not completely understood nor uniformly implemented. During this consultation we reviewed the mechanics of data collection in detail, left detailed instructions in Spanish, and called CBD officials after our return to Atlanta to insure that there would not be any misunderstanding on data collection procedures so that data is collected on a more timely basis. We recommend that the new procedures begin immediately as discussed below.

Since field work is underway to collect data for the fourth quarter of 1981 and since field workers are collecting data covering varying periods of time, e.g., 3 to 5 months, we recommend that data collection continue through March, including revisiting distribution posts that had been visited earlier in the quarter in order to obtain more complete data for the first quarter of 1982, so that a 6-month report that encompasses October 1981 through March 1982 can be prepared. Given the lack of uniformity in which data is currently being collected, it would be impossible to separate data that corresponds to the last quarter of 1981 from that of the first quarter of 1982. A semester report would avoid this problem, and AHPF can return to quarterly reports in the second quarter of 1981.

It should be noted that due to the mechanics of the new data collection procedures, performance indicators, such as contraceptives sold to users and number of active users reported for the period October 1981-March 1982, will be artificially low because the month of March will not be reported completely for some of the posts. However, this will be automatically corrected beginning with the second quarter report as the new data collection procedures require quarterly reports by post on a 3-month cycle.

## B. Management Issues

### (1) Number of Distribution Posts

The goal of the program is to have 1,240 distribution posts operational by year's end. However, data were unavailable on the number of distribution posts that were operational in each of the program regions. Thus, it was impossible to evaluate the progress of the program on a region-by-region basis. At the national level, program officials did report that at the end of the third quarter 706 posts were operational in the country. This would be an average of 38 active users per distribution post. In January 1981, there were 437 posts. Thus, over a period of 9 months, 269 new distribution posts were established, an increase of 62 percent. However, since the total number of active users has not substantially changed, the number of active users per distribution post has decreased. As mentioned in the previous section, the maintenance of previous users has been neglected during the expansion phase of the program.

The unavailability of data on the number of distribution posts by region at the central level is troublesome. We feel that these data are essential to the evaluation of the program. Therefore, we recommend that the regional supervisors report to the CBD Central Office each quarter, the number of distribution posts supervised and resupplied by each of the promoters working in their respective regions. This would facilitate closer monitoring of the program and the performance of each promoter.

(2) Education and Promotion

During our field trips we identified that some distributors are not adequately prepared to handle all problems that users might experience, and appropriate educational materials to instruct users in the proper use of methods are not available. In addition, instructions on the use of oral contraceptives was not clearly understood by some distributors and promoters in Region II, nor by their regional supervisor. For example, their understanding was that after initiating the use of oral contraceptives, the user should begin taking a new cycle of 28 pills (21 hormonal, 7 iron) on the fifth day of the menstruation cycle. In fact, the correct method is to go from one cycle of 28 pills to another without interruption.

In general, the distributor's manual is lacking with respect to instructions on the use of all methods. We recommend that the program provide the distributors with precise written and illustrative instructions on the use of all methods as well as additional training in handling minor problems that users might experience. Materials developed by the MOH of El Salvador were sent to the AHPF via USAID/Honduras to be used as a guide in developing these instructions.

With respect to oral contraceptives, we also learned that it is program policy to discontinue the sale of orals to women 40 years of age or older. This presents a problem for women who want to continue taking the pill who are not experiencing any problems and who do not want to use another method. Risks from taking the pill increase with age, especially among women who smoke. However, at the same time, the risks of complications from pregnancy and congenital abnormalities also increase with age. We recommend that women 40 years of age or older, who insist on not stopping pill use, be allowed to continue if they are not experiencing side effects and no other contraindications, such as smoking, exist.

During our field trips, we also noted that there is little or no coordination between the promoters and distributors in scheduling community education and promotion. Given the fact that more time should be available for these activities when the tickler file is discontinued, promoters and distributors should begin to establish schedules for these activities. By working together in the community, the promoters can provide on-the-job training to the distributors in family planning education and promotion and, thus, increase the confidence and effectiveness of the distributors.

3. Supervision

One of the goals of program officials should be the efficient use of all resources in the delivery of services. We found that this was not always the case. For example, in Region II we found that the work areas of some promoters overlapped and that mobile promoters were supervising relatively

accessible posts that could be easily supervised by promoters (area promoters) who rely on public transportation. In addition, it did not appear that the regional supervisor was coordinating the activities of his promoters, thus the overlapping, or closely monitoring their progress. We recommend that the regional supervisors take the following actions:

- (a) require the promoter to submit weekly work plans on a monthly basis for his review and approval,
- (b) accompany each of the promoters at least once a month to assist in field work and to evaluate performance, and
- (c) with the use of maps, delineate the areas of responsibility of each promoter and to record the opening and closing of posts of each promoter. This can be done by the use of different colored pens--a different color for each promoter.

#### 4. Concluding Comments

During our evaluation of the CBD program we identified problems in the collection and reporting of data, supervision, and educational and promotional activities. Because of these problems the program is not as efficient as it could be. We feel that if these problems are corrected, the program will have a good chance of achieving its objective of 1,240 distribution posts and 55,000 active users by year's end. We recommend that FPED/CDC consultants evaluate the program when the report for the second quarter of 1982 is available, which should be July if our recommendations on data collection procedures are adopted.

#### IV. CONTRACEPTIVE PROCUREMENT TABLES

In addition to evaluating the AHPF/CBD program, AID/S&T/POP/FPSD requested that we assist USAID/Honduras in preparing the FY 1984 Contraceptive Procurement Tables, which are part of the Annual Budget Submission (ABS). While in Honduras, data to complete the tables were collected from the MOH, the AHPF, and the Commercial Retail Sales (CRS) Project Director. The tables were completed after our return to Atlanta and reviewed with Mr. Anthony Boni, AID/S&T/POP/FPSD, in Washington, D.C., on Friday, February 26, 1982. Copies of the tables and supporting statistics that were approved by Mr. Boni were left with him. The same material was also sent to Mr. John Massey, USAID/Honduras, on March 5.

Based on the calculations appearing in the Procurement Tables, the following should be highlighted:

- (1) In order to meet estimated demand for CY 1982 and to begin to fill the pipeline for CY 1983 for the CBD and clinic programs, Family Planning International Assistance (FPIA) should make 925,000 cycles of Noriday, 163,000 cycles of Norminest and 21,000 pieces of condoms available to the AHPF no later than October 1982. Estimates of supply requirements for Noriday and Norminest for subsequent years may need to be modified, based on the performance of the CRS program and the acceptability of Norminest.

- (2) The supply requirements for the CRS program were estimated by Mr. Michael Thomas, Project Director. The CRS program will be supplied by FPIA. Presently, Mr. Thomas is awaiting a shipment of 600,000 pieces of condoms (in white wrapper) and 397,440 tablets (in foil strips) of NeoSampoon. It is important that these shipments arrive well in advance of the June 1, 1982 sales launch date.
- (3) Only 99,000 cycles of Noriday (received in October 1981) and 2,200 cycles of Microgynon (donated by UNFPA) are on hand in the MOH central warehouse located in Tegucigalpa. No condoms are currently on hand. Although small quantities of contraceptive supplies are currently on hand in the MOH central warehouse, a substantial number of cycles of Norinyl/Noriday and pieces of condoms (Tahiti) were issued to the MOH health regions during the latter part of 1981; 1,377,600 cycles of Norinyl/Noriday and 588,016 pieces of condoms. Approximately 43 percent of the orals, or 595,800 cycles, were reported to have been stored in the warehouse for a long period of time. Dr. Danilo Velasquez, Chief, MOH Maternal and Child Health Division, told me that some of the orals were manufactured as early as 1973. No information was available on stock levels of orals and condoms in each of the health regions. Thus, the above figures represent the minimum stock on hand of these methods in the health regions. Based on these figures and Dr. Velasquez's estimate that 80 percent of pill users in the MOH program use Microgynon, we recommend that 603,600 cycles of Noriday that AID has scheduled for shipment to the MOH between July 1982 and June 1983 be cancelled.

An analysis of condom requirements shows that given current in-country stock levels in the health regions (588,016 pieces), the MOH will not require additional supplies until 1984.

- (4) Estimating AID contraceptive requirements for the MOH would be facilitated if the number of contraceptives dispensed to users and balances on hand in the field, as well as in the central and regional warehouse, were reported periodically to USAID/Honduras. If this information had been available in 1981, it is unlikely that 496,200 cycles of Noriday would have been shipped to the MOH in 1981. This information would also be useful to determine if supply imbalances exist in the field. Since this information is not reported, it would be safe to assume that a given health region could run out of supplies and not be aided by another region that had large quantities of contraceptives on hand. This could result in a request for additional AID contraceptive supplies when, indeed, they would not be needed. We recommend that the Mission request that the MOH make this information available. In addition, the Maternal and Child Health Division of the MOH should immediately require the health regions to report current balances on hand of orals and condoms by date of manufacture. If large quantities of Norinyl are on hand with a manufacture date earlier than 1976, samples of these orals should be sent to AID/POP/W to be assayed.

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The MOH may require technical assistance in establishing a contraceptive supply reporting system. I discussed this with Dr. Barry Smith, USAID/Honduras, in a telephone conversation on March 2, 1982. He stated that Management Sciences for Health (MSH) may be the logical choice to provide this assistance in developing forms and reporting procedures, since they just recently won a contract to provide technical assistance in management to the MOH, including logistics. If not, assistance could be provided by FPED/CHPE/CDC consultants, if requested.

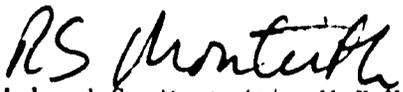
  
Richard S. Monteith, M.P.H.

TABLE 1

Units of Contraceptives Sold to Users and Couple Years  
of Protection (CYP) by Method and Quarter  
Community-Based Distribution Program  
Asociación Hondureña de Planificación de Familia  
April-September, 1981

<u>Method</u>	<u>Units Sold</u>		<u>CYP's Sold</u>	
	<u>Second Quarter</u>	<u>Third Quarter</u>	<u>Second Quarter</u>	<u>Third Quarter</u>
<u>Total Orals<sup>1</sup></u>	<u>74,557</u>	<u>83,745</u>	<u>22,940</u>	<u>25,769</u>
Noriday/Norinyl	56,967	64,500	17,528	19,846
Norminest	13,065	13,257	4,020	4,079
Ovral	4,525	5,992	1,392	1,844
<u>Vaginals</u>				
<u>Total Vaginals</u>	<u>NA<sup>5</sup></u>	<u>NA</u>	<u>365</u>	<u>450</u>
NeoSamoon <sup>2</sup>	324	257	216	171
Emko/Rumses <sup>3</sup>	223	419	149	279
<u>Condoms<sup>4</sup></u>	<u>11,472</u>	<u>15,710</u>	<u>459</u>	<u>628</u>
TOTAL	NA	NA	23,764	26,847

<sup>1</sup>Cycles<sup>2</sup>Tubes of 20 tablets<sup>3</sup>Tubes<sup>4</sup>Pieces<sup>5</sup>NA - Not Applicable

TABLE 2

Money Collected From Sale  
of Contraceptives by Quarter  
Community-Based Distribution Program  
Asociación Hondureña de Planificación de Familia  
April-September, 1981

<u>Quarter</u>	<u>Money Collected (in Lempiras)</u>		
	<u>Total</u>	<u>Distributor</u>	<u>Program</u>
Second	43,182.00	23,623.40	19,558.60
Third	50,161.50	26,935.40	23,226.10
TOTAL	93,343.50	50,558.80	42,784.70
US \$.	46,671.75	25,279.40	21,392.35

TABLE 3

Number of Active Users by Quarter and Region  
 Community-Based Distribution Program  
 Asociación Hondureña de Planificación de Familia  
 January-September, 1981

<u>Quarter</u>	<u>Total</u>	<u>Program Region</u>		
		<u>I</u>	<u>II</u>	<u>III</u>
First	26,942	15,621	9,746	1,575
Second	23,762	13,185	9,012	1,565
Third	26,847	15,260	9,778	1,809
Percent Change Second & Third Quarter	+ 13.0	+ 15.7	+ 8.5	+ 15.6

TABLE 4

Number of New Acceptors by Quarter and Region  
 Community-Based Distribution Program  
 Asociación Hondureña de Planificación de Familia  
 April-September, 1981

<u>Quarter</u>	<u>Total</u>	<u>Program Region</u>		
		<u>I</u>	<u>II</u>	<u>III</u>
Second	5,298	2,818	1,985	495
Third	7,820	3,590	3,409	821
Percent Change	+ 47.0	+ 21.5	+ 71.7	+65.9