

RESOURCE SUPPORT SERVICES AGREEMENT

ANNUAL REPORT

FISCAL YEAR 1979

DS/POP/FPSD
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FPED/BE/CDC
RSSA ANNUAL REPORT
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I. Background

A. Introduction

The Resource Support Services Agreement (RSSA) between AID and DHEW, Center for Disease Control (CDC), supports services provided by the CDC for the improvement of family planning programs in the LDCs. When requested and with the agreement of AID, CDC will conduct evaluations, provide necessary information and data to AID and participating countries, and assist in the implementation of recommendations and innovative program strategies.

Since program initiation in February , CDC personnel have made 181 trips to 43 LDCs to provide consultation and evaluation services directed toward improving the management and operations of family planning programs and organizations. During FY 1979, 43 person-trips to 13 LDCs were accomplished and reports were submitted to AID/POP/FPSD. Technical assistance has included: 1) design, implementation and analysis of contraceptive prevalence surveys; 2) evaluation of contraceptive distribution systems, including community-based programs; 3) training programs for LDC personnel involved in maintaining service statistics and contraceptive logistic system; 4) evaluation of the completeness of and quality of family planning data systems; 5) studies on the epidemiology of fertility control and pregnancy outcome; 6) demographic analysis; 7) design and implementation of a patient flow analysis model; 8) health and demographic impact of family planning activities and other fertility control behavior; 9) contraceptive continuation studies, and 10) preliminary work on adolescent fertility

B. Scope of Work

The Center for Disease Control will provide evaluative information and actionable recommendations concerning family planning programs and will assist in the collection of data on contraceptive prevalence or service statistics

suitable for analysis and planning purposes. As problem areas that hinder goal achievement are identified, on-site technical assistance will be furnished and alternative strategies or corrective measures will be presented to appropriate host country personnel as feasible. AID will be provided with technical reports detailing the scope of technical assistance provided, the nature of existing problems, and specific program needs.

CDC will arrange to visit approximately 20 countries during FY 1980. During these visits specific areas of concern will be addressed, in-country progress will be analyzed to determine the levels of contraceptive prevalence and assistance will be given in collecting data on active users of contraceptives, new acceptors, number of clinics, commodities, and other statistics required for program evaluation and management purposes. If accurate reporting systems do not exist, the data may be gathered by survey or site visits to family planning facilities. CDC will assure that the required data are assembled and analyzed according to program needs and that information on contraceptive commodities is analyzed in terms of volumes received and dispensed. Stock imbalances, bottlenecks in the distribution system, or other supply deficiencies will be reported so that corrective action can be taken. In addition, clinic activities will be studied to improve efficiency of operations and program acceptance. Follow-up visits will be arranged as needed.

In addition, community-based distribution and other innovative programs will be evaluated on request. These evaluations will include accuracy of active user reporting, logistics management, contraceptive sales and revenue collection procedures, agent effectiveness, and overall management of program.

The safety of reproduction and fertility control is usually not studied among populations in developing countries, yet real and perceived harmful effects of fertility control methods markedly affect their acceptability and use. FPED will continue to apply epidemiologic techniques so that attributable risks of fertility control can be reduced and/or compared to maternal mortality in developing countries.

C. Technical Assistance Activities

CDC shall provide evaluative information on programs, training and services to improve family planning programs and organizations in less developed countries. In consultation with DS/POP/FPSD, CDC/FPED undertakes the following activities:

- a) Determine prevalence of contraceptive use using service statistics or other record systems, analysis of existing survey data, or by conducting prevalence surveys;
- b) Develop and/or evaluate logistics systems for distributing family planning supplies and services;
- c) Assist in the development, implementation and evaluation of family planning service statistics systems, including continuation studies as appropriate;
- d) Assist in the development, implementation and evaluation of community-based distribution programs and other innovative program strategies, including the service statistics and logistics components;
- e) Define demographic goals and determine measurable, specific program targets related to these goals;
- f) Evaluate epidemiology of maternal health and reproductive loss to improve family planning strategies and reduce health problems;

- g) Assess health and/or demographic impact of family planning programs and activities;
- h) Provide consultation and/or technical assistance to improve international agency and host government policies on fertility control;
- i) Identify and propose solutions for administrative and/or management problems;
- j) Conduct, arrange or evaluate family planning evaluation training activities;
- k) Provide assistance to USAID Missions regarding the determination of future contraceptive commodity requirements, including the use and interpretation of survey and service statistics for the preparation of contraceptive procurement tables;
- l) Perform evaluations and analyses of family planning related activities as appropriate, and
- m) Participate on Population Officer's Conferences upon request.

II. PROGRAM HIGHLIGHTS - FY 79

A. Contraceptive Prevalence Surveys

During Fiscal Year 1979, results of 3 contraceptive prevalence surveys conducted during calendar year 1978 in Sao Paulo State, Brazil, El Salvador, and Guatemala, were submitted to AID/Washington and respective USAID Missions. A Portuguese language report for the Sao Paulo Survey was issued by the Catholic University of Campinas in January, and the final English report (in collaboration with IFRP) was submitted to AID/Washington in June 1979. Presentations on the El Salvador and Guatemala Surveys were made in Washington on August 15 and September 12, respectively. The final draft of the Spanish language report for El Salvador, to be issued by the Demographic Association, has been reviewed and is in press. A second draft of the Spanish language report for Guatemala has been reviewed, and the final draft should be available for review in January 1980.

Technical assistance was provided to surveys in 3 areas in Fiscal Year 1979: Piaui State, Brazil (in collaboration with Columbia University), Panama and the U.S.-Mexico Border Area. Results are currently under analysis for Piaui and some data is presented here. A Portuguese language report has been scheduled for April 1980, and a presentation at AID/Washington can be scheduled for late March 1980. The Panama Survey is currently in the data processing stage, and an edited tape should be available in March 1980. The U.S.-Mexico Border Survey is in the data analysis stage, and data processing requirements are being coordinated with the Coordinacion Nacional de Planificacion Familiar of Mexico for a joint presentation at the U.S.-Mexico Border Public Health Meeting in Saltillo in April 1980.

A review of contraceptive prevalence survey data in Latin America is shown in Table 1. Results are now available for 12 of 24 countries with a population of at least 500,000. Surveys have been conducted in 5 additional countries, but results are not yet generally available. Westinghouse Health Systems has provided technical assistance to the agencies conducting prevalence surveys in Costa Rica, Mexico, and Colombia, and CDC has provided technical assistance to local agencies conducting surveys in El Salvador, Guatemala, Panama, Brazil, and Paraguay.

An inverse relationship between crude birth rates and percentage of married women contracepting is apparent, and higher contraceptive use levels are associated with any given crude birth rate when compared to previous associations published by the Population Council. This is probably due to the fact that the private sector was generally not included in contraceptive use data available to the Population Council. Although it should be noted that the crude birth rate may be influenced by factors other than contraceptive use such as age at marriage, age distribution, breastfeeding practices, method mix, and use of abortion, the following general relationship has been calculated by fitting a regression line to available data:

Percent of Married Women 15-44 Using Contraception	Estimated Crude Birth Rate
20%	46
25%	44
30%	41
35%	39
40%	36
45%	33
50%	30
55%	28
60%	26
65%	23

1 yr adjustment needed.

TABLE 1

Status of Contraceptive Prevalence Information for Latin America¹
January 1980

	Year of Survey			Percent of Married ² Women 15-44 Using Contraception			Population Estimate (Millions)	CBR ³
	Fieldwork			WFS	CPS1	CPS2	1978	
	WFS	CPS1	CPS2					
<u>Caribbean</u>								
Cuba							9.7	20
Dominican Republic	1975			33			5.4	36
Haiti	1977						5.5	43
Jamaica	1976	1979					2.2	29
Puerto Rico		1974*			61		3.3	23
Trinidad and Tobago	1977						0.9	28
							<u>27.0</u>	
<u>Middle America</u>								
Costa Rica	1976	1978		64**	64		2.1	29
El Salvador		1975	1978		22	34	4.5	40
Guatemala		1978			18		6.6	44
Honduras							3.5	46
Mexico	1976	1978	1979		38		65.8	38
Nicaragua							2.4	46
Panama	1976	1974	1979	54	31		1.8	31
							<u>86.7</u>	
<u>South America</u>								
Argentina							26.5	23
Bolivia							5.1	46
Brazil (States)							116.6	32
Sao Paulo		1978			64		22.6	24
Piaui		1979			31		2.2	39
Bahia		(1980)					9.4	
Paraiba		(1980)					2.9	
Pernambuco		(1980)					6.5	
Rio Grande do Norte		(1980)					2.1	
Other States							86.5	
Chile							10.8	24
Colombia	1976	1978		42	46		25.8	29
Ecuador	1979						7.8	42
Guyana	1975						0.8	26
Paraguay	1979	1977			26		3.1	46
Peru	1977	(1981)		25			16.8	41
Uruguay							2.9	21
Venezuela	1977						14.0	36
							<u>235.8</u>	
							<u>349.5</u>	

*Ever married women 15-49

**Women 20-49

¹Includes countries with 500,000 or more population²Includes women in consensual union³Crude birth rate available for year of contraceptive prevalence data; if no contraceptive prevalence data or contraceptive prevalence not yet available, the crude birth rate is for the most recent year available

WFS = World Fertility Survey

CPS = Contraceptive Prevalence Survey

Contraceptive use by method is shown in Table 2 for 10 countries and 2 States in Brazil. Surgical contraception is the most prevalent method in 4 areas--Panama, Dominican Republic, Piaui State, Brazil, and Guatemala--and is an important method in Sao Paulo State, Brazil and Costa Rica. Intrauterine devices have been relatively important methods in Costa Rica and Colombia, and in only Costa Rica and Sao Paulo State, Brazil are more than 2% of couples using condoms. Rhythm is the most prevalent method (11%) in Peru.

The effect of prolonged breastfeeding is illustrated in Table 3. In Guatemala, contraceptive use was 40% in the Department of Guatemala compared with 22% for Ladinos and only 4% for Indians in the Interior of the country. However, you will note that fertility levels are approximately equal among the Ladino and Indian populations. A demographic analysis currently in progress is investigating this apparent anomaly and the possible effect of non-contraceptive factors.

Data from the survey indicate median duration of breastfeeding of 15 months for Indians and 9 months for Ladinos. Assuming a comparable difference between the 2 groups in postpartum amenorrhea, it was estimated that the Indian total fertility rate would increase by about 1.4 children if they adopted the Ladino breastfeeding pattern. Thus, the prolonged lactation pattern of the Indian group appears to be a powerful factor that, in part, counteracts their low level of contraceptive use.

Results from the contraceptive baseline survey, conducted in Piaui State, Brazil in 1979, are shown in Table 4. Overall, in the entire state, 30.8% of currently married women aged 15-44 were currently using contraception. In the municipio of Teresina (capital city) 45% were contracepting, and in the

TABLE 2

Percentage of Currently Married Women Age 15-44 Using Contraception by Method,
Selected Areas in Latin America with Contraceptive Prevalence Surveys
or World Fertility Surveys Since 1975

Current Use and Method	Sao Paulo State, Brazil (1978)	Costa Rica (1978)	Panama* (1976)	Colombia (1978)	Mexico (1978)	Dominican Republic (1975)	El Salvador (1978)	Piaui State, Brazil (1979)	Paraguay (1977)	Peru (1977)	Guatemala (1978)
<u>Currently Using</u>	<u>35.2</u>	<u>33.2</u>	<u>33.2</u>	<u>42.1</u>	<u>36.7</u>	<u>33.0</u>	<u>34.4</u>	<u>30.8</u>	<u>28.7</u>	<u>25.4</u>	<u>18.2</u>
Orals	27.8	23.2	17.0	17.2	14.0	5.4	9.7	10.0	10.1	4.2	5.4
Sterilization	16.1	14.8	21.8	7.5	7.0	12.4	13.0	15.4	2.9	2.7	6.4
IUD	0.4	5.1	3.7	7.7	7.0	3.0	3.3	0.0	3.4	1.4	1.3
Condom	6.6	8.4	1.2	1.4	1.0	1.6	1.5	0.1	1.8	1.1	0.8
Other Methods	13.0	12.6	10.4	12.2	9.0	7.6	2.9	5.3	7.4	16.0	4.3
<u>Not Currently Using</u>	<u>36.1</u>	<u>36.1</u>	<u>46.1</u>	<u>53.2</u>	<u>62.0</u>	<u>67.0</u>	<u>65.6</u>	<u>69.2</u>	<u>74.3</u>	<u>74.6</u>	<u>31.8</u>
<u>Number of Married Women (in sample)</u>	1,880	2,037	2,723	2,085	2,663	1,808	1,476	1,269	1,208	NA	1,915
<u>Reported or Esti- mated Crude Birth Rate (per 1,000 population)</u>	23.2	29.8	30.8	29.0	35.0	36.0	40.0	39.0	46.0	41.0	44.3

*Includes only women 20-49. It is estimated that 47% of currently married women age 15-44 were currently using contraception.

*when
should be
for subsequent
years.*

TABLE 3

Guatemala: Percent of Currently Married Women 15-44 Currently Using Contraception, and Estimated Total Fertility Rates 1978 Contraceptive Prevalence Survey

	<u>TOTAL</u>	<u>Dept. of Guatemala</u>	<u>Interior</u>	
			<u>Ladinos</u>	<u>Indians</u>
Percent Using Contraception	18.1	40.4	31.6	4.0
Estimated TFR	6.1	4.1	6.5	6.7
Estimated TFR Controlling Breastfeeding Ladinos & Indians ^a	--	--	6.5	8.1

^aEstimated increase in TFR if Indians had the same breastfeeding pattern as Ladinos and a comparable increase in postpartum amenorrhea.

TABLE 4

Percent of Currently Married Women Aged 15-44
Currently Using Contraception by Residence and Method,
Piauí State, Brazil

<u>Currently Using</u>	<u>Total</u>	<u>Teresina</u>	<u>Interior</u>
	30.8	44.9	28.7
Sterilizations	15.4	28.2	13.5
Orals	10.0	11.2	9.8
Rhythm	2.6	3.4	2.5
Withdrawal	2.4	0.7	2.6
Other*	0.3	0.9	0.3
<u>Not Using</u>	69.2	55.1	71.3
• Total	100.0	100.0	100.0
No. of Cases (unweighted)	1269	595	674
Estimated CBR	39	25	41

* Condom, Foam, Jelly, Suppositories

Interior 29% were contracepting. In both areas surgical contraception was the most prevalent method, perhaps reflecting the lack of nonpermanent methods of contraception prior to the initiation of a community-based distribution program in April 1979. The data on the prevalence of surgical contraception will be very important in adjusting the target populations for the CBD program. In addition, as more detailed information becomes available the target population will also be adjusted for the proportion of women in the population who are subfecund. The baseline survey has also been important in establishing baseline fertility rates prior to the initiation of the CBD program. For Piauí State, as in other Northeastern states in Brazil, the most recent estimates of fertility levels were based on the 1970 census, since vital statistics registration is very deficient in this area. The estimated crude birth rate of 39 per 1,000 for Piauí is consistent with the level of the crude birth rate shown for Northeast Brazil available from the 1976 National Household Survey. Prior to the CBD program, the current estimated crude birth rate represents a significant decline from the estimate of 50 per 1,000 from 1970 census data, and a careful analysis of survey data will be made to document the proportion of sterilizations that have occurred since 1970.

Another use of the contraceptive prevalence survey is to obtain information on nonusers that desire to use a contraceptive method, the knowledge of availability of services, and their method of choice. As shown in Table 5, there is much less knowledge of where to obtain a contraceptive method in Guatemala than in either El Salvador or São Paulo State, Brazil. It is noteworthy that almost one-third of nonusers in Guatemala desire to use a contraceptive method, and orals is the predominant method of choice. In El Salvador,

TABLE 5

Percent of Non-users* that Desire to Use a Contraceptive Method,
 Knowledge of Availability of Contraception, and Method Desired:
 El Salvador, Guatemala, and Sao Paulo State, Brazil
 1978

	<u>El Salvador</u>	<u>Guatemala</u>	<u>Sao Paulo State, Brazil</u>
Percentage of Non-users that Desire to Use a Contraceptive Method	26.3	31.8	44.4
Percentage with Knowledge of Where to Obtain a Contraceptive Method	87.5	42.9	75.0
Method of Choice:			
Sterilization	38.3	13.6	NA
Orals	27.7	34.3	NA
Condom	3.8	0.3	NA
IUD	3.1	3.2	NA
Other Method	16.1	21.7	NA
Any Method	8.3	5.7	NA
Don't know/Unknown	<u>3.8</u>	<u>21.3</u>	NA
	100.0	100.0	

*Currently married women aged 15-44

NA - Not available

the predominant method of choice is sterilization followed by oral contraceptives. Knowledge of availability of services do not appear to be a problem in El Salvador compared, for example, to Guatemala. However, accessibility to contraception may be an important problem in rural El Salvador. As shown in Table 6, only one-third of women in rural areas, who are not currently using contraception, live within 30 minutes of a known source of contraception compared to over 80% of women in urban areas. Even in Sao Paulo State, Brazil, which is the most developed state in Brazil with a good highway network, only two-thirds of women live less than 30 minutes from a known source of contraception compared with 94% or greater in urban areas. In Guatemala, the percent of non-contracepting currently married women, who live less than 30 minutes from a known source of contraception, declines from 77% in the capital city to 59% in Ladino areas and 47% in Indian areas. If 30 minutes is to be regarded as a maximum for contraception to be considered accessible, the results of these surveys show that contraception is not very accessible to the majority of rural women in El Salvador and Indian women in Guatemala and is even less accessible to rural women in Sao Paulo State, Brazil, as compared to their urban counterparts.

The contraceptive prevalence survey has been rapidly accepted as an important instrument in the evaluation of progress toward family planning program achievement. Results from these surveys have also been important for policy makers by making known, for the first time, information on desire for more children, knowledge of availability of contraceptive services, information on unplanned pregnancies, and data necessary to estimate the population in need of services. It is recommended to AID that contraceptive prevalence surveys be supported in those countries where there is a lack of information on prevalence of contraceptive use. The 2 countries in Latin America that obviously fall in this

TABLE 6

Percent of Non-Contracepting Currently Married Women
15-44, Who Live Less Than 30 Minutes From a Known
Source of Contraception by Residence
El Salvador, Guatemala, and Sao Paulo State, Brazil
1978

<u>Residence</u>	<u>Percentage of Women Who Are 30 Minutes or Less From a Source of Contraception</u>		
	<u>El Salvador</u>	<u>Guatemala*</u>	<u>Sao Paulo State, Brazil</u>
TOTAL	52.4	59.5	91.3
Capital City	88.2	76.7	94.4
Other Urban Areas	82.1	59.2	95.2
Rural Areas	34.8	47.1	66.3

*For Guatemala, the capital city stratum includes the entire
Department of Guatemala and the Ladino and Indian Areas
correspond to other urban area and rural areas, respectively

category are Honduras and Nicaragua. In addition, countries with active programs, where data from the World Fertility Survey is at least 3 years old, should be priority countries for targeting contraceptive prevalence surveys. This category would include the Dominican Republic, Trinidad and Tobago, and Venezuela. Other countries such as Haiti, Guyana, and Peru would fall into a lower priority. Several countries, such as El Salvador, Mexico, Panama, and Colombia have already institutionalized the surveys as an evaluation tool with surveys conducted every 2 to 3 years.

B. Logistics

Jack Graves provided technical assistance in supply management to the Arab Republic of Egypt Family Planning Program. This assistance was to review the practices related to contraceptive supply management and make recommendations for improvement. During the consultation, contacts were made in the MOH, Population and Family Planning Board (PFPB), UNICEF, and USAID/Cairo. In addition, field trips were made to clinics in 3 governorates (provinces), manufacturing plant, and 2 distribution centers.

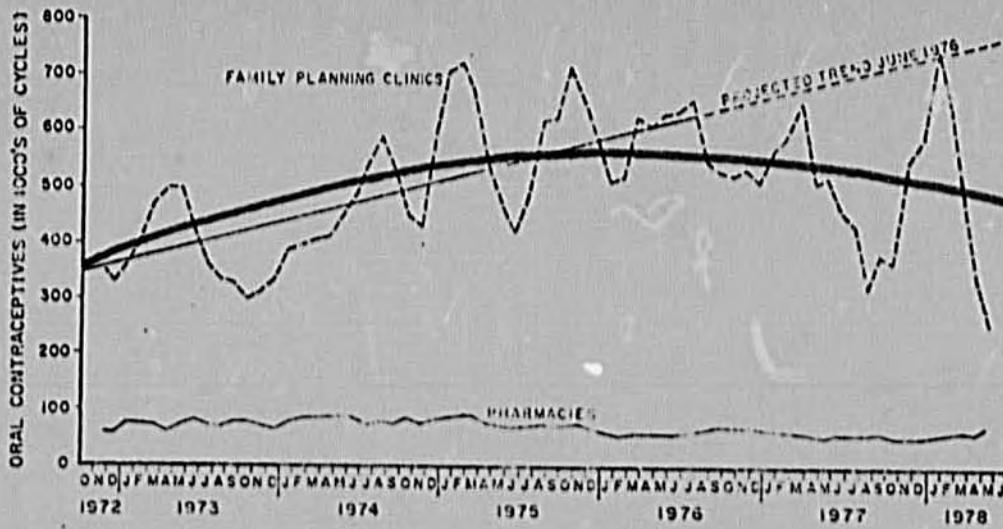
Program policy states that 3 month's supplies will be continuously available in clinics and 6 month's supplies will be available at central locations in the governorates. These quantities should be sufficient to assure continuing availability to program clients. However, ^{he} I found that these quantities were not being generally maintained. Several reasons, such as lack of storage capacity, lack of transportation, insufficient funds, poor staff attitude, and low demand, were given for not adhering to program policy. However, the most likely reason is that the supply system is not well documented, and personnel seem not to understand the importance and mechanism for maintaining adequate supplies. Supply problems seem to be related more to implementation than to the system for distribution.

who is in charge?

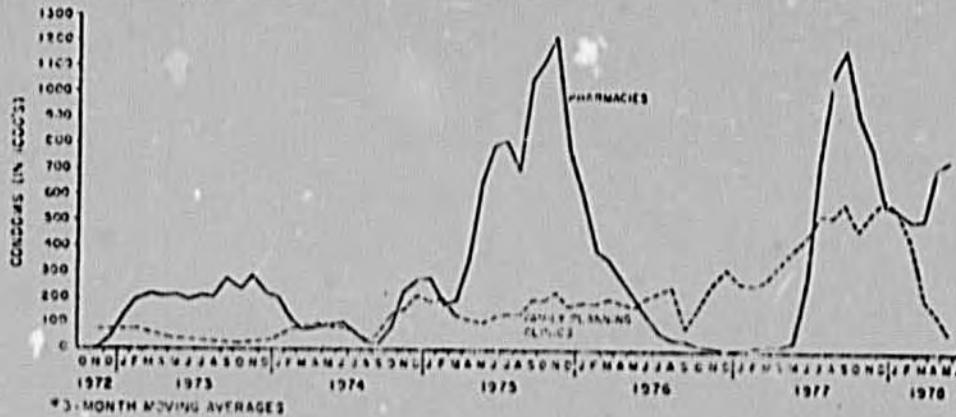
At the beginning of 1978, an attempt was made to place the required quantities of contraceptives in the clinics and governorate stores. In the places visited, this attempt was successful, but instead of maintaining these quantities, they were used without monthly replacement so that inventories are again at a low level. This is reflected in the graph shown on the following page for both orals and condoms. The graphs show that monthly distributions to

FIGURE 1

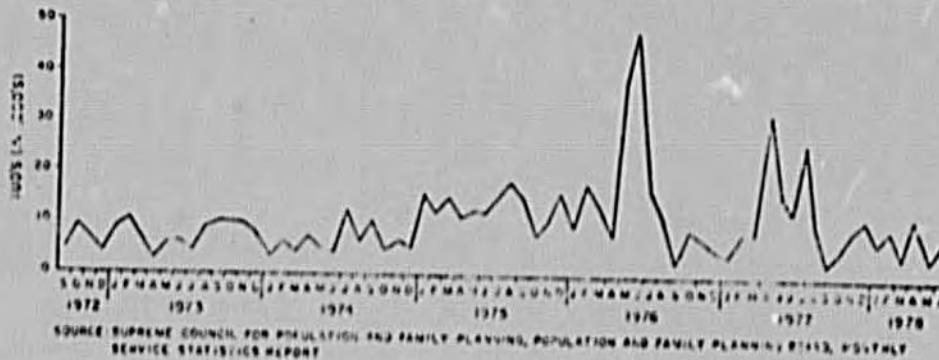
MONTHLY DISTRIBUTION¹ OF ORAL CONTRACEPTIVES TO FAMILY PLANNING CLINICS AND PHARMACIES, EGYPT, OCTOBER 1972-JUNE 1978



MONTHLY DISTRIBUTION² OF CONDOMS TO FAMILY PLANNING CLINICS AND PHARMACIES, EGYPT, OCTOBER 1972-JUNE 1978



MONTHLY DISTRIBUTION OF IUD'S TO FAMILY PLANNING CLINICS, EGYPT, SEPTEMBER 1972-JUNE 1978



clinics were increasing and at a high level immediately prior to January 1978, and rather abruptly declined between that date and June 1978 (which was the latest month for which data were available). Unless these patterns of supply distribution are caused by inconsistent and/or incomplete reporting, the only other conclusion that one could draw from the patterns shown in the graphs, is that the program has been declining since January 1978, i.e., demand for con-
OR CONTRACEPTIVES ARE NOT CONVENIENTLY AVAILABLE.
traceptives is decreasing. Indeed, the distributions of orals was showing an increase up to 1976, but the trend since then has been in the opposite direction.

In addition, the graph for the distribution of condoms to pharmacies shows sharp peaks in November 1975 and September 1977 and, in general, an erratic picture since 1972. The graphs for distribution of orals, condoms, and IUDs show similar inconsistencies over time. This indicates that not enough attention is being paid to the contraceptive supply system. One would expect that after 3 or 4 years these graphs would show little month-to-month fluctuation and, hopefully, a steady increase.

While the success of the family planning program does not rest entirely on a smooth working supply system, the program clearly cannot provide for maximum benefit unless there is a continuous flow of the necessary items to its participants. Nothing is more discouraging to clinic staff than to see their efforts to provide a needed service to their patients nullified because the basic commodities of the service are not available. Needless to say, this is a most frequent contributor to what is generally known as "poor staff attitude." In addition, it is very difficult to regain the confidence of patients who have dropped out of the program because they are not always able to obtain the needed supplies.

What improvements have been effected

In addition to logistics assistance provided to Egypt, FPED staff members provided logistics, management and/or acceptor reporting assistance to Honduras, Guatemala, El Salvador, and Brazil during the fiscal year. In addition, discussions were held with USAID Missions in Peru and Panama for logistics assistance in FY 80. Logistics assistance has already been scheduled for FY 80 in Bangladesh, Haiti, the Dominican Republic, and Zaire.

C. CBD Evaluation

- a. Honduras: Technical assistance was provided in February 1979 to the Asociacion Hondurena de Planificacion de Familia (AHPF), the International Planned Parenthood Federation (IPPF) affiliate in Honduras, in the evaluation of its community-based distribution (CBD) Program of contraceptives, which was initiated in November 1976. The request for technical assistance was initiated by the Pathfinder Fund with the concurrence of USAID/Honduras. As of November 1978, the AHPF was selling contraceptives through 414 community-based distributors living in 349 different communities throughout the country.

From November 1976 through November 1978, 49650 new acceptors had been admitted to the program. However, since January 1977, there has been a general decline in the monthly average number of new acceptors recruited by the program. In 1977, the monthly average number of new acceptors was 2,007 compared to 1,840 for the January-November 1978 period, or a decrease of 8.3%. The Central Zone and the metropolitan areas of Tegucigalpa and San Pedro Sula were identified as the geographical areas with the greatest decline in new acceptors.

Money collected from the sale of contraceptives has steadily increased since the beginning of the program. For the third quarter of 1978 collections had increased to 127,817.95 (U.S. \$13,908.97). Although revenue collected in one quarter has generally exceeded revenue in the previous quarter, increases from one quarter to the next have generally declined. Based on revenue collected during October-November 1978 total collections for the fourth quarter of 1978 may not exceed the previous quarter. The stabilization in revenue collected reflects a decline in the number of new acceptors admitted to and the number of active users maintained in the program.

Two analyses were made to evaluate the accuracy and completeness of reporting of users in the program. Based on these analyses, the following general observations can be made:

1. Inactive users in the program are under-reported.
2. Terminated and active users are over-reported. The over-reporting of active users ranged from 3% to 78% with a median of 21%.
3. Readmissions in the Northern Zone are over-reported.
4. In some instances, the definition and reporting of users in the data system are distinct for the 2 programmatic zones of the CBD program.

Based on our analysis of 2 independent sets of data, we estimated that 18,545 and 18,965 users were active in the program at the end of September and November 1978, respectively. This compares with the 27,756 users that would have been reported as active by the program the end

*Follow
them?*

of November. Recommendations were made to rectify the problems we encountered in the definition and reporting of users in the program.

The principal recommendations are:

1. Standardize definitions and reporting procedures for both zones.
2. The classification of "continuing user" should be discontinued and only active users should be reported.
3. If adopted, the above recommendations should be implemented as soon as possible, either in the preparation of the January 1979 monthly report or the February report. We further recommend that earlier reports not be redone to reflect these recommendations because of the time and expense that would be involved in correcting them.

An analysis of terminated users suggests that the cost-benefit of following up these users may be low, as the majority of women leave the program for reasons of personal convenience that follow-up activities would have no effect on. We recommend that the follow-up program be discontinued.

A break-even analysis was done to determine when the AHPF CBD program could become self-supporting with the receipts from the sale of contraceptives. With an annual program budget of \$216,325, revenue from 166,404 active users would be required in order for the program to break even.

Since it was initiated, the CBD program has been actively expanding its coverage both in terms of field workers and communities served.

The increases have been substantial and impressive. However, during 1979 we recommend that attention be given to consolidating the program and making it more efficient and effective in attracting and maintaining users. Specific recommendations were made for consolidation including:

1. Emphasis of the program should be placed on recruiting new acceptors and maintaining them in the program. Promoters and distributors should both be responsible for the recruitment of new acceptors.
 2. In order that promoters have more time for educational and informational activities in the community, the number of their visits to distributors for the purpose of resupply, collection of money, and general supervision, should be reduced to 1 visit per 3-month period.
 3. The education, information, and motivation component of the CBD program should be evaluated. For this evaluation it may be desirable to obtain the services of an outside consultant.
 4. A system of monetary and non-monetary incentives to reward excellent performance in the program should be developed as a means to reduce turnover in field personnel.
- b. Baseline Survey - CBD Program, Piauí, Brazil. Initial contacts concerning the Piauí baseline survey were made with BEMFAM officials and advisors from Columbia University in July 1978 (see Brazil RSSA report dated August 2, 1978). A statewide community-based distribution program was scheduled to begin in January 1979 in that state and advanced planning would provide the opportunity to conduct a baseline survey to

collect data against which program impact could be measured 2 or 3 years later. Not only is there a complete absence of information on contraceptive use in Piauí, vital statistics are incomplete and irregular. Between 1971 and 1977, the crude birth rate (CBR) has been reported to vary between 32 per 1,000 and 50 per 1,000 as follows:

1971 - 32
1974 - 50
1975 - 38
1976 - 42
1977 - 38

In 1971, the CBR in Teresina (the state capital and major urban area of the state) was reported to be 45 per 1,000 compared with a state-wide figure of 32 per 1,000, which indicates under-reporting in rural areas and existing reports by occurrence rather than residence. In addition, only 21% of the births (32% in Teresina) registered in 1971 took place that year; the great majority having taken place in previous years, although registered in 1971.

Although it would have been ideal to do the survey field work in January and February 1979, this was logistically impossible because the rainy season extends through March, and many roads are impassable at that time of the year. July 2 was set as the beginning date of the survey as this was the dry season, and university students would be available to work as interviewers during their winter holidays. However, this apparent delay of 6 months between program initiation and the survey was shortened to 3 months as the CBD program was delayed and did not begin until April. To compensate for this delay the questionnaire was designed so that contraceptive prevalence could

be determined as of March 1979 and July 1979. Specifications of the survey included an independent 2-stage probability sample of 1,500 households in each 2 strata: the municipio of Teresina and the rest of the state (Interior). With 1,000 women between 15-44 years of age in each strata, the confidence interval (95%), including design effect, will be about $\pm 4.0\%$ for the variable: actual use of contraception. For the entire state, the confidence interval, including design effect, will be about $\pm 2.5\%$. With an independent sample design in each strata, Teresina will be oversampled and the Interior under-sampled so that sampling probabilities will not be equal in the 2 strata. In order to make statewide estimates, weighting factors will be applied to account for unequal sampling probabilities.

In January, appropriate contacts were made with federal and state officials in Piauí concerning availability of interviewers, local salary, and per diem schedules, availability of malaria maps and road conditions. The 2 days in Piauí in January confirmed the logistic problems associated with the rainy season as we had 2 days of torrential rains. The Planning Institute (IPAM) provided an updated detailed map of Teresina, and SUCAM provided updated locality maps for rural areas that were being used in the malaria program. Thus, following an initial selection of census sectors from the 1970 census, second-stage selection of sample points could take into account the updated maps available in Piauí and be adjusted accordingly. The first stage selection of census sectors took place at IBGE in Rio de Janeiro in February, and the corresponding census sector maps were provided to BEMPAM in March.

The questionnaire was similar to that used in Sao Paulo (for comparison purposes--Sao Paulo being the richest state and Piaui the poorest state in Brazil) with an additional module on the use of the maternal-child health services. The questionnaire was pretested in May and after minor modifications, was ready for use on July 2 when training began as scheduled.

As mentioned above, an additional question was added during interviewer training to determine contraceptive use as of March 1979, prior to the CBD program as well as during July-August 1979 so that the early impact of the program could also be measured. Preliminary results of the survey are presented elsewhere in this report.

Reports from the Piaui CBD program, initiated in April 1979, are available for April through June 1979. During the first month (April) there were 2,546 new clients followed by an increase to 4,252 in May and 3,279 in June for a 3-month total of 10,077. The preliminary goal for the first year of the program is 29,836 new clients.

The BEMFAM CBD program in 6 states (Rio Grande do Norte, Piaui, Paraiba, Pernambuco, Alagoas and Parana) has now registered 626,977 new clients from 1974 through June 1979. More than half (56%) of new clients in 1978 were 20-29 years of age, and an additional 16% are less than 20 years of age. Fifty percent of new clients have less than 3 children and probably reflects a desire to space children rather than limit their childbearing. However, one-fourth of new clients have 5 or more living children and may be candidates for surgical contraception if available.

An assessment of contraceptives distributed by Dr. Leo Morris has resulted in an estimate of about 196,000 women active in the CBD program as of June 1979, an increase of 21,000 active users over the previous estimate of 175,000 made in September 1978. In addition, it is estimated that there are 116,000 active users of contraception in the BEMFAM clinic program.

C. Midwife CBD Program - Nicaragua

During 1978, 164 Parteras Empiricas were trained in 10 different locations. Because of civil unrest in Nicaragua during 1978 it was impossible to conduct all of the training courses that had been programmed. Thus, as of the end of 1978, 768 Parteras have been trained in 47 different courses conducted in 40 different locations in 7 different states of the country. The states are primarily located in the northern, less densely populated part of the country. Initially, the goal of the project was to train 2,000 Parteras by the end of 1979.

Of the 768 trained Parteras, only 500, or 65%, reported at least once to an MOH health facility during 1978 for resupply. High turnover of MOH clinic personnel was cited as one of the factors associated with the absenteeism of the Parteras, and replacement personnel were not knowledgeable of the Partera Program and their role in it. As a result, some Parteras were not resupplied when they visited a health facility.

Although overall 35% of the trained parteras did not report for resupply during 1978, some health facilities reported high participation rates. There were 10 of the 40 facilities in which participation rates ranged from 82% to 93%.

Who is in charge?

During January-November 1978 the 500 "active" Parteras purchased the following commodities:

<u>Commodity</u>	<u>Quantity</u>
Oral Contraceptives	11,748 cycles
Condoms	11,689 units
Mebendazole	26,001 pills
Multivitamins	225,354 pills
Aspirin	166,521 pills
Oralyte	4,286 packages

= failure
2 women
1/4 ♂

Taking into account only the contraceptive distribution figures, the average "active" Partera purchased 23 cycles of oral contraceptives and 23 condoms during the year. These figures translated into 1.8 couple years of protection from oral contraceptives (23 ÷ 13) and 0.2 couple years of protection from condoms (23 ÷ 144) purchased per "active" Partera during 1978.

The figures presented in the table above do not take into account the quantities of each commodity supplied initially to the 164 Parteras trained in 1978 and in earlier years of the program. For oral contraceptives and condoms the initial supply is 60 cycles and 1 gross, respectively. Thus, the average number of active users maintained by each Partera probably exceeds the number suggested by the CYP figures discussed above.

Household distribution?

For the health centers that reported the highest sales of contraceptives to Parteras, the average number of oral contraceptives purchased by Parteras that are resupplied by these centers ranged from 42.2 to 106.5 cycles. Similarly, the average number of condoms purchased by these Parteras ranged from 0.2 to 60.7 units.

Since the beginning of the project and as of December 31, 1978, C\$64,457.50 (U.S. \$9,208.21) from the sale of commodities has been deposited in a special account for the program.

D. Epidemiologic Studies on Fertility Control and Pregnancy Outcome

a. Maternal/Abortion Mortality: Bangladesh. Between May 23 and June 8, 1979, Dr. M. Rosenberg visited Bangladesh to complete data collection and editing on a project to define causes of maternal mortality and abortion complications as well as to estimate the annual rate of abortion deaths and the degree to which they may be preventable. Data were collected over a 6-month period beginning in December 1978 on a total of 1,496 complications of abortion (including 498 deaths) and 1,435 maternal (excluding abortion) deaths which occurred since 1977. Most came from rural health care facilities, which serve the majority of Bangladesh's population and form the focus of this study (See Table 7).

Results indicate that abortions are sought mostly by married women (82%) and by women in whom half (46%) are in the first trimester of pregnancy. Most abortions are performed by dais (women who medically attend during delivery), most commonly with a root inserted into the uterus until abortion or complications evolve. Only 14% of abortions were performed by licensed physicians, and 9% of abortions were performed by either menstrual regulation or dilatation and curettage. Thirty-one percent (31%) of reported abortions resulted in death, and 49% of the procedures, which resulted in death, were performed by dais. Eighteen percent (18%) of these procedures were done by registered physicians, although there was no differentiation within this group by legality of procedure.

The 1,435 maternal deaths (excluding abortion deaths) recorded is believed to represent approximately 5% of the annual maternal mortality rate for the country. This sample revealed that most women dying were married (97%) and that death was most common during the eighth and ninth month of pregnancy and the month immediately following pregnancy (95% of those with known dates of death). Common predisposing problems with maternal health were malnutrition (25%) and anemia (44%). Common complications of pregnancy included eclampsia (37%) and prolonged or obstructed labor (18%). Combination of these data and extrapolation based on previous studies lead us to a conservative estimate of 9,700 annual deaths in Bangladesh due to abortion.

A portion of the study was concerned with the attitudes of Bangladesh's rural physicians toward abortion. Current law permits abortion only to save the life of the mother, and virtually all physicians in the study (99%) favored abortion in other circumstances.

An outgrowth of this work was to identify other fertility research needs. A proposal was prepared for a prospective study of major medical complications resulting from male and female sterilizing procedures and has been submitted for funding. This proposal includes ongoing consultation by the CDC for its expected 18-month duration.

m

Handwritten notes: 250, 100.7, 700, 1750, 7-800 deaths per 100,000 births, 34/3, 30, 800, 7%

Handwritten note: @ 30,000

Handwritten notes: 4,000, Same, 700, 45,000, 23,500, 26,000, 3,325,000, 10,000

TABLE 7

Maternal Deaths Known to Health Workers*
Bangladesh, 1978

<u>Reported Cause</u>	<u>No.</u>	<u>Percent</u>
Abortive		
Induced abortion	498	25.8
Spontaneous abortion	34	1.8
Ectopic	17	0.9
Antepartum		
Eclampsia	528	27.3
Intrapartum		
Bleeding	469	24.3
Difficult labor/de-		
livery	252	13.0
Uterine rupture	113	5.8
Postpartum		
Tetanus	14	0.7
Other infections	66	3.4
Other	171	8.8
TOTAL**	1,933	111.8

*Survey conducted by Institute for Statistical Research and Training with PIACT support for field work, Ford Foundation support for Dr. A. Measham, and USAID support for consultants Dr. R. Rochat, Dr. M. Rosenberg, and Statistical support staff at CDC

**Total exceeds 100% because of multiple causes of some deaths

Before leaving Bangladesh, Dr. Rosenberg briefed Sallie Craig-Huber of USAID/Dacca on the status of the survey and tentative plans to disseminate its information.

- b. Abortion Morbidity Philippines. The following is an abstract of a paper recently completed by Charlie Chen, Ph.D., a Demographer in the Program Evaluation Branch of FPED. The data were made available by Dr. Juan Flavier, who is co-author of the paper which has been accepted for publication by Studies in Family Planning. The title of the paper is, "Knowledge About, Attitude Toward, and Practice of Induced Abortion in Rural Villages of Cavite, Philippines."

A survey of all married women from 15 through 49 was conducted in 1976 in 5 rural villages in the Philippines by the International Institute of Rural Reconstruction. Data were analyzed at the Center for Disease Control on a collaborative basis. Of 676 respondents, 17% admitted that they had had at least one induced abortion. The hillots, doctors, and drugstores were the major providers of abortion; and the methods used ranged from oral tablets to herbs, injection, D&C, and massage. About 12% of respondents were hospitalized with complications from abortion. An upward trend toward abortion over time was speculated. There was an age difference in reported abortion experience. A large minority were aware of how an abortion could be performed and believed that abortions were easily obtained in their communities. Half the respondents approved of abortion, and 57% stated that abortion is legal. Medical, health, and religious rather than legal factors, were the primary concerns of those who disapproved of abortion. To supplement the shortcomings of this study, it was recommended that a large-scale survey be designed to study morbidity associated with induced abortion.

- c. Sterilization Surveillance. The following information was sent to Dr. James Shelton, Research Division, AID, in answer to his request for information about FPED's efforts in studying the epidemiology of surgical sterilizing operations. Four major efforts were detailed for AID's information. We appreciate AID/W's support for some of these activities in the past and look forward to continuing these important efforts.

The first major activity that we are involved in is a surveillance of morbidity associated with surgical sterilizing operations in women. We call this the Collaborative Review of Sterilization (CREST). This surveillance is accomplished by contracting with institutions and physicians who perform the sterilizing operations. They interview a woman before her operation, abstract medical records after the operation, and call back in 8 weeks and 1 and 2 years after the procedure. By analyzing this information, we hope to document

which sterilizing operations are the safest, both in terms of long and short-term complications, and which have the lowest failure rates. Our plan is to obtain information on approximately 1,500 procedures of each type performed at each time. That is, a particular sterilizing operation (e.g. electrocoagulation) could be performed postpartum, postabortion or not in relation to a pregnancy event. Hence, we need 1,500 electrocoagulations done at each of these 3 times for a total of 4,500 electrocoagulation procedures. Likewise for bandings, mini-laps, Pomeroy's, and so forth. Currently we have contracts with institutions to provide us with approximately 3,500 procedures. As monies become available over the next several years we anticipate letting contracts to acquire information on approximately 22,000 procedures. To this date CREST has been mainly supported by CDC funds. Effective, rapid implementation of this project will require more funds than CDC can presently budget.

Because technology used in this country is fairly similar to that used in other places, we anticipate that the results of this study should be directly transferable to the international situation. Knowing which procedures are the safest should help the Agency for International Development in its efforts to provide safe and effective surgical sterilization around the world.

The second area we are working in is gathering information on deaths related to surgical sterilizing operations in women. Work on this activity was begun in 1978-79 by Dr. Sherry Thacker with monies provided through the AID/CDC RSSA. The goal of this activity is to assemble a list of all deaths related to surgical sterilizing operations in the United States and to investigate each one of them. So far, we have identified over 70 deaths. The case reports will then be analyzed to determine the chain of events leading to the death. This work will be reviewed by a group of medical, legal, and other experts, who will help identify ways in which such deaths can be prevented in the future. This methodology is similar to that which we used for studying abortion deaths and has resulted in a dramatic decline in deaths related to ~~surgical sterilization~~. *abortion*.

The information uncovered in this surveillance should be directly transferable to the international situation. Similar techniques are used both in the U.S. and abroad, and many overseas physicians are trained in the U.S. or by U.S. physicians. Hence, we would expect the technology to be similar and the results of our surveillance directly transferable.

We plan to uncover deaths related to surgical sterilization in 3 ways: (1) The Commission of Professional and Hospital Activities (CPHA) maintains a surveillance on over 40% of

discharges from U.S. short-term hospitals. We will contract with them to obtain a list of the deaths of which they are aware. (2) We will work through State Maternal and Child Health and Vital Registry activities to ascertain additional deaths. (3) We will depend (as we do in our abortion surveillance system) on reports from our informal network of interested family planners.

The third activity relates to establishing a count of surgical sterilizations in the United States. This count serves as a denominator so that we can calculate morbidity and mortality rates. While the activity itself is not directly usable by AID, the resulting morbidity and mortality rates should be.

The fourth activity is direct consultation to developing countries in assessing the safety of sterilization as practiced there. We recently drafted a protocol to study the safety of sterilization procedures in Bangladesh. In late June 1979 Bill Bair (AID/W) visited CDC and asked if we could provide assistance with a similar study in Colombia. These studies should help identify operator and patient risk factors under conditions which do not occur in the United States.

E. Country Reports

1. Bangladesh

National family planning service statistics, for the years 1972-1978, are presented in Table 8. Tubectomies have increased significantly since 1976. Between February 22 and March 11, Dr. Rochat visited Bangladesh to review the status of the maternal mortality/abortion complication/physician services survey. Slightly over 50% of rural health workers in Bangladesh have been interviewed, including 233 physicians and 367 Family Welfare Visitors (FWVs). A total of 1,122 case reports have been obtained: 539 maternal deaths, 177 abortion-related deaths, and 406 abortion-related complications (Table 9). Almost 90% of abortion-related deaths were verified by obtaining a report in the deceased's village, which is consistent with the health workers report. We estimate that less than 5% of all maternal deaths are being detected through this survey, but believe the survey reflects the conditions under which such deaths occur more accurately than hospital-based statistics (Table 10).

Preliminary analysis of the first half of this survey shows that most of the 233 physicians (80%) deliver babies and provide family planning services. Of the fertility control methods examined, the two most commonly provided were oral contraceptives (77%) and menstrual regulation (33%); the least common was IUD insertion (11%). Virtually all physicians (96%) approved of abortion if pregnancy endangered the woman's health, and more than 50% approved if the pregnancy resulted from rape, occurred before marriage, or if the woman already had a large family. An outgrowth of this work was to identify other fertility research needs. A proposal was prepared for a prospective study of major medical complications resulting from male and female sterilization procedures. In January 1980 two FPED/CDC consultants departed for Bangladesh to begin work on this study.

Table 8

NATIONAL FAMILY PLANNING SERVICE STATISTICS, BY CALENDAR YEAR,
Bangladesh, 1972-1978

Year	Tubec- tomy	Vasec- tomy	MR	IUD	Injection (doses) (1,000s)	Pills (cycles) (1,000s)	Condoms (doz.) (1,000s)	Emko (vials) (1,000s)
1972	217	265	--	8,477	--	67.8	1,050.1	38.1
1973	231	172	--	18,566	--	211.0	1,428.3	90.9
1974	2,565	4,190	--	34,844	--	1,686.0	776.9	88.5
1975	7,625	29,368	1,820	67,640	233	2,926.6	2,596.7	202.1
1976	15,321	38,683	6,402	77,911	2,962	5,909.8	4,169.0	98.2
1977	50,431	73,814	6,237	44,523	3,528	6,017.9	3,311.0	44.1
1978	70,737	31,622	5,609	32,498	6,242	7,731.0	5,741.8	31.9
TOTAL	147,127	178,114	20,074	284,459	12,965	24,550.1	19,073.8	593.8

SOURCE: Population Control and Family Planning Division. These service statistics are based on reports from thana health centers of contraceptive services provided.

- NOTES: 1. In January 1976, a nationwide house-to-house campaign to distribute condoms and pills resulted in a 3-4 month supply being distributed that month.
2. A major vasectomy-tubectomy campaign in late 1976-early 1977 led to a transient increase in vasectomies, but contributed to a substantial rise in tubectomies.
3. A single clinic in Dacca reportedly performs more MRs than are reported by PCFP; MRs are undoubtedly under-reported in these statistics.

TABLE 9

Status Report of Pregnancy/Abortion Mortality Study
 Institute for Statistical Research and Training
 Dacca, Bangladesh, February 26, 1979

District Subdivision	No. Centers Selected	No. Centers Interviewed	Respondents		Deaths		Abortion Complications
			Drs.	FWVs	Preg.	Abortn.	
Dacca	102	69	33	70	49	11	32
Comilla	56	49	32	48	87	15	78
Mymensingh	88	84	51	63	63	23	38
Sylhet	43	43	36	39	137	37	58
Tangail	38	39	11	33	29	12	65
Pabna	34	30	9	25	26	5	43
Faridpur	54	47	19	35	24	10	15
Noakhali	26	31	19	24	45	5	37
Chittagong	35	34	23	30	79	59	40
TOTAL	476	426	233	367	539	177	406

TABLE 10

Results of Attempts to Verify Abortion Death Reports
 in Village of Residence

	(1) First Reports	(2) Cases Selected	(3) Cases Verified	(4) Ratio (3)/(2)
Dacca	11	8	8	1.00
Comilla	16	9	9	1.00
Mymensingh	23	11	9	0.82
Sylhet	35	16	11	0.69
Tangail	12	11	11	1.00
Pabna	5	4	3	0.75
Faridpur	13	6	2	0.33
Noakhali	5	?	?	--
Chittagong	60	34	34	1.00
TOTAL	175	99	87	0.88

Follow-up technical assistance was also provided to the Government of Bangladesh in October 1979 in the evaluation of its contraceptive supply system. Implementation of the logistics system was found to be incomplete, especially in the area of reporting. Problems were also identified in the movement of supplies from district to thana levels. A detailed report on this consultation will be available in January 1980.

2. Brazil

During January and July 1979, Dr. Leo Morris, Chief, Program Evaluation Branch, Family Planning Evaluation Division, CDC, traveled to Brazil at the request of AID/POP/Washington to 1) provide technical assistance to the Catholic University of Campinas, Sao Paulo, in completing a Portuguese language report for the 1978 Sao Paulo Contraceptive Prevalence Survey, 2) review BEMFAM community-based distribution program activities in Pernambuco State, 3) plan and implement the baseline contraceptive prevalence survey in Piaui State, and 4) brief the USAID Health Nutrition and Population Officer on the progress of these activities. In January, the Portuguese language report was written with colleagues from the Catholic University of Campinas and was released on January 31, 1979, as part of a special presentation to state and local health officials, census officials, and invited guests from other Catholic universities and from family planning programs in Brazil. Copies of the report were sent to USAID/Brazil and AID/POP/Washington, and a presentation was made at AID/Washington on March 1, 1979. The final English version of the report and a working paper on demographic measurement were submitted to AID in June.

A statewide community-based distribution program was scheduled to begin January 1979 in the State of Piauí, and advance planning provided the opportunity to conduct a baseline survey to collect data against which program impact could be measured 2 or 3 years later. Not only is there a complete absence of information on contraceptive use in Piauí, vital statistics are incomplete and irregular. The start of the CBD program was delayed until April, and the baseline survey scheduled for July-August 1979 (See Sections II.A and II.C for additional information).

Field work was completed during the third week of August as scheduled, and coding of household questionnaires was initiated on September 17 as scheduled in the timetable for processing and analysis activities (see CDC RSSA Report dated August 3, 1979). For coding purposes, the 2 strata--the municipio of Teresina and the Interior--were separated, and coding was completed for Teresina on September 28. The timetable for data processing and analysis is on schedule as outlined in August. The schedule of activities through the report stage is as follows:

July-August 1979	Field Work
September-October 1979	Coding
November 1979	Key punching
November-December 1979	Editing
January-February 1980	Data Analysis
March 1980	Preliminary Report
April 1980	Final Report and Presentation in Piauí

A working group, consisting of representatives from Columbia University, the International Fertility Research Program, USAID/Brazil, and Dr. Leo Morris of FPED/CDC, met with BEMFAM personnel in September to initiate planning for a 1980 Program Impact Survey in Northeast Brazil that will include 3 northeastern states, which have had extensive CBD programs operating in the past several years, plus a fourth state in which organized family planning services have not been available to date but will be in the near future. Although CBD programs

have been in operation in the northeastern states for 5 years, they did not have the benefit of a baseline survey prior to the initiation of field operations as did Piaui. With the exception of an acceptor follow-up study in Rio Grande do Norte, there has been no overall Program Impact Survey in which contraceptive prevalence can be documented both within the program as well as in the private sector. In addition, vital statistics are incomplete in Northeast Brazil, and there has been no adequate measurement of fertility levels since the 1970 census.

The BEMFAM community-based distribution program in 6 states has now registered 626,077 new clients from 1974 through June 1979. For the year 1978, 56% of these new clients were 20-29 years of age, and an additional 16% were less than 20 years of age. Fifty percent had less than 3 living children indicating a desire to space children rather than limit childbearing. However, 24% of new clients had 5 or more living children. It is estimated that about 196,000 women were active users in CBD programs as of June 1979, and 116,000 women were active users of contraception in the clinic program, for a total of an estimated 312,000 active users in BEMFAM programs.

BEMFAM has requested a follow-up consultation in February 1980 to assist them in preparing a Portuguese report on the results of the Piaui baseline survey, as well as making site visits to State Health Departments in those states that will take part in the 1980 Program Impact Survey.

In addition, Dr. Michael Rosenberg of FPED's Epidemiologic Studies Branch, assisted the Faculty of Medicine, State University of Campinas, Sao Paulo, with a case-control study to evaluate the number of ovulatory menstrual cycles during a woman's reproductive life time as a risk factor for malignant and benign breast disease. Computer editing programs were written and priorities

for the project were established along with a detailed timetable which calls for completion of the analysis by May 1980.

3. Colombia

At the request of USAID/Colombia an FPED/CDC physician met with Colombian Ministry of Health (MOH) personnel to review the MOH's new surgical contraception program. As of November 1979 the Division of Maternal and Child Health and Population Dynamics, in coordination with PROFAMILIA, has provided training in female sterilization techniques to 47 physicians and nurse teams at regional training centers. Some 61 additional teams are scheduled to be trained by mid-year 1980. A number of areas of possible cooperation between FPED/CDC and the MOH were discussed. These included assistance in improving sterilization surveillance and logistics and a follow-up study of sterilization acceptors. These areas will be discussed further during a February 1980 visit to FPED/CDC by key MOH officials.

4. El Salvador

During February 26-March 16, 1979, Patient Flow Analysis (PFA) was demonstrated in two health units (Unidades de Salud) of the Ministry of Health of El Salvador. The first clinic studied provides family planning services during established hours by designated staff in addition to other health services. The second clinic provides family planning services in an integrated setting.

In the first clinic studied, most of the family planning patients arrived before 7:00 a.m. to attend a health education session, but then waited until almost 10:00 a.m. to receive family planning services. Because of this long wait, patients spent an average of 3 hours, 38 minutes in the clinic while receiving only 40 minutes of service. Overall, only 18% of the patient's time in the clinic was spent receiving service. Forty-six percent of personnel time was spent with patients. Depending on type of personnel, 3% to 69% of

personnel time was spent in contact with patients. If family planning patients were given appointments for either 9:00 a.m. or 9:30 a.m., approximately 2 hours of waiting time would be eliminated.

The results of the second clinic in which PFA was demonstrated were similar to those of the first clinic studied. The disorganization of the second clinic was such that average patient time in the clinic was 3 hours, 49 minutes, while only 33 minutes of service was received, or 16% of the patient's time in the clinic. Fifty-three percent of personnel time was actually spent serving patients with a range of 5% to 84%, depending on type of personnel. Copies of the PFA output for these two clinics have been forwarded to AID with previous reports.

Because of their positive experience with the first two patient flow studies, the Ministry of Health decided that they would conduct similar studies at 24 other Ministry of Health clinics. It was planned that the results would be used not only to make improvements in the study clinics, but that perhaps some results could be generalized for improvement of all MOH clinics in El Salvador.

From May 14-17, Dr. Carlos Huezo, who was appointed by the MOH to manage the 24 studies, attended a PFA training session in Kansas City. At this training session he received full instruction in data collection, data editing, output interpretation, and the coordination activities related to doing PFA studies. On May 18, Dr. Huezo visited FPED headquarters to further discuss plans for PFA implementation in El Salvador.

During the week of May 21-26, the PFA output from the first two clinics studied was formally presented to the MOH and a FPED/CDC consultant reviewed written plans for the study of the 24 clinics and a draft version of the PFA manual in Spanish. Several suggestions for modifications were made.

During the week of August 13-17, 1979 FPED/CDC consultants assisted the MOH in training MOH personnel in PFA data collection. During the following week FPED/CDC consultants provided consultation in the field for the first week of a five-week study period. As of September 30, 1979, 15 of the 24 data sets had been collected and processed.

In addition, technical assistance was provided to the Asociación Demográfica Salvadoreña in coding, data processing and analysis, and the preparation of reports on the Contraceptive Prevalence Survey conducted in El Salvador in 1978. At the request of USAID/El Salvador assistance was also provided in the planning of the "Oriente" CBD program, which is scheduled for implementation in 1980, and in the planning and preparation of the baseline survey which will be compared with the results of a later survey in order to measure the impact of the CBD program. Consultation was also provided to the USAID Mission and the MOH in the evaluation of the family planning component of the Rural Health Aide programs.

5. Guatemala

Technical assistance was provided to the Asociación Pro-Bienestar de la Familia (APROFAM), both in Guatemala and Atlanta, in coding, data processing and analysis, and the preparation of reports on the Contraceptive Prevalence survey which was conducted in Guatemala in late 1978. FPED/CDC also assisted APROFAM in an evaluation of its Direct Distribution of Contraceptive Materials Program (DDP) which was distributing contraceptives to 569 of 609 Ministry of

Health (MOH) facilities in May 1979. An important part of that evaluation was to estimate the number of women active in the program prior to reporting responsibilities being shifted from APROFAM to the MOH (See CDC RSSA Report dated Dec. 20, 1979). In addition, reporting forms were drafted for MOH use in 1980 that can provide data on users and contraceptive inventory levels required in AID's quarterly and annual reports. FPED/CDC consultants also found large stocks of Norinyl 1 + 80 on hand with 1974-75 inspection dates and recommended that excess supplies be shipped to another country or distributed as quickly as possible in Guatemala with written guidelines for their use.

6. Honduras

On two different occasions during 1979 FPED/CDC provided technical assistance to the Asociación Hondureña de Planificación de Familia (AHPF), the International Planned Parenthood Federation affiliate in Honduras, in the evaluation of its community-based distribution program. During both consultations, the accuracy and completeness of reporting of users in the program was evaluated. In February 1979 FPED/CDC found that active users were over-reported by 46%. Following the implementation of recommendations made by FPED/CDC, the overreporting of active users was found to have decreased to 8.6% in September 1979. Further improvements in the data system were recommended by FPED/CDC consultants in October including a reduction in the number of forms for promoters from 10 to 2 forms (See Section IIC. of this report and CDC RSSA Report dated November 9, 1979).

During both consultations, FPED/CDC consultants also evaluated and/or made recommendations regarding the logistics and supervisory systems, the expansion of the program, and the conduct of a national contraceptive prevalence survey to define the need for family planning services.

7. Panama

Demographic and family planning data were also reviewed in February to assist USAID/Panama in preparation of the AID Population Project Paper. A report, which was based in part, on special tabulations prepared in Atlanta from the 1976 National Fertility Study of Panama, was prepared in Panama covering demographic trends and women in need of services.

During FY 1979 technical assistance was provided to the Population Studies Office, Ministry of Health (MOH) in the planning and implementation of a 3,155 household contraceptive prevalence survey scheduled to be conducted during a 2-month period beginning July 26, 1979. Although field work had been terminated by the end of September only 86% of the sample households were contacted. Insufficient funds was the reason cited for not completing all households in the sample, in part, because of increases in gasoline costs during the survey period. Of households contacted, the proportion with at least one woman 15-44 years of age was slightly lower than expected in the rural stratum. The overall expected proportion was 63%, and 70% of rural households were expected to have an eligible woman; 62% of all households contacted had at least one woman eligible for interview but rural households yielded only 60 percent. The failure to complete all households scheduled and the lower than expected proportion of households in rural areas with at least one woman 15-44 years of age could affect the representativeness of the data as well as limit detailed statistical analysis for some subgroups. It was recommended that the survey be completed by the December holidays and that supplementary rural segments also be selected and interviewed before the December holiday begins in Panama. The amount needed to complete field work (\$2,000) and sample supplementary segments (\$4,350) represents less than a 10% cost overrun. USAID/Panama officials agreed that the survey was important enough to provide

the additional funds, but cautioned that allocating funds in a timely manner, may be a problem.

Tentative plans were made for FPED/CDC consultants to assist the Panama Ministry of Health (MOH) in an evaluation of its contraceptive logistics system in February 1980. A visit to the MOH central warehouse revealed that many of the problems I encountered in this warehouse 2 years ago still exist. I estimate that the logistics consultancy in February 1980 will require approximately 4- to 6-person weeks. In the meantime, an inventory of contraceptives on hand in the central warehouse should be made, commodities restacked by date of manufacture and in uniform stacks to facilitate inventory counts, and separate inventory control cards should be maintained for Norinyl 1 + 50 and Norinyl 1 + 80 and kept for Neogampoon.

III. SUMMARY OF ACTIVITIES
 A. FPED/CDC INTERNATIONAL TRAVEL
 Fiscal Year 1979

<u>DATE(S)</u>	<u>COUNTRY AND PERSON(S)</u>	<u>PURPOSE</u>
10/1-9/78	Brazil (Morris)	Data processing--Contraceptive Prevalence Survey: Sao Paulo State
10/1-7/78	El Salvador (Rubin)	Follow-up consultation on Rural Health Technician Program
10/23-11/3/78	Philippines (Rochat)	Participate in WFS Meeting and provide consultation to Iglesia ni Cristo family planning program
11/4-14/78	Bangladesh (Rochat)	Field phase of the maternal morbidity/mortality study designed during June visit
11/9-12/7/78	Egypt (Graves)	Logistics and management assistance
11/15-18/78	WHO-Geneva (Rochat)	Consult with WHO on the effect of drug regulations in developed countries on availability of contraceptives in developing countries
11/27-12/8/78	Philippines (Smith)	Consultation to Iglesia ni Cristo (INC) program to set up supplemental fertility and contraceptive use questionnaire to INC census
11/29-30/78	Guatemala (Morris)	Review of field work and completion of coding book--contraceptive prevalence survey
12/1-6/78	El Salvador (Morris)	Data processing--contraceptive prevalence survey
12/4-15/78	El Salvador (Paris, Conn)	Follow-up TDY assisting MOH analyze sterilization data
1/7-13/79	El Salvador (Bernhart)	As consultant to FPED, CDC, and at request of USAID/El Salvador and AID/W, to review the personnel and management needs of the new Population Coordination Office in the Ministry of the Presidency
1/10-11/79	Panama (Morris)	Consult with USAID/Panama and MOH on proposed contraceptive prevalence survey in 1979
1/12-2/3/79	Brazil (Morris)	a) Report on Sao Paulo Contraceptive Prevalence Survey results, and b) consult with BEMFAM on CBD baseline survey in Piaui
1/21-25/79	Haiti (Rochat)	Site visit to evaluate Columbia University international work at request of AID/W

III.A. FPED/CDC INTERNATIONAL TRAVEL
Fiscal Year 1979 (Continued)

<u>DATE(S)</u>	<u>COUNTRY AND PERSON(S)</u>	<u>PURPOSE</u>
1/31-2/2/79	Guatemala (Monteith)	Review APROFAM coding procedures for 1978 contraceptive prevalence survey
2/3-17/79	Honduras (Monteith, Friedman)	At the request of AID/W and Pathfinder, design evaluation of Demographic Association CBD program
2/7-9/79	WHO-Geneva (Tyler)	Participate in meeting of WHO Steering Committee for the Task Force on Oral Contraceptives (Non-AID funding)
2/22-3/11/79	Bangladesh (Rochat)	a) Maternal mortality/abortion complication study b) Review family planning activities in Sulla District c) Determine follow-up logistics assistance needs
2/26-3/13/79	El Salvador (Monteith, Bailowitz)	Implement patient flow analysis at request of MOH and USAID/El Salvador
2/27-3/3/79	Panama (Anderson)	Demographic chapters for USAID project paper and review sampling frame for proposed contraceptive prevalence survey in 1979
2/28-3/4/79	ISFP-France (Ory)	Report on oral contraceptives and benign liver tumors at International Symposium of Fertility Regulation
3/5-6/79	England (Ory)	a) Consult with Dr. Valerie Beral, London School, on case-control contraceptive studies b) IPPF-review progress of lactation-use of oral contraceptive survey
3/9-12/79	Egypt (Anderson)	At request of Population Council and Institute of Statistics, present paper on family planning and fertility (Non-AID funding)
3/12-30/79	El Salvador (Rubin)	Implement training and field work portion of evaluation of rural health assistant project including the family planning component
3/12-13/79	India (Rochat)	Discuss Government of India's decision to use oral contraceptives with no more than 30 micrograms estrogen
3/25-4/1/79	IPPF-London (Strauss)	Implement second mailing for lactation-use of oral contraceptives study

III.A. FPED/CDC INTERNATIONAL TRAVEL
Fiscal Year 1979 (Continued)

<u>DATE(S)</u>	<u>COUNTRY AND PERSON(S)</u>	<u>PURPOSE OF TRAVEL</u>
4/8-10/79	U.S.-Mexico Border Health Association Meeting-San Diego (Rochat, Morris, Friedman)	Discuss with PAHO and Mexican officials the U.S.-Mexico Border Family Planning/MCH Survey
4/16-21/79	Jamaica (Anderson)	Consult with AID Mission concerning proposed contraceptive prevalence survey
4/23-26/79	Mexico (Morris, Friedman)	Consult with SSA and CNPF officials on the implementation of U.S.-Mexico Border Family Planning/MCH Survey
4/23-26/79	IPPF-London (Cates)	Annual Central Medical Committee Meeting
5/6-10/79	Korea (Greenspan)	Fourth International Conference on Voluntary Sterilization
5/14-16/79	Panama (Morris)	Finalize questionnaire and field work plans for contraceptive prevalence survey scheduled for July 1979
5/17-22/79	Guatemala (Morris)	Discuss preliminary results from 1978 Contraceptive Prevalence Survey with AID Mission and APROFAM
5/21-26/79	El Salvador (Monteith)	Follow-up assistance in implementation of patient flow analysis
5/23-25/79	El Salvador (Morris)	Provide assistance to ADS in completing Spanish language report on 1978 Contraceptive Prevalence Survey
5/23-6/8/79	Bangladesh (Rosenberg)	Follow-up consultation-maternal mortality family planning survey
6/11-13/79	Mexico (Tyler)	WHO Steering Committee for the Task Force on Oral Contraception (Non-AID funding)
6/27-28/79	Panama (Morris)	Review training schedule and field work plans for contraceptive prevalence survey scheduled for July 1979
6/29-7/21/79	Brazil (Morris)	a) Training and implement field work for Piaui CBD baseline survey
6/29-8/4/79	Brazil (Harrison)	b) Discuss final English report on 1978 Sao Paulo Contraceptive Prevalence Survey with USAID and PUCG

III.A. FPED/CDC INTERNATIONAL TRAVEL
Fiscal Year 1979 (Continued)

<u>DATE(S)</u>	<u>COUNTRY AND PERSON(S)</u>	<u>PURPOSE OF TRAVEL</u>
7/1-3/79	Mexico (Rochat)	U.S.-Mexico Border Family Planning/MCH Survey
7/9-19/79	Panama (Monteith, Anderson)	Training and implement field work for Contraceptive Prevalence Survey
7/22-24/79	Peru (Morris)	Discuss logistics and survey needs with USAID
8/13-25/79	El Salvador (Monteith, Hudgins)	Implement patient flow analysis in 24 MOH clinics
8/16-18/79	Mexico (Rochat)	U.S.-Mexico Border Family Planning/MCH Survey
9/16-30/79	Brazil (Morris)	Coding phase of Piaui CBD baseline survey and preliminary plans for 1980 evaluation survey in States of Northeast Brazil with existing CBD programs
9/21-10/12/79	Honduras (Monteith, Oberle)	Follow-up evaluation of Demographic Association CBD program; review implementation of recommendations made in February 1979
9/28-10/12/79	Brazil (Rosenberg)	Technical assistance to CEMICAMP, Campinas, Sao Paulo, in study of epidemiology of oral contraceptives and risk factors of breast cancer

III. SUMMARY OF ACTIVITIES
 B. Travel of Foreign Nationals to CDC

<u>DATE(S)</u>	<u>PERSON(S)</u>	<u>COUNTRY</u>	<u>PURPOSE</u>
2/10-23/79	Lic. Federico Guerra Population Studies Office Ministry of Health Lic. Paul Batista, Chief Department of Statistics Ministry of Health	Panama	Data processing of family planning data from WFS tape for use in USAID project
4/30-5/12/79	Lic. Angela Mendoza Chief, Department of Studies & Evaluation, Salvador Demographic Association	El Salvador	Data processing of contraceptive prevalence survey--prepare preliminary report in Spanish
5/14-18/79	Dr. Carlos Huevo, Maternal/Child Health and Family Planning Program, Ministry of Health	El Salvador	Attend training course for Patient Flow Analysis Methodology
8/28-9/7/79	Lic. Antonieta Pineda Chief, Department of Evaluation, APROFAM	Guatemala	1978 Guatemala Contraceptive Prevalence Survey--prepare preliminary report in Spanish

III. SUMMARY OF ACTIVITIES
C. RSSA Reports
Fiscal Year 1979

<u>Date of Trip Report</u>	<u>Country/Project</u>	<u>Travel Date(s)</u>	<u>Person(s)</u>
10/26/78	<u>Brazil</u> : Contraceptive Prevalence Survey, Sao Paulo State	10/1-7/78	L. Morris
10/26/78	<u>Guatemala</u> : Contraceptive Prevalence Survey	9/17-10/7/78	L. Morris G. Benussi G. Rubin
11/1/78	<u>IPPF/London</u> : Survey of lactation and postpartum contraceptive prescription practices	9/27-10/4/78	L. Strauss
11/16/78*	<u>PAHO/El Paso</u> : Binational-PAHO Task Force on U.S.-Mexico Border family planning and health needs	9/24-10/27/78	R. Monteith
12/5/78	<u>El Salvador</u> : Evaluation of Rural Health Aide Project	9/12-16 and 10/1-7/78	G. Rubin
12/4/78	<u>Jamaica</u> : Logistics Assistance	9/5-22/78	N. Ewen
12/11/78	<u>El Salvador</u> : Discussions with American Embassy and USAID Mission concerning feasibility of assigning regional family planning advisor to CDC field station in El Salvador	8/30-9/1/78	J. Giordano C.W. Tyler L. Morris
1/25/79	<u>Philippines</u> : Consultation to Iglesia Ni Cristo (INC) to set up supplemental fertility and contraceptive use questionnaire to INC Census	11/27-12/8/78	J. Smith
1/30/79	<u>El Salvador</u> : Review personnel and management needs of Population Office in Ministry of the Presidency	1/7-12/79	M. Bernhart
2/1/79	<u>Philippines</u> : Participate in WFS Meeting and provide consultation to Iglesia Ni Cristo family planning program	10/23-11/3/78	R. Rochat
2/1/79	<u>Bangladesh</u> : Field phase of maternal morbidity/mortality study	11/4-17/78	R. Rochat
2/23/79	<u>Haiti</u> : Site visit to evaluate Columbia University project at request of AID/Washington	1/25-29/79	R. Rochat

*Report to Office of International Health, DHEW and PAHO

III. SUMMARY OF ACTIVITIES
C. RSSA Reports
(Continued)

Date of Trip Report	Country/Project	Travel Date(s)	Person(s)
2/27/79	<u>Egypt</u> : Logistics Assistance	11/9-12/7/78	J. Graves
3/15/79	<u>ISFP/Paris and IPPF London</u> : International Symposium of Fertility Regulation and consultation on survey of lactation and contraceptive use	2/28-3/6/79	H. Ory
3/16/79	<u>WHO/Geneva</u> : WHO Steering Committee for the Task Force on Oral Contraception	2/7-9/79	C. Tyler
3/19/79	<u>Panama</u> : Demographic Chapters for USAID project paper and review sampling frame for 1979 Contraceptive Prevalence Survey	2/27-3/3/79	J. Anderson
3/30/79	<u>Bangladesh and India</u> : Maternal morbidity/mortality, abortion complication survey and determine basis for government of India's decision to use oral contraceptives with no more than 30 micrograms estrogen in its national program	2/22-3/13/79	R. Rochat
4/2/79	<u>Egypt</u> : Presentation of paper, "Measuring the Relationship Between Child Health & Fertility," at Seminar on Intermediate Variables Affecting Fertility (non-AID funding)	3/7-13/79	J. Anderson
4/12/79	<u>Honduras</u> : Evaluation of Demographic Association CBD Program	2/3-2/17/79	R. Monteith
4/25/79	<u>El Salvador</u> : Patient Flow Analysis	2/26-3/13/79	R. Monteith A. Bailowitz
5/7/79	<u>El Salvador</u> : Implement training and field work portion of MOH Rural Health Aide project evaluation	3/12-30/79	G. Rubin
5/21/79	<u>Jamaica</u> : Consult with AID Mission and UWI concerning proposed contraceptive prevalence survey	4/16-21/79	J. Anderson

III. SUMMARY OF ACTIVITIES
 C. RSSA Reports
 (Continued)

Date of Trip Report	Country/Project	Travel Date(s)	Person(s)
5/23/79	<u>Mexico</u> : Consult with SSA and CNPF on the U.S.-Mexico Border Family Planning Survey	4/23-26/79	L. Morris
5/30/79	<u>El Salvador</u> : Follow-up TDY assisting MOH analyze sterilization data	12/4-15/78	A. Paris
6/4/79	<u>IPPF/London</u> : Implement second mailing for lactation--use of oral contraceptives study	3/25-4/1/79	L. Strauss
6/4/79	<u>IPPF/London</u> : Annual Central Medical Committee Meeting	4/23-26/79	W. Cates
6/7/79	<u>El Salvador</u> : Follow-up technical assistance to MOH on the implementation of patient flow analysis	5/21-26/79	R. Monteith
7/16/79	<u>Bangladesh</u> : Maternal/abortion mortality study	5/23-6/8/79	M. Rosenberg
8/3/79	<u>Brazil</u> : Report on Sao Paulo Contraceptive Prevalence Survey and implementation of Piaui CBD baseline survey	6/29-7/21/79	L. Morris
8/3/79	<u>Panama</u> : Training of interviewers and implementation of Contraceptive Prevalence Survey: technical assistance to MOH	7/9-19/79	R. Monteith J. Anderson
8/17/79	<u>Brazil</u> : Training, implementation and supervision of Piaui CBD baseline survey	6/29-8/4/79	L. Harrison
8/24/79	<u>Mexico</u> : U.S.-Mexico Border Family Planning/MCH Survey	7/1-3/79 and 8/16-18/79	R. Rochat
9/4/79	<u>El Salvador</u> : Implementation of Patient Flow Analysis in 24 MOH clinics	8/13-25/79	R. Monteith T. Hudgins
9/18/79	<u>Mexico</u> : WHO Steering Committee for the Task Force on Oral Contraception (non-AID funding)	6/11-13/79	C. Tyler

III. SUMMARY OF ACTIVITIES

D. Other Projects/Reports

<u>Date(s)/Month</u>	<u>Project/Report</u>
February 5-9	TDY to Washington to assist AID/POP/FPSD in developing revision of Annual Budget Submission (ABS) table and service statistics reporting (Graves and Monteith)
March 1	Presentation at AID/W on 1978 Sao Paulo State, Brazil Contraceptive Prevalence Survey (Morris)
May	Working Paper: Demographic Measurement: 1978 Sao Paulo Contraceptive Prevalence Survey (Anderson)
June	Final Report: Sao Paulo Contraceptive Prevalence Survey, 1978 (Morris, Anderson)
August 15	Presentation at AID/W on 1978 El Salvador Contraceptive Prevalence Survey (Morris, Warren)
August	Working Paper: Fertility Measurement: 1978 Contraceptive Prevalence Survey, El Salvador (Anderson)
September 12	Presentation at AID/W on 1978 Guatemala Contraceptive Prevalence Survey (Morris, Anderson, Chen)
September 19	TDY to Washington to assist AID/POP/FPSD in preparation of instructions for Annual Budget Submission tables (Graves)
September	Working Paper: Reported Incidence of Abortion in World Fertility Surveys and Contraceptive Prevalence Surveys (Anderson)

III. SUMMARY OF ACTIVITIES

E. CATEGORIZATION OF INTERNATIONAL ACTIVITY UNITS¹
 BY ACTIVITY AND CONTINENT
Fiscal Year 1979: October 1978-September 1979

Activity	Continent					
	Total	Latin America	Asia	Europe ³	Africa	Other
<u>TOTAL</u>	<u>70</u>	<u>49</u>	<u>11</u>	<u>6</u>	<u>2</u>	<u>2</u>
Estimation of contraceptive prevalence including surveys	24	22	2	0	0	0
Logistics	8	7	0	0	1	0
Consultant to other agencies	7	1	0	6	0	0
Design and/or evaluate innovative Programs ²	6	6	0	0	0	0
Overall program evaluation/management	6	5	1	0	0	0
Epidemiology of fertility control and pregnancy outcome	5	1	4	0	0	0
Service statistics	4	3	1	0	0	0
Demographic analysis	4	3	0	0	1	0
Meeting/workshops	4	0	2	0	0	2
Population policy	2	1	1	0	0	0

Cumulative: July 1974-September 1979

<u>TOTAL</u>	<u>342</u>	<u>229</u>	<u>56</u>	<u>31</u>	<u>18</u>	<u>8</u>
Logistics	70	42	19	2	7	0
Service statistics	59	48	10	0	1	0
Estimation of contraceptive prevalence, including surveys	56	51	5	0	0	0
Design and evaluate innovative programs ²	38	36	0	0	2	0
Meeting/Workshops	28	7	3	7	3	8
Overall program evaluation/management	25	16	7	0	2	0
Consultant to other agencies	22	1	0	21	1	0
Epidemiology of fertility control and pregnancy outcome	17	6	9	0	2	0
Demographic Analysis	16	13	2	0	1	0
Population policy	11	9	1	1	0	0

¹Defined as an activity conducted by an FPED consultant while overseas and described in that consultant's RSSA report; most consultants performed more than one activity per trip and most trips were funded by AID. Some meeting and consultant travel was funded from other sources (WHO, IPPF)

²Chiefly community-based distribution (CBD) or direct distribution of contraceptives

³Activities related to IPPF (London) and WHO (Geneva) rather than government programs.

Source: RSSA reports reviewed by Jim Shelton in March 1977 and updated by Leo Morris in January 1980

IV. BUDGET DATA

A. Estimated Person-Weeks of CDC Staff Time Used for International Family Planning Activities Consistent with AID/CDC RSSA October 1978-September 1979

<u>Person</u>	<u>Scheduled Weeks</u>	<u>Total Weeks Worked</u>	<u>Types of Activity</u>
Tyler	8	11	A, S, M
Rochat	30	37	A, DA, IC, PIC, M, S, T
Morris	35	43	A, DA, IC, PIC, M, S, T
Friel	8	8	A
Monteith	39	50	DA, IC, PIC, T
Graves	26	16	DA, IC, PIC, M, T
Anderson	39	49	DA, S, T, PIC, IC
Chen	52	52	DA
Gould & Conn	78	50	DA, PIC, IC
Warren	39	39	DA
Friedman	39	41	DA, IC, PIC, T
Thacker	39	39	DA
Other Medical Staff	39	18	DA, IC, PIC, T
Mollenkamp	21	21	0
Other Scientific Staff	86	62	DA, PIC, IC, T, M
Other Statistical Staff	85	101	DA, IC, PIC
Secretarial Staff	139	155	0
Other Staff	43	62	0
TOTAL	845	853	

Legend:

- A = Administration-related to RSSA
- DA = Data analysis and report writing
- IC = International consultation
- PIC = Preparation for international consultation
- M = Professional meetings, organizational activities
(e.g., IPPF, APPP, EIS, AID)
- S = Supervision and training of CDC staff
- T = Consultation to AID/W, AID/M, or internationals at CDC
- TR = Training course taken
- 0 = Other activities

IV. BUDGET DATA
 B. Expenditure Report, AID/CDC RSSA
 October 1, 1978-September 30, 1979

<u>Budget Category</u>	<u>Amount Budgeted</u>	<u>Estimated Expenditures*</u>
Personnel (including benefits)	\$ 401,817	\$ 411,661
Travel	115,147	88,275
Rent, Communication, Utilities	11,300	11,300
Printing and Reproduction	9,500	10,500
Other services (including consultants and special studies)	115,000	109,800
Supplies	3,500	3,500
Equipment	<u>12,500</u>	<u>7,936</u>
Direct	\$ 668,764	\$ 642,972
Indirect (20%)	<u>133,753</u>	<u>128,594</u>
 TOTAL**	 \$ 802,517	 \$ 771,566

*Agreement with AID/POP/FPSD on August 29, 1979, to transfer unexpended funds in travel and equipment categories (\$38,579) to Personnel (\$9,844), Printing and Reproduction (\$1,000) and Other Services (\$27,735).

**Unexpended balance of \$30,951 earmarked for facilities survey in Mexico which was not undertaken in FY 79 as proposed.

V. International Visitors to FPED/CDC
October 1978-September 1979

DATE(S)	NAME	COUNTRY	TITLE
10/5	Dr. K.B.A. Stanley	Jamaica	Medical Officer Specialist, Ministry of Health
12/4-22	Dr. Lidiija Andolsek	Yugoslavia	Director, Family Planning Institute, Ljubljana, Yugoslavia
12/20	Dr. Ramon Alvarez	Mexico	Ministry of Health, Office of International Affairs
2/5-16	Lic. Federico Guerra	Panama	Population Studies Office, Ministry of Health
2/5-16	Lic. Raul Batista	Panama	Chief, Department of Statistics, Ministry of Health
2/13	Mrs. Gladys Mumuhe	Kenya	Nurse, Ministry of Health
	Miss Lucy Njugu	Kenya	Nurse, Ministry of Health
	Mrs. Esther Aruwa	Kenya	Nurse, Ministry of Health
	Miss Pearly Asila	Kenya	Nurse, Ministry of Health
	Miss Jane Muchumo	Kenya	Nurse, Ministry of Health
	Mrs. Esther Mukatha	Kenya	Nurse, Ministry of Health
	Ms. Mary Njoki Mwangi	Kenya	Nurse, Ministry of Health
2/15-16	Dr. Mario Tenzer	Uruguay	Chief, Data Processing Latin America Center of Perinatology and Human Development
3/6	Mr. Haryantd Rohadi	Indonesia	Chief, Research & Development Division, BKKBN, Ministry of Health
3/29-30	Mrs. S.L. Chinnappa	India	Documentation Officer, Institute for Research in Reproduction, Bombay
4/30-5/11	Ms. Angela Merlos de Mendoza	El Salvador	Director, Operations Division, El Salvador Demographic Association
5/19	Dr. Carlos Huezco	El Salvador	Medical Officer, MCH/FP/MOH
5/21-7/27	Ms. Ophelia M. Mendoza	Philippines	Department of Epidemiology and Biostatistics, University of the Philippines
6/11	Dr. Toshitaka Nakahara	Japan	Medical Officer, MCH Division, MOH
6/28	Dr. Elsadiz Mahgoub El-Tayeb	Sudan	Pearson Fellow

<u>DATE(S)</u>	<u>NAME</u>	<u>COUNTRY</u>	<u>TITLE</u>
7/25	Dr. Tony Measham	Bangladesh	Ford Foundation
8/22	Dr. P.A. Lancaster	Australia	Fellow, Australian National Health and Medical Research Council
8/29-9/7	Lic. Antonieta Pineda	Guatemala	Department of Evaluation, APROFAM (IPPF affiliate)
9/6	Dr. Rafik Boukhris	Tunisia	Director, Family Planning Biomedical Research Center
9/6	Dr. Rafaat Mdar-Dali	Tunisia	Director, Biomedical Research Section, National Office of Family Planning and Population

VI. Activities Planned for FY 1980

A. Latin America

1. Brazil: Analyze data and finalize report on baseline contraceptive prevalence survey conducted in Piaui State where CBD program was initiated in April 1979. Provide consultancy to BENFAM (Brailia's IPPF affiliate) to conduct survey(s) to evaluate CBD programs in Northeast Brazil. Assist the State University of Campinas, Sao Paulo CEMICAMP) in analysis of oral contraceptive study. Logistics assistance upon request.
2. Colombia: Conduct study in collaboration with MCH on health impact of surgical contraception program; logistics assistance upon request.
3. Dominican Republic: Review CONAPOFA family planning logistics system and make recommendations for improvement.
4. El Salvador: Continue review of data systems development and evaluation and analysis of current data collection as requested by AID. Complete final report on 1978 El Salvador Contraceptive Prevalence Survey. Results from this survey will help evaluate the impact of family planning programs on contraceptive use and fertility change. Provide USAID Mission with assistance in establishing baseline data for proposed CBD program in the Eastern Region of the country. Assist the Salvador Demographic Association in evaluation of proposed CBD program, including development of management data system. Assess development of logistics system as requested by Mission; continue to provide the Ministry of Health assistance in analysis of data relating to surgical contraception. Make recommendations based on analysis of patient flow study implemented in FY 79.

5. Guatemala: Provide follow-up assistance as may be requested by USAID Mission and AID/W to further support APROFAM (IPPF affiliate) logistics system for distributing family planning supplies.
Continue to assist Mission with the collection, evaluation, and analysis of service statistics data as requested by AID. Complete analysis and final report for 1978 Contraceptive Prevalence Survey.
6. Haiti: Provide logistics assistance as requested by AID.
7. Honduras: Evaluation of Pathfinder-funded CBD program and logistics assistance. Provide assistance in the extension of the IPPF affiliate CBD program and to the development of other non-clinic based distribution programs.
8. Mexico: Code and analyze the family planning-maternal child health survey of the U.S.-Mexico Border Area to assess the need for and knowledge of the availability of family planning services, provide baseline data for future measurement of program outcome, and obtain information essential for future planning. Also, develop a related survey of public and private contraceptive outlets. AID will contribute exclusively to the surveys to be conducted on the Mexican side of the border and will not fund more than 50% of total project costs.
9. Panama: Continue service statistics data collection, evaluation and analysis as requested by AID. Analyze and report on 1979 Contraceptive Prevalence Survey and begin consultations on program and logistics management.
10. Paraguay: Continue to evaluate service statistics and logistics management as requested by MOH and USAID Mission.

11. Peru: Provide logistics assistance as requested by USAID Mission.
12. Other: Collaborate with the Center for Population Activities (CEFPA) in the planning, organization, and presentation of a Central American Workshop on logistics management and use of contraceptive prevalence survey data to influence management and evaluation of programs as well as policy decisions.

B. Asia

1. Bangladesh: Follow-up CDC-devised logistics system and training program; provide additional technical and training assistance; continue to evaluate new logistics system in pilot areas. Analysis of on-site field review to characterize mortality and epidemiology of abortion. Conduct study of health impact of sterilization.
2. Philippines: Continue technical support and training assistance as requested by Mission/MOH for improving logistic support capabilities. Complete analysis of acceptor fertility and impact of outreach CBD program using data provided by International Institute of Rural Reconstruction.

C. Near East--North Africa

1. Egypt: Provide technical, logistical, and operation's research assistance as requested by AID.
2. Lebanon: Special training at CDC in epidemiology and family planning for physicians from the American University of Beirut.

D. Africa

1. Cameroon: Study prevalence of infertility and relationship of epidemiology of infertility to current family planning efforts and reproductive health problems.

2. Sudan: In collaboration with WHO, study the prevalence of infertility and relationship of epidemiology of infertility to current family planning efforts and reproductive health problems.
3. Zaire: Logistics management.
4. Zambia: Training of MCH Director at CDC, including the planning for evaluation of family planning activities in Zambia.
5. Other:

During FY 1980, the Center for Disease Control will intensify its work on family planning evaluation in Africa. Prior to FY 1980, CDC had provided limited assistance to selected African countries in work in technical topics such as survey analysis (Egypt), the epidemiology of illegal abortion (7 countries), and prevention of abortion mortality (IPPF's Africa Region and its affiliates), and family planning supplies management (Tanzania and Egypt). In addition, assistance to AID Missions in the completion of Annual Budget Submission (ABS) tables on levels of contraceptive need and services has been provided in Ghana, Cameroon, Kenya, Botswana, and Lesotho. Through its work with the International Planned Parenthood Federation's Central Medical Committee and Law Panel, as well as the IPPF Africa Region Office, CDC staff members have offered technical input to that Federation's key decisions on family planning in Africa.

In FY 1980, CDC will take 2 major steps forward in Africa. First, CDC staff members will be more active in helping African nations address their own population problems. In order to do this, CDC has begun the long-term training of 2 physicians, who are obstetricians committed to work in the field of family planning and public health. One is the Acting Director of Maternal and Child Health for the Ministry of Health in Zambia; the other will join the

faculty at the School of Public Health of the American University of Beirut* where many physicians from Sub-Sahara Africa are trained. CDC staff members began their intensified African activities by meeting in the final quarter of FY 1979 with members of AID's Population Office Africa Bureau and the USAID Mission to Cameroon. This was followed by a subsequent meeting in which officials from the Government of Cameroon joined AID and CDC staff members. As a result of these meetings, ways have been identified in which CDC can apply its work in family planning evaluation and epidemiology to assist Cameroon with the resolution of its population and reproductive health problems. Specifically, CDC plans to help in the analysis of the Cameroon World Fertility Survey with regard to the prevalence of infertility in that country. Moreover, CDC plans to send staff members to visit Cameroon early in FY 1980.

The second major step for CDC will be the planning and implementation of a major Africa project. This work, begun at the request of AID, has entered the planning stages. The CDC Director has committed 3 personnel positions to this project. The administrative complexities of the work will be substantial because of existing Government-wide personnel limitations. The assistance provided will be the identification and solution of country problems related to population and reproductive health.

E. AID/Washington

1. Provide assistance to DS/POP/FPSP in the evaluation and modification, if necessary, of the quarterly and annual service statistics reporting forms, including guidance to the field on completing the form.

*Funds used to train these 2 physicians are provided, in part, by AID, in part by CDC, and in part through an agreement between the Rockefeller Foundation and CDC.

2. Provide assistance to DS/POP/FPSD in developing guidelines for USAID Missions on management of contraceptive logistics systems and development of commodity data system with a view toward improving supply conditions and coordination among international donor agencies.
3. Ad hoc studies and/or literature reviews on subjects such as the health impact of family planning programs and the success of vertical versus horizontal health programs.