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FINAL NARRATIVE REPORT

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I INTRODUCTION

This document represents the final narrative report for the Population Council with Profamilia, "Community Distribution of Contraceptives in Rural Areas" (AID/DSPE-C-0084). The project was initiated on September 30, 1980 and terminated 31 December, 1984.

This report describes the background, objectives and organization of the project. In each of the substudies conducted, a summary of specific objectives, methods, results and costs will be provided. The dissemination and utilization of the results for policy making will also be reviewed and remaining challenges and lessons learned during the project period will be highlighted. This report will attempt to place project activities in the larger perspective of Colombia's CBD programs. Extensive details have been provided previously in three annual workplans and narrative progress reports.

A complete listing of principal collaborators on the project, both from Profamilia and the Population Council as well as a listing of publications and previous reports can be found in the Appendices.

II BACKGROUND

Colombia, with an area of 1,138,914 square kilometers, is located on the North-western coast of South America. Although the total population was estimated at 27 million in 1982, 97% of the inhabitants live on less than one half of territory in the mountainous Andean regions in Central Colombia. The projects supported by this contract are located in nine provinces, including parts of the semi-arid Atlantic coast, and the Central and Eastern mountainous provinces dominated by large valleys, plains and plateaus (Figure 1). Although Colombia is increasingly urban (currently approximately 70% urban), most of the projects are concentrated in rural areas assigned to Profamilia clinics in the secondary cities.

Colombia is remarkable in that it has experienced in the past twenty years one of the most rapid fertility declines in the world (Ochoa, 1984). With the initiation of the demographic transition in Colombia in the 1950's, a rapidly declining death rate and continuing high fertility produced population growth rates of up to 3.5% during the 1960's. At that time family planning services were available only through private physicians and a limited number of commercial outlets. In 1966 as an outgrowth of the private practice of Dr. Fernando Tamayo, Profamilia was organized as an affiliate of IPPF and activities were initiated to provide family planning services to the mass of the population. Although early service delivery efforts were largely clinic based, in 1970 Profamilia began offering services in a few rural areas, in collaboration with the National Federation of Coffee Growers. By 1974, approximately 12,400 women had purchased contraceptives at

distribution posts in 370 rural villages. The principal guidelines of the rural program were the following:

1) The primary focus of the program was rural communities;

2) The women responsible for communication and motivation were from the same rural area and were similar to the population they serve;

3) The family planning methods offered were those that could be dispensed without medical attention e.g. orals, condoms, spermicides;

4) Contraceptives were distributed in each community by a volunteer who was selected from among the natural leaders of the community;

5) The existing infrastructure in the community e.g. agricultural extension, was used by the program so that parallel structures did not have to be created;

6) Systems of registration, record keeping, and administration conformed to the highest technical standards;

7) The basis of the program was education and its success was based on the thoroughness with which the people were convinced of the benefits of family planning and knew how to use the available methods; and finally,

8) The family planning program was part of integrated rural development and was not considered an end in itself.

By 1975 the innovative non-clinical family planning program operated in both urban and rural areas and provided services to 85,000 women from 1300 distribution posts. An evaluation of the rural program showed a 12 month all contraception continuation rate of at least 56.4 percent and as high as 82.4% (Bailey, 1975). In approximately two years, the program provided family planning services to nearly 20 percent of eligible women where it operated. At the same time 40 urban clinics provided services to over 126,000 actives users. During the late 1970's the number of CBD posts expanded to over 4,000. Due to changes in funding and administrative methods, by the end of 1984 the number of CBD posts totaled 3,452 covering 582 (59%) of the 985 municipalities in the country. A total of 28 urban clinics continued to provide basic services as well as receive referrals for sterilization and the insertion of IUDs (see the section on the organization of Profamilia for more details on individual programs).

The government of Colombia, albeit at a slower pace, followed this trend in the extension of family planning services. Since 1970 the National Development Plan has included a population policy stating the need for altering internal migration patterns, reducing the rate of population growth and making information and medical services available

so that couples may make an informed decision and exercise their right to determine family size. In practice this has meant that the Ministry of Health has provided family planning services in 120 general hospitals, 475 smaller regional hospitals and 2409 health posts within the maternal child care program and does not interfere with private sector efforts.

Because of these efforts, data from the Second Contraceptive Prevalence Survey indicates that knowledge of contraceptive methods has reached 96% of ever married women (Ochoa and Richardson, 1980). Contraceptive levels for currently married women at risk of pregnancy in 1980 was 55% with levels of 60% in urban areas and 42% in rural areas. Oral contraceptives ramain the most popular method followed by sterilization and the IUD. Important changes also occurred during the 1970's in the mix of methods. Most notable was the decline in the use of traditional methods and their replacement by more efficient methods e.g. in urban areas the use of traditional methods declined from 22% in 1969 to 8% in 1980. Due primarily to the increase in contraceptive prevalence, the total fertility rate dropped during the period 1969-1980 from 6.7 to 3.6 and in rural areas from 9.2 to 5.3. It is estimated that of the 1.6 million current users of family planning in the country (Ochoa, 1982) approximately 22% are users of Profamilia clinics, 30% are served by the Ministry of Health, and the remainder by the private sector (i.e. drugstores, private physicians) or the social security system.

Since the initiation of the Profamilia's rural CBD program, basic issues surrounding the cost of community services, their coverage, and the quality of services provided have influenced its evaluation. This operations research project sought to test and document the impacts of different service delivery, promotion and maintenance, strategies and to provide rapid feedback to the CBD program managers. It has tested variables influencing the success of different delivery strategies and substantially reduced program costs while extending coverage and modifying services to better reflect the users' needs.

III PROGRAM OBJECTIVES

A. General Objectives

The project objective was to develop an alternative service delivery system to the traditional Profamilia Rural CBD approach for areas with high levels of contraceptive knowledge. This alternative system would reduce program costs while increasing coverage rates and meeting the needs of contraceptive users.

B. Specific Objectives

1. Test distinct strategies for the maintenance of community-based distribution systems (CBD) in the departments of Narino and Santander using mail, bus service and central distributors in the resupply of distribution posts.

2. Test the impact of a mobile team of community educators versus that of the traditional instructor based CBD system on knowledge and use of family planning methods in the departments of Cesar and Cauca.

3. Identify reasons for non-use among women who have stated that they do not desire to have more children, yet are not using contraception (unmet need) in the project areas of Cesar and Cauca where the team-instructor experiment was implemented.

4. Compare the cost-effectiveness of an incentive strategy for instructors versus the team model with respect to the sale of contraceptive methods and couple years of protection in the departments of Sucre, Cordoba, Bolivar, Magdalena and Atlantico.

5. Conduct a national survey of community distributors to determine their knowledge of the methods sold, how they communicate this information to the community and how they manage their post. The results should suggest modifications in the training, supervision and resupply activities of the national CBD distribution system.

IV ORGANIZATION OF THE PROJECT

A. Profamilia - The Population Council

The project structure and funds were defined by the terms of the contract with the Research Division of the Office of Population (S&T/POP/R). The Population Council was the principal contractor, while Profamilia was the sole subcontractor. Key personnel for the Population Council were originally Marg ret McEvoy, Dr. P.H., Project Director, Marcia Townsend, Ph.D., Staff Associate, and Fernando Gomez, Advisor. Fernando Gomez and Marcia Townsend left the Council during 1983 and 1984 respectively; during the remainder of the project, John W. Townsend, Ph.D., served as the resident advisor in Bogota, Colombia and was responsible for the preparation of this report.

The original director of the subcontract was the head of the rural Profamilia program, Dr. Gonzalo Echeverry. In 1981, the Profamilia executive director, Dr. Miguel Trias, assumed this role. The functions of each of the Profamilia collaborators is described in greater detail below. In general, the obligation of Profamilia as subcontractor was to design, implement and evaluate the specific CBD interventions. The role of the Population Council was to provide technical assistance to Profamilia in all stages of program development, maintain quality and fiscal control of the subcontract, and to prepare progress and final reports to AID.

B. Profamilia Organizational Structure and Functions

The goals of Profamilia are to promote and defend the human right to family planning in Colombia and to offer information and services in this field. To reach these goals Profamilia has developed four service programs (Figure 2): First, the clinical program provides information and family planning services in 28 clinics located in the

principal cities of Colombia. In addition, services include a program for the detection of uterine cancer and many clinics offer out-patient gynecological services and pregnancy tests. During 1983, for example, Profamilia (1983) provided 329,244 consultations of which 34.3% were to new users; 127,266 cytologies and 25,222 pregnancy tests. Secondly, the surgical program is designed to provide voluntary sterilization services to couples. During 1983 this program provided 51,270 sterilizations of which little more than 1% were vasectomies. Of the female sterilizations 61.8% were laparoscopies, 33.9% minilaparotomies and 4.3% were conducted post-partum.

Third, the community distribution system under the direction of Lily Bracht de Bucheli supplied and supervised a total of 3,468 information posts (private houses, small stores) in 1983 in the entire country and distributed 1,816,860 cycles of orals, 772,661 condoms and 1,150,711 vaginal tablets as well as significant quantities of anti-helmintics and oral rehydration salts. The project focused most of its activity on testing strategies for lowering costs and increasing the effectiveness of this program. Fourth, the social marketing program under the direction of Gustavo Merizalde provides contraceptives at moderate prices to approximately 60% of the pharmacies, drugstores and other commercial outlets. In 1983 the program distributed 3,412,520 cycles of orals, 4,568,844 condoms and 4,922,968 vaginal tablets.

The support programs include Information, Education and Communication (IE&C), Evaluation and Research, and Local Resources. Each of these support programs is designed to improve the coverage effectiveness, quality and self-sufficiency of the service programs. Although the project has concentrated on the CBD services, each of these programs has contributed significantly to the success of the project activities. Lily Bracht de Bucheli, as director of Information and Education, has been responsible for the functioning of the experimental CBD projects. Gabriel Ojeda Ph.D., as director of the evaluation and research program has been responsible for the design of information systems as well as the collection, processing and analysis of survey data and data from the service centers on project performance. The administrative support and contract management provided by Miguel Trias and Myriam Gutierrez respectively insured the smooth functioning of services and the timely preparation of financial reports.

V SUBSTUDIES

This section describes each of the OR projects conducted during the project period. The six projects discussed include the Narino-Santander Maintenance Experiment, Cesar-Cauca Team Supply study, the Traditional CBD Program in Magdalena, North Santander and Cauca, the Unmet Need Study, Incentive versus Team Strategies on the Atlantic Coast and finally the CBD Distributor Study. In each of the following subsections, a summary of the study's specific objectives, methods, results and costs will be provided. Although all the six studies were conducted independently, each represents an effort to produce marginal improvements on the existing CBD model. A listing of the service

delivery models is provided in Table 1. A final summary of the results from all substudies is provided in a later section.

A. Narino-Santander Maintenance Experiment

The maintenance experiments were a follow-up to the USAID Mission financed collaborative project between the Population Council and Profamilia entitled Extended Medical Supervision in Rural Colombia, which operated in the departments of Narino and Santander from 1975 to 1979. Narino which is located in the Pacific Region is composed of 52 municipalities. According to the 1973 Census, it is the eighth most populated department with 809,000 inhabitants. Nevertheless only 37 percent of the population is urban compared with 64 percent for the country as a whole. Santander is located in the Eastern Region and is the third largest department in Colombia with 77 municipalities. Of its nearly 1.1 million inhabitants, 54 percent are urban. In both project areas, approximately 280,000 women 15 to 49 years of age were in union and exposed to the risk of pregnancy. More than half (57 percent) of the exposed women were estimated to desire no additional children, yet were not using an efficient method (Ochoa and Richardson, 1980). Nearly 90 percent had heard of at least one contraceptive method. The total fertility rates in 1980 for the Eastern and Pacific Regions were 5.2 and 4.6 respectively (Ochoa, 1982).

During the previous project in Narino and Santander, CBD instructors were trained to make community visits in their assigned areas (Figures 3 and 4). In communities with interest in receiving family planning services, a person was identified as a community leader and trained to be a distribution post manager. The distributor's tasks include the promotion and provision of information on family planning, the distribution of orals, condoms and spermicides and the referral of couples for IUD insertion and sterilization services to Profamilia. The instructor returned monthly to the community to resupply the distribution post, continue the training of the post manager, collect service statistics, promote contraceptive use and to consult with program users as required.

The results of this intervention, when compared to the changes in matched control areas, were admittedly mixed. During the three year period, contraceptive prevalence increased 18 percentage points (from 20 to 38%) in Narino and 8 percentage points (from 51 to 59%) in Santander. The magnitude of results in Santander were smaller than expected when compared to an increase in 9 percentage points (from 33 to 42%) in control areas of Norte Santander, where no additional programmatic efforts were made. (For a more detailed description of the Narino-Santander model, see the Council's final narrative report, Extended Medical Supervision in Rural Colombia, presented to the AID Mission in Colombia, August 1979).

Given this background, the objective of the present maintenance study was to identify alternative service delivery models, which reduce program costs while at the same time increase coverage rates and meet the needs of contraceptive users. A second objective of this project was to test different resupply systems for maintenance areas, for

example via mail, public transport or through central distributors. These systems would free instructor's time to increase promotional activities and improve the quality of services provided by existing posts.

From October 1, 1980, through 31 December, 1981 four new instructors were employed by Profamilia, two for each of the departments of Narino and Santander. As in the previous project, their work during this maintenance phase consisted principally of resupplying already established distributors with contraceptives, maintaining service statistics and collecting funds from sales. However, because monthly visits had been costly due to the small number of users in most parts, several innovative resupply systems were introduced in selected areas of Santander.

Several modalities were attempted: 1) a central distributor was identified from existing posts, and surrounding distributors were to travel to her post for resupply; 2) a central distributor was given a small incentive of about US$0.70 for each local distributor supplied in compensation for her additional travel as well as lunch when visiting outlying distributors; 3) a quarterly resupply system by mail and 4) a quarterly resupply visit by the promotors instead of monthly visits. Each of the options presented problems. The work of the cental distributors was more complex in its organization than anticipated and the incentive scheme, although well received, failed to make the task more simple. Because many of the distributors either tended small stores or cared for children, frequently they had little time for travel which resulted in problems of irregular supply. The delivery of contrceptive supplies by bus seemed feasible but the remission of service statistics and sales money proved more difficult. Mail service worked best in the larger more accesible communities, but was inadequate for smaller towns. Moreover the transfer of cash by mail was accepted with great reluctance by distributors. Finally, the service statistics records for distributors supplied on a quarterly basis were complicated when embedded within a system designed for monthly reports.

Similar experiments were programmed in Narino but were never carried out for a number of administrative reasons. Thus, based on the limited results in Santander, the following scheme was selected as the best alternative for the national CBD program. Instructors would make quarterly visits to each post to collect service statistics and receipts for sales as well as resupply the post with contraceptive methods. This visit would be conducted during the last month of each quarter to standardize the reportng period. The other two months would be devoted to supervision and promotional activities. Distributors identified as in need of retraining and closer supervision would be given priority during this period. This resolution offered several advantages over the other alternatives. It reduced both the travel time and costs of the monthly visit, simplifed the data collection process and allowed instructors to concentrate their supervisory efforts on those most in need of training. Slightly greater amounts of supplies were left with the posts to accommodate the needs of users during the three month period. Distributors who were unable to adapt

to less frequent visits were gradually replaced over time, if supervisory visits did not improve the quality of their record keeping or educational efforts.

The resupply innovations were, however, secondary to the test of maintenance efforts following extensive promotion in Narino and Santander. The basic difference between the traditional CBD promotion and maintenance phases was that during maintenance, staff and promotional activities were reduced to a minimum support level. Although the specific characteristics of maintenance may vary depending on the region, the effort was made to reduce promotional activities and costs without producing a decrement in contraceptive use. In the case of Narino and Santander personnel were limited to one supervisor, two coordinators, two instructors and 184 distributors; and services were restricted to 61 municipalities.

Table 2 provides information on program activity for 11 months in Narino and 12 months in Santander following project start-up in October, 1980. As has been observed since Profamilia began providing services in these departments in 1976, Narino continued to attract more users. Perhaps most noteworthy is the number of new acceptors recruited in Narino in just eleven months of maintenance. This represents 32% of the total number of 8,293 new acceptors (including sterilization) recruited in Narino during the previous three years of promotion. Santander remained behind in the number of new acceptors and total sales, although the number of educational activities was virtually the same in both departments. While the low level of new acceptors may be explained by the relatively high rate of contraceptive use prevalence (59% versus 38% in Narino), the lower total sales in Santander could only be attributed to greater availability of other sources , differences in the placement of posts or the quality of promotion and distribution in the area. Nevertheless, during this 12 month maintenance phase the rate of contraceptive sales in Santander was higher than during the previous three year period for each method. For orals this represents 577 cycles per month versus 479 per month during the promotion phase; for condoms 583 units during maintenance versus 36 units per month during promotion phase. Clearly, the pattern of contraceptive use was not changed drastically by transferring program efforts from promotion to maintenance activites. The number of municipalities covered decreased only in Narino, where increased sales were noted despite the reduction in number of active posts from 71 to 63. In Santander, the number of posts decreased by only 4 during the maintenance phase.

Since only records of new acceptors were kept in 1981, an estimate of the number of active users retained by the program can be made by applying the life table continuation rates from the 1978 Posttest to new acceptors in the CBD progrm according to month of acceptance. The estimated number of active users of all methods excluding sterilization for at the end of the first nine month period in Narino was 2,113 and for Santander 170 (Townsend, 1981).

From these rates, it was possible to estimate cost per active user (excluidng sterilization) which for Narino was US$5.08 and for

Santander US$63.18. Costs per new acceptor of all methods, including sterilization, for both departments were US$4.15 for Narino and US$51.39 for Santander. The cost per couple years of protection (CYP) for 11 months of service delivery in Narino was US$5.66 and in Santander for 12 months service, US$24.47. This compares favorably with the cost per CYP found for Narino and Santander between 1976 and 1979. The reason for the large disparity in cost effectiveness is solely due to the number of users and volume of sales, as both departments were similar in terms of personnel and program costs.

Three major policy conclusions were drawn from these maintenance studies. First, once a department is subjected to prolonged promotion, little is lost in terms of the volume of services provided or program utilization when the CBD strategy is shifted to the maintenance of the program. Second, the quarterly scheduling of resupply visits developed during the project was identified as a viable alternative for the national CBD program because of the lower cost and administative burden. And finally, distinct strategies must be developed to respond to the large departmental differences observed in program utilization and cost-effectiveness. Thus, the first in this series of operations research projects contributed valuable information for addressing Profamilia's policy concerns in the CBD program.

B. Cesar-Cauca Team Experiment

This second study in Cesar and Cauca was designed to further develop the CBD model tested in Narino and Santander. Cesar and Cauca are two departments located at opposite extremes of Colombia, Cesar as part of the Atlantic region and Cauca part of the Pacific region. In 1973, Cesar had a population of approximately 321,000 and Cauca was somewhat larger with 529,000 inhabitants. Cesar is an area of more recent immigration due to large agrobusiness development in the department, principally cotton and cattle. Cauca on the other hand, has a small coastal area that is largely mountainous and agriculture is based on small farms.

Because of the high costs observed in Narino and Santander, the objective of this project in Cesar and Cauca was to test the effect on contraceptive prevalence and unit costs of replacing the instructor during the promotion phase with a two member team (one male and one female). Two teams were formed of individuals who had previously worked in community development, and were to be trained by Profamilia to conduct the promotional activities required in each department. Each team was equipped with a jeep and a movie projector, IE&C manuals, flip charts and audiovisual aids. Their task was to promote contraceptive use through large group meetings rather than household visits and resupply distributors every three months instead of monthly as in the traditional CBD system. A team was to intensively work in an area for one year, then leave it in maintenance phase where little staff time would be needed and little promotional activity would be carried out.

Because one of the Cesar-Cauca project's objectives was to test the team modality which operates primarily through group meetings rather than household visits, a flip chart was designed with a standard

core of information to be given in each meeting and which would also promote group participation. At the same time since the teams' contact with the distributors was limited to one visit every three months a new distributors' manual was designed so that the distributor would have access to some reference materials during this long lapse of time. One manual already existed which was designed by Profamilia's IE&C Department but it was considered inadequate, given the three-month return visit time.

In order to better design the project's IE&C component to recruit new acceptors and meet the user's needs, a series of questions were also asked of current users of orals, the condom, rhythm, withrawal and vaginal suppositories related to how these methods were practiced. Current users of all methods were questioned if they had received, prior to adopting a method, information on contraceptive alternatives and secondary effects. If a user had suffered side effects from the method in use, she was asked if she had been advised on what to do about it.

Nearly all (96%) users of both the 21 and 28 oral cycles could identify the number of pills their monthly cycle contained (Table 3). Those taking the 21 pill cycle were also questionned as to how many days they wait from the time they took the last pill in a cycle before starting a new package. Even though the percent of women giving the correct response in Cauca was double that found for Cesar (30 percent vs 16 percent), 70 percent of the 21 cycle oral users in Cauca and 84 percent in Cesar could not tell the correct number of days between cycles.

Even more alarming was the percent of 21 oral cycle users who could not describe what should be done in case the user does not menstruate after taking all 21 pills. As can be observed in Table 3, only 10 percent in Cesar and 16 percent in Cauca knew what steps to follow. Although nearly all oral users in Cauca stated that they take the pill daily, 13 percent in Cesar did not. Only about one-third of the 21 cycle users could describe how the method should be practiced if the user forgot to take one pill. Similar results were obtained for 28 cycle users: 26 percent in Cesar and 38 percent in Cauca knew what to do if they forgot to take one pill.

While questions were asked of users of condoms, withdrawal, rhythm and vaginal tablets on how they practiced their method, the responses indicate that either oral users were less informed, the oral is a more difficult method, or that the questions were poorly constructed and/or administered. At the same time there were an insufficient number of users of each of those methods in the study ($n<30$) to place much importance on the implications of the findings. All of the respondents using these methods, except for condom users, answered the questions relating to method use correctly. In the case of condom users, they were questionned if it was used for every sexual act and if it was used from the initiation of intercourse or some time later. While 95 percent of the condom users said they used the condom for every sexual act, only 57 percent used it from the time the sex act began.

On the issue of contraceptive alternatives and side effects, a little less than one-fourth of all current users were not provided information at the time of adopting their current method regarding contraceptive alternatives (Table 4). Of those women who were informed about other available methods, 71 percent in Cesar and 85 percent in Cauca received information on other efficient methods.

It is noteworthy that only one-quarter of all current users in Cauca, before adopting their current method, were advised that some methods could produce secondary effects. The method most mentioned as causing side effects was the oral contraceptive followed by the IUD, injections and vaginals. Nearly half of the women who were told the oral produces secondary effects were advised it caused cancer. Fifty-six percent who received information on possible adverse effects of the IUD had been told it is cancer producing. As might be expected, the information being given about vaginal suppositories was that it is an inefficient method since 62 percent of the respondents reported that they had been told that the method fails to protect against unwanted pregnancies.

A total of 25 percent of all current users had suffered or were suffering from side effects from their method (Table 11), of those women with side effects 70 percent had been advised that they can change methods. Two thirds of the women (66 percent) who are experiencing secondary effects were pill users.

As a consequence of these preliminary results technical assistance was contracted by the project from a Colombian agency, Foundation for Continuing Education in Colombia/Center for the Development of Non-formal Education (FEDEC/CEDEN), to design training materials in collaboration with Profamilia and the Population Council. The content of the messages was primarily the responsibility of Profamilia and the Council, while FEPEC elaborated how these messages should best be communicated. Using the results from available data soures, it was decided that the messages should explain clearly how each efficient method should be properly used, explain possible secondary effects and what to do about them, point out the nearest supply sources according to the method desired and provide answers to dispel erroneous beliefs with regard to the secondary effects of oral contraceptives.

Studies carried out by the Javeriana University, during the PAN campaign to promote breastfeeding on the images Colombians understand as well as cost considerations, led FEPEC to recommend realistic drawings of figures rather than comic figures (which Profamilia had used in the past) or photographs. An artist was then contracted to draw scenes representative of the final messages. Scenes were used in all cases except for when a method was discussed in which case the actual methods were fastened to the flip chart. Vaginal tablets could not be fixed to the flip chart because they melted in hot climates.

Both the manual and the chart were field tested with the teams in Cesar and Cauca. The corrections to the manual that resulted from the field test were made, so that the manual is complete (Profamilia, 1981). The teams in both areas received a three-day training course in

January 1982 on how to use these materials. As more flip charts were produced, their use was extended to other regions.

To test the cost-effectiveness of the team approach, selected municipalities in the departments of Cesar and Cauca were assigned to experimental or control areas (Table 5). The experimental municipalities, had not previously received Profamilia services. In the control municipalities, some of which had at most several months of experience with Profamilia services, the traditional promotion phase modality was implemented as it was previously practiced in Narino and Santander. During this promotional phase, four instructors worked in the control areas of Cesar and four in the control areas of Cauca. Project activity began in the control areas in February, 1981, in 13 municipalities with a total of 82 distribution posts, 54 in Cesar and 28 in Cauca.

Before service delivery began in the experimental areas (in April in Cesar and May in Cauca), the four final candidates were selected from a group of eight applicants. All had participated in a two-week training seminar provided by Profamilia. Each team selected initially spent one week in a practicum in the field. Following the field practice, a baseline sample survey was conducted in Cesar and Cauca with the participation of all instructors and female team members as interviewers.

The purpose of this survey was to provide data, which along with service statistics and accounting records, would determine if the team approach met the project goal. The survey provided information on ever married women on (a) contraceptive knowledge and use levels; (b) how current users of the oral, condom, suppositories, rhythm and withdrawal were using their method; (d) why past users stopped using; (e) desire for future use; (f) source of current service; (g) source of sterilization; (h) source of sterilization referral and, (i) information on secondary effects and the family planning informal network within the studied communities. A second survey was conducted between April and June 1982, 12 months following the initiation of the experimental services and a third survey was conducted 12 months following the initiation of maintenance activities in the same areas.

The inital sample was a multistage stratified cluster sample representative of 58,334 rural and urban ever married women 15 to 49 years of age in 24 municipalities in Cauca and Cesar. These municipalities are listed in Table 5. From them, 12 strata were formed to serve on the primary samplying unit, 3 for each experimental and control group in both departments. Since some of the strata were composed of more than one municipality, those municipalities finally included in the sample were randomly selected from others in the same strata. The municipalities finally selected were Bolivar, Balboa, Mercaderes, El Tambo, La Vega and Purace in Cauca. In Cesar, they were Aguachica-Gamarra, Rio de Oro-Gonzalez, Curumani, El Copey, Chiriguana and Chimichagua.

Segments of each PSU were randomly selected in both the urban and rural sectors of each PSU. These segments were outlined on maps and a sampling fraction assigned to each one. All of the ever-married women

were interviewed in each household that was selected in each segment according to the sampling fraction.

The three surveys differed somewhat in their size and composition. The first sample of households included 1304 ever-married women. The second survey over sampled urban women in an effort to better measure the quality of contraceptive use. The total sample of ever-married women in the second survey was 2309. The third survey was designed as a mini-survey to merely follow-up in a proportion of the previous samples. The total number of ever-married women surveyed in this follow-up was merely 859. All three surveys employed independent random samples of the population, and adjustments for oversampling were made by weighting cases, so the results could be compared between surveys. Since all samples were random, and independent, differences may exist due to sampling error. For example, only 3.6% of the women who participated in the second survey were interviewed in the first (Appendix 7).

The results which are presented in the tables that follow include data for the three surveys by department (Cesar and Cauca) and by treatment group (control and experimental). In general, differences found in dependent variables between the first and second survey may be attributed to the effect of the team intervention. Differences in dependent variables between the second and third survey may be attributed to the effect of placing the treatment areas on a maintenance phase.

Table 6 describes the characteristics of households in the second Cesar-Cauca sample. As no systematic differences were found between departments or experimental treatments, an overall summary of the characteristics of the sample is provided. The total number of households visited was 2,771 during the second survey and the average household size was 5.3. A total of 78.6% of the households heads were either married or in consensual union and 83.5% of the households have children. A total of 45.7% of the population was of reproductive age and 42.8% were under the age of 15 years. Finally, 70.8% of the households were located in urban areas with over 2,500 inhabitants. The overall picture provided by these data is that the characteristics of the sample surveys are representative of the population of households in the regions studied.

Table 7 illustrates the characteristics of ever-married women by intervention group. The mean age of ever-married women interviewed was approximately 31 years. She had received an average of three years of formal education and had experienced approximately 4.5 live births during her reproductive life. In terms of exposure status, small differences were noted between the Cesar and Cauca samples. In the second survey, 14% of the women were currently pregnant in Cesar, while 8% were reportedly pregnant in Cauca. Approximately 60% (range 51-71%) of the women were reported fecund at the time of each survey. Only in the Cauca control group were significant differences between surveys observed in the percentage of women reported fecund, which may be explained by an apparent increase both in the percentage of women no

longer in union (from 17 to 27%) and the percentage of couples sterilized (from 7 to 14%).

With respect to knowledge of contraception, Table 8 presents the percentage of currently married fecund women who knew of at least one contraceptive method. As can be observed, knowledge was near or above 90% in all subgroups. Overall, knowledge of contraceptive methods was lower in Cauca than in Cesar, particularly in the control group. The breakdown by age, number of live births, education and place of residence are all in the expected direction. The most knowledgeable women were between 20 and 39 years old, had at least one birth, had somewhat more primary education and lived in urban areas. Nevertheless, the differences observed between groups were generallly small or inconsistent.

The next table (9) describes the percentage of currently married fecund women who knew of contraceptives by specific method. By the third survey less than 2% of these women could not name a specific method. In order of familiarity, the best known method was orals with over 90% of women reporting knowledge, followed by female sterilization, the injection, the IUD, vaginal suppository spermicides, the condom, rhythm and withdrawal. The least known method was the vasectomy with only approximately 25% of women reporting knowledge. Between the first and second survey little change in knowledge was observed in Cesar where most methods were well known prior to the beginning of the project. In contrast, in Cauca significant increments in knowledge were observed for virtually all methods.

Table 10 presents data on the percentage of married non-pregnant fecund women who were currently using contraception. Between the first and second survey, the experimental areas experienced increments of 12 percentage points in Cesar (36 to 48%) and 30 percentage points in Cauca (24 to 54%). In the control areas, Cesar experienced a decrement of 6 points (50 to 44%) and Cauca a considerable increment of 14 points (37 to 51%). Within each department, the marginal benefit of the team approach appears quite strong. The Cesar control group however, was unique in that the prevalence of contraceptive use was initially quite high (50%) as well as 13 percentage points higher than the Cauca control and 14 to 26 percentage points higher than the experimental groups in prevalence of use. In each department the experimental groups were 13 to 14 percentage points lower in prevalence at the time of the first survey than the matched controls. As expected, those groups which were lowest in prevalence at the outset, experienced the greatest increment in prevalence.

After the second survey all groups were placed on maintenance to determine the effect on contraceptive use of reducing the intensity of promotion. Again there were differences in response by department. In Cesar, prevalence of use continued to rise; 13 percentage points in the control and 7 points in the experimental group. In Cauca, on the other hand, both groups lost four to five percentage points, a non-significant reduction. One could conclude from this analysis that contraceptive prevalence is not significantly negatively affected by the change from a promotion to maintenance phase.

Looking at results across time, from the first to the third survey the experimental groups demonstrated a consistently larger increment in contraceptive prevalence than the control groups. In Cesar, for example, the advantage was 12 percentage points. Despite the advantage, however, no differences in contraceptive prevalence on the third survey were observed between experimental and control groups within each department. In Cesar the weighted average was 56% and in Cauca the corresponding figure was 45%. The breakdown by age, education, number of live births and residence are consistent and similar to those found for knowledge of contraceptives.

These data would be somewhat easier to interpret if one examined the percentage distribution of current users according to the type of method being used. As can be seen from Table 11, the vast majority of methods used were artifical rather than natural methods. The most popular artificial methods were orals, female sterilization and the IUD. Traditional calendar rhythm and withdrawal were the most commonly used natural methods. Again marked differences appeared not only between the Cesar and Cauca departments, but also across time between surveys. In the Cesar control group the percentage of women who used orals decreased by 11 points, while that of female sterilization increased by 10 percentage points. In the experimental group, the relative use of orals and IUDs increased, whereas the percentage of women who had received sterilization services decreased. In Cauca, on the other hand, the use of natural methods increased by more than 20 percentage points. In the Cauca control group, the percentage of users of orals dropped from 43 to 13%, while the percentage with sterilization increased from 27 to 47%. In the experimental group the relative use of orals increased and the percentage of IUD and sterilization users decreased.

What these results suggest is that the team approach within a CBD program improves the sale of orals, while the control condition, without the additional promotion of reversible methods places more emphasis on referrals for sterilization services. Theoretically this should not be the case as all methods were promoted by each system. Perhaps, most striking however, is the major increments in the use of natural methods in Cauca. During the period project both teams and instructors were trained in the rhythm method as part of the mix of methods offered. Perhaps religious groups promoting natural family planning were also more active in Cauca. Another possibility is that Cauca is a more traditional department and although family planning is an increasingly important concern, increments in use are easier to obtain through the availability of a wide range of methods, including more information on natural alternatives. Couples may first adopt an inefficient method for birth spacing before going on to more efficient ones.

Part of these differences may be explained by the source of family planning services. Table 12 presents the percent of ever-married women who named a specific source for family planning services. From the time of the first survey to the third (two years), respondents were much more able to mention a specific source. The most frequently mentioned services were the public health services with the percentage ranging from 44 to 60% in the experimental groups and 31 to 51% in the control groups. Profamilia, on the other hand, was mentioned in the

third survey by approximately 17% in the experimental group and between 12% and 20% in the control groups, figures comparable to those reported for drugstores. These results are somewhat surprising given the active presence of Profamilia in these areas. Nevertheless several interpretations are possible. Profamilia in each of these areas operates through multiple mechanisms, i.e. it supplies the drugstores with methods and refers couples to public facilities for clinical servicēs. Moreover, for many couples, Profamilia is considered an official government service associated with the national family welfare services. Even half of the CBD program distributors think that Profamilia is part of the government or at least a semi-autonomous public agency (see latter section on the distributor's study). Because of the volume of methods distributed by all Profamilia programs and the training provided to MOH personnel, Profamilia claims direct responsibility for 65% of the use of contraceptive methods nationally.

Table 13 provides more evidence for the important role of this health sector support system. The MOH was always an important supplier of contraceptives, particularly in Cauca, where at the time of the first survey more than two-thirds of current users were supplied by the MOH. Already important sources at the outset of the project, drugstores accounted for a third to one-half of all users by the third survey. The Profamilia CBD program showed impressive increments as a source of supply in the Cauca experimental area and the Cauca control area, but overall Profamilia failed to be identified by 20% of the market. Again this may be due to the evolving strategy of the national CBD program to move away from the use of household distribution posts in favor of small commercial outlets. Despite the fact that most distribution posts are clearly identified by the green and white Profamilia logo and price lists highlight the name of Profamilia, it is possible that the outlet is identified best as a pharmacy if it sells drugs, specifically family planning methods (see photographs in appendices). Similar results are demonstrated in Table 14 for users of orals. In general, private physicians are an insignificant source of family planning services for couples in these areas.

Table 15 describes the distribution of sterilized women by source of service according to department. Figures are not presented by experimental and control groups due to the small sample size. As in the case with other methods, the public health services were perceived as the most important source of sterilization services. By the third survey, less than 10% of respondents identified Profamilia as the source of service. Private clinics were more frequently cited by women, although some of these may be physicians contracted by Profamilia to provide these services. Profamilia operates in many areas out of MOH hospitals and clinics. In fact, nearly all sterilizations conducted by the mobile units are conducted in governmental rural clinics. What is clear is that most couples, regardless of the ultimate source, believe that the Ministry of Health is the foremost provider of family planning services in these departments and this is independent of whatever particular CBD strategy is operant.

Table 16 summarizes the overall pattern of use of currently married fecund women. Perhaps most impressive is that in a relatively

short time span of two years a significant number of additional women had been exposed to and at least tried some family planning method. In the experimental areas the percentage of women who had never used a contraceptive method decreased from 65 to 33% in Cauca and 36 to 32% in Cesar. Corresponding decrements of 14% (58 to 44%) in Cauca and 9% (35 to 26%) in Cesar were found in the control areas.

In conclusion, this study offers the following policy conclusions for Profamilia. First, all CBD efforts tend to increase prevalence, while the team strategy may provide a larger impact in the short term. Second, the transition from a promotion phase to maintenance is feasible after one year of operation and the negative impact on contraceptive prevalence is negligible. Third, CBD programs regardless of strategy, have their greatest impact in areas where existing contraceptive prevalence is low. Finally, in spite of the polemic regarding family planning at the national level and the promotion of Profamilia at the local level, the Ministry of Health is still viewed as the principal provider of family planning services in these departments. This has implications both for Profamilia's strategic planning as well as for IE&C efforts at the local level. Finally, the issues of quality of use and use-effectiveness require more attention in the development of IE&C materials and training. The implications of these results are discussed in the broader context of the research in a later section.

C. Traditional CBD Services in Magdalena, North Santander and Cauca

In order to estimate the sensitivity of the cost-effectiveness of traditional CBD services and serve as a control area two traditional zones were formed of 14 countries in Magdalena and North Santander where three instructors worked and 7 counties in Cauca where two instructors were assigned. The total number of women 15-49 years of age in these areas was 51,551 in the former and 20,442 in the latter. These areas are similar in geography and economic conditions to the experimental areas in Cesar and Cauca.

Tables 17 and 18 indicate the number of new acceptors and the volume of contraceptive sales for the 21 municipalities constituting the two traditional or control zones. Although the number of new acceptors in Cauca reached 1,370 for this period as compared to 820 recruited in Cesar, the quality of the information reported for Cauca is questionable given that only 2,661 cycles of orals were reported to have been sold when 55 percent (760) of the new acceptors there used orals. From the large volume of sales in the Cesar promotion zone (over 12,000 cycles of orals), it is clear that considerable service activity had been occurring in the area for some time.

Costs for the promotion areas are shown in Table 19. Although there is some difference between the two zones in terms of cost per CYP (US$9.31 in Magdalena/North Santander versus US$7.29 in Cauca), the cost per new acceptor in Cesar is more than double (US$19.43) the cost in Cauca (US$8.2).

Because the objective of the project was to test service models which would be less costly than the Narino-Santander CBD model, in

previous reports cost comparisons have been made between the traditional and team approaches. Although the experiment to test these two models was run from April 1981 to March 1982, and the following six-month period (which is covered in this section) was not intended to serve as a test for policy making, it should be pointed out that the cost per new acceptor (US$5.99) in the Cauca experimental zone was around two dollars less than that in the promotion zone (US$8.21). At the same time, the cost per CYP where the team worked in Cauca was US$12.41 as compared to US$7.29 in the traditional instructor zones of that department. However, because so many personnel changes occurred producing delays and problems in communication, it is inappropriate to make that same cost comparison between the Bolivar/Magdalena team zone and the Magdalena/North Santander instructor zone. Finally, the inadequate reporting on project activities through the service statistics system on the atlantic coast has made these cost estimates unreliable and therefore they should be used with caution.

D. Unmet Need Study in Cesar and Cauca

Although the Second Contraceptive Prevalence Survey reported high overall prevalence rates, a large unmet need persists in Colombia. Unmet need is defined as the percentage of exposed women not using contraceptives who wish to cease childbearing (Ochoa and Richardson, 1982). The level of unmet need in Colombia was 43% in 1980, although urban-rural differentials exist for nearly all regions (56% rural and 57% urban).

The goal of this study was to design a low-cost service strategy which could be incorporated into the ongoing PROFAMILIA rural CBD system that meets the family planning needs of women who desire no additional children yet were not using a contraceptive method. The proposed purpose was to explore the reasons for non-use and potential barriers to service delivery.

In November and December, 1983, PROFAMILIA revisited a non-random subsample of 58 couples of the 487 who had been classified six months earlier as having unmet need in the second round Cesar Cauca survey, (the total sample size was 1787). Originally ethnographic research techniques were to be used to describe the couples with unmet need for family planning. It was expected that in-depth case studies of these couples would provide the programmatic information needed to design service delivery systems and which had not been captured in previous surveys. Due to the difficulties of programming the ethnographic research, however, a survey was finally planned and conducted by the Profamilia evaluation unit.

Specifically, the criteria for entering the sub-sample were the following:

a) the women had to be between 15 and 49 years of age;

b) the couple had to be fecund and in union;

c) both male and female members had to have completed the interview;

d) they did not currently want more children, and,

e) they were currently not using any method of family planning.

Though all 58 selected couples reported they did not currently want more children, 10.6% of the men and 14.0% of the women admitted that they were not very certain of their decision to limit future childbearing. As anticipated, there were notable differences between the resulting subsample of women and ever-married women in the Cesar-Cauca sample. Table 20 briefly describes some of these differences. The women with unmet need were more rural in residence, were on the average six years older, had somewhat less formal schooling, and had experienced nearly three more live births during their reproductive life than their counterparts in the Cesar-Cauca sample. These results are similar to those reported in the 1980 contraceptive prevalence survey. In terms of general characteristics of the unmet need sample, the husbands were seven years older than their spouses with an average age of 44±10 and had one additional year of education (3.7±3 years). The couples had been in union for an average of 16.3 years (±8.1), approximately half being formally married. Most (70.7%) of the males were engaged in agriculture. Only one-third of the women (34.4%) were involved in a remunerative activity, and most of them worked independently as small merchants.

The summary of the housing characteristics of the couples are described in Table 21. Typically the couples lived in small towns nearly two hours (117 min.±109) from the county seat. Nevertheless, nearly half of the families reported (45%) a health post and more than half (53.4%) had a Profamilia distribution post in their community. Approximately 45% of the couples live in communities with a pharmacy and over 85% of the pharmacies provide orals, condoms and vaginal methods.

Table 22 presents data on the percentage of women and men with unmet need who know of contraceptive methods. Knowledge of both artificial and natural methods was remarkably high for the women e.g. over 90% reported knowledge of female sterilization and orals and approximately half knew of rhythm and withdrawal. Their spouses, on the other hand, reported considerably less knowledge of all methods, from one-quarter to one-half the level of the women. In terms of previous use of contraceptive methods, 36.2% of the women admited having used at least one method (Table 23). By far the most commonly used method was oral contraception, with more than 20% of the men indicating use by their spouse and nearly 30% of the women reporting use. Nearly 7% of the men also reported using condoms whereas their spouses only reported usage of 1.7%.

As may be concluded from the previous table, the last method used by the majority of couples was orals, although nearly 15% reported rhythm and withdrawal. The average date for last contraceptive use was 1979, or roughly four years prior to the interview. The average months

of use for the last method was 33 months (±24). The principal reason for discontinuing use was for health concerns or perceived secondary effects, which accounted for approximately 50% of all reasons for discontinuance. Women also reported being tired of use (14.3%) or felt contraceptives were not needed because of their age (14.3%); 21.4% of the men also felt that age was a reason for not using a contraceptive method.

As can be observed in Table 24, the couples still report sexual relations which are comptabile with continued fertility. Women report somewhat more frequent relations than their spouse and also significatly less personal satisfaction (72.4%) than their spouses (91.4%). Nevertheless, none of the couples report using family planning methods currently. Interestingly, half the men did not know why they were not using, and other 22.4% reported they had insufficient information for use. The women on the other hand were much more knowledgeable and direct. More than one third (37%) felt that they were too old to become pregnant, 20.7% occasionally used unspecified folk methods unknown to their spouse and only 12.1% felt they lack sufficient information. The folk methods referred to were independent of periodic abstinence and may be related to home remedies for menstrual regulation or induced abortions. Approximately one-quarter of the couples had considered using another method, but had not made a definite decision. Of those methods being considered, sterilization, orals and the IUD were the most preferred by women. Although many know superficially about a variety of methods less than half of the respondents could specify the particular advantages or disadvantages of any given method. Security and effectiveness are commonly mentioned as advantages, while health concerns were mentioned with equal frequency as disadvantages, even for rhythm.

The reasons for not wanting another child were quite distinct from those for not wanting to use a contraceptive method as illustrated in Table 25. First, the average number of live births experienced by women with unmet need was 7.3±4.5 where the number of children she would have liked to have had was 3.7±1.4, approximately half. For their spouses, the ideal number of children would have been 5.9±4.6. For both men and women, the uncertain economic situation in Colombia was the most determining factor in the decision to have no more children. Women (30.6%) also commonly feel that they are too old to care for more children, or that children require too much attention. The men (32%) also felt they have had enough children or would like to better provide for the children they have. More than 15% of the sample of men and women, however, could not respond to the question, suggesting the difficulty of the item or their ambivalence about the decision.

Less than 30% (n=17) of the couples had talked to each other about family planning. Even for the minority that do, the subject is breached only rarely or occasionally. Only 12% of the women and 5% of the men report that family planning is a frequent topic of conversation. For couples in this socioeconomic group, family planning must be a rather sophisticated issue. For the majority of those couples who did not talk, family planning was either an inappropriate theme to discuss

with a spouse or it simply never occurred to them. Nevertheless, even for those couples who did not talk about family planning most felt that their spouse would be in favor or at least indecisive about the use of family planning. On the issue of whose opinion was more important, 41.4% of the women felt that the male's opinion was more important, while another 34.4% of the women and 72.4% of the men felt that the opinion of each member was equally important.

When asked whether their important reference groups were in favor of family planning, the responses were quite positive (Table 26). Friends, parents and the community tended to be in favor of family planning, according to both men and women. In fact, over half of the friends and relatives of women and a third of those of the men had used family planning. Even the church was reported quite in favor of family planning by 10% of the women and nearly 16% by the men. Nearly two-thirds really did not know what the position of the church was with regard to family planning.

In terms of where these couples could obtain services, most mentioned that the closest source was a MOH health post. Of the 51 men and women who mentioned a preferred source for information and family planning services, the order of preference was the following: the MOH (53%), Profamilia (20%), private physician (12%) and drugstore (10%).

Following the home visit, the interviewers were asked their opinion about why these couples did not use family planning. Nearly half (49.1%) felt that the couples had inadequate knowledge about family planning methods and sources. Although many couples did have sufficient knowledge, because of their age, frequency of sexual relations or folk beliefs, family planning was of little interest to them.

What they can be concluded from this study of couples with unmet need? First, it is clear that this group is demographically distinct from the Cesar-Cauca survey sample as a whole. It is more rural, older and the families are larger. Nevertheless, knowledge levels are not unlike those reported for the larger sample and more than a third have used at least one method during their reproductive years. Certainly the existence of community resources and the positive opinions of their peers toward family planning would be conducive to future use. For this group, given the high parity and interest in limiting childbearing, sterilization services would seem most appropriate. However, two potential obstacles to the delivery of this service must be met: 1) men must become better informed about the risk of additional births for their spouses and the couples should be encouraged to decide how this risk may best be reduced and, 2) the distance to centers where this service is provided must be reduced. Referral systems are vital, but at the same time greater efforts can be made in terms of outreach by bringing IE&C and sterilizaiton services to more rural areas, either through mobile units or by increasing collaboration with the Ministry of Health.

Several lessons were learned from this study. First, it became clear in data cleaning that in six months many couples had changed their minds about both their desire for more children and their use of

family planning. Originally over 120 couples from the second Cesar Cauca survey were visited and yet only 58 qualified for the final analysis. Methodologically, one would prefer more information on the reliability of the items used for classificatin as well as a better understanding of the psychological consequences of the apparent dissonance between attitudes against continued fertility and failure to use contraception. Secondly, it was somewhat of a surprise to encounter that the males were not strongly against the use of family planning. Survey of males are rarely undertaken yet many program managers blame male attitudes for low level of contraceptive use. Although better communication between spouses on this issue should increase the probability of use, it was not clear whether the problem of unmet need lies in better intrafamilial communication or in the broader cultural context of the under utilization of existing services. Thirdly, this study of unmet need might have provided more insight into the beliefs and motivations of these couples if a survey format had not been chosen. Previous surveys have provided sufficient information on the characteristics and history of contraceptive use. More insightful qualitative data and a good theoretical framework might have proved to be more helfpul for program planning.

E. Modified Team Strategy versus Promotion Incentive Study

Based upon the results from Narino, Santander, Cesar and Cauca, a modified CBD team delivery system was designed for Sincelejo, Sucre and Monteria, Cordoba. The notion was to test this simplified team strategy against the traditional CBD program with the addition of promotion incentives for instructors. The incentive program was developed by the Profamilia clinic areas in Santa Marta, Magdalena, Barranquilla, Atlantico and Cartagena, Bolivar. The team strategy placed explicitly more emphasis on group promotion and education, as a mechanism for increasing sales while the incentives strategy implicity relied on the increased economic motivation for instructors to increase sales. The incentive scheme was merely one more step in the transiton of the CBD model to a more commercial structure.

The entire project was conducted on the Atlantic coast. Although much of the population in the semi-arid region is involved in irrigated agriculture and cattle rising, most of the economically active population is employed in the commercial and service sectors. Approximately 60% of the population of the region is urban, that is, reside in communities of more than 2,500 inhabitants.

The team delivery strategy tested in these areas differed from that which was tested in Cesar and Cauca in the following ways: (1) the Cauca male team meber was transferred to Sincelejo where he was paired with a Sincelejo clinic instructor to act as the female team member; (2) no re-supply activities were carried out by the team (instructors resupplied); (3) return visits to a county once it had been covered were not made; (4) few distribution posts were opened by the team and, (5) the male team member was responsible for driving and maintenance of the jeep and its equipment rather than sharing this responsibility with the female member. Under the Cesar-Cauca model the female team member was selected and specially trained for the kind of IE&C work required

for large group meeting and management of audio-visual materials, while instructors recruited under the traditional CBD model were trained to work through small group meetings and household visits, infrequently employing audio-visual aids and depending on pamphlets and charts prepared by themselves. While team members in the Cesar-Cauca model were selected because they were experienced in community development work, the instructors had not received this training.

The incentive system was another alternative considered to improve sales and possibly reduce the costs associated with a highly trained mobile team. Just as Profamilia gave its clinic staff a small stipend for each sterilization achieved above a minimum goal to increase the volume of sterilizations, it was hypothesized that an incentive system applied to the sales of orals, condoms and vaginals through the instructor would augment the sale of these methods. In turn, the cost of service delivery would be lower because the increase in sales would more than offset the incentive payment. This hypothesis had been partially tested on a limited scale for nearly a year with the following results in sales: Bogota (±13.1%), Girardot (±16.1%), Barrancabermeja (±39.9%) and Villavicencio (no change). Instructors in these areas were paid a base salary plus per diems and then instructed that they would receive an added incentive for each cycle of orals, unit (tablet) of vaginals and condom sold exceeding a base level set for them for each method by the head of the IE&C Division. These instructors were then permitted to sell contraceptives to small pharmacies and stores for cash in additio to the usual distribution posts where contraceptives are generally left on consignment.

The cost of each contraceptive to the distributor and to other sources was fixed by Profamilia. However, while the cost to the consumer who purchases his/her method from the CBD distributor was established by Profamilia, pharmacies and other stores could sell at the price they wished. Under this experiment, the instructor was free to organize her work schedule as she wished as long as she complied with the system requirements for accounting and reporting.

The revised team strategy was initiated in Sincelejo in January, 1983 and lasted for six months. In July, 1983, the team was transferred to Monteria, where it continued to operate for one year until June 30, 1984. Service delivery in the incentive work zones began in January, 1983 and was associated with the Profamilia clinics in Cartagena, Barranquilla and Santa Marta. Table 17 describes the number of municipalities, areas and women of fertile age covered by the project. The team project covered 41 municipalities and a total of 145,943 women, while the incentive project covered 48 municipalities and more than 80% more women of fertile age, 266,357.

Although the selection criteria were the same for both groups (Figure 3), the incentive project included only females, while the team project included one male instructor/driver and four females. Table 28 describes the 11 instructors who participated in the project. The average age of the team members was 27, while that for the incentive project was 30, the youngest instructor was the only male who was 23 when the project started. All but one instructor had at least 18

months of experience in this position prior to project start up. By the end of the project, the team managed 328 distribution posts and the incentive instructors supervised 387 posts. The team always used a jeep to facilitate trasnportation to large group meetings, but one additional instructor in each department always used a public bus to supervise posts. The incentive group instructors only used public transportation.

Tables 29 and 30 highlight the IE&C activities conducted by the team and incentive instructors during 1983 and the first semester of 1984. Overall, the presence of the team in Sincelejo during the first semester of 1983 and in Monteria during the last half of 1983 and first semester of 1984 nearly doubled the number of conferences held and increased the number of persons in attendance by a factor of four to five. The incentive group continued to rely principally on household visits, personal contacts and conferences to smaller groups.

The team was designed to work in an area for only a short period, promoting family planning in large groups before moving to another area. Data was collected from 2 departments, Sincelejo and Monteria, during three periods. The team was present for three of these data collection activities(one in Sincelejo and two in Monteria), while in the remaining three the existing instructors continued to provide services using the routine CBD procedures. Comparing the production of services and their associated costs in the team and incentive areas during this 18-month period provides the most appropriate test of the relative cost-effectiveness of these two alternative systems.

Tables 31 and 32 provide data on the production of services in the two promotion conditions. The results are presented by method and semester. The methods sold in the program include orals, condoms and vaginal suppositories. In addition, the number of sterilizations performed on women outside the departmental capital are attributed to the CBD program, as they are principally responsible for the corresponding promotion and referral in rural areas. No vasectomies were conducted in these departments during the period of the study. At the base of each table, the production figures are combined by calculating couple years of protection. For the purposes of these analyses, one couple year of protection (CYP) is equivalent to 13 cycles of orals, 100 condoms and 100 vaginal suppositories; similarly, one sterilization is equivalent to 12.5 CYPs.

As can be observed in Table 32, the number of products sold increased dramatically across the project period, 1983-1984, in the incentive condition. The largest increases in sales per semester were observed for orals (42,000 cycles) and vaginal suppositories (34,000 units). The number of sterilizations, however, incresed only slightly over the three semesters. In the team condition (Table 31), on the other hand, sterilizations increased significantly over the period, but perhaps more importantly at a total rate more than 70% higher than in the incentive condition during the three semesters covered by the project. Sales per semester in the team condition increased only slightly during the same time period (4,500 cycles of orals, 2,500

condoms and 1,500 vaginal suppositories). For both groups, sterilizations reached their highest point during the second semester of 1983, whereas the highest sales figures occurred during the first semester of 1984. Because of the large contribution of sterilizations to CYP, the total number of CYP was always higher in the team condition.

Table 33 describes the incentives paid per semester in the CBD program in Santa Marta, Barranquilla and Cartagena. The largest proportion of incentives (over 70%) were paid for the sale of orals, followed by condoms and vaginal supositories. Overall, antihelmintics for children accounted for only 6.4% of the incentives received. Given the rates offered, the incentive for couple year of protection varied by method as follows: Orals 39 pesos, condoms 100 pesos, Norforms 20 pesos and Neo-Sampoon 50 pesos. Given the impressive increments in sales, the total amount of cash incentives paid was quite modest, an average of $1,676 dollars per semester. Similar gains in sales could not be obtained by adding additional personnel at the same cost.

Table 34 presents data on goal achievement for each of the CBD conditions, Team and Incentives. Goals are set per semester by the head of the national CBD program, as a stimulus for improved sales performance and as a criterion for instructor evaluation. In the incentive condition, these goals were independent of those established for minimum performance, the level above which additional sales were awarded. As can be observed, the performance of instructors with incentives was always well above Profamilia goals and much more impressive than the team performance. For example, only in the first semester of 1984 did the team condition surpass all its goals. Also noteworthy is the degree to which the goals for vaginal suppositories and antihelmintics were surpassed, at times by over 1,000%. The function of setting such low goals is not clear and certainly the process should be examined to improve procedures for defining challenging, yet reachable goals.

Table 35 describes expenditures by item for team and incentive areas used to calculate cost per couple years of protection. Costs are generally broken down by personnel, including salary and benefits, travel expenses and overhead. The cost of supervision is particularly low because the position of local supervisor was eliminated during the early months of the project. Other costs not included are those associated with the evaluation, those of the contraceptives distributed, and of the personnel and supplies for sterilization services. In 1985, the cost to Profamilia of each sterilization was US$37.00. Within the CBD program, orals, condoms and vaginal suppositories was basically sold to distributors at the cost of purchase and handling. An increment in cost to the public was authorized by Profamilia as an incentive and was maintained by the distributor according to the following schedule (Colombian pesos) adopted in September, 1983:

Brand	Price for Distributor	Incentive	Price for Public
Noriday	$30.00	$10.00	$40.00
Eugynon	30.00	10.00	40.00
Neogynon 21	30.00	10.00	40.00

Neogynon CD	30.00	10.00	40.00
Microgynon 30	30.00	10.00	40.00
Noral	30.00	10.00	40.00
Tahiti Mayo 1/84	15.00	3.00	18.00
Norforms	80.00	10.00	90.00
NeoSampoon Tub.	165.00	15.00	180.00
NeoSampoon Tabl.	13.00	2.00	15.00
Nandol	2.00	0.50	2.50
Pirantel	6.00	1.00	7.00

The cost of the regular CBD instructors in the team condition was covered with non-project funds by Profamilia. The figures correspond to the salary, benefits and expenses of three instructors for the entire 18-month period. Including the 15% Profamilia overhead, the total cost for services in the team condition (without sterilization) was $81,843.00 US dollars and in the incentive condition $93.696.00.

Table 36 presents the figures for total CYP provided by each delivery strategy, the associated cost and the estimated cost effectiveness per CYP. Because of the large difference in the number of sterilizations conducted on rural women in the Team areas, the data are presented both with and without CYP attributable to sterilization. If sterilizations are included, and their cost also included at a rate of US$37.00 per operation, the Team and the Incentive strategies are about equally cost-effective with a cost of US$3.35 per CYP. It should be noted that no incentive was paid to either CBD group for sterilizations conducted in the Profamilia clinics. If sterilizations are not included and one really wanted to examine the effect of incentives on sales, the Incentive condition appears 30% more cost effective than the Team condition ($4.86 per CYP versus $6.34). Both figures, when sterilization is included, are significantly lower than the cost per CYP encountered in most other project areas (see Table 19) which varied from $2.10 to $12.41 and for Profamilia services nationally (Ojeda, et al. 1981). Finally, costs per CYP are subject to substantial fluctuation whenever sterilizations are included. Costs per new acceptor are not presented, as longitudinal data are no longer maintained on new or continuing users.

After reviewing the data, one could conclude that both systems are feasible to implement. Because both systems are goal oriented, the procedures for goal setting at the central level should be reviewed. It is possible that adjustments may be made to improve the motivation of instructors even outside an incentive-based delivery system. Depending on the role of sterilization, both systems appear to be improvements over previous CBD service-delivery systems. The Team may be more effective in motivating referrals for sterilization and, certainly, the financial incentives for increased sales are remarkably effective. Because the team conditions require more highly-trained personnel and an initial substantial investment for vehicles ($12,000 per jeep) and audiovisual equipment ($1,500) the incentive scheme may be more flexible in the short run. It promises short-term increments in sales in areas where other CBD systems have reached a plateau. The cost per additional CYP obtained was roughly $0.26, once the system of instructors and posts was established.

Both strategies, however, are less attractive in terms of cost when compared to commercial social marketing schemes, which basically are income generating (+0.97 per CYP). The advantages, however, of the CBD formats are that they can reach underserved rural areas and have the potential for maintaining a higher quality IE&C component to improve use-effectiveness. However, data were not collected on this issue, so it remains a speculative benefit. Supervision is a related theme that merits a closer look. The position of local supervisor was deleted early in the project, but it remains to be seen if central level coordinators can maintain the contact necessary to detect problems and take steps to correct them efficiently in the field. A final option, which may be considered, is adding other low cost products to the CBD package. Pirantel is quite popular and may contribute to the improved institutional status of young children. Oral rehydration salts is another example of a product with obvious impact on child survival, which may be marketed without major revision in the CBD format. Profamilia has data on its promotion and use in Cundinamarca which could provide the basis for additional operations research efforts on product mix and income generation.

F. CBD Distributor Study

During supervisory field visits to the project distributors, frequently they could not adequately describe how to correctly use the methods sold at their posts and in many cases mistaken information was given about a method's use.* These observations plus the results from the Cauca-Cesar Baseline Survey reported earlier which show that many users of the oral contraceptives do not know how to correctly use the method, have raised questions regarding the training of distributors and even the level of their capacity to provide quality service to the community. In turn, this reflects on the costs incurred by Profamilia to train distributors and has suggested for future CBD program the delivery of methods through small drugstores rather than distributors or the use of distributors only in remote areas where no drugstores exist.

For these reasons the study of distributors intended to measure (1) distributor's knowledge or information about the methods sold; (2) how that information is communicated and, (3) how the post is managed. It was expected that distributors with high sales volume would rank highest on these three variables. Intervening variables considered important are: a) the training and supervision of the distributor (content and frequency): b) personal characteristics such as educational, previous or current use of methods and, c) characteristics of the post.

Because of the implications of the study for all of Profamilia's CBD programs, a random sample of distribution posts was selected from the 3,452 posts operative in the county during the second semester of 1984. These posts were supervised by 75 instructors and were located in 582 municipalities. Because of the high cost of visiting sample units

* See for example, M. Townsend's memo to files of June 7, 1982, concerning the distributors in El banco.

in municipalities, the final sample included only those municipalities with three or more posts in the sample. Given the criterion the final sample consisted of 616 distribution posts.

Table 37 describes the coverage of this survey. A total of 531 distributors were interviewed of the 556 operating posts (95.5%) visited. Perhaps most alarming was the discovery that 9.7% of the supposedly active posts were no longer operative, suggesting problems in the management of large volumes of information at the central level of the CBD program.

As illustrated in Table 38, of the posts visited, 86.6% were located in urban areas with more than 2,500 inhabitants. More than 63% of the posts were located in commercial establishments, e.g. small stores, cooperatives, whereas the private home, once the principal outlet, accounted for merely 36.8%. Although two of the obligations of the distributors are to display the Profamilia sign and display the price list, compliance observed was only 80% with signs and 65% with the price list. Only slightly more than half of the distributors had Profamilia publications on hand, including the distributor's manual. Nearly 30% of the posts had Profamilia posters, particularly in small stores, while only about 14% had the contraceptive methods on display in a show-case. Most distributors kept the methods in a separate box to facilitate inventories and accounting.

Table 39 describes the characteristics of the distributors sampled. The mean age of distributors was 40 years, nearly all are female and almost 90% had been married at same time. In terms of education 4% completed five years of primary school and the mean number of years completed for the sample was six. Only 3.4% of the distributors could not read the training manual. Nearly 90% of the distributors had children, and for those with children the average number of live births was four (range 1-16). Three-fourths of the distributors had previously used some form of contraception, of which the last methods used were the following: sterilization 28.7%, orals 28.7%, IUD 12.2%, vaginal tablets 8.2%, condom 6.9% and other 5.0%. Slightly more than half were current users, with sterilization and orals predominating in terms of methods. On the average, they had four years of experience as distributors at the time of the survey, although some had only a few months on the job and one had served for over 14 years. Most were motivated to become distributors by the desire to serve their community or assist Profamilia in promoting responsible parenthood. Interestingly enough, despite continued education , almost half considered Profamilia a public institution. Only 9.0% were principally motivated by the income received. Many (61%) received the assistance of other family members in the tasks of promotion and sales.

Although formal inservice training is a recommended annual activity, 72.5% had received some formal training during the past two years and 14.4% reported never having received formal training (Table 40). This may be due to the natural turnover in posts or additional emphasis placed on non-formal training during the quarterly supervisory visits. Most of the distributors did not actively promote sales in the community, rather they responded to demand generated by personal contacts.

Nevertheless 9% reported making household visits and conducting group meetings. More than two-thirds referred couples for IUD insertion and sterilization, nearly all to the nearest Profamilia clinic (88.5%). Other sources of methods in the community included the Ministry of Health clinics (53.0%), pharmacies (47.7%), the Profamilia clinics (34.2%), and other CBD distributors (26.6%). Six brands of orals were sold, four of which have two presentation (21 and 28), and the most common being Noriday, Neogynon, Noral and Microgynon. In terms of training materials, most used the methods themselves to illustrate user, rather than printed matter, even when pamphlets are available.

As part of the survey, distributors were asked to respond to 31 test questions taken directly for the Distributors Training Manual. The items were then scaled and given one point for each correct answer. The results of this test are presented in Table 41. The average score for the group was 20 items correct (range 1-29) or about 64.5% correct. While 16% of the distributors scored over 80% correct, 19% could barely respond correctly to half the questions. Table 42 describes the 12 items with the highest and lowest percentage of correct responses. The easiest items had to do with when to take the pill and the number of relations per condom, both over 95% correct. The most difficult questions were related to the counterindications for the use of orals (mean correct 29.4%) including high blood pressure (45%), varicose veins (50%), cancer (38%), other cardio-vascular problems (12.4%) and hepatitus (7.3%). Perhaps most distressing was that less than half knew what to recommend, if someone forgot to take the pill for one day, or when a user should begin a new cycle of orals. As providers of information on rhythm, the distributors were also deficient as less than half could indicate correctly which days of the cycle were fertile. Undoubtedly, more directed inservice training will be required to improve the quality of IE&C efforts of the distributors.

Table 43 presents sales information for contraceptives, oral rehydration salts and the anti-helmintic drug, Pirantel. All posts visited in fact sold contraceptives with the average CYP sold per post during the previous six months of 14. The range was enormous, from a newly established post still without sales to one selling the equivalent of 367 CYPs. Less than 5% of the posts sold oral rehydration salts, although an increasing demand on the part of users is evident, particularly on the Atlantic coast. The anti-helmintic drug, Pirantel, was sold by 42% of posts and the average sale per semester was 23 tablets. Again the range was considerable, from 0 to 485 tablets.

No relationship was found between knowledge about contraceptive methods and amount of sales. On the other hand, the highest significant correlations with knowledge were the distributor's years of education ($r=.34$), previous use of contraception ($r=.25$) and age ($r=.22$). Though marginally significant ($p<.10$), the highest correlations with sales were years of experience as distributor and the size of the community. Distributors who worked in larger communities and had more experience sold more contraceptives. Those distributors with family members assisting also reported more sales ($r=.17$).

The majority of distributors (86.3%) had no particular problems in completing their tasks. Of the 70 problems cited by the remaining 14%, about one third of the problems were associated with the need for more IE&C training both for themselves and in the community. About a fourth (28.2%) cited problems of program management and drug supply and 27% reported problems with prices and competition from other sources of supply, particularly the Ministry of Health.

In summary, this study has described the characteristics, knowledge and sales of CBD program distributors nationally. In general, they tend to be somewhat older and have several more years of education than their peers but in most respects, they are simply concerned individuals interested in providing a service to their community. Although sales data would indicate that the progrm is operating quite well, several issues require comment. First, better control should be maintained on the number and location of posts. The survey indicated that nearly ten percent of the supposedly active posts were no longer operative. Given that the information is solely managed by full time Profamilia personnel, the management of post information should be improved. Secondly, 20-30 of the posts neither displayed a Profamilia sign nor a price list. Compliance with these norms is important to promote awareness of the availability of family planning methods in the community and certainly one of the minimum tasks during supervision should be to insure that the post is properly identified. Third, the level of knowledge demonstrated by distributors suggests that much more emphasis should be placed on the contents of the manual during supervision. Although one might argue that the distributors are volunteers and that this lack of knowledge does not affect sales, the competence of Profamilia representatives in providing information on how to appropriately use the method sold is esential. The task of educating distributors is, of course difficult, but for the same reason it should be a continuous effort. Selective more intensive supervision may be required in those areas of the country where knowledge and sales are particularly low. Finally, the sheer volume of sales and number of posts is an impressive demonstration of the potential for service Profamilia has harnessed in rural communities of Colombia. The effort should be strengthened and perhaps more emphasis placed on IE&C, in addition to the existing tasks of resupply and sales accounting.

VI INTEGRATED TIMETABLE OF OPERATIONS

A graphic timetable of project operations is presented in Figure 5. The contract between AID and the Population Council was signed 29 September, 1980. Following the completion of the Extended Medical Supervision project which the AID Mission financed with the Population Council and Profamilia during the 1975-1980 period in Narino and Santander, these two departments were placed in a maintenance phase. Resupply maintenance experiments were conducted in Santander through the first fifteen months of the project, while in Narino these experiments begain in May, 1981 (month eight) and continued for the remainer of the year.

Promotional services in the control areas of Cesar and Cauca departments began in October 1980 and continued through March 1982 (12 months). The baseline survey in Cesar and Cauca was conducted during April-May 1981. Shortly thereafter the promotion phase of the team experiment began, during April, 1981 in Cesar and one month later in May in Cauca. This promotion phase continued through March, 1982 (12 months). The second round survey was conducted in Cesar-Cauca during April-May, 1982 to test the effectiveness of the team strategy. Immediately upon completion of the promotion phase, both experimental and control areas in Cesar and Cauca were placed on maintenance.

At the same time two traditional zones were formed of 14 counties in Magdalena and North Santander and seven counties in Cauca, where instructors provided family planning services according to the traditional instructors system. The services in Magdalena, North Santander and Cauca continued for eight months until the end of November 1982. The maintenance services in Cesar and Cauca continued for another four months until the end of March 1983 (total time in maintenance 12 months). During April-May, 1983 a third survey was conducted in Cesar and Cauca to detect possible changes in knowledge or prevalence of use during the maintenance phase.

Service delivery began in the instructor incentive study areas (Cartagena, Barranquilla, and Santa Marta) in January, 1983 and continued for 18 months until June, 1984. Service delivery by the education team began in January 1983 in Sincelejo, and in July 1983 in Monteria; when the team withdrew from the area it was replaced by the routine instructor services.

The study of unmet need was conducted between July and November, 1983 following the third survey in Cesar and Cauca. Finally, the Distributor Study was carried our in November and December 1984. Much of 1984 was devoted to the processing of data from the surveys as well as the consolidation of service statistics for those areas without surveys. The preparation for the final report began in July 1984 and continued through 31 January, 1985.

VII DISSEMINATION AND UTILIZATION OF RESULTS

A. Use of Results in the Profamilia Management Process

1. Service Programs

The use of the results of this operations research project in the development of a more cost-effective community distribution program has been remarkable. The early CBD program (Echeverry, 1975) had been designed as an integral part of the comprehensive community services provided by the Colombia Coffee-Growers Association. The field workers provided families with a wide range of information including nutrition education, cooking and manual arts because at that time most rural couples in Colombia did not respond well to a direct approach on the subject of contraception. Thus family planning was presented in the context of rural development.

Because the CBD methodology was developed in this integrated fashion and due to the intense personal involvement of the instructors during the household level promotion of these services, the cost per couple year of protection in 1973 was relatively high $10.84. Although comparable with the costs in other family planning programs in Latin America, it was still too high for Profamilia to sustain without substantial external funding.

A related characteristic of this early CBD model was the complexity of the service statistics system. Each month the following information was recorded per county: new cases, reentrants, previous month's participants, defaulters, present month's participants, the volume of contraceptives distributed by method, number of educational meetings, total attendance and the number of home visits made. Though innovative in 1974, by 1982 the maintenance of a longitudinal system for following users was onerous and costly. Moreover, analyses conducted by the evaluation unit to test the validity of the system detected unacceptable levels of error in characterizing contraceptive use. As a result, a simpler method of tabulating all contraceptive sales to calculate couple years of protection was adopted. Moreover the system has been computerized under the direction of Ing. Miguel Zapata and later Ing. Richard Alban. Nearly 60% of the service statistics for the CBD program, approximately 45,000 records per trimester, were currently being processed on the NCR I-9020, 256K donated to Profamilia by Pathfinder; the remaining 40% should be included by the end of 1985. This electronic processing of CBD sales information facilitates the accounting and the supervision of the nearly 3500 distribution posts in the country.

This trend for integrated services to a more vertical orientation to service delivery has also been accompanied by efforts to simplify and specialize the structure of service delivery. Previously urban and rural CBD programs were integrated to lower costs. Early in this project, it became clear that program supervisors were not necessary to maintain the volume of service delivery. During the first trimester of 1982, this position was eliminated and the responsibility for regular supervision was transferred directly to the regional coordinator. This position although based in Bogota requires the supervisor to spend at least 15 working days per month visiting project areas. The impacts of specialization have been tested using the team strategy. As described earlier in this report, the team strategy employed personnel specialized in the communication of family planning information to large groups in place of the household level contacts which characterized the traditional instructor system. As a result of this project, the team is used periodically in other regions of the country as a routine IE&C resource for Profamilia.

Perhaps the most marked trend in the community program has been its gradual transition to a more commercial format. Small stores and pharmacies now greatly outnumber the family home as sites for distribution posts. Although user information and education remain a priority, goals and the performance of instructors are evaluated on the basis of sales. The incentive strategy for instructors which has been adopted in many areas of the country is evidence of this trend. In the field, the

underlying current of competition for users between the CBD and social marketing programs is acknowledged by all staff. The new Profamilia commercial social marketing (CSM) project in Cundinamarca and Santander (Cooperative Agreement DPE-3030-A-00-0500, Subagreement I.A84.20A) is an effort to compare the cost-effectiveness of these two systems (CBD and CSM) in areas that are mutually exclusive.

In summary, the development of cost-effective strategies for CBD and their adoption as routine service delivery procedures is a direct consequence of this project. The process of decision making with the aid of data is an intriguing one in Profamilia. The process is generally as follows:

1) Following agreement upon study design and procedures, the service program and the evaluation unit proceed independently. The Executive Director insures adherence to the rules of evidence.

2) Preliminary data on results are presented to Drs. Fernando Tamayo and Miguel Trias, President and Executive Director respectively, by Dr. Gabriel Ojeda.

3) The implications of the results are then discussed in group by the directorsof all service and support programs.

4) The final results are presented to Drs. Tamayo and Trias and decisions are made on future policy.

5) The new policy is explained in the group session of program directors and follow-up activities are defined.

Perhaps more remarkable is the flexibility of Profamilia to allow the test of a series of alternatives and utilize these results for decision making. The role of the evaluation unit in this process is crucial. The data which is presented is timely, oriented to assist decision making and is directed toward those who must define policy. A brief summary of the impact of this project on the Evaluation and Research Unit follows.

2. Evaluation and Research Unit

Support for evaluation research in Profamilia has been largely a role played by the Population Council. Only recently, have other major donors required some systematic evaluation component in their projects. The changes that have occurred in the evaluation unit since 1976 can be summarized as follows:

1) The service statistics system has been simplified.

2) Quarterly reports available to the public describe the results of all family planning services by clinic area.

3) Previously the Population Council was largely responsible for conducting all components of the research; now this responsibility is

shared and certain components, e. g. sampling, training and supervision of surveyors, are assumed completely by Profamilia or other qualified nationals. Furthermore, other evaluation studies have been conducted without Population Council assistance, e. g. the follow-up of sterilizations, the use of condoms.

4) The evaluation unit and in particular Dr. Ojeda is now providing technical assistance to other family planning service agencies in the region.

5) Data processing has become an internal priority and as a result Profamilia has ordered the purchase of a microcomputer for the evaluation unit.

A good deal remains to be accomplished. For example, the evaluation unit should begin to disseminate results through the publication of results in international journals and conduct more profound secondary analysis of existing data. A more systematic effort to provide training to other agencies would have major impacts. The development of the evaluation unit as a consequence of this project is, however, indisputable.

3. Other Family Planning Service Agencies

The results of this project are now being disseminated through several media: the technical assistance which Profamilia provides to other agencies, the training of personnel from other institutions and Spanish-language publications. Preliminary results have been transmitted to APROFE and SEMOPLAF in Ecuador, ASHONPLAFA in Honduras and APROFAM and the Ministry of Health in Guatemala. Nevertheless, a more systematic dissemination of results is being explored in the context of the Population Council's regional operations research project INOPAL.

VIII NEW CHALLENGES AND LESSONS LEARNED

A. Problems Encountered and Lessons Learned

The problems encountered in the development of this project are in part a product of the operations research process and in part due to the reality or idiosyncracies of Colombia and Profamilia. Perhaps, the most resounding problem and one that is still facing family planning OR in Colombia is the changing attitude of the Government with respect to family planning services and international assistance. During this project the government position has been at times quite positive, e.g. when Dr. Alfonso Jaramillo Salazar was Minister of Health, at times indifferent, and during others reluctant to promote the further extension of family planning services. Because the Ministry of Health is potentially a major provider of these services, unpredictable or abrupt changes in government policy has tremendous impacts on the demand for services from Profamilia as well as the legal restrictions which Profamilia must face in the administration of its programs. Although the

most recent polemic in June 1984 did not directly affect the quality of services provided by the project, the debate certainly affected the volume of services provided by Profamilia, particularly sterilization services.

Operations research itself often produces anxiety in field personnel due to the frequent changes in plans and procedures called for by multiple time series designs with evolving interventions. Although the personnel of Profamilia have been remarkable in their capacity to change direction and responsibilities based upon research results, research protocols require both a loyalty and strict adherence to instructions and the maturity to judge one's performance base upon changing criteria. This problem is mitigated somewhat when the goals and objectives of the research are carefully explained to field personnel and when employment is less dependent on being a participant in the cost-effective treatment condition, then on excellent performance of the required task.

A third problem is the cost of evaluation and operations research activity. It is unlikely that Profamilia would be able to mount the number of surveys and maintain the number of personnel employed in evaluation activities were international assistance reduced. This is not to say that the research has not proven to be a valuable tool, but that the costs of maintaining increasingly professional support staff requires tremendous savings to be made in service programs. One might argue that the investment in operations research in Profamilia is really a regional investment; that is, research conducted in Colombia need not be replicated elsewhere. On the other hand if OR is to become a local management tool, we must begin to explore methods for reducing research costs or considering the costs of the research and probable savings to service programs in the selection of research topics. We are not working for front-end econometric conclusions about probable program impacts, but perhaps the need for a closer look at our methods.

Finally the problem of limited local resources must be cited. By most research standards, the evaluation unit of Profamilia is small both in terms of physical and human resources. Space for maintaining files and running a high quality computer center is extremely limited. Perhaps more serious, only one professional is devoted to operations research activities; the sole professional in the evaluation unit now produces data for reports for a wide range of contracts. The Population Council has also been unable to insure continuity in its technical assistance, due to the changes in staff or in reduced time available due to requirements for assistance elsewhere in the region. Paraprofessional assistance, though abundant, needs continuing education to keep up with the demands of increassingly more complex research requirements. This problem should be addressed directly in the design of future projects with Profamilia.

The lessons learned in the process of conducting this research have been invaluable. The first lesson is that when well thought out, operations research can produce information which can have quantifiable impacts in terms of savings for the service agency. The evaluation budget for Profamilia is currently 2% of total funds; due to sharply

reduced costs per CYP in the CBD program the evaluation unit has been able to demonstrate that this 2% has been a good investment. The executive director of Profamilia has become convinced of the value of information, not only in reducing costs but in making programs more effective and providing services of higher quality. Moreover, the question of whether a better service delivery system can be developed is an ever present challenge to program directors.

The issue of costs has been long confronted by Profamilia. In the face of the unbridled commitment to expand services, costs become paramount. In order to serve a greater number of couples, services have to be inexpensive, not only for the institution but for the user as well. Though inevitably this concern with costs has moved Profamilia ever closer to the commercial sector, it has provided the institution with a larger client base while at the same time self-sufficiency has increased from 42% - 53%. Because of this concern for cost-effectiveness, Profamilia is perhaps better equipped than other institution in the region to deal with future budget limitations.

Another lesson learned has been that of the need to simplify the structure of the organization. During the past five years, the once distinct urban and rural programs have been merged, the number of levels of supervision have been reduced, contractual services have been developed to replace full time salaried professionals. Each of these steps made Profamilia a more manageable, dynamic institution. On the other hand, the need for distinguishing service program staff from support staff has been an increasing concern. For example, the staff of the community program and the IE&C support services are largely indistinguishable. As the CBD program becomes more commercial, its absorption by the social marketing project may become inevitable. Certainly Profamilia is demonstrating an openness to exploring new structures and operations research has been an agile mechanism for testing their viability.

Finally, Profamilia has learned that evaluation has a role to play not only in accounting for program performance, but in the management of the organization. Policy and its administration are better conducted when decisions are supported by data and documented experience.

B. Pending Challenges

The remaining challenges are quite clear. First Profamilia must continue to make the transition to a more commercial operation to augment its self-sufficiency. But it must be achieved without sacrificing quality in the information provided to users or the extension of services to areas underserved by the existing commercial marketing system. Another danger is that the pharmaceutical companies may re-evaluate their relationship with Profamilia if the new commercial retail sales program begins to compete more directly with their own marketing efforts. The current advantage that Profamilia holds is its major investments in IE&C, the large number of distribution posts in rural areas and its market research capacity. Should the existing structure be changed, it is likely that the pharmaceutical companies

will be more difficult in negotiating the local purchase of contraceptive methods.

The concern for quality of use will increase dramatically. As more of the population knows about the existence of methods and sources of supply, greater emphasis will have to be placed on the quality of use rather than on the total CYP. The appropriate use of methods distributed by the community program was first explored in - the second Cesar-Cauca survey and later in the distributor survey. In each case, the need for better user education was obvious.

At the same time, the issue of financing program services must continue to be addressed. With the prospect of reduced international assistance, renewed efforts must be made to increase the auto-sufficiency of service programs. Inflation and the devaluation of national currencies are endemic problems in the region and the budgets of service providing agencies are not immune to their pernicious effects. Also increasing charges to the public as a cost-recovery mechanism is particularly difficult when the objective of the agency is to serve marginal populations. Though complete independence is unlikely before the end of the century, costs will continue to be a factor in nearly all policy and management decisions.

The research unit must likewise begin the process of strengthening internal procedures and upgrading the level of competence of its personnel. The acquisition of a micro-computer and the prospect of continuing education suggests that improvement is possible in the short term. Nevertheless, selective technical assistance and the institutionalization of data processing/analysis capacity will require a clearer vision of the need for information on overall institutional performance.

Finally, the experience of Profamilia should receive greater dissemination in the region. A more carefully thought out strategy, exploring the impact of diverse media and methods for dissemination are required. Videotape, subregional conferences and short tutorials are options that are being reviewed, in addition to more traditional strategies for the publication of project results in international journals. The new Population Council regional operational research project INOPAL should provide a framework for confronting some of these challenges; others must be addressed in a much broader forum of family planning service providers and donors.

IX SUMMARY AND CONCLUSIONS

With this final narrative, the Populatin Council and Profamilia have complied with all the terms of the contract (AID/DSPE-C-0084). As a result of this effort operations research is now well integrated into the Profamilia management process. Moreover, cost-effective CBD service delivery systems have evolved as a result of the structure and results of the research strategies. The trend toward more commercial delivery systems is widely accepted. It is also clear that operations research can be done in a wide range of cultural settings with relatively few staff with research skills if timely technical assistance is available.

The results of this research should receive greater dissemination, through regional training activities, spanish-language publications and papers in international journals.

In terms of specific results, the projects demonstrated that promotion in the context of CBD services is an effective vehicle for increasing contraceptive prevalence. Following intense periods of promotion, maintenance level services are feasible and very little is lost in terms of community level knowledge or prevalence of use of contraception. The resupply of distributors is still a costly operation, although the change from monthly to quarterly intervals reduces travel costs and improves the opportunities for selective supervision. Similarly, the use of a simplified data collection system facilitates the calculation of couple years of protection and cost accounting, while freeing the instructor and distributor of the enormous task of following up on individual users. The more commercial the program orientation, the less likely adequate follow-up will occur.

Improved knowledge of family planning methods and use-effectiveness remain principal concerns. The team approach is efficient for providing mass education, particularly in rural areas, but it requires the initial investment in vehicles and audiovisual equipment as well as the support of instructors and adequate resupply systems during maintenance.

The incentive scheme is not very expensive and is capable of increasing rapidly the volume of sales in most areas. Nevertheless, it is also approximating a more commercial model as increasing sales are made to stores and pharmacies, rather than private homes. The distributors need additional training to be really knowledgeable about the methods they provide. Couples who wish to space or limit births may receive incorrect information due to the inadequate training and supervision of distributors. Unmet need remains an issue and new strategies for serving this subgroups of couples must be developed.

Clearly the trend is toward a more commercial service delivery model as the social marketing program now accounts for more than half of all sales, and at the same time provides a source of income for Profamilia. However, if the trend toward commercialization continues, the suppliers of contraceptives in the private sector may decide at any time that the intermediary role of Profamilia is not necessary. Perhaps the best safeguard against this is the considerable investment made in Profamilia in IE&C and the large number of outlets devoted almost exclusively to the sale of contraceptives. Moreover, Profamilia provides the suppliers with market research data on the characteristics and preferences of target populations through its survey and evaluation activities.

Finally challenges remain to reduce costs and increase coverage, consolidating the growth and development in Profamilia service and support programs. In the future the utilization of results and technical cooperation with other family planning service agencies will be critical for the development of the organization.

X REFERENCES

Bailey, J. and J. Correa, Evaluation of the Profamilia Rural Family Planning Program. Studies in Family Planning, Vol.6, No. 6, June, 1975, pp.148-155.

Echeverry, G., Development of the Profamilia Rural Family Planning Program in Colombia. Studies in Family Planning, Vol. 6, No.6, June, 1975, pp.142-147.

Echeverry, C. Community-Based Distributionof Contraceptives: A Result of the Evolution of Family Planning. Unpublished manuscript, Bogota, April, 1979.

Ochoa, L.H., The Evaluation of the Impact of Family Planning Programs on Fertility" The Case of Colombia. In United Nations Studies to enhance Family Planning Evaluation: The Cases of Colombia, Costa Rica, Sri Lanka and Pakistan. New York (in press, 1984).

Ochoa, L.H., and P. Richardson, Second Contrceptive Prevalence Survey Colombia 1980: General Results. Corporacion Centro Regional de Poblacion, Bogota, 1982.

Ochoa, L.H. and P. Richardson, Fertility levels and contraceptive use in Colombia: Policy Implications, Bogota, Colombia, October 4, 1980.

Patton, M.Q., Utilization Focused Evaluation, Sage: Beverly Hills, California, 1978.

Profamilia, Annual Statistical Summary, Bogota, Colombia, 1983.

Profamilia, Manual sobre Metodos Anticonceptivos (para el Equipo y Distribuidores), Bogota, Colombia, Octubre, 1981.

Quick, S.D., Country Demographic Profile: Colombia, US Department of Commerce, Bureau of the Census; Washington, D.C., October, 1979.

Townsend, M.C., "Narrative Program Report (AID/DSPE-C-0084), October 1, 1980 to July 31, 1981," August 1981.

Townsend, M.C., "First Year Narrative Progress Report (AID/DSPE-C-0084), September 30, 1980 to September 29, 1981."

Townsend, M.C., "Six Month Progress Report (AID/DSPE-C-0084), October 1, 1981 to March 31, 1982," October 1982.

Townsend, M.C., "Second Year Program Report (AID/DSPE-C-0084), October 1, 1981 to November 30, 1982."

Townsend, M.C., "Progress Report (AID/DSPE-C-0084), December 1, 1982 to June 30, 1983," August 1983.

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APPENDIX 1

List of Collaborators

Name	Position
Miguel Trias	Project Director
Gabriel Ojeda	Principal Investigator
Lily B. de Bucheli	Director Div. IE & C

Evaluation Division

Ana Vega	Data Analyst
Carmenza Castro	Supervisor
Consuelo Vázquez	Supervisor
Fernando Cadavid	Supervisor
Olga Palacio	Supervisor
Santiago Luna	Supervisor
María Eugenia Vega	Supervisor
Mayra Horta	Supervisor
Mercedes Sánchez	Support
Marta de Leiva	Support
Miriam de Romero	Support
Gloria Parra	Secretary
Esther Saenz	Secretary
Luis Carlos Gómez	Consultant
Clara Inés Ortiz	Data Entry
Miguel Zapata	Systems Analyst

An innumerable group of interviewers, drivers, collaborative informants and data processing assistants.

IE & C Division

Luisa de Murillo	CBD Coordinator
Blanca de Restrepo	Supervisor
Isabel Altamar	Instructor
Adilza González	Instructor
Fanny Miranda	Instructor
Ener María Gutiérrez	Instructor
Maruja Llamas	Instructor
Adalgiza Bossio	Instructor
Soledad Zamudio	Instructor
María González	Instructor
José Fidolo Camelo	Instructor
Nohora Conde	Instructor
Nuriz Díaz	Instructor
Carmen Meléndez	Instructor
Juana Arcos	Instructor

Innumerable group of other supervisors, instructors, distribution post managers and community collaborators.

APPENDIX 2

List of Previous Reports on this Project

Townsend, M. C., "Narrative Program Report (AID/DSPE-C-0084), October 1, 1980 to July 31, 1981," August 1981.

Townsend, M. C., "First Year Narrative Progress Report (AID/DSPE-C-0084), September 30, 1980 to September 29, 1981."

Townsend, M. C., "Six Month Progress Report (AID/DSPE-C-0084), October 1, 1981 to March 31, 1982," October 1982.

Townsend, M. C., "Second Year Program Report (AID/DSPE-C-0084), October 1, 1981 to November 30, 1982."

Townsend, M. C., "Progress Report (AID/DSPE-C-0084), December 1, 1982 to June 30, 1983," August 1983.

APPENDIX 3

Forms for Cesar-Cauca 1, 2 and 3

Forms for Distribution Study

PROFAMILIA	ENCUESTA BASICA: CESAR Y CAUCA 1981 CUESTIONARIO INDIVIDUAL	CONFIDENCIAL FINES CIENTIFICOS

I. IDENTIFICACION DEL CUESTIONARIO

CODIGOS

(101) Número de identificación — 1 [ ][ ][ ][ ][1] 5

(102) Municipio _____ — 6 [ ][ ] 7

(103) Segmento [ ][ ] — 8 [ ][ ] 9

(104) Zona — Urbana [1] — Rural [2] — [ ] 10

(105) Número del Hogar [ ][ ] — 11 [ ][ ] 12

(106) Nombre y No. de Orden de la mujer _____ [ ][ ] — 13 [ ][ ] 14

(107) Mes de la Entrevista _____ MES — [ ] 15

RESULTADO:
1 Completa
2 Incompleta
3 Rechazo
4 Ausencia de la mujer
5 Otro

II. CARACTERISTICAS DE LA ENTREVISTADA

CODIGOS

(201) En que mes y año nació Usted? _____ MES 19 ____ AÑO — No sabe [ ] — [ ][ ][ ][ ] 16 17 18 19

(PASE A 203)

(202) Entonces cuántos años cumplidos tiene Usted? [ ][ ] AÑOS — [ ][ ] 20 21

(203) Cuál es su estado civil (conyugal) actual?

Casada [1] Viuda [3]

Conviviente [2] Divorciada/ Separada [4] — [ ] 22

(204) Hablando de su educación, cual fue el año o curso más alto que usted aprobó?

ENCIERRE EN UN CIRCULO EL NIVEL MAS ALTO ALCANZADO Y EL ULTIMO AÑO APROBADO EN ESTE NIVEL. SI LA ENTREVISTADA NUNCA FUE A LA ESCUELA, MARQUE PRIMARIA CERO

	NIVEL	AÑOS
1	Primaria	0 1 2 3 4 5
2	Secundaria	1 2 3 4 5 6 7
3	Universitario	1 2 3 4 5 6 7 o más

[ ] 23 [ ] 24

(205) Ha tenido Ud. hijos alguna vez?

SI [1] (PASE A 207) NO [2] — [ ] 25

(206) Ha estado embarazada alguna vez?

SI [1] (PASE A 211) NO [2] (PASE A 214) — [ ] 26

(207) En total en toda su vida cuantos hijos nacidos vivos ha tenido?

[ ][ ] NUMERO — [ ][ ] 27 28

(208) Ha tenido hijos que nacieron vivos pero murieron después, aunque hayan vivido solo unos minutos?

SI [1] NO [2] — [ ] 29

(209) En total, en toda su vida, cuantas veces ha estado embarazada?

[ ][ ] NUMERO — [ ][ ] 30 31

(210) ENTREVISTADOR (A): RESTE DE 209 (TOTAL EMBARAZOS) 207 (NACIDOS VIVOS) Y ANOTE RESULTADO AQUI _____ Y AHORA DIGA A LA ENTREVISTADA: "ES DECIR, Ud. HA TENIDO _____ ABORTOS Y NACIDOS MUERTOS. ES ESTO CORRECTO?

SI [1] (PASE A 212) NO [2] CORRIJA DONDE SEA NECESARIO — [ ][ ] 32 33

45

CARACTERISTICAS. CONTINUACION — CODIGOS

(211) Cuántas veces ha estado embarazada? [ ] NUMERO — [ ] 34

(212) Está Ud. embarazada actualmente?

SI [1] NO [2] NO SABE [3] — [ ] 35

(PASE A 215)

(213) Desea Ud. tener otro niño fuera del que está esperando?

SI [1] NO [2] NO SABE [3] — [ ] 36

(PASE A 301)

(214) Hasta donde Ud. sabe, Ud y su marido son capaces de tener un hijo si Uds. lo quieren?

SI [1] NO [2] NO SABE [3] — [ ] 37

(PASE A 301)

(215) Desea Ud. tener un (otro) niño?

SI [1] NO [2] NO SABE [3] — [ ] 38

III. CONOCIMIENTO Y USO DE METODOS — CODIGOS

LAS PREGUNTAS 301 A 306 DEBEN DILIGENCIARSE EN EL ESQUEMA EN LA PAGINA SIGUIENTE

(301) Hay varias formas, maneras o métodos para que una pareja pueda demorar o evitar un embarazo o un hijo si no lo desea.

Conoce Ud. o ha oído acerca de alguna forma, manera o método para planificar la familia o medio para evitar un nacimiento?

[1] SI

[2] NO → (PASE A 304) — [ ] 39

(302) Qué métodos de planificación familiar o medio para evitar un nacimiento conoce Usted?

COLOQUE UN CIRCULO EN "1" DE LA COLUMNA A1 DEL ESQUEMA POR CADA METODO MENCIONADO

(303) POR CADA METODO DENTRO DE UN CIRCULO EN LA COLUMNA A1 PREGUNTE:
Ha usado Ud o su esposo (compañero) alguna vez _____ METODO

COLOQUE UN CIRCULO EN LA RESPUESTA APROPIADA EN LA COLUMNA A3 DEL ESQUEMA

(304) POR CADA METODO QUE NO ESTE DENTRO DE UN CIRCULO EN LA COLUMNA A1 PREGUNTE:
Para estar bien segura ha oído hablar de _____ METODO O MEDIO

COLOQUE UN CIRCULO EN "2" O EN "3" EN LA COLUMNA A2 DEL ESQUEMA. SI LA RESPUESTA ES AFIRMATIVA (CIRCULO EN "2") HAGA LA PREGUNTA 305 ANTES DE PREGUNTAR SOBRE EL PROXIMO METODO

(305) Ha usado Ud. o su esposo (compañero) alguna vez _____ METODO

COLOQUE UN CIRCULO EN LA RESPUESTA APROPIADA EN LA COLUMNA A3 DEL ESQUEMA

CONTINUACION CONOCIMIENTO Y USO METODOS

(306) Actualmente usted(es) está(n) usando o ha(n) usado durante el último mes algún método de planificación familiar para evitar un embarazo?

[1] SI → cuál? _____

SI MAS DE UN METODO PREGUNTE CUAL ES EL DE USO MAS FRECUENTE Y MARQUE EL CODIGO CORRESPONDIENTE EN LA COLUMNA A4 Y PASE A 307.

[2] NO → SI EN LA COLUMNA A3 DEL ESQUEMA NO EXISTE ALGUNA RESPUESTA AFIRMATIVA (CODIGO "2" PARA TODOS LOS METODOS) PASE A 401. SI HAY ALGUNA RESPUESTA AFIRMATIVA (CODIGO "1" EN ALGUN METODO) PASE A 323

40

41 42

ESQUEMA DE CONOCIMIENTO Y USO

METODOS DE PLANIFICACION FAMILIAR	A.1 302 Sin Ayuda SI	A. 2 304 Con Ayuda SI	A. 2 304 Con Ayuda NO	A. 3 303 Ha usado alguna vez SI	A. 3 305 Ha usado alguna vez NO	A. 4 306 Método que usa actualmente		
01 Píldora	1	2	3	1	2	01 Píldora	43	44
02 Condón	1	2	3	1	2	02 Condón	45	46
03 DIU	1	2	3	1	2	03 DIU	47	48
04 Esterilización Femenina	1	2	3	1	2	04 Esterilización Femenina	49	50
05 Esterilización Masculina	1	2	3	1	2	05 Esterilizacion Masculina	51	52
06 Inyección	1	2	3	1	2	06 Inyección	53	54
07 Vaginales	1	2	3	1	2	07 Vaginales	55	56
08 Ritmo	1	2	3	1	2	08 Ritmo	57	58
09 Retiro	1	2	3	1	2	09 Retiro	59	60
10 Otros	1		3	1	2	10 Otros	61	62
Ninguno	96			97		98		

(307) ENTREVISTADOR(A): PASE A LAS SIGUIENTES PREGUNTAS DEPENDIENDO DEL METODO QUE LA SEÑORA ESTA ACTUALMENTE USANDO. COLOQUE UNA "X" EN LA CASILLA APROPIADA

[1] píldora → 308
[2] Condón → 313
[3] Ritmo → 316
[4] Retiro → 317
[5] Ovulos → 318
[6] Esterilización Femenina
[7] Esterilización Masculina } → 401

[8] DIU
[9] Otros
[10] Inyección } → 321

(308) Cuántas píldoras trae el paquete o cartón que Usted generalmente usa

21 [1] 28 [2] NO SABE [3]

(PASE A 311) — 63

(309) Cuándo Ud. termina el paquete o cartón cuántos días espera para comenzar uno nuevo?

_____ DIAS — 64

(310) Que haría Ud. si no le viene la menstruación después de haber tomado las 21 píldoras?

[1] Continua
[2] Consulta al médico
[3] Abandona
[4] Continua y va donde el médico
[5] Otro _____ (ESPECIFIQUE) — 65

(311) Cada cuánto se toma Ud. una píldora?

_____ — 66

(312) Cuándo a Ud. se le olvida tomar una píldora que hace?
(COLOQUE UNA "X" EN LA CASILLA APROPIADA)

Tan pronto se acuerda se la toma y sigue el ciclo normal [1]
Toma dos al siguiente día en forma simultánea [2]
Toma una al siguiente día [3]
Las suspende definitivamente [4]
Otros _____ [5]
(ESPECIFIQUE)

(PASE A 321) — 67

(313) Dónde guarda los condones?

_____ — 68

(314) Siempre usa un condón cuando tienen relaciones sexuales?

SIEMPRE [1] A VECES [2] — 69

(315) Lo usa:
Desde el comienzo de la relación [1]
En algún momento durante la relación [2]
(PASE A 321) — 70

(316) Cuándo Ud. tiene relaciones sexuales, las tiene:

Hasta 10 días después de iniciar la menstruación [1]
En los 10 días antes de iniciar la menstruación [2]
En los dos casos anteriores [3]
En el período intermedio entre los dos primeros [4]
Durante la menstruación [5]
En cualquier momento del ciclo [6]
(PASE A 321) — 71

(317) Si Ud. usa el método del retiro en que momento saca su marido el pene?

Antes de la eyaculación [1]
Durante la eyaculación [2]
Después de la eyaculación [3]
Otro [4]
(PASE A 321) — 72

48

CONTINUACION CONOCIMIENTO Y USO METODOS

(318) Cada vez que usted tiene relaciones sexuales usted se coloca un óvulo?

SI [1] NO [2] [ ] 73

(319) Cuando los usa en que momento se los coloca?

Antes del acto sexual [1]
Durante el acto sexual [2]
Después del acto sexual [3] [ ] 74

(320) Usted coloca el óvulo en la vagina lo más profundo que pueda?

SI [1] NO [2] A VECES [3] [ ] 75

(321) Ha pensado alguna vez en cambiar de método?

SI [1] NO [2] [ ] 76

(322) Por qué? (PASE A 401)

_____

_____ [ ] 77

(PASE A 401)

(323) Por qué dejó Ud. de usar el último método?

_____

_____ [ ] 78

(324) Ha pensado usar un método en el futuro?

SI [1] NO [2] [ ] 79

(PASE A 401)

(325) Qué método ha pensado usar?

_____ [ ] 80

IV. CONOCIMIENTO Y USO DE FUENTES DE SERVICIO DE PLANIFICACION FAMILIAR

IDENTIFICACION [ ][ ][ ][ ][2] 1 5

(401) Sabe Ud. en donde le pueden dar información o métodos (servicios) de planificación familiar?

SI [1] NO [2] [ ] 6

(PASE A 403)

(402) Dónde le pueden dar información o métodos (servicios) de planificación familiar?

	INFORMACION	METODO, SERVICIO SUMINISTRO
Puesto de Salud	1	1
Droguería	2	2
PROFAMILIA	4	4
Médico particular	8	8
Amiga o vecina	16	16
Otro _____ (ESPECIFIQUE)	32	32
No sabe	00	00

[ ][ ][ ][ ] 7 8 9 10

49

CONOCIMIENTO Y USO DE FUENTES, CONTINUACION

CODIGOS

(403) MARQUE LA CASILLA APROPIADA

ACTUALMENTE USA NO ESTERILIZADA [1] → NO USA ACTUALMENTE [2] (PASE A 501)

ESTERILIZADA [3] →

[ ] 11

(404) A dónde va con más frecuencia (normalmente) a solicitar servicios de planificación familiar?

- Puesto de Salud, hospital, promotora del Ministerio de Salud. [1]
- Droguería [2]
- PROFAMILIA [3]
- Médico Particular [4]
- Otro _____ [5]

(ESPECIFIQUE)

[ ] 404 12

(405) Volverá a este servicio?

SI [1] NO [2] → (PASE A 502)

(406) Por quién fue remitida para esta operación?

_____

_____

[ ] 405 13

(407) Dónde le hicieron la operación?

_____

_____

_____

(ESPECIFIQUE)

[ ] 406 14

[ ] 407 15

AGRADEZCA A LA ENTREVISTADA POR SU COLABORACION Y TERMINE LA ENTREVISTA

V OPINION DE SERVICIOS Y METODOS

CODIGOS

(501) Señora, para estar bien segura, Ud. ha pensado en usar un método de planificación familiar en el futuro aunque en el momento no está planificando?

SI [1] (PASE A 511) NO [2] → AGRADEZCA A LA ENTREVISTADA POR SU COLABORACION Y TERMINE LA ENTREVISTA

[ ] 16

(502) Sabe su marido (compañero) que Ud. usa metodo anticonceptivos?

SI [1] NO [2]

[ ] 17

(503) Antes de que ud empezara a usar un método, le dijeron que había otros métodos diferentes del que Ud. usa actualmente?

SI [1] NO [2] (PASE A 505)

[ ] 18

(504) Cuales métodos le explicaron?

- Píldora [1]
- Condón [2]
- DIU [4]
- Esterilizacion femenina [8]
- Esterilización masculina [16]
- Inyección [32]
- Vaginales [64]
- Ritmo [128]
- Retiro [256]
- Otros [512]

[ ][ ][ ][ ] 19 20 21 22

(505) Antes de empezar a usar un método le dijeron que algunos métodos pueden producir complicaciones?

SI [1] NO [2] (PASE A 507)

[ ] 23

50

OPINION DE SERVICIOS Y METODOS CONTINUACION | CODIGOS

(506) De qué complicaciones le hablaron?

[1] Píldora _____
[2] DIU _____
[4] Inyección _____
[8] Vaginales _____
[16] Otros _____
(ESPECIFIQUE)

[ ][ ] 24 25

(507) Ud. ha tenido algunas molestias con el método que está usando actualmente?

SI [1] NO [2]
(PASE A 510)

[ ] 26

(508) Le han dicho que Ud. puede cambiar de Metodo?

SI [1] NO [2]
(PASE A 510)

[ ] 27

(509) A cuál método?

_____
_____

[ ] 28

(510) Ud. ha recomendado planificación familiar a otras personas de su comunidad?

SI [1] NO [2]

[ ] 29

(511) De quién preferiría Ud. recibir información y métodos de planificación familiar?

Enfermera [1]
Médico [2]
Droguista [3]
Promotora [4]
Amiga, Vecina [5]
Otro _____ [6]
(ESPECIFIQUE)
No sabe [9]
(PASE A 513)

[ ] 30

(512) Por qué?

_____
_____

[ ] 31

(513) Conoce Ud. otras usuarias de planificación familiar en su comunidad?

SI [1] NO [2]

AGRADEZCA A LA ENTREVISTADA POR SU COLABORACION Y TERMINE LA ENTREVISTA

[ ] 32

(514) Cómo llegó a conocerlas?

_____
_____
_____

[ ] 33

AGRADEZCA A LA ENTREVISTADA POR SU COLABORACION Y TERMINE LA ENTREVISTA.

PROFAMILIA	ENCUESTA BASICA: CESAR Y CAUCA 1981 CUESTIONARIO DE HOGAR	CONFIDENCIAL FINES CIENTIFICOS

I. IDENTIFICACION DEL CUESTIONARIO

(101) Número del Cuestionario [ ][ ][ ][ ] (1 2 3 4)

(102) Municipio Balboa [1][0] (5 6)

(103) Segmento [0][1] (7 8)

(104) Zona Urbana 1 / Rural 2 [1] (9)

(105) Número de Hogar [0][7][0] (10 11 12)

Vereda _____

Encuestadora Amparo de Bernal

FECHA DE ENTREVISTA 25 (DIA) Febrero (MES)

CUESTIONARIO _____ de _____

II. PARA TODOS LOS MIEMBROS DEL HOGAR

NUMERO DE ORDEN DE LA PERSONA	NOMBRES Y APELLIDOS	PARENTESCO	SEXO	EDAD	15 AÑOS Y MAS: ESTADO CIVIL		ELEGIBILIDAD
	Por favor dígame los nombres de las personas que normalmente viven en este hogar, aunque no hayan dormido aquí anoche.	Cual es el parentesco o relación de..... ..... con el jefe del hogar Jefe [1] Esposa [2] Hijos [3] Parientes [4] Otros [5]	Es hombre o mujer? H [1] M [2]	Cuántos años cumplidos tiene?	Ha estado casado o unido alguna vez? SI [1] CONTINUE NO [2] PASE A LA SIGUIENTE PERSONA	Cuál es su estado civil actual? Casado [1] Conviviente [2] Viudo [3] Separado o divorciado [4]	Numere la mujer elegible para la entrevista individual en orden consecutivo.
(201)	(202)	(203)	(204)	(205)	(206)	(207)	(208)
13-14		15	16	17-18	19	20	21
01							
02							
03							
04							
05							
06							
07							
08							
09							
10							
11							
12							
13							
14							

(209)	Número de personas en el hogar	22 [ ][ ]
(210)	Número de mujeres elegibles	24 [ ]

RESULTADO DE LA VISITA

- [1] Completa
- [X] Ningun adulto en la casa
- [3] Casa desocupada
- [4] Rechazo
- [5] No es vivienda
- [6] Otro

PROFAMILIA CONSEJO DE POBLACION	SEGUNDA ENCUESTA: CESAR Y CAUCA 1982 CUESTIONARIO DE HOGAR	CONFIDENCIAL FINES CIENTIFICOS

I. IDENTIFICACION DEL CUESTIONARIO

(101) Número del Cuestionario [ ][ ][ ][ ] 1 2 3 4

(102) Municipio _____ [ ][ ] 5 6

(103) Segmento [ ][ ] 7 8

(104) Zona — Urbana 1, Rural 2 [ ] 9

(105) Número de Hogar [ ][ ][ ] 10 11 12

Vereda _____

Encuestadora

NOMBRE _____ CODIGO [ ]

FECHA DE ENTREVISTA

DIA _____ MES _____

CUESTIONARIO _____ DE _____

II. PARA TODOS LOS MIEMBROS DEL HOGAR					15 AÑOS y MAS		TODAS LAS MUJERES 15-49 AÑOS			
NUMERO DE ORDEN DE LA PERSONA	NOMBRES Y APELLIDOS	PARENTESCO	SEXO	EDAD	ESTADO CIVIL		HIJOS NACIDOS VIVOS			ELEGIBILIDAD
	Por favor dígame los nombres de las personas que normalmente viven en este hogar, aunque no hayan dormido aquí anoche. INICIE CON EL JEFE	Cual es el parentesco o relación de con el jefe del hogar JEFE [1] ESPOSA [2] HIJOS [3] PARIENTES [4] OTROS [5]	Es hombre o mujer? H [1] M [2]	Cuántos años cumplidos tiene?	Ha estado casado o unido alguna vez? SI [1] CONTINUE NO [2] PASE A LA SIGUIENTE PERSONA	Cual es su estado civil actual Casado [1] Conviviente [2] Viudo [3] Separado o divorciado [4]	Ha tenido hijos alguna vez? SI [1] NO [2] SI ES NO, PASE A LA SIGUIENTE PERSONA	Cuantos hijos nacidos vivos ha tenido?	En que fecha tuvo su último hijo nacido vivo? (MES Y AÑO) Enero 01 Febrero 02 Marzo 03 Abril 04 Mayo 05 Junio 06 Julio 07 Agosto 08 Septiembre 09 Octubre 10 Noviembre 11 Diciembre 12	Numere la mujer elegible para la entrevista individual en orden consecutivo.
(201)	(202)	(203)	(204)	(205)	(206)	(207)	(208)	(209)	(210)	(211)
13-14		15	16	17-18	19	20	21	22-23	24-27	28
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										

(212)	Número de personas en el hogar	29 [ ][ ]	30
(213)	Número de mujeres elegibles	31 [ ][ ]	

(214) Fue entrevistada en la primera encuesta (Abril-Mayo, 1981) SI 1, NO 2 [ ] 32

RESULTADO DE LA VISITA [1] Completa [2] Ningún adulto en casa [3] Casa desocupada [4] Rechazo [5] No es vivienda [6] Otro

PROFAMILIA CONSEJO DE POBLACION	SEGUNDA ENCUESTA: CESAR Y CAUCA 1982 CUESTIONARIO INDIVIDUAL	CONFIDENCIAL FINES CIENTIFICOS

A. IDENTIFICACION DEL CUESTIONARIO

CODIGOS

(101) Número de identificación — 1 [ ][ ][ ][ ][1] 5

(102) Municipio _____ — 6 [ ][ ] 7

(103) Segmento [ ][ ] — 8 [ ][ ] 9

(104) Zona — Urbana [1] — Rural [2] — 10 [ ]

(105) Número del hogar [ ][ ][ ] — 11 [ ][ ][ ] 13

(106) Nombre y número de orden de la mujer _____ [ ][ ] — 14 [ ][ ] 15

B. RESULTADO DE LA ENTREVISTA

CODIGOS

(107). Visita	(108). Fecha		(109). Hora de iniciación	(110). Hora de terminación	(111). Resultado
	día	mes			
1o.					
2o.					

16 [ ]

17 [ ]

CODIGO DE RESULTADO DE LA VISITA (S)

1. Completa
2. Incompleta
3. Rechazo
4. Ausencia de la mujer
5. Otro

C. CONTROL DE SUPERVISION Y PROCESAMIENTO

CODIGOS

(112.) Nombre de la encuestadora _____

Observaciones _____

_____

18 [ ]

(113.) Nombre del supervisor _____

Observaciones _____

_____

(114.)

	SUPERVISOR	CRITICO	CODIFICADOR
Fecha			
Nombre			

II. CARACTERISTICAS DE LA ENTREVISTADA

CODIGOS

(201). A Ud. la entrevistó PROFAMILIA en Abril o Mayo del año Pasado?

SI [1] NO [2] — 19 [ ]

(202) ¿En qué mes y año nació usted? _____ 19____ NO SABE [ ] — 20 [ ][ ][ ][ ] 23

MES AÑO

(PASE A 204)

(203) Entonces cuantos años cumplidos tiene Usted? [ ][ ] — 24 25

AÑOS

(204) Cual es su estado civil (conyugal) actual? — 26 [ ]

Casada [1] Viuda [3]

Conviviente [2] Divorciada/Separada [4]

(205) Cual fue el año o curso más alto que Usted aprobó?

> ENCIERRE EN UN CIRCULO EL NIVEL MAS ALTO ALCANZADO Y EL ULTIMO AÑO APROBADO EN ESTE NIVEL. SI LA ENTREVISTADA NUNCA FUE A LA ESCUELA, MARQUE PRIMARIA CERO

NIVEL	AÑOS
1 Primaria	0 1 2 3 4 5
2 Secundaria	1 2 3 4 5 6 7
3 Universitario	1 2 3 4 5 6 7 o más

27 [ ] 28 [ ]

(206) Ha tenido Ud. hijos alguna vez? — 29 [ ]

SI [1] NO [2]

(PASE A 208)

(207) Ha estado embarazada alguna vez? — 30 [ ]

SI [1] NO [2]

(PASE A 213) (PASE A 216)

(208) En total en toda su vida cuantos hijos nacidos vivos ha tenido? — 31 32 [ ][ ]

NUMERO [ ][ ]

(209) Ha tenido hijos que nacieron vivos pero murieron después, aunque hayan vivido solo unos minutos? — 33 [ ]

SI [1] NO [2]

(210) En total, en toda su vida, cuantas veces ha estado embarazada? — 34 35 [ ][ ]

NUMERO [ ][ ]

(211) ENTREVISTADOR (A): RESTE DE 210 (TOTAL EMBARAZOS) 208 (NACIDOS VIVOS) Y ANOTE RESULTADO AQUI _____ Y AHORA DIGA A LA ENTREVISTADA: ES DECIR, Ud. HA TENIDO _____ ABORTOS Y NACIDOS MUERTOS. ES ESTO CORRECTO? — 36 37 [ ][ ]

SI [1] NO [2] CORRIJA DONDE SEA NECESARIO

(212) Dígame ahora en qué mes y año tuvo su último hijo nacido vivo? — 38 41 [ ][ ][ ][ ]

_____ 19____ NO SABE [ ]

MES AÑO

(PASE A 214)

CARACTERISTICAS. CONTINUACION	CODIGOS
(213) Cuántas veces ha estado embarazada? ☐ NUMERO	☐ 42
(214) Está Ud. embarazada actualmente? SI [1] NO [2] NO SABE [3] → (PASE A 217)	☐ 43
(215) Desea Ud. tener otro niño fuera del que está esperando? SI [1] NO [2] NO SABE [3] → (PASE A (301)	☐ 44
(216) Hasta donde Ud. sabe, Ud. y su marido son capaces de tener un hijo si Uds. lo quieren? SI [1] NO [2] NO SABE [3]	☐ 45
(217) Desea Ud. tener un (otro) niño? SI [1] NO [2] NO SABE [3]	☐ 46

III. CONOCIMIENTO Y USO DE METODOS	CODIGOS
LAS PREGUNTAS 301 HASTA LA 306 DEBEN DILIGENCIARSE EN EL ESQUEMA DE LA PAGINA SIGUIENTE.	
(301) Hay varias formas, maneras o métodos para que una pareja pueda demorar o evitar un embarazo o un hijo si no lo desea. Conoce Ud. o ha oído acerca de alguna forma, manera o método para planificar la familia o medio para evitar un embarazo? SI [1] NO [2] (PASE A 304)	☐ 47
(302) Qué métodos de planificación familiar o medio para evitar un embarazo conoce Ud.?	
COLOQUE UN CIRCULO EN "1" DE LA COLUMNA A1 DEL ESQUEMA POR CADA METODO MENCIONADO.	
(303) POR CADA METODO DENTRO DE UN CIRCULO EN LA COLUMNA A1 PREGUNTE: Ha usado Ud. o su esposo (compañero) alguna vez _____ METODO	
COLOQUE UN CIRCULO EN LA RESPUESTA APROPIADA EN LA COLUMNA A 3 DEL ESQUEMA	
(304) POR CADA METODO QUE NO ESTE DENTRO DE UN CIRCULO EN LA COLUMNA A 1 PREGUNTE: Para estar bien segura ha oído hablar de _____ METODO O MEDIO	
COLOQUE UN CIRCULO EN "2" O EN "3" EN LA COLUMNA A2 DEL ESQUEMA. SI LA RESPUESTA ES AFIRMATIVA (CIRCULO EN "2") HAGA LA PREGUNTA 305 ANTES DE PREGUNTAR SOBRE EL PROXIMO METODO.	

CONOCIMIENTO. CONTINUACION

CODIGOS

(305) Ha usado Ud. o su esposo (compañero) alguna vez _____
METODO

COLOQUE UN CIRCULO EN LA RESPUESTA APROPIADA EN LA COLUMNA A3 DEL ESQUEMA

(306) Actualmente usted (es) está (n) usando o ha (n) usado durante el último mes algún método de planificación familiar para evitar un embarazo?

[1] SI ——→ Cuál? _____ [ ] 48

SI MAS DE UN METODO PREGUNTE CUAL ES EL DE USO MAS FRECUENTE Y MARQUE EL CODIGO CORRESPONDIENTE EN LA COLUMNA A4 Y PASE A 307

[2] NO ——→ [ ][ ] 49 50

PARA LAS SEÑORAS QUE NO CONOCEN NINGUN METODO Y POR LO TANTO NUNCA HAN USADO ("96" EN LA COLUMNA A. 1) PASE A 401. TODAS LAS DEMAS PASAN A 315.

ESQUEMA DE CONOCIMIENTO Y USO

METODOS DE PLANIFICACION FAMILIAR	A. 1 (302) Sin ayuda SI	A. 2 (304) Con ayuda SI	A. 2 (304) Con ayuda NO	A. 3 (303) Ha usado Alguna vez SI	A. 3 (305) Ha usado Alguna vez NO	A. 4 (306) Método que usa actualmente		
01 Píldora	1	2	3	1	2	01 Píldora	51 [ ]	[ ] 52
02 Condón	1	2	3	1	2	02 Condón	53 [ ]	[ ] 54
03 DIU	1	2	3	1	2	03 DIU	55 [ ]	[ ] 56
04 Esterilización femenina	1	2	3	1	2	04 Esterilización femenina	57 [ ]	[ ] 58
05 Esterilización masculina	1	2	3	1	2	05 Esterilización masculina	59 [ ]	[ ] 60
06 Inyección	1	2	3	1	2	06 Inyección	61 [ ]	[ ] 62
07 Vaginales	1	2	3	1	2	07 Vaginales	63 [ ]	[ ] 64
08 Ritmo	1	2	3	1	2	08 Ritmo	65 [ ]	[ ] 66
09 Retiro	1	2	3	1	2	09 Retiro	67 [ ]	[ ] 68
10 Otros	1		3	1	2	10 Otros	69 [ ]	[ ] 70
Ninguno	96			97		98		

(307) Cuándo comenzó a usar este método? _____ 19____
MES AÑO

71 [ ][ ][ ][ ] 74

No recuerda, no sabe [ ]

CONOCIMIENTO Y USO. CONTINUACION	CODIGOS
(308) Por que medio se enteró Ud. por primera vez del método que está usando actualmente?	
01 Equipo de Profamilia	
02 Instructora (promotora) de Profamilia	
03 Distribuidora de Profamilia	
04 Clínica de Profamilia	
05 Promotora de salud	75 76
06 Puesto o centro de salud	
07 Hospital	
08 Médico particular	
09 Droguería	
10 Avisos, prensa, radio	
11 Otro _____ (ESPECIFIQUE)	
(309) ENTREVISTADORA: MARQUE LA CASILLA APROPIADA PARA EL METODO DE USO ACTUAL	
1 Píldora; 2 Condón; 3 Ritmo; 4 Retiro; 5 Esterilización femenina; 6 Esterilización masculina; 7 Ovulos; 8 DIU; 9 Inyección; 0 Otros → (PASE A 315)	77
(310) Cuántas píldoras trae el paquete o cartón que Ud. usa?	
21 1; 28 2 → (PASE A 312); No sabe 3 → (PASE A 312)	78
(311) Cuando Ud. termina el paquete o cartón cuantos días espera para comenzar uno nuevo? _____ DIAS	79
(312) Cada cuanto se toma Ud. una píldora?	
1 Todas las noches o a diario	
2 Cada vez que tiene relaciones sexuales	80
3 Otro _____ (ESPECIFIQUE)	
IDENTIFICACION	1 [ ][ ][ ][ ] 2 5
(313) Qué haría Ud si no le viene la menstruación después de haber tomado un ciclo de píldoras?	
1 Continua; 2 Descontinua y consulta al médico; 3 Abandona; 4 Continua y va donde el médico; 5 Otro _____ (ESPECIFIQUE)	6
(314). Cuando a Ud. se le olvida tomar una píldora qué hace?	
1 Tan pronto se acuerda se la toma y sigue el ciclo normal	
2 Toma dos al día siguiente en forma simultánea	7

CONOCIMIENTO Y USO. CONTINUACION	CODIGOS
[3] Toma una al día siguiente [4] Las suspende definitivamente [5] Otro _____ (ESPECIFIQUE)	
(315) ENTREVISTADORA: COMENTE A LA SEÑORA LO SIGUIENTE: "SEÑORA: AHORA QUISIERA QUE HABLEMOS SOBRE COMO SE USAN ALGUNOS METODOS ANTICONCEPTIVOS AUNQUE UD. NO ESTE USANDO NINGUNO DE ESTOS METODOS". LAS USUARIAS DE LA PILDORA PASAN A LA 319. LAS DEMAS PASAN A LA 316.	
(316) Cuándo debe una señora comenzar a tomar la píldora al iniciar el uso de este método? [1] Al 5o. día de haber comenzado la menstruación [2] 5 días después de pasar la menstruación [3] 7 días después de haber empezado la menstruación (PASE A 317) [4] Cualquier día del mes [5] Otro _____ (ESPECIFIQUE) [0] No sabe [6] No conoce el método → (PASE A 319)	8
(317) Cada cuanto se debe tomar la píldora? [1] Todas las noches/diario [2] Cada vez que tiene relaciones sexuales [3] Otro _____ (ESPECIFIQUE) [0] No sabe	9
(318) Cuando se le olvida tomar una píldora que debe hacer la señora? [1] Tan pronto se acuerda se la toma y sigue el ciclo normal [2] Toma 2 al siguiente día en forma simultánea [3] Toma una al siguiente día [4] Las suspende definitivamente [5] Otro _____ (ESPECIFIQUE) [0] No sabe	10
(319) Me puede decir cuando debe usar una señora la tableta vaginal? [1] Después del acto sexual [2] Antes del acto sexual [3] Antes y después (PASE A 320) [4] Otro _____ (ESPECIFIQUE) [0] No sabe [5] No conoce el método → (PASE A 321)	11
(320) Para cuantas relaciones sirve cada tableta vaginal? [1] Una [2] Más de una [0] No sabe	12
(321) Donde se coloca el DIU (anillo, churrusco, T-Dorada) en la mujer? [1] En el útero [2] Otro _____ (ESPECIFIQUE) [3] No conoce el método → (PASE A 323) [0] No sabe	13

CONOCIMIENTO Y USO. CONTINUACION	CODIGOS
(322) Cuánto tiempo se puede durar con el DIU? [1] Indefinidamente [2] _____ Años [3] Otro _____ (ESPECIFIQUE) [0] No sabe	14
(323) En qué consiste la ligadura de trompas o esterilización femenina? [1] Le ligan o cortan las trompas de falopio [2] Le quitan la matriz [3] Otro _____ (ESPECIFIQUE) (PASE A 324) [0] No sabe [4] No conoce el método → (PASE A 325)	15
(324) Después de la ligadura de trompas o esterilización femenina, una señora puede volver a tener hijos? SI [1] NO [2] No sabe [0]	16
(325) ENTREVISTADOR (A): COLOQUE UNA "X" EN LA CASILLA APROPIADA ACTUALMENTE USA, NO ESTERILIZADA [1] ESTERILIZADA [2] (PASE A 401) HA USADO PERO NO USA [3] (PASE A 328) NUNCA HA USADO [4] (PASE A 401)	17
(326) Ha pensado alguna vez en cambiar de método? SI [1] NO [2] (PASE A 401)	18
(327) Por qué? ANOTE SOLAMENTE LA RAZON PRINCIPAL [1] Motivos de salud [2] Por otro método [3] No es fácilmente disponible [4] Método no es seguro [5] Produce efectos colaterales [6] Dificultad de usarlo [7] Muy costoso [8] Otra razón _____ (ESPECIFIQUE) (PASE A 401)	19
(328) Cuál es el último método que usted usó? SI USO MAS DE UN METODO ANOTE EL DE USO MAS FRECUENTE [1] Píldora [2] Condón [3] DIU [4] Inyección [5] Vaginales [6] Ritmo [7] Retiro [8] Otros _____ (ESPECIFIQUE)	20
(329) Por qué dejó Ud de usar el último método? ANOTE LA RAZON PRINCIPAL [0] Se separó del marido [1] Deseaba un (otro) niño [2] Se cansó de usarlo [3] Le falló como anticonceptivo [4] Producía efectos colaterales [5] Motivos de salud [6] Difícil de usar [7] Muy costoso [8] Otra razón _____ (ESPECIFIQUE)	21
(330) Ha pensado usar un método en el futuro? SI [1] NO [2] (PASE A 332)	22

CONOCIMIENTO Y USO. CONTINUACION	CODIGOS
(331) Qué método ha pensado usar? **ANOTE EL METODO PRINCIPAL** [0] Píldora [1] Condón [2] DIU [3] Esterlilización /Vasectomía [4] Inyección [5] Vaginales [6] Ritmo [7] Retiro [8] Otros _____ (ESPECIFIQUE)	[ ] 23
(332) Cuál es la razón principal por la cual usted (o su esposo) no está (n) usando un método de planificación familiar? [01] Está embarazada [02] Desea embarazo [03] No tiene compañero actualmente o no tiene relaciones sexuales [04] Acaba de tener un hijo y está lactando [05] No puede quedar embarazada. Sabe o no la razón [06] Menopausia [07] Motivos religiosos o morales [08] Porque afecta la salud [09] Oposición del marido [10] Vergüenza o temor de averiguar o comprar métodos [11] Le produce efectos colaterales [12] Otro _____ (ESPECIFIQUE)	[ ][ ] 24 25

IV. CONOCIMIENTO Y USO DE FUENTES DE SERVICIO DE PLANIFICACION FAMILIAR	CODIGOS
(401) Sabe Ud. en dónde le pueden dar información o métodos (servicios) de planificación familiar? SI [1] ↓ NO [2] (PASE A 403)	[ ] 26
(402) Dónde le pueden dar información o métodos (servicios) de planificación familiar?	[ ][ ][ ][ ] 27 30

	INFORMACION	METODO SERVICIO SUMINISTRO
Puesto de salud, hospital	[1]	[1]
Droguería	[2]	[2]
Puesto de distribución de Profamilia	[4]	[4]
Clínica de Profamilia	[8]	[8]
Médico particular	[16]	[16]
Otro _____ (ESPECIFIQUE)	[32]	[32]
No sabe	[00]	[00]

(403) **MARQUE LA CASILLA APROPIADA**

ACTUALMENTE USA NO ESTERILIZADA [1] ↓	NO USA ACTUALMENTE [2]	ESTERILIZADA [3]
	(PASE A 501)	(PASE A 414)

[ ] 31

CONOCIMIENTO Y USO DE FUENTES DE SERVICIO. CONTINUACION	CODIGOS
(404) A dónde va con más frecuencia (normalmente) a solicitar servicios de planificación familiar? [1] Puesto de distribución de Profamilia [2] Puesto de salud, hospital [3] Clínica de Profamilia [4] Médico particular [5] Otro _____ (ESPECIFIQUE) (PASE A 413)	32
(405) Cómo se llama la señora (el señor) que atiende en ese lugar? [1] _____ NOMBRE [2] No sabe No recuerda	33
(406) Ud. usualmente va a comprar el anticonceptivo a ese lugar? SI [1] (PASE A 408) NO [2]	34
(407) Entonces cómo lo consigue? [1] Lo compra un hijo [2] Lo compra el esposo [3] Lo compra otra persona [4] La distribuidora se lo trae a la casa [5] Otro _____ (ESPECIFIQUE)	35
(408) De las veces que Ud. ha ido (o la persona que le consigue el sobre) a ese lugar lo ha encontrado cerrado? SI [1] NO [2] (PASE A 411)	36
(409) Qué hizo Ud. (o la persona)? [1] Volvió más tarde [2] Esperó hasta que abriera [3] Compró en otro lugar _____ (ESPECIFIQUE) [4] Dejó de usar un tiempo [5] Otro _____ (ESPECIFIQUE)	37
(410) Cuántas veces Ud. o la persona que compra el anticonceptivo ha encontrado cerrado el lugar? [1] Una vez [2] Dos o tres veces [3] Más de tres veces [4] Otro _____ (ESPECIFIQUE)	38
(411) En alguna ocasión al ir a comprar el anticonceptivo lo ha encontrado agotado? SI [1] NO [2] (PASE A 413)	39
(412) Qué hizo Ud. (o la persona)? [1] Volvió otro día [2] Compró en otro lugar _____ (ESPECIFIQUE) [3] Dejó de usar un tiempo [4] Otro _____ (ESPECIFIQUE)	40
(413) En qué mes y año comenzó Ud. a usar este servicio? _____ MES 19___ AÑO No sabe, No recuerda [ ] (PASE A 423)	41 44
(414) En qué ciudad o población la operaron? _____	

67

CONOCIMIENTO Y USO FUENTES DE SERVICIO. CONTINUACION	CODIGOS
(415) Recuerda el sitio donde le hicieron la operación? SI [1] NO [2] (PASE A 417)	45
(416) Cuál fué ese sitio? [1] Hospital [2] Centro de salud [3] Clínica de Profamilia [4] Consultorio o clínica particular [5] Otro sitio _____ (ESPECIFIQUE)	46
(417) Quién le remitió o envió a ese lugar? [1] Puesto de salud [2] Amiga o vecina [3] Personal de Profamilia [4] Médico de hospital o clínica [5] Médico particular [6] Esposo [7] Un familiar, voluntad propia [8] Otro _____ ESPECIFIQUE	47
(418) Recuerda Ud. el precio que pagó por la operación? SI [1] NO [2] (PASE A 420)	48
(419) Cuánto pagó? [1] Fué gratis [2] Menos de $200 pesos [3] $200-$500 pesos [4] $501-$1.000 pesos [5] $1.001 - $1.500 pesos [6] $1.501 y más	49
(420) Cómo fue la atención que recibió el día de la operación? LEA LAS RESPUESTAS Muy buena [1] Buena [2] Regular [3] Mala [4] Muy mala [5]	50
(421) A raíz de la operación ha tenido algún problema o complicación? SI [1] NO [2] → (PASE A 423)	51
(422) Cuál? _____ _____ _____	52

CONOCIMIENTO Y USO FUENTES DE SERVICIO. CONTINUACION	CODIGOS
(423) Por qué medio se enteró Ud. por primera vez del servicio que está usando actualmente (donde le hicieron la esterilización? 01 Equipo de Profamilia 02 Instructora (promotora) de Profamilia 03 Distribuidora de Profamilia 04 Clínica de Profamilia 05 Promotora de salud 06 Puesto o centro de salud 07 Hospital 08 Médico particular 09 Droguería 10 Avisos, prensa, radio 11 Otro _____ (ESPECIFIQUE)	53 54

V. EL MEDIO DE INFORMACION Y EL MENSAJE	CODIGOS
(501) Durante el último año Ud ha asistido a alguna charla de planificación familiar? SI 1 ↓ NO 2 (PASE A 512)	55
(502) A cuántas charlas de planificación familiar ha ido Ud. en el último año? 1 Una (PASE A 504) 2 Dos o más ↓	56
(503) En qué mes y año fue la última charla a que Ud. asistió? _____ MES 19___ AÑO	
(504) La (ésta última) charla fue organizada por quién? 1 Profamilia 2 Puesto de salud 9 No sabe 3 Médico Particular 4 Otro _____ (ESPECIFIQUE)	57
(505) Cómo supo Ud de la (última) charla? 1 Le invitó _____ (RESPUESTA DE LA 504) personalmente 2 Le contó una amiga, pariente, esposo 3 Oyó sobre la charla por el altoparlante 4 Avisos de prensa, radio 5 Otro _____ (ESPECIFIQUE)	58
(506) Más o menos cuantas personas asistieron a la (última) charla? 1 Menos de 5 2 De 6 a 15 3 De 16 a 30 4 De 31 a 50 5 Más de 50	59
(507) Asistieron señores y señoras a la (esa) reunión? SI 1 ↓ NO 2 (PASE A 510)	60

MEDIO DE INFORMACION Y MENSAJE. CONTINUACION	CODIGOS
(508) Le acompañó su esposo/compañero a la (esa última) reunión? SI [1] (PASE A 510) NO [2] Actualmente no está en unión [3] (PASE A 510)	61
(509) Por qué no? [1] No lo invitaron [2] No le gusta la planificación familiar [3] Estaba trabajando [4] Se opone a la planificación familiar [5] Razones de salud [6] Otro _____ (ESPECIFIQUE)	62
(510) A qué hora fué la (última) charla? [1] En la mañana [2] En la tarde [3] En la noche	63
(511) Cuánto tiempo duró la (última) charla? [1] Menos de media hora [2] 30 a 60 minutos [3] Entre una y dos horas [4] Más de dos horas (PASE A 518)	64
(512) Sabe Ud. si en el último año ha habido una campaña o propaganda de planificación familiar en su comunidad? SI [1] NO [2] (PASE A 601)	65
(513) Por quién fue promovida? [1] Profamilia [2] Puesto de salud [3] Médico particular [4] Otro _____ (ESPECIFIQUE)	66
(514) Tuvo algún encuentro personal con alguno de los organizadores de esta campaña? SI [1] NO [2] (PASE A 518)	67
(515) En dónde tuvo oportunidad de conversar con esa (esas) persona (s)? [1] En su casa [2] En la calle [3] Otro _____ (ESPECIFIQUE)	68
(516) La invitaron a alguna charla? SI [1] NO [2] (PASE A 518)	69
(517) Por qué no fué a la charla? [1] Motivos religiosos o morales [2] Razones de salud [3] Por el trabajo	70

MEDIO DE INFORMACION Y MENSAJE. CONTINUACION	CODIGOS
[4] Por los hijos [5] Otro _____ (ESPECIFIQUE)	
(518) Le hablaron de métodos de planificación familiar? SI [1] ↓ NO [2] (PASE A 601)	[–] 71
(519) Cuáles métodos de planificación familiar le explicaron? [1] Píldora [32] Inyección [2] Condón [64] Vaginales [4] DIU [128] Ritmo [8] Esterilización femenina [256] Retiro [16] Esterilización masculina [512] Otros _____ (ESPECIFIQUE)	[ ][ ][ ][ ] 72 75
(520) Qué es lo que Ud. más recuerda de lo que le dijeron sobre planificación familiar? _____ _____ _____ _____	[ ][ ] 76 77

VI. OPINION DE SERVICIOS Y METODOS	CODIGOS
(601) MARQUE LA CASILLA APROPIADA ACTUALMENTE USA INCLUYENDO ESTERILIZADAS [1] ↓ (PASE A 603) NO USA ACTUALMENTE [2] ↓	[ ] 78
(602) Señora, para estar bien segura, ha pensado Ud. en usar un método de planificación familiar en el futuro, aunque en el momento no esté planificando? SI [1] (PASE A 616) NO [2] → AGRADEZCA A LA ENTREVISTADA POR SU COLABORACION Y TERMINE LA ENTREVISTA	[ ] 79
(603) Antes de que Ud. empezara a usar un método, le informaron que había otros métodos diferentes del que Ud. usa actualmente? SI [1] ↓ NO [2] (PASE A 605)	[ ] 80
IDENTIFICACION	1 [ ][ ][ ][ ][3] 5
(604) Qué metodos le explicaron? ENTREVISTADORA: MARQUE UNA "X" EN LA CASILLA QUE CORRESPONDE AL METODO O METODOS QUE LA SEÑORA DIGA. DESPUES MARQUE UNA "X" EN LA CASILLA ,"1" O "2" DEPENDIENDO DE LOS METODOS MENCIONADOS. [ ] Píldora [ ] Vaginales [ ] Condón [ ] Retiro	

OPINION SERVICIOS Y METODOS. CONTINUACION

CODIGOS

☐ DIU
☐ Esterilizacion
☐ Inyección
☐ Otros

[1] Método eficiente
[2] Método ineficiente

☐ 6

(605) Antes de empezar a usar un método le dijeron que algunos métodos pueden traer complicaciones?

SI [1] ↓ NO [2] (PASE A 613)

☐ 7

(606) De cuáles métodos le hablaron que podrían traer complicaciones?

ENTREVISTADORA: MARQUE UNA "X" EN LA (S) CASILLA (S) APROPIADAS (S) Y PASE A LAS PREGUNTAS 607 HASTA 612 DEL CUADRO EN LA SIGUIENTE HOJA

[1] Píldora
[2] DIU
[4] Inyección
[8] Vaginales
[16] Esterilización
[32] Otros _____ (ESPECIFIQUE)

☐☐ 8 9

(607 a 612)

POR CADA METODO MARCADO EN LA 606 PREGUNTE:

Qué complicaciones del (de la) _____ le hablaron?
METODO

COLOQUE UN CIRCULO EN LA RESPUESTA APROPIADA SEGUN EL METODO EN EL CUADRO

NUMERO DE PREG.	METODO	COMPLICACION							
		CANCER	DOLOR CABEZA	FALLA DE METODO	CAMBIO DE PESO	CAMBIO CICLO MENSTRL.	CAMBIO VIDA SEXUAL	VARICES	OTRO
607	Píldora	1	2	4	8	16	32	64	128
608	DIU	1	2	4	8	16	32	64	128
609	Inyección	1	2	4	8	16	32	64	128
610	Vaginales	1	2	4	8	16	32	64	128
611	Esterilización	1	2	4	8	16	32	64	128
612	Otros	1	2	4	8	16	32	64	128

_____ (ESPECIFIQUE)

10 ☐☐☐ 12
13 ☐☐☐ 15
16 ☐☐☐ 18
19 ☐☐☐ 21
22 ☐☐☐ 24
25 ☐☐☐ 27

(613) Ha tenido Ud. algunas molestias con el método que está usando actualmente?

SI [1] ↓ NO [2] (PASE A 615)

☐ 28

(614) Qué le han sugerido que haga para evitar esa molestia?

[1] Cambiar de método
[2] Seguir usando el método

OPINION SERVICIOS Y METODOS .. CONTINUACION	CODIGOS
[3] Suspender el método [4] Ir donde el médico [5] Otro _____ (ESPECIFIQUE)	29
(615) Ud. ha recomendado la planificación familiar a otras personas de su comunidad? SI [1] NO [2]	30
(616) De quién preferiría Ud. recibir información y servicios de planificación familiar (LEA LAS ALTERNATIVAS) [1] Enfermera [2] Médico [3] Droguista [4] Promotora de Salud [5] Distribuidora de Profamilia [6] Instructora de Profamilia [7] Equipo de Profamilia [8] Otro _____ (ESPECIFIQUE)	31
(617) Por qué? [1] Saben más [2] Mayor confianza [3] Mejor atención [4] Hace visitas [5] Otro _____ (ESPECIFIQUE)	32
(618) Conoce Ud. otras usuarias de planificación familiar en su comunidad? SI [1] ↓ NO [2] → AGRADEZCA A LA ENTREVISTADA POR SU COLABORACION Y TERMINE LA ENTREVISTA	33
(619) Cómo llegó a conocerlas? [1] Son amigas, familiares [2] Reuniones en la comunidad [3] En donde compra anticonceptivos o recibe información sobre planificación familiar [4] En el trabajo [5] Otro _____ (ESPECIFIQUE)	34
AGRADEZCA A LA ENTREVISTADA POR SU COLABORACION Y TERMINE LA ENTREVISTA	

PROFAMILIA CONSEJO DE POBLACION	**TERCERA ENCUESTA · CESAR Y CAUCA** 1983 CUESTIONARIO DE HOGAR	CONFIDENCIAL FINES CIENTIFICOS

I. IDENTIFICACION DEL CUESTIONARIO

(101) Número del Cuestionario [ ][ ][ ][ ] 1 2 3 4

(102) Municipio _____ [ ][ ] 5 6

(103) Segmento [ ][ ] 7 8

(104) Zona 1 Urbana 2 Rural [ ] 9

(105) Número de Hogar [ ][ ][ ] 10 11 12

(106) Vereda _____

(107) Encuestadora NOMBRE

_____ 13 [ ][ ] 14
NOMBRE CODIGO

(108) Fecha de Entrevista

DIA _____ MES _____ [ ][ ][ ][ ] 15 18

(109) Cuestionario

_____ de _____

II. PARA TODOS LOS MIEMBROS DEL HOGAR

NUMERO DE ORDEN DE LA PERSONA	NOMBRES Y APELLIDOS	PARENTESCO	SEXO	EDAD	15 AÑOS y MAS ESTADO CIVIL		ELEGIBILIDAD
	Por favor dígame los nombres de las personas que normalmente viven en este hogar, aunque no hayan dormido aquí anoche.	Cuál es el parentesco o relación de _____ con el jefe del hogar? Jefe [1] Esposa [2] Hijos [3] Parientes [4] Otros [5]	Es hombre o mujer? H [1] M [2]	Cuántos años cumplidos tiene?	Ha estado casado o unido alguna vez? SI [1] CONTINUE NO [2] PASE A LA SIGUIENTE PERSONA	Cuál es su estado civil actual? Casado [1] Conviviente [2] Viudo [3] Separado o divorciado [4]	Numere la mujer elegible para la entrevista individual en orden consecutivo.
(201)	(202)	(203)	(204)	(205)	(206)	(207)	(208)
19-20		21	22	23-24	25	26	27
01							
02							
03							
04							
05							
06							
07							
08							
09							
10							
11							
12							
13							
14							

(209) Número de personas en el hogar 28 29 [ ][ ]

(210) Número de mujeres elegibles 30 [ ]

(211) Fue entrevistado en la primera encuesta? (Abril-Mayo, 1981) [1] SI [2] NO 31 [ ]

(212) Fue entrevistado en la segunda encuesta? (Abril – Mayo, 1982) [1] SI [2] NO 32 [ ]

(213) RESULTADO DE LA VISITA [1] Completa [2] Ningún adulto en casa [3] Casa desocupada [4] Rechazo [5] No es vivienda [6] Otro

PROFAMILIA - CONSEJO DE POBLACION	TERCERA ENCUESTA: CESAR Y CAUCA 1983 CUESTIONARIO INDIVIDUAL	CONFIDENCIAL FINES CIENTIFICOS

A. IDENTIFICACION DEL CUESTIONARIO

CODIGOS

(101) Número de identificación — 1 [ ][ ][ ][ ][1] 5

(102) Municipio _____ — 6 [ ][ ] 7

(103) Segmento [ ][ ] — 8 [ ][ ] 9

(104) Zona — Urbana [1] — Rural [2] — 10 [ ]

(105) Número del hogar [ ][ ][ ] — 11 [ ][ ][ ] 13

(106) Nombre y número de orden de la mujer _____ [ ][ ] — 14 [ ][ ] 15

B. RESULTADO DE LA ENTREVISTA

CODIGOS

(107) Visita	(108) Fecha		(109) Hora de iniciación	(110) Hora de terminación	(111) Resultado
	día	mes			
1o.					
2o.					

16 [ ]

17 [ ]

CODIGO DE RESULTADO DE LA VISITA (S)

1. Completa
2. Incompleta
3. Rechazo
4. Ausencia de la mujer
5. Otro

C. CONTROL DE SUPERVISION Y PROCESAMIENTO

CODIGOS

(112) Nombre de la encuestadora _____

Observaciones _____

_____

18 [ ]

(113) Nombre del supervisor _____

Observaciones _____

_____

(114)

	SUPERVISOR	CRITICO	CODIFICADOR
Fecha			
Nombre			

10

II. CARACTERISTICAS DE LA ENTREVISTADA

CODIGOS

(201) A Ud. la entrevistó PROFAMILIA en Abril o Mayo de 1981 ?

SI [1] NO [2] — 19 [ ]

(202) En qué mes y año nació usted? _____ 19 ____ NO SABE [ ] — 20 [ ][ ][ ][ ] 23

MES AÑO

(PASE A 204)

(203) Entonces cuantos años cumplidos tiene Usted? [ ][ ] — 24 25

AÑOS

(204) Cuál es su estado civil (conyugal) actual?

Casada [1] Viuda [3] — 26 [ ]

Conviviente [2] Divorciada/Separada [4]

(205) Cual fue el año o curso más alto que Usted aprobó?

> ENCIERRE EN UN CIRCULO EL NIVEL MAS ALTO ALCANZADO Y EL ULTIMO AÑO APROBADO EN ESTE NIVEL. SI LA ENTREVISTADA NUNCA FUE A LA ESCUELA, MARQUE PRIMARIA CERO

NIVEL	AÑOS
1 Primaria	0 1 2 3 4 5
2 Secundaria	1 2 3 4 5 6 7
3 Universitario	1 2 3 4 5 6 7 o más

27 [ ] 28 [ ]

(206) Ha tenido Ud. hijos alguna vez? — 29 [ ]

SI [1] NO [2]

(PASE A 208)

(207) Ha estado embarazada alguna vez? — 30 [ ]

SI [1] NO [2]

(PASE A 213) (PASE A 216)

(208) En total en toda su vida cuantos hijos nacidos vivos ha tenido? — 31 32 [ ][ ]

NUMERO [ ][ ]

(209) Ha tenido hijos que nacieron vivos pero murieron después, aunque hayan vivido solo unos minutos? — 33 [ ]

SI [1] NO [2]

(210) En total, en toda su vida, cuantas veces ha estado embarazada? — 34 35 [ ][ ]

NUMERO [ ][ ]

(211) ENTREVISTADOR (A): RESTE DE 210 (TOTAL EMBARAZOS) 208 (NACIDOS VIVOS) Y AÑOTE RESULTADO AQUI _____ Y AHORA DIGA A LA ENTREVISTADA: ES DECIR, Ud. HA TENIDO _____ ABORTOS Y NACIDOS MUERTOS. ES ESTO CORRECTO? — 36 37 [ ][ ]

SI [1] NO [2] (CORRIJA DONDE SEA NECESARIO)

(212) Dígame ahora en qué mes y año tuvo su último hijo nacido vivo? — 38 41 [ ][ ][ ][ ]

_____ MES ____ AÑO NO SABE [ ]

(PASE A 214)

CARACTERISTICAS. CONTINUACION	CODIGOS
(213) Cuántas veces ha estado embarazada? [ ][ ] NUMERO	[ ] 42
(214) Está Ud. embarazada actualmente? SI [1] NO [2] NO SABE [3] (PASE A 217)	[ ] 43
(215) Desea Ud. tener otro niño fuera del que está esperando? SI [1] NO [2] NO SABE [3] (PASE A (301)	[ ] 44
(216) Hasta donde Ud. sabe, Ud. y su marido son capaces de tener un hijo si Uds. lo quieren? SI [1] NO [2] NO SABE [3]	[ ] 45
(217) Desea Ud. tener un (otro) niño? SI [1] NO [2] NO SABE [3]	[ ] 46

III. CONOCIMIENTO Y USO DE METODOS	CODIGOS
LAS PREGUNTAS 301 HASTA LA 306 DEBEN DILIGENCIARSE EN EL ESQUEMA DE LA PAGINA SIGUIENTE.	
(301) Hay varias formas, maneras o métodos para que una pareja pueda demorar o evitar un embarazo o un hijo si no lo desea. Conoce Ud. o ha oído acerca de alguna forma, manera o método para planificar la familia o medio para evitar un embarazo? SI [1] NO [2] (PASE A 304)	[ ] 47
(302) Qué métodos de planificación familiar o medio para evitar un embarazo conoce Ud.?	
COLOQUE UN CIRCULO EN "1" DE LA COLUMNA A1 DEL ESQUEMA POR CADA METODO MENCIONADO.	
(303) POR CADA METODO DENTRO DE UN CIRCULO EN LA COLUMNA A1 PREGUNTE: Ha usado Ud. o su esposo (compañero) alguna vez _____ METODO	
COLOQUE UN CIRCULO EN LA RESPUESTA APROPIADA EN LA COLUMNA A 3 DEL ESQUEMA	
(304) POR CADA METODO QUE NO ESTE DENTRO DE UN CIRCULO EN LA COLUMNA A 1 PREGUNTE: Para estar bien segura ha oído hablar de _____ METODO O MEDIO	
COLOQUE UN CIRCULO EN "2" O EN "3" EN LA COLUMNA A2 DEL ESQUEMA. SI LA RESPUESTA ES AFIRMATIVA (CIRCULO EN "2") HAGA LA PREGUNTA 305 ANTES DE PREGUNTAR SOBRE EL PROXIMO METODO.	

CONOCIMIENTO. CONTINUACION

CODIGOS

(305) Ha usado Ud. o su esposo (compañero) alguna vez _____
METODO

COLOQUE UN CIRCULO EN LA RESPUESTA APROPIADA EN LA COLUMNA A3 DEL ESQUEMA

(306) Actualmente usted (es) está (n) usando o ha (n) usado durante el último mes algún método de planificación familiar para evitar un embarazo?

[1] SI ——→ Cuál? _____ [ ] 48

SI MAS DE UN METODO PREGUNTE CUAL ES EL DE USO MAS FRECUENTE Y MARQUE EL CODIGO CORRESPONDIENTE EN LA COLUMNA A4 Y PASE A 401

[2] NO ——→ (PASE A 401) [ ][ ] 49 50

ESQUEMA DE CONOCIMIENTO Y USO

METODOS DE PLANIFICACION FAMILIAR	A. 1 (302) Sin ayuda SI	A. 2 (304) Con ayuda SI	A. 2 (304) Con ayuda NO	A. 3 (303) Alguna vez SI	A. 3 (305) Alguna vez NO	A. 4 (306) Método que usa actualmente			
01 Píldora	1	2	3	1	2	01 Píldora	51		52
02 Condón	1	2	3	1	2	02 Condón	53		54
03 DIU	1	2	3	1	2	03 DIU	55		56
04 Esterilización femenina	1	2	3	1	2	04 Esterilización femenina	57		58
05 Esterilización masculina	1	2	3	1	2	05 Esterilización masculina	59		60
06 Inyección	1	2	3	1	2	06 Inyección	61		62
07 Vaginales	1	2	3	1	2	07 Vaginales	63		64
08 Ritmo	1	2	3	1	2	08 Ritmo	65		66
09 Retiro	1	2	3	1	2	09 Retiro	67		68
10 Otros	1		3	1	2	10 Otros	69		70
Ninguno	96			97		98			

IV. CONOCIMIENTO Y USO DE FUENTES DE SERVICIO DE PLANIFICACION FAMILIAR

CODIGOS

(401) Sabe Ud. en dónde le pueden dar información o métodos (servicios) de planificación familiar?

SI [1] NO [2] (PASE A 403) — 71

(402) Dónde le pueden dar información o métodos (servicios) de planificación familiar?

	INFORMACION	METODO SERVICIO SUMINISTRO
Puesto de salud, hospital	1	1
Droguería	2	2
Puesto de distribución de Profamilia	4	4
Clínica de Profamilia	8	8
Médico particular	16	16
Otro _____ (ESPECIFIQUE)	32	32
No sabe	00	00

72 75

(403) MARQUE LA CASILLA APROPIADA

ACTUALMENTE USA NO ESTERILIZADA [1] — 76

NO USA ACTUALMENTE [2]

ESTERILIZADA [3]

(404) A donde va con más frecuencia (normalmente) a solicitar servicios de planificación familiar?

- Puesto de Salud, hospital, promotora del Ministerio de Salud [1]
- Droguería [2]
- PROFAMILIA [3]
- Médico Particular [4]
- Otro _____ (ESPECIFIQUE) [5]

(405) Por quién fué remitida para esta operación? — 77

_____ — 78

(406) Dónde le hicieron la operación? — 79

_____

_____

_____ (ESPECIFIQUE)

AGRADEZCA A LA ENTREVISTADA POR SU COLABORACION Y TERMINE LA ENTREVISTA

PROFAMILIA

PRIMERA ENCUESTA
DISTRIBUIDORES
1984

CONFIDENCIAL
FINES CIENTIFICOS

I. A. IDENTIFICACION DEL CUESTIONARIO

CODIGOS

(101) Número del cuestionario 1 [ ][ ][ ][1] 4

(102) Departamento _____ 5 [ ][ ] 6

(103) Centro _____ 7 [ ][ ] 8

(104) Municipio _____ 9 [ ][ ][ ] 11

(105) Zona Urbana [1] Rural [2] 12 [ ]

(106) Nombre del (a) distribuidor (a) _____ 13 [ ][ ][ ] 15

(107) Dirección del distribuidor (a) _____

B. RESULTADO DE LA VISITA

VISITA	FECHA		RESULTADO				
	Día	Mes	Completa	Incompleta	Rechazo	Ausente	Otro
1a.							
2a.							

16 [ ][ ] 17

18 [ ][ ] 19

20 [ ]

C. CONTROL DE SUPERVISION Y PROCEDIMIENTO

Nombre del encuestador _____

Observaciones del encuestador _____

Nombre del supervisor _____

Observaciones del supervisor _____

	FECHA	NOMBRE
SUPERVISION		
CRITICA		
CODIFICADOR		

II CARACTERISTICAS DEL (A) DISTRIBUIDOR (A)

CODIGO

(201) En qué mes y año nació usted [ ][ ] Mes [ ][ ][ ][ ] Año NO SABE [ ] — 21 [ ] 24

(202) Entonces cuántos años cumplidos tiene usted? [ ][ ] Años — 25 [ ] 26

(203) Cuál es su estado civil (conyugal) actual?

[1] Casado (a) [2] Viudo (a) [5] Soltero

[3] Conviviente [4] Divorciado (a)/ Separado (a) — 27 [ ]

(204) Cuál fue el año o curso más alto que usted aprobó?

ENCUESTADORA: ENCIERRE EN UN CIRCULO EL NIVEL MAS ALTO ALCANZADO Y EL ULTIMO AÑO APROBADO EN ESTE NIVEL. SI LA ENTREVISTADA NUNCA FUE A LA ESCUELA, MARQUE PRIMARIA CERO.

NIVEL	AÑOS
1. Primaria	0 1 2 3 4 5
2. Secundaria	1 2 3 4 5 6 7
3. Universitaria	1 2 3 4 5 6 7 o más

28 [ ] [ ] 29

ENCUESTADORA: SI EL ENCUESTADO DICE HABER ESTUDIADO HASTA TERCERO DE PRIMARIA O MENOS HAGALE LA SIGUIENTE PREGUNTA, DE LO CONTRARIO PASE A LA PREGUNTA 206.

(205) Puede usted leer el manual correctamente?

SI [1] NO [2] — 30 [ ]

(206) Ha tenido usted hijos alguna vez?

SI [1] (Pase a 208) NO [2] — 31 [ ]

(207) Ha estado embarazada alguna vez?

SI [1] NO [2] NO CORRESPONDE [3] — 32 [ ]

(PASE A 209)

(208) En total en toda su vida cuántos hijos nacidos vivos ha tenido?

NUMERO [ ][ ] — 33 [ ][ ] 34

(209) Ha usado usted o su esposo(a)/ compañero (a) alguna vez, algún método de Planificación Familiar?

SI [1] NO [2] (pase a 213) — 35 [ ]

16

CODIGOS

(210) Que métodos han usado? ENCUESTADORA: PUEDE MARCAR MAS DE UNA RESPUESTA

- 01 Píldora
- 02 Condón
- 04 DIU
- 08 Esterilización Femenina
- 16 Esterilización Masculina
- 32 Inyección
- 64 Vaginales
- 128 Ritmo
- 256 Retiro
- 512 Abstinencia
- 1024 Otros

36 [ ][ ][ ][ ] 39

(211) Cuál fue el último método usado?

- 01 Píldora
- 02 Condón
- 03 DIU
- 04 Esterilización Femenina
- 05 Esterilización Masculina
- 06 Inyección
- 07 Vaginales
- 08 Ritmo
- 09 Retiro
- 10 Abstinencia
- 11 Otros

40 [ ][ ] 41

(212) Qué método están usando actualmente?

- 01 Píldora
- 02 Condón
- 03 DIU
- 04 Esterilización Femenina
- 05 Esterilización Masculina
- 06 Inyección
- 07 Vaginales
- 08 Ritmo
- 09 Retiro
- 10 Abstinencia
- 11 Otros
- 12 No usa actualmente

42 [ ][ ] 43

(Pase a 214)

(213) Por qué nunca ha usado métodos de planificación familiar o medios de evitar embarazos?

44 [ ][ ] 45
Anexo

_____

_____

(214) Cuánto tiempo (en años) hace que usted es distribuidor (a) de PROFAMILIA?

[ ][ ]
Años

46 [ ][ ] 47

77

II. CARACTERISTICAS DEL (A) DISTRIBUIDOR (A) (Continuación)

(215) Qué lo(a) motivó o impulsó a usted a ser distribuidor (a) de PROFAMILIA?

- Aspectos económicos [1]
- Servicios a la comunidad [2]
- Por Distracción [3]
- Por compromiso con la comunidad [4]
- Por compromiso con PROFAMILIA [5]
- Otro [6]

Cuál? _____

_____

48 [ ]

III. CONOCIMIENTO DE METODOS

ENCUESTADORA: LAS SIGUIENTES PREGUNTAS SE RELACIONAN CON EL CONOCIMIENTO Y USO DE METODOS

(301) Cuándo debe una señora comenzar a tomar la píldora al iniciar el uso de este método?

- [1] Al 5o. día de haber comenzado la menstruación
- [2] 5 días después de pasar la menstruación
- [3] Una semana (7 días) después de pasar la menstruación
- [4] Cualquier día del mes
- [5] Otro

  Cuál? _____
- [6] No sabe

49 [ ]

(302) Cuando una señora termina un ciclo o cartón de píldoras, cuántos días debe esperar para comenzar uno nuevo?

	Cartón de 21 Píldoras	Cartón de 28 Píldoras
Al día siguiente	[1]	[1]
A los 5 días	[2]	[2]
Otro	[3]	[3]
Cuál? _____		
No sabe	[4]	[4]

50 [ ]

51 [ ]

78

CODIGOS

(303) Cada cuánto se debe tomar la píldora?

Todos los días [1]

Cada dos días [2]

Cada vez que tiene relaciones sexuales [3] 52 ☐

Otro [4]

Cuál? _____

No sabe [5]

(304) Cuando a una señora se le olvida tomar una píldora que debe hacer?

[1] Tan pronto se acuerda se la toma y sigue el ciclo normal

[2] Toma dos al siguiente día en forma simultánea

[3] Toma solo una al siguiente día 53 ☐

[4] Las suspende definitivamente

[5] Otro

Cuál? _____

(305) Si una señora está lactando (dando pecho) a un niño puede tomar píldoras anticonceptivas?

SI [1] → (Pase a 306)

NO [2] → (305A) Por qué no? 54 ☐

[1] Acaba con la leche

[2] Le hace daño al niño 55 ☐

[3] Otra razón

Cuál? _____

(306) Si una señora no va a tener relaciones sexuales durante una semana puede suspender el consumo de píldoras durante ese período?

SI [1] NO [2] 56 ☐

19

III. CONOCIMIENTO DE METODOS (Continuación)	CODIGOS
(307) En cuáles enfermedades o alteraciones no se debe usar la píldora?	
ENCUESTADORA: PUEDE MARCAR MAS DE UNA RESPUESTA	
01 Presión Arterial Alta	
02 Várices muy pronunciadas o inflamadas	
04 Enfermedades Cerebro-Vasculares	57 ☐☐ 58
08 Enfermedades Hepáticas (Ictericia, Hepatitits)	
16 Cáncer	
32 Otros	
Cuáles? _____	
(308) Usted recomendaría el uso de la píldora a una señora de más de 35 años de edad?	
SI 1 NO 2	59 ☐
(309) En qué momento una señora se debe colocar la tableta vaginal?	
1 Después del acto sexual	
2 Durante el acto sexual	
3 Antes del acto sexual	60 ☐
4 Antes y durante el acto sexual	
5 Otro	
Cuál? _____	
(310) Para cuántas relaciones sirve la tableta vaginal	
1 Una 2 Más de una	61 ☐
(311) Cuando el hombre se debe colocar el condón?	
1 Antes de introducir el pene en la vagina	
2 Durante la relación sexual o coito	62 ☐
3 Después de terminada la relación sexual	
4 Otro	
Cuál? _____	
(312) Para cuántas relaciones sirve cada condón?	
1 Una 2 Más de una	63 ☐

(313) En qué consiste la ligadura de trompas o esterilización femenina?

- [1] Le ligan o cortan las trompas de falopio
- [2] Le sacan la matriz a la mujer
- [3] Le sacan los ovarios
- [4] Le sacan los ovarios y la matriz
- [5] Otro

Cuál? _____

64 [ ]

(314) Después de la Ligadura de trompas o esterilización femenina, una señora puede volver a tener hijos?

SI [1] NO [2]

65 [ ]

(315) La Ligadura de trompas o esterilización femenina en algunas raras ocasiones puede fallar?

SI [1] NO [2]

66 [ ]

(316) La ligadura de trompas o esterilización femenina produce cambios en el comportamiento o carácter de la mujer?

SI [1] NO [2] (Pase a 318)

67 [ ]

(317) Cuáles cambios? _____

_____

68 [ ][ ] 69
Anexo

(318) Después de la Ligadura de trompas o esterilización femenina una mujer sigue teniendo menstruaciones o reglas?

SI [1] NO [2]

70 [ ]

(319) ¿La ligadura de trompas o esterilización femenina produce cambios en la sexualidad de la mujer?

SI [1] NO [2]

71 [ ]

(320) En qué consiste la vasectomía o esterilización masculina?

- [1] Se ligan o cortan los conductos deferentes
- [2] Se le quitan los testículos al hombre
- [3] Se le quita el pene al hombre
- [4] Se le quitan los testículos y el pene al hombre
- [5] Otro

Cuál? _____

72 [ ]

81

(321) La vasectomía es lo mismo que castración?

SI [1] NO [2] 73

(322) La vasectomía impide que el hombre tenga eyaculaciones?

SI [1] NO [2] 74

(323) **La vasectomía o esterilización masculina produce cambios en la sexualidad del hombre?**

SI [1] NO [2] 75

(324) La vasectomía o esterilización masculina produce cambios en el comportamiento o carácter del hombre?

SI [1] NO [2] 76

(325) Dónde se coloca el DIU (anillo, churrusco, T. Dorada o T de Cobre) en la mujer?

[1] No conoce el método

[2] En el útero

[3] En la vagina 77

[4] En el abdomen

[5] Otro

Cuál? _____

(326) Cuánto tiempo puede una mujer durar con el DIU (Especifique—

_____

_____ 78 Anexo

_____

(327) El ritmo y el retiro son métodos de planificación familiar?

SI [1] NO [2] 79

(328) En qué días dentro del ciclo menstrual cree usted que una mujer puede quedar embarazada más fácilmente?

[1] Durante la regla o menstruación

[2] En la primera semana después de la regla

[3] En la segunda y tercera semanas después de la regla o mitad del ciclo? 80

[4] Una semana antes de la regla o al final del ciclo

[5] Al principio y al final del ciclo

[6] Otro (especifique) _____

97

IV PLANIFICACION FAMILIAR Y PROFAMILIA

COL.

IDENTIFICACION 1

(401) ¿Qué es Planificación Familiar?

[1] Es tener menos hijos

[2] Es tener los hijos que se quiere en el momento que se desea 5

[3] Es no tener hijos

[4] Otro

¿Cuál? _____

(402) ¿Planificación Familiar es lo mismo que control de natalidad?

SI [1] → (Pase a 403) NO [2] → (402A) ¿Por qué no? _____ 6

_____ 7 8 Anexo

(403) PROFAMILIA es lo mismo que el Instituto Colombiano de Bienestar Familiar?

SI [1] NO [2] 9

(404) PROFAMILIA es una institución u organización:

[1] Privada

[2] Oficial o del Gobierno 10

[3] Mixta

[4] Otro

¿Cuál? _____

(405) ¿Tiene usted algunas publicaciones de PROFAMILIA?

SI [1] → NO [2] → (Pase a 406) 11

(405A) ¿Cuáles?

_____

_____ 12 13 Anexo

_____

_____

93

(406) Tiene usted muestras de anticonceptivos?

SI [1] NO [2] 14 [ ]

(407) Tiene usted lista de los anticonceptivos en lugar visible?

ENCUESTADORA: CONSTATE ESTA RESPUESTA

SI [1] NO [2] 15 [ ]

(408) Ha recibido afiches o calcomanías de PROFAMILIA?

SI [1] NO [2] 16 [ ]

ENCUESTADORA CONSTATE LAS RESPUESTAS A LAS PREGUNTAS 409 -- 410 y 411

(409) Tiene usted aviso de Puesto de Distribución en lugar visible?

SI [1] NO [2] 17 [ ]

(410) Qué métodos de Planificación Familiar está vendiendo actualmente?

ENCUESTADORA: PUEDE MARCAR MAS DE UNA RESPUESTA

[1] Píldoras
[2] Condón
[4] DIU
[8] Inyección
[16] Vaginales
[32] Otro, cuál? _____

18 [ ][ ] 19

(411) Qué clase de establecimiento es este?

[1] Vivienda [2] Tienda [3] Otro, Cuál? _____ 20 [ ]

(412) Le ayuda otra persona en la venta de anticonceptivos?

SI [1] NO [2] 21 [ ]

(Pase a 413)

(412A) Quiénes? _____

_____

_____

_____

22 [ ][ ] 23

Anexo

84

(413) En qué año recibió la última capacitación?

Año [ ][ ]

(414) Qué tipo de capacitación ha recibido de PROFAMILIA?

ENCUESTADORA: PUEDE MARCAR MAS DE UNA RESPUESTA

[1] Cursillo

[2] Charlas domiciliarias

[4] Charlas colectivas

[8] Otro, cuál? _____

26 [ ][ ] 27

(415) A qué sitios y en qué forma remite a las posibles usuarias de los siguientes métodos?

DIU: Forma _____ Sitio _____ 28 [ ] [ ] 29 Anexo

ESTERILIZACION:

Forma: _____ Sitio _____ 30 [ ] [ ] 31 Anexo

OTROS:

Forma: _____ Sitio _____ 32 [ ] [ ] 33 Anexo

(416) Qué hace para motivar a la comunidad?

ENCUESTADORA: PUEDE MARCAR MAS DE UNA RESPUESTA

[1] Visitas domiciliarias

[2] Cursos o reuniones

[4] Otro, cuál? _____

[8] No la motiva → (Pase a 420)

34 [ ][ ] 35

(417) Qué tipo de material didáctico utiliza en las reuniones?

ENCUESTADORA: PUEDE MARCAR MAS DE UNA RESPUESTA

[1] Tablero

[2] Papelógrafo

[4] Laminario

[8] Otro, cuál? _____

36 [ ][ ] 37

(418) Qué material utiliza para ilustrar a las usuarias sobre los diferentes métodos de planificación familiar?

ENCUESTADORA: PUEDE MARCAR MAS DE UNA RESPUESTA

[1] Cartelera

[2] Muestrario

[4] Afiches

[8] Otro, cuál? _____

38 [ ][ ] 39

(419) Qué tipo de material divulgativo (informativo) impreso entrega usted a las usuarias?

1 _____

2 _____

3 _____

4 _____

40 [ ][ ] 41
Anexo

(420) Cuántos habitantes tiene esta comunidad o barrio?

_____

42 [ ][ ][ ][ ][ ] 46

(421) Cuáles de los siguientes establecimientos prestan servicio de planificación familiar a esta comunidad o barrio?

ENCUESTADORA PUEDE MARCAR MAS DE UNA RESPUESTA

1 Clínica de PROFAMILIA

2 Ministerio de Salud

4 Farmacia

8 Otro, cuál? _____

47 [ ][ ] 48

(422) Hay otros distribuidores de PROFAMILIA en esta comunidad o barrio?

SI 1 NO 2

49 [ ]

DE LOS AGRADECIMIENTOS Y TERMINE LA ENCUESTA

APPENDIX 4

Data Collection Forms for Distributors

PROFAMILIA

NIT. 60.013.779

1) Centro _____ | | | 2) Fecha | | | | | | (AÑO MES DIA) 3) FACTURA Nº 02143

4) Nombre Distribuidor/Comprador: _____

5) Dirección _____ Barrio _____ Municipio _____

Corregimiento _____ 6) Clase de Establecimiento _____

7) Tipo de Cliente Pto. Distrib. ☐ Contado ☐ 8) Puesto No. | | | | | | | |

9)

	PRODUCTOS	EXIST. ANT.	INVENTARIO	VENTA	V/R. UNIT	V/R. VENTA	NV. ENTR.	REINT.	NV EXIST.
	a	b	c	d	e	f	g	h	i
PILDORAS	01015801 Eugynon								
	01015802 Microgynon CD								
	01015803 Microgynon 21								
	01015804 Neogynon 21								
	01015805 Neogynon CD								
	01016201 Noriday								
	01017001 Noral 21								
	01017002 Noral 28								
CONDONES	01020602 Tahiti Tiras								
OVULOS	01032402 Neo-Sampoon Tubos								
	01032403 Neo-Sampoon Tabletas								
	01034414 Norforms Cja X12								
OTROS	10274503 Pirantel 250 mg								
10)	TOTALES					$			

11) Nota: Por Ventas Contado utilizar columnas | d | | e | | f |

12) Forma de Pago: Efectivo $ _____ Cheque _____

13) Firma Distribuidor/Comprador

14) Nombre Instructor (a)

_____ _____

c. c. de

15) OBSERVACIONES: _____

16) ORIGINAL : CLIENTE
COPIA ROSADA: CONTABILIDAD
AMARILLA: I E C BOGOTA
AZUL: CENTRC

P C 003

1,000X20X4-08-84

PROFAMILIA

PROGRAMA COMUNITARIO

RESUMEN DE VENTAS Y EXISTENCIAS

1) CLINICA No. [ ][ ] 2) Mes o meses a que corresponde la recolección _____

3) Puestos Recolectados _____ 4) Puestos Existentes _____

5) Resumen Puestos de Distribución:

	PRODUCTOS	1 Existencia Anterior	2 Cantidad Vendida	3 Valor Unit. $	4 Valor Venta (2x3)	5 Nueva Entrega	6 Reintegro a Bodega de Puestos	7 Nueva Existencia (1-2+5-6)	8 Solicitud Droga a Bodega	9 Reintegro Sobrante a Bodega
ANOVULATORIOS	NORIDAY									
	EUGYNON									
	NEOGYNON 21									
	NEOGYNON CD									
	MICROGYNON CD									
	NORAL 28									
Cond.	TAHITI - TIRAS									
Vaginales	NORFORMS									
	NEO - SAMPOON									
OTROS	NANDOL									
	PIRANTEL									
			TOTAL VENTA $							

6) A. Nuevos Puestos No. (Relacionarlos en la forma I.E.C. 001)

7) B. Puestos Cerrados No. (Relacionarlos en la forma I.E.C. 001)

8) C. Cambio Distribuidor (Relacionarlos en la forma I.E.C. 001)

9

	RESUMEN VENTAS DE CONTADO			
	PRODUCTOS	Cantidad Vendida	Valor Unitario $	Valor Venta (2x3)
ANOVULATORIOS	NORIDAY			
	EUGYNON			
	NEOGYNON 21			
	NEOGYNON CD			
	MICROGYNON CD			
	NORAL 28			
Cond.	TAHITI - TIRAS			
Vaginales	NORFORMS			
	NEO - SAMPOON			
OTROS	NANDOL			
	PIRANTEL			
		TOTAL VENTA $		

10

CASOS ESPECIALES [Control Mini-Bodega]					
1	2	3		4	5
Existencia Anterior	Solicitud a Bodega	ENTREGAS A		Reintegro a mini-bodega	Nueva Existencia (1+2-3+4)
		Puestos	Contado		

PRINTER TEL. 249 99 90

Forma P. C. 002

ORIGINAL: Contabilidad Bogotá
1a. COPIA: Comunitario Bogotá
2a. COPIA: Div. Eval. y Estad. Bog.
3a. COPIA: Archivo Centro

CONTABILIDAD

11) Bogotá

	VALOR TOTAL VENTAS EN PUESTOS $	
	VALOR TOTAL VENTAS DE CONTADO $	

12)

CANCELACION DEUDAS MESES ANTERIORES		
	NOMBRE PUESTO	VALOR
	1 $	
	2 $	
	3 $	
	4 $	
	5 $	
	6 $	
	7 $	
	VALOR TOTAL CANCELACION DEUDAS $	

13)

DEUDAS PRESENTE MES		
	NOMBRE PUESTO	VALOR
	1 $	
	2 $	
	3 $	
	4 $	
	5 $	
	6 $	
	VALOR TOTAL DEUDAS PRESENTE MES $	

14)

	TOTAL DE INGRESOS $	

15)

	TOTAL CONSIGNADO EN EL CENTRO $ RECIBI: _____	

16)

NUEVO ESTADO DE DEUDORES		
	NOMBRE PUESTO	VALOR
	1 $	
	2 $	
	3 $	
	4 $	
	5 $	
	6 $	
	TOTAL DEUDAS $	

17)

Resumen Ventas Precios Anteriores				
	PRODUCTOS	Cantidad Vendida	Valor Unitario	Valor Venta
ANOVULATORIOS	NORIDAY			
	EUGYNON			
	NEOGYNON 21			
	NEOGYNON CD			
	MICROGYNON CD			
	NORAL 28			
Cond	TAHITI - TIRAS			
Vaginales	NORFORMS			
	NEO - SAMPOON			
OTROS	NANDOL			
	PIRANTEL			

18) Observaciones: _____

19) Fecha ☐☐ AÑO ☐☐ MES ☐☐ DIA

20) Nombre Informante: _____

21) Vo. Bo. _____

ORIGINAL: Contabilidad Bogotá

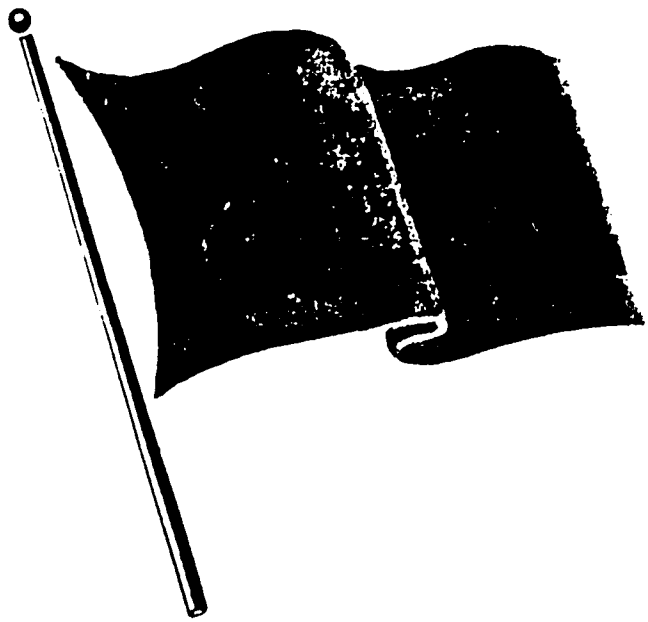
90

APPENDIX 5

Educational Materials for Distributors

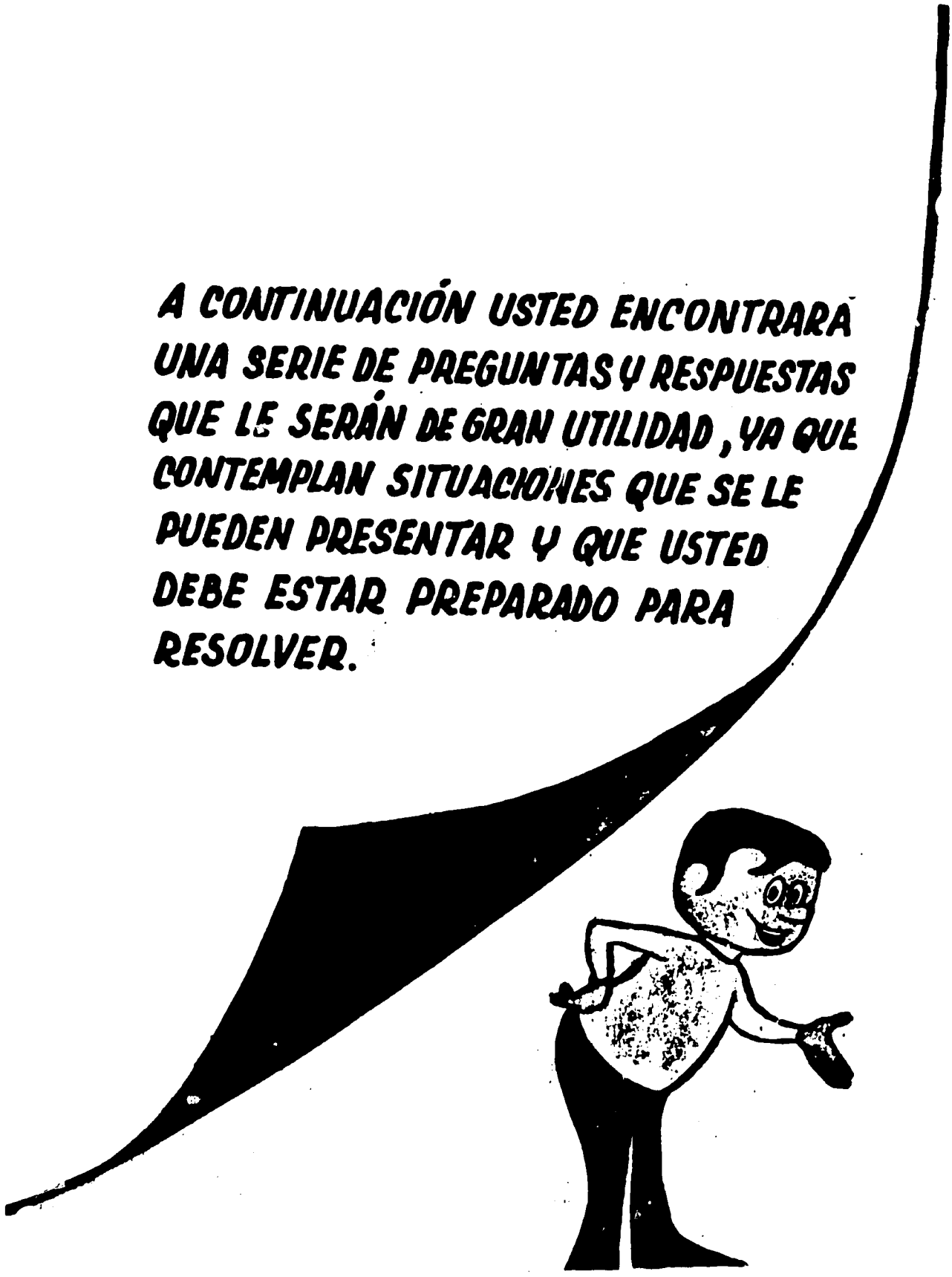
PROFAMILIA

PLANIFICACION FAMILIAR



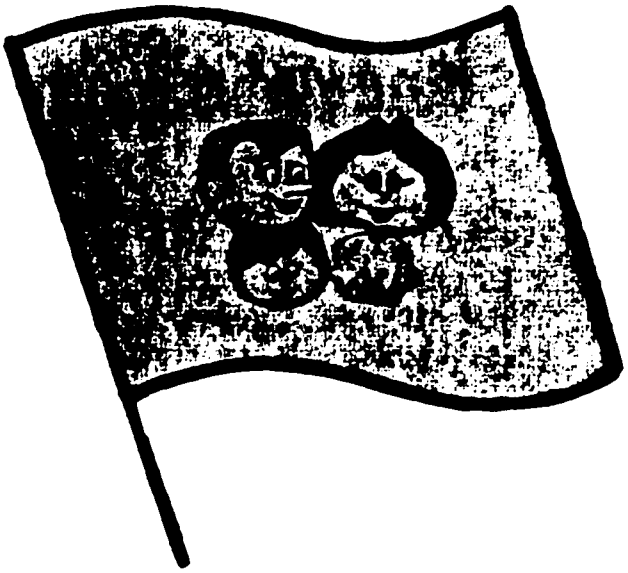
Métodos Anticonceptivos

A CONTINUACIÓN USTED ENCONTRARÁ UNA SERIE DE PREGUNTAS Y RESPUESTAS QUE LE SERÁN DE GRAN UTILIDAD, YA QUE CONTEMPLAN SITUACIONES QUE SE LE PUEDEN PRESENTAR Y QUE USTED DEBE ESTAR PREPARADO PARA RESOLVER.

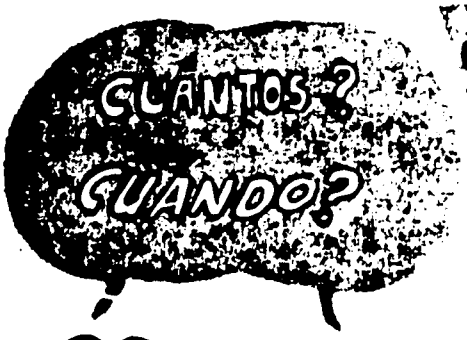


QUE ES PROFAMILIA?

ES UNA INSTITUCION PARTICULAR, SIN ÁNIMO DE LUCRO QUE COLABORA CON LA COMUNIDAD EN PLANIFICACION FAMILIAR



QUÉ ES PLANIFICACIÓN FAMILIAR?



PLANIFICACIÓN FAMILIAR ES TENER SÓLO EL NUMERO DE HIJOS QUE UNA PAREJA QUIERA TENER Y CUANDO LOS QUIERA TENER.

PORQUÉ ES IMPORTANTE LA PLANIFICACIÓN FAMILIAR ?

EXISTEN MUCHAS RAZONES PARA QUE UNA PAREJA DEBA PLANIFICAR LA FAMILIA Y ESPACIAR EL NACIMIENTO DE SUS HIJOS:

Salud de la madre

LOS EMBARAZOS FRECUENTES AFECTAN LA SALUD DE LA MADRE. PARA QUE LA MUJER PUEDA TENER BUENA SALUD Y ATENDER LA CRIANZA Y EL CUIDADO DE LOS HIJOS, LOS EMBARAZOS DEBEN SER ESPACIADOS PARA QUE LA MADRE PUEDA RECUPERARSE COMPLETAMENTE ANTES DE OTRO EMBARAZO

Salud del hijo

LA SALUD DE LOS HIJOS DEPENDE TAMBIEN DEL NÚMERO DE HIJOS DE CADA FAMILIA Y DE LA FRECUENCIA DE LOS NACIMIENTOS.

ESTA DEMOSTRADO QUE LOS HIJOS DE FAMILIAS MAS PEQUEÑAS Y CON NACIMIENTOS MAS ESPACIADOS, SON MAS SANOS Y FUERTES QUE LOS DE FAMILIAS NUMEROSAS Y CON NACIMIENTOS MAS SEGUIDOS.

Amor y cuidado a los hijos

LA PLANIFICACIÓN FAMILIAR PERMITE DAR A CADA HIJO TODA LA ATENCIÓN Y EL CARIÑO QUE NECESITA. UN HIJO DESEADO Y ENCARGADO VOLUNTARIAMENTE, SIEMPRE DISFRUTARÁ DEL AMOR Y LA ATENCIÓN DE SUS PADRES.

Educación

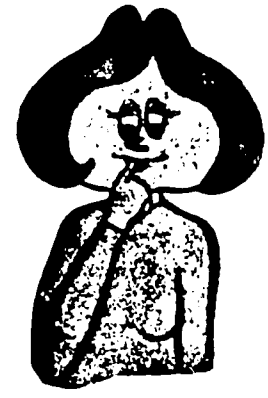
LA FAMILIA PLANIFICADA PERMITE DAR A CADA HIJO UNA MEJOR EDUCACIÓN Y POR CONSIGUIENTE HACER DE CADA UNO UN ELEMENTO ÚTIL A LA SOCIEDAD Y AL PAÍS.

Estabilidad de la familia

LOS HIJOS DESEADOS, DIFICILMENTE ABANDONARÁN EL HOGAR, YA QUE ENCUENTRAN EN ÉL LA ATENCIÓN Y EL AMOR QUE NECESITAN.

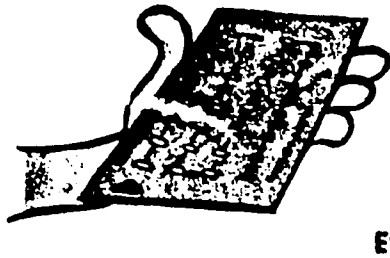
LA SATISFACCIÓN Y EL BIENESTAR DE LOS HIJOS TRAEN COMO CONSECUENCIA SATISFACCIÓN Y BIENESTAR DE LOS PADRES.

COMO SE PUEDE PLANIFICAR LA FAMILIA?



UTILIZANDO MÉTODOS ANTICONCEPTIVOS TALES COMO: LA PÍLDORA, EL DISPOSITIVO (ANILLO, CHURRUSCO), LOS ÓVULOS (TABLETAS VAGINALES), EL PRESERVATIVO O CONDÓN, LA ESTERILIZACIÓN FEMENINA (LIGADURA DE TROMPAS) Y LA ESTERILIZACIÓN MASCULINA (VASECTOMÍA)

CÓMO SE USA LA PÍLDORA?

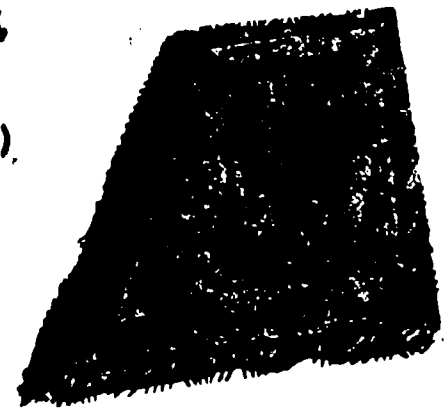


PARA COMENZAR A USARLA, ESPERE A QUE LE VENGA LA REGLA O MENSTRUACIÓN. CUENTE LOS DÍAS DESDE EL PRIMER DÍA DE LA REGLA, Y EL QUINTO DÍA, EMPIECE A TOMAR LAS PÍLDORAS. UNA TODOS LOS DIAS, MAS O MENOS A LA MISMA HORA, PREFERIBLEMENTE DESPUÉS DE LA COMIDA DE LA NOCHE.

EJEMPLO: SI LA REGLA LE VINO EL MARTES, ÉSE SE CUENTA COMO EL PRIMER DÍA Y ENTONCES EL SÁBADO, QUE ES EL QUINTO DÍA, DEBE COMENZAR A TOMAR LA PRIMERA PÍLDORA ANTICONCEPTIVA.

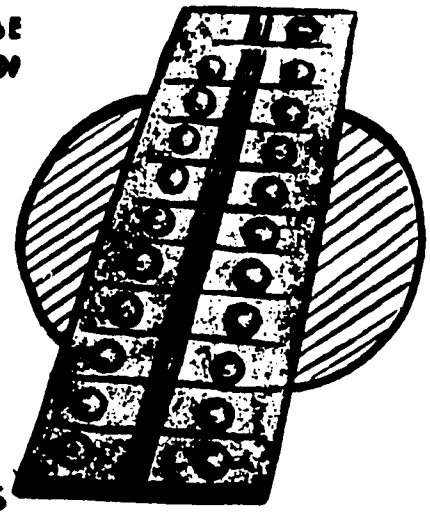
Cartón de 28 píldoras

CUANDO EL CARTÓN TIENE 28 PÍLDORAS, SE INICIA EL CARTÓN EL 5º DÍA DE LA MENSTRUACIÓN, EMPEZANDO POR EL GRUPO DE MAYOR NÚMERO (21 PÍLDORAS) Y DEJANDO DE ÚLTIMAS LAS PÍLDORAS DE OTRO COLOR QUE VIENEN EN MENOR CANTIDAD (7 PÍLDORAS). TERMINANDO EL CARTÓN, DEBE COMENZAR UNO NUEVO SIEMPRE POR EL GRUPO DEL MAYOR NÚMERO (21 PÍLDORAS).



Cartón de 21 píldoras

EN ESTE CASO, LAS PÍLDORAS SON TODAS DE UN MISMO COLOR. SE DEBE COMENZAR EL 5º DÍA DESPUÉS DE INICIAR LA MENSTRUACIÓN Y CONTINUAR TOMANDO UNA, TODOS LOS DÍAS SIN INTERRUPCIÓN HASTA QUE SE TERMINE EL CARTÓN, CUANDO SE HAYA TERMINADO, SE ESPERA, UNA SEMANA SIN TOMAR NINGUNA PÍLDORA Y PASADA ESTA SEMANA SE COMIENZA UN NUEVO PAQUETE O CARTÓN.
EJEMPLO: SI SE TERMINA UN CARTÓN EL DÍA MIÉRCOLES, EL PRÓXIMO CARTÓN SE COMENZARÁ EL DÍA JUEVES DE LA SEMANA SIGUIENTE.
DURANTE LA SEMANA DE DESCANSO DEBE PRESENTARSE LA REGLA Ó MENSTRUACIÓN, EL NUEVO CARTÓN DEBE EMPEZARSE A TOMAR A LOS OCHO DÍAS DE HABERSE TERMINADO EL ANTERIOR, SEA QUE LA MUJER ESTÉ TODAVÍA CON LA MENSTRUACIÓN O QUE ESTA YA HAYA TERMINADO.



QUÉ DEBE HACERSE SI AL TERMINAR UN CICLO DE PÍLDORAS NO LE VIENE LA MENSTRUACIÓN?

SI LA SEÑORA ESTÁ TOMANDO DEL CARTÓN DE 28 PÍLDORAS Y TIENE SEGURIDAD DE HABERLAS TOMADO DIARIAMENTE, DEBE INICIAR UN NUEVO CARTÓN AL DÍA SIGUIENTE DE HABER TERMINADO EL ANTERIOR.
SI ESTA TOMANDO EL CARTÓN DE 21 PÍLDORAS, DEBE DEJAR PASAR 7 DIAS DESPUÉS DE TOMADA LA ÚLTIMA Y EL DÍA OCTAVO INICIAR UN NUEVO CARTÓN
SI AL TERMINAR EL SEGUNDO CARTÓN AÚN NO SE PRESENTA LA MENSTRUACIÓN, DEBE CONSULTAR EN EL CENTRO DE PLANIFICACION FAMILIAR MÁS CERCANO

OLVIDÓ TOMAR LA PÍLDORA POR UN DIA?

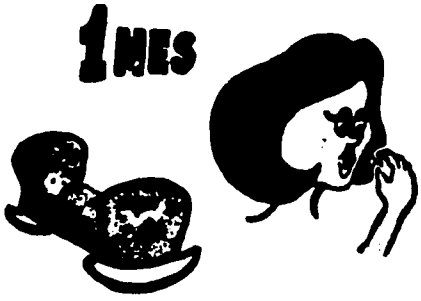
AL ACORDARSE TOME INMEDIATAMENTE LA QUE OLVIDÓ Y POR LA NOCHE LA CORRESPONDIENTE A ÉSE DÍA.

SI LA OLVIDÓ POR MÁS DE UN DÍA, CONTINUE TOMÁNDOLAS, PERO NO TENGA RELACIONES SEXUALES O USE OTRO ANTICONCEPTIVO (CONDÓN, OVULOS, TABLETAS VAGINALES) HASTA QUE TERMINE EL CARTÓN, PORQUE UN OLVIDO DE DOS (2) O MAS DÍAS ES UN RIESGO DE EMBARAZO.

CUÁNDO COMIENZA A HACER EFECTO LA PÍLDORA Y CUÁNTO DURA SU EFECTO?

LA PROTECCIÓN CONTRA EL EMBARAZO SE INICIA EL MISMO DÍA EN QUE COMIENZA LA TOMA DE PÍLDORAS Y DURA SOLAMENTE MIENTRAS SE ESTÉ EN TRATAMIENTO.

CUANDO UNA MUJER ESTA EN DIETA, CUÁNDO DEBE COMENZAR A TOMAR PASTILLAS?



EL MEJOR MOMENTO PARA COMENZAR A TOMAR LA PÍLDORA DESPUÉS DE UN PARTO, ES A LOS 30 DÍAS O SEA CUANDO EL NIÑO CUMPLA EL 1

CUÁNDO DEBE COMENZAR A TOMAR PASTILLAS DESPUÉS DE UN ABORTO?

INMEDIATAMENTE DESPUÉS DEL ABORTO.

SI UNA SEÑORA ESTA DANDO PECHO A SU NIÑO, LA PÍLDORA LE AFECTA EN ALGO?

LA PÍLDORA PUEDE DISMINUÍR LA LECHE EN LAS MADRES, ESPECIALMENTE EN LOS PRIMEROS TRES MESES. CUANDO ESTÁ DANDO EL PECHO A SU NIÑO ES PREFERIBLE QUE USE OTRO MÉTODO O QUE POR LO MENOS NO COMIENCE LA PÍLDORA HASTA DESPUÉS DE LOS TRES MESES, PROTEGIÉNDOSE MIENTRAS TANTO CON OTRO MÉTODO (CONDÓN, ÓVULOS, TABLETAS VAGINALES).

PUEDE LA PÍLDORA OCASIONAR PROBLEMAS DE SALUD?

PARA LA MAYORÍA DE MUJERES, ESTE MÉTODO NO PRESENTA DESVENTAJAS. A ALGUNAS MUJERES LAS PÍLDORAS LES CAUSAN MOLESTIAS TEMPORALES Y PASAJERAS. OTRAS EXPERIMENTAN NÁUSEAS O DOLORES DE CABEZA. EN OTROS CASOS PUEDE SUCEDER QUE SE PRESENTE UN LIGERO SANGRADO COMO SI EMPEZARA LA REGLA EN UNA FECHA INDEBIDA. ESTO ES NORMAL DURANTE LOS TRES PRIMEROS MESES EN QUE SE HA EMPEZADO A TOMAR LA PÍLDORA. SI EL SANGRADO CONTINÚA DESPUÉS DE LOS TRES PRIMEROS MESES, ES CONVENIENTE REMITIR A LA SEÑORA AL CENTRO DE PROFAMILIA MAS CERCANO, A CONSULTA MÉDICA. SI NO HAY CENTRO DE PROFAMILIA, REMÍTALA A UN MÉDICO Y SI NO HAY MÉDICO, ACONSÉJELE QUE SUSPENDA LA PÍLDORA Y USE OTRO MÉTODO.

ES CIERTO QUE LA PÍLDORA ENGORDA?

ALGUNAS MUJERES ENGORDAN UN POCO CUANDO EMPIEZAN A TOMAR LA PÍLDORA, DEBIDO A QUE UNA MENOR PREOCUPACIÓN HACE QUE MEJORE SU APETITO.

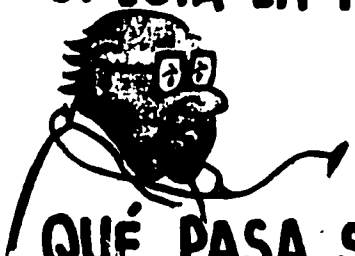
ES CIERTO QUE LA PÍLDORA MANCHA LA PIEL?

EN CIERTOS CASOS PUEDE MANCHAR LA PIEL, PERO ESTO NO TIENE IMPORTANCIA Y ES PASAJERO.

ES CIERTO QUE LA MUJER QUE HA TOMADO PASTILLAS POR ALGUN TIEMPO Y LAS SUSPENDE, AL QUEDAR EMBARAZADA, TIENE MELLIZOS?

NO ES CIERTO.

PUEDE UNA SEÑORA TOMAR PASTILLAS, SI ESTA EN TRATAMIENTO MÉDICO?



SI, LA PÍLDORA ANTICONCEPTIVA NO ESTÁ CONTRAINDICADA CON OTRAS DROGAS.

QUÉ PASA SI UN NIÑO TOMA LAS PASTILLAS?

NO LES HARÁ DAÑO, PERO ES MEJOR GUARDARLAS EN UN LUGAR DONDE LOS NIÑOS NO LAS COJAN.

PERJUDICA LA PÍLDORA, SI UNA MUJER LA TOMA CUANDO ESTA EMBARAZADA ?

NO, PERO DEBE SOSPENDERLAS CUANDO SEPA QUE ESTÁ EMBARAZADA.

POR CUÁNTO TIEMPO PUEDE UNA MUJER TOMAR LAS PÍLDORAS ?

SI LAS TOLERA PUEDE TOMARLAS POR VARIOS AÑOS. LAS MUJERES DE MAS DE 35 AÑOS NO DEBEN TOMAR PÍLDORAS PERO PUEDEN DECIDIRSE POR UN MÉTODO DEFINITIVO.

ES UN MÉTODO SEGURO ?

SI

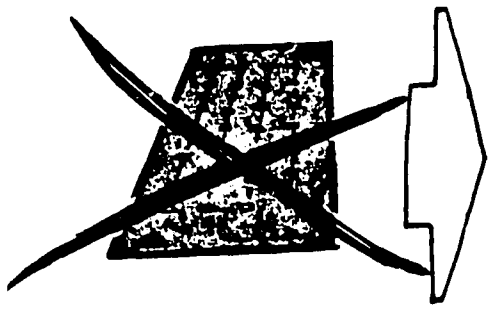
ESTE MÉTODO NO FALLA, O SEA, NO HAY EMBARAZOS; LAS FALLAS SON CAUSADAS POR LAS SEÑORAS QUE SE OLVIDAN DE TOMAR LAS PÍLDORAS O LAS TOMAN INCORRECTAMENTE.

EL USO DE LA PÍLDORA ESTERILIZA LA MUJER ?

NO !

TODAS LAS MUJERES PUEDEN TOMAR PÍLDORAS?

CASI TODAS LAS MUJERES PUEDEN TOMAR LAS PÍLDORAS. SIN EMBARGO NO DEBE ACONSEJARSE ESTE MÉTODO A MUJERES QUE TENGAN O HAYAN TENIDO:



* PRESIÓN ARTERIAL ALTA
* COLOR AMARILLO EN LA PIEL O EN LOS OJOS (BUENAMOZA, ICTERICIA, HEPATITIS)
* CÁNCER
* AZUCAR EN LA SANGRE (DIABETES)
* DERRAMES CELEBRALES
* ATAQUES AL CORAZÓN
* VÁRICES MUY PRONUNCIADAS O INFLAMADAS
* QUE TENGA MÁS DE 35 AÑOS DE EDAD.
* FUMADORA

EN ESTOS CASOS, SE ACONSEJARA OTRO MÉTODO O SE ENVIARÁ LA SEÑORA AL MÉDICO.

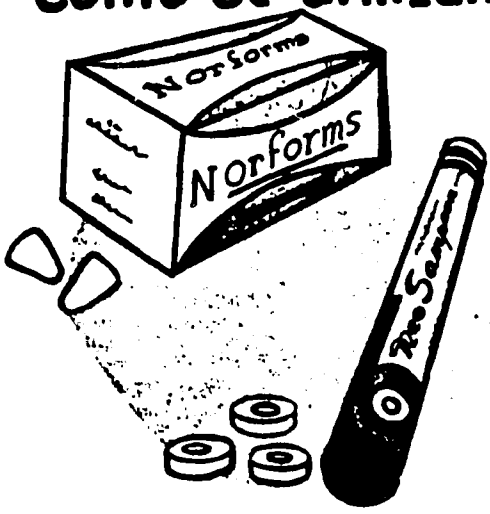
DEBE INTERRUMPIRSE LA PÍLDORA CADA UNO O DOS AÑOS PARA QUE EL ORGANISMO DESCANSE ?

NO ES NECESARIO INTERRUMPIRLA

SI LA MUJER LA TOLERA BIEN PUEDE TOMARLA HASTA LOS 35 AÑOS DE EDAD.

ÓVULOS Y TABLETAS VAGINALES

Cómo se utilizan?

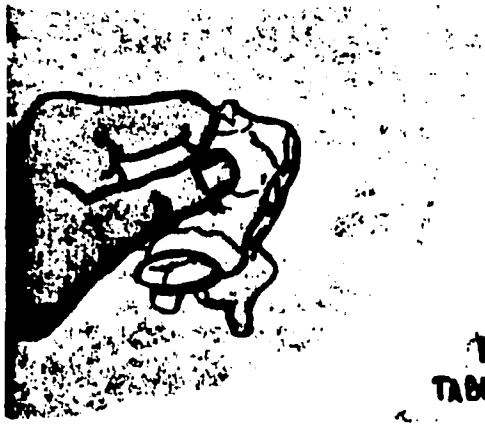


LOS USA LA MUJER COLOCANDOSE UNO EN LA VAGINA, LO MAS PROFUNDO QUE PUEDA, 10 MINUTOS ANTES DE LA RELACIÓN SEXUAL.
SI SE REPITE LA RELACIÓN HAY NECESIDAD DE APLICAR UN NUEVO ÓVULO O TABLETA VAGINAL.

CONDÓN O PRESERVATIVO

ES EL ANTICONCEPTIVO UTILIZADO POR EL HOMBRE.

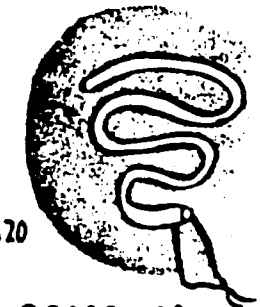
Cómo se utiliza?



SE DESENROLLA EN EL PENE O MIEMBRO, CUANDO ESTÁ RIGIDO, ANTES DE LA RELACIÓN SEXUAL.
EL CONDÓN RECOGE EL SEMEN Y EVITA QUE LOS ESPERMATOZOIDES (SEMILLA DEL HOMBRE) PENETREN EN EL ÚTERO DE LA MUJER.
SE USA UNO PARA CADA RELACIÓN SEXUAL.
ESTE MÉTODO ES MÁS SEGURO QUE LOS ÓVULOS Y TABLETAS VAGINALES

DISPOSITIVO INTRAUTERINO

Qué es el Dispositivo Intrauterino (anillo, churrusco) ?

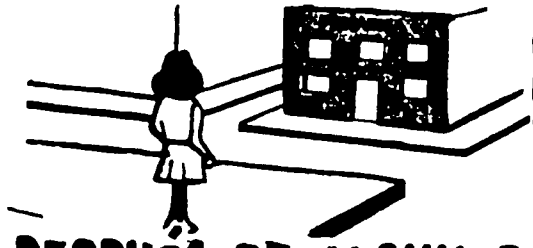


SON PEQUEÑOS OBJETOS PLÁSTICOS DE DIFERENTES FORMAS Y TAMAÑOS, QUE SE COLOCAN DENTRO DE LA MATRIZ O ÚTERO.
ES UN MÉTODO BASTANTE SEGURO PARA EVITAR EL EMBARAZO

AFECTAN LA MENSTRUACIÓN O CAUSAN MALESTAR?

LA NORMALIDAD DE LOS PERIODOS MENSTRUALES ES ALGO AFECTADA.
A VECES SE PRESENTAN ALGUNOS MALESTARES, PERO SON MUY LEVES Y PASAN RÁPIDO

CUÁNDO SE APLICA EL DISPOSITIVO ?



PARA APLICARSE EL DISPOSITIVO, TIENE QUE ACERCARSE AL CENTRO DE PROFAMILIA, CON EL SEGUNDO O TERCER DÍA DE LA REGLA.

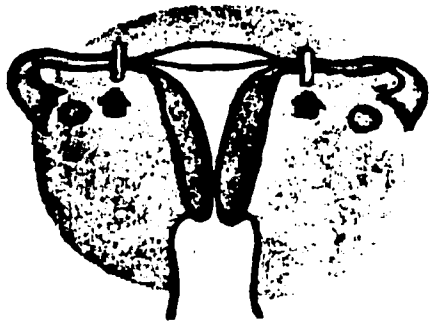
DESPUÉS DE ALGUN PARTO O ABORTO, A QUÉ TIEMPO SE COLOCA EL DISPOSITIVO?

SE PUEDE COLOCAR INMEDIATAMENTE Ó EN LA DIETA DESPUES DE UN PARTO.
DESPUES DE UN ABORTO INMEDIATAMENTE

Nota: *LOS DISPOSITIVOS INTRAUTERINOS, SON DE MUY BAJO PRECIO, NO AFECTAN LAS RELACIONES SEXUALES Y PUEDEN DEJARSE COLOCADOS POR MUCHOS AÑOS, SIN PELIGRO. SIN EMBARGO, ES ACONSEJABLE EL CONTROL MÉDICO UNA VEZ AL AÑO.*

LIGADURA DE TROMPAS

EN QUE CONSISTE?



CONSISTE EN CORTAR Y LIGAR LAS TROMPAS PARA IMPEDIR EL PASO DEL ÓVULO (SEMILLA DE LA MUJER) AL ÚTERO. LA OPERACIÓN DE LIGAR LAS TROMPAS ES SENCILLA, LA HACE EL MÉDICO CON ANESTESIA LOCAL.

LOS SISTEMAS EMPLEADOS SE LLAMAN: LAPAROSCOPIA Y MINILAPAROTOMÍA.

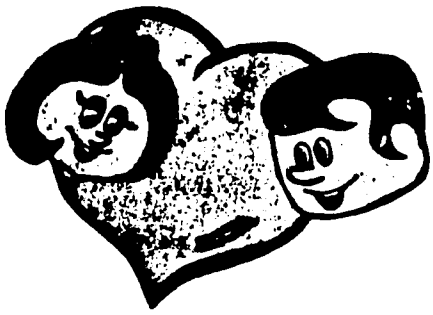
HAY NECESIDAD DE HOSPITALIZACIÓN?

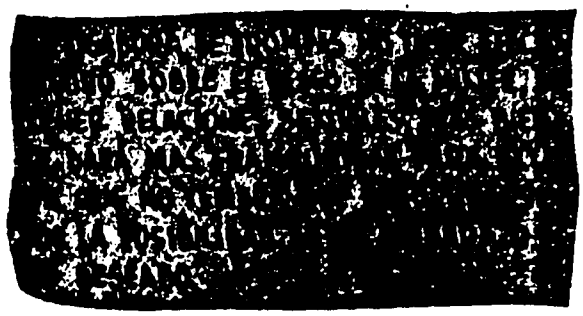
NO SE NECESITA HOSPITALIZACIÓN; SÓLO SE RECOMIENDA UNAS 6 HORAS DE DESCANSO MIENTRAS SE RECUPERA.

QUÉ REQUISITOS GENERALES SE NECESITAN PARA LA LIGADURA DE TROMPAS?

- LA MUJER DEBE TENER MÁS DE 25 AÑOS.
- DEBE TENER TRES (3) O MAS HIJOS
- DEBE SABER QUE UNA VEZ REALIZADA LA OPERACIÓN, LA MUJER NO PUEDE TENER MAS HIJOS.

AFECTA LA VIDA SEXUAL LA LIGADURA DE TROMPAS ?





AFECTA LA MENSTRUACIÓN ?

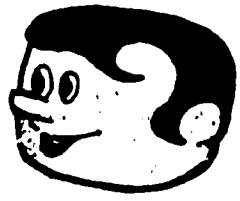
NO LA MUJER SEGUIRÁ TENIENDO SUS MENSTRUACIONES COMO ANTES.

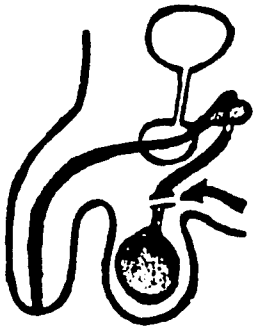
QUÉ SE DEBE HACER CON LA MUJER QUE SOLICITA LIGADURA DE TROMPAS ?

ENVIARLA AL CENTRO DE PROFAMILIA.

VASECTOMÍA

EN QUÉ CONSISTE ?





CONSISTE EN LIGAR LOS CONDUCTOS O CANALES QUE LLEVAN LOS ESPERMATOZOIDES (SEMILLA DEL HOMBRE) AL PENE.
NO ES QUITAR LOS TESTICULOS, ASI QUE ES COMPLETAMENTE DIFERENTE A LA CASTRACIÓN.

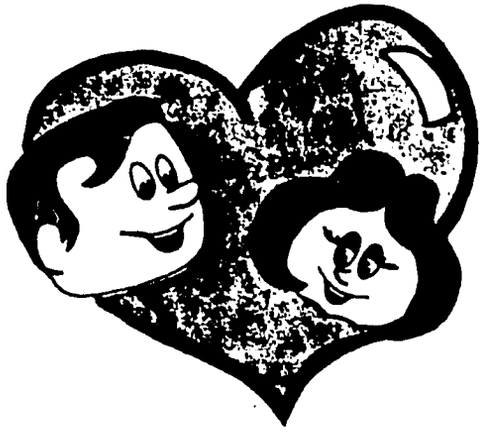
HAY NECESIDAD DE HOSPITALIZACIÓN ?

LA VASECTOMÍA ES UNA OPERACIÓN SENCILLA QUE TIENE UNA DURACIÓN DE 20 MINUTOS, CON ANESTESIA LOCAL Y QUE NO REQUIERE HOSPITALIZACIÓN.

QUÉ REQUISITOS SE NECESITAN PARA LA VASECTOMÍA ?

- EL HOMBRE DEBE TENER 28 AÑOS DE EDAD O MÁS.
- DEBE TENER COMO MINIMO TRES (3) HIJOS
- SABER QUE DESPUÉS DE LA OPERACIÓN YA NO PODRÁ VOLVER A TENER HIJOS.

INTERFIERE LA VASECTOMÍA EN LAS RELACIONES SEXUALES?



LA VASECTOMÍA NO INTERFIERE PARA NADA EN LA VIDA SEXUAL; EL HOMBRE SEGUIRÁ TENIENDO EL MISMO PLACER Y TENDRÁ DERRAME DE LÍQUIDO, LA ÚNICA DIFERENCIA ES QUE NO LLEVARÁ ESPERMATOZOIDES (SEMILLA DEL HOMBRE).

QUÉ SUCEDE CON LOS ESPERMATOZOIDES QUE DEBERÍAN PASAR POR EL CANAL DEFERENTE?

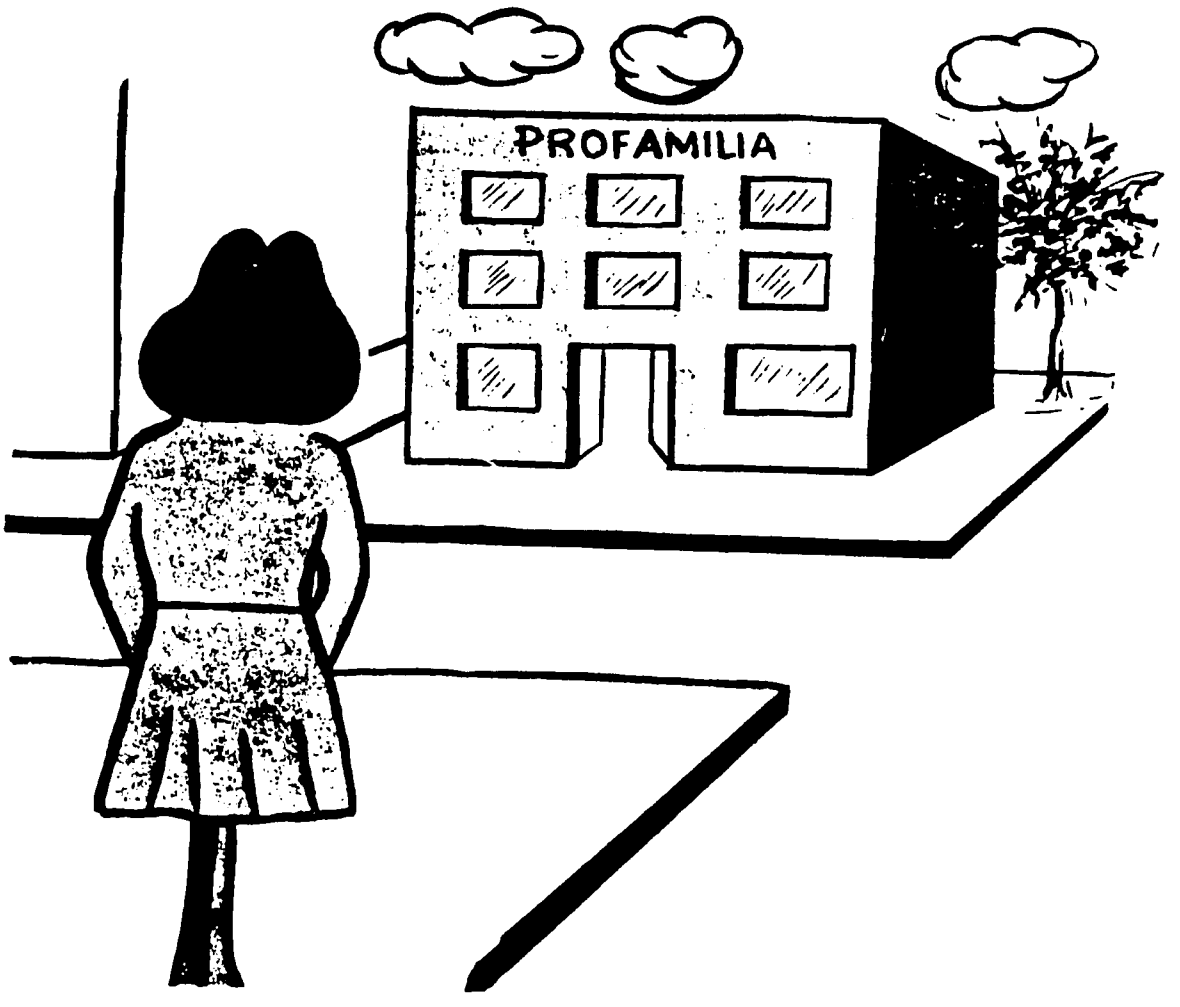
SON ABSORBIDOS POR EL ORGANISMO, SIN CAUSAR TRASTORNO ALGUNO.

QUÉ SE DEBE HACER CON UN HOMBRE QUE DESEA LA VASECTOMÍA?

PONERLO EN CONTACTO CON LA PROMOTORA DE PROFAMILIA
O ENVIARLO AL CENTRO DE PLANIFICACION FAMILIAR

CASOS EN QUE LA USUARIA DEBE SER REMITIDA A PROFAMILIA

* PARA LA APLICACIÓN DE UN DISPOSITIVO (ANILLO); EN TAL CASO ES ACONSEJABLE QUE LA MUJER ESTÉ CON EL SEGUNDO O TERCER DIA DE LA MENSTRUACION. TAMBIEN PUEDE APLICARSE EL DISPOSITIVO DESPUES DEL PARTO Ó ANTES DE CUMPLIR LA DIETA, EN CASOS DE ABORTOS INMEDIATAMENTE DESPUES DE ESTE.
* CUANDO DESPUÉS DE TRES MESES DE ESTAR TOMANDO PÍLDORAS NO APAREZCA LA MENSTRUACION, O TENGA MOLESTIAS GRAVES.



* CUANDO LA MUJER TIENE DISPOSITIVO Y ESTA PRESENTANDO MOLESTIAS

* CUANDO DESEEN ESTERILIZACIÓN (LIGADURA DE TROMPAS Ó VASECTOMÍA), ES INDISPENSABLE QUE ACUDAN MARIDO Y MUJER AL CENTRO DE PROFAMILIA.

* CUANDO ESTEN INTERESADAS EN ALGÚN MÉTODO DIFERENTE A LOS EXISTENTES EN SU PUESTO DE DISTRIBUCIÓN.

* CUANDO ESTEN INTERESADAS EN ALGUN MÉTODO DIFERENTE PORQUE EL QUE ESTÁN USANDO ESTA PRESENTANDO PROBLEMAS DE SALUD.

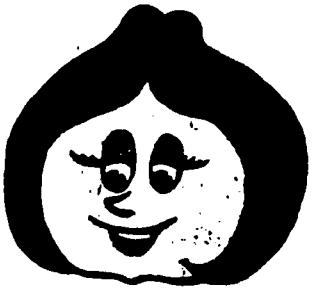
CUÁNTOS HIJOS DEBO TENER ?

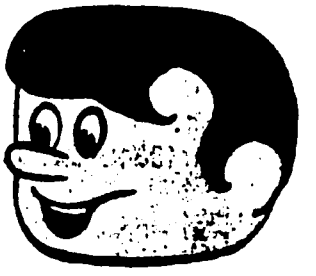
A CUÁNTOS PUEDO EDUCAR ?

A CUÁNTOS PUEDO MANTENER ?

A CUÁNTOS PUEDO ALIMENTAR ?

CÓMO SE PUEDEN PLANIFICAR ?





PROFAMILIA

LE ORIENTA Y LE SIRVE

CENTROS DE PROFAMILIA EN EL PAIS

BOGOTA

CENTRO PILOTO
Calle 34 No. 14-52
Conmutador: 287- 21 - 00

FUND. REFUGIO LAS COLINAS
Carrera 18 No. 31-18 Sur
Tel. 2 39-09-53

ARMENIA
Carrera 14 No. 21-51
Tel. (960) 44-299

BARRANCABERMEJA
Calle 7a. No. 16-52
Tel. (9710) 4359 - 4700

BARRANQUILLA
Carrera 43 No. 65B-11
Tel. (95) 410-910 - 416-150
416-199
(Apartado Aéreo No. 50230)

BUCARAMANGA
Carrera 20 No. 37-80
Tel. (971) 25-611

BUENAVENTURA
Calle 4a. No. 5A-25
Tel. (9310) 3235

CALI
Calle 23 N No. 3N-40
Tel. (93) 63-17-30
68-99-84

CARTAGENA
Pie de la Popa Calle Real
No. 20-192 - Piso 2o.
Tel. (959) 47-640

CUCUTA
Avenida 2a. No. 13-08
Tel. (970) 20-142

GIRARDOT
Calle 19 No. 8-18 - Piso 2o.
Tel (9832) 4797

IBAGUE
Carrera 2a. No. 13-50
Tel. (982) 34-470

MANIZALES
Calle 21 No. 20-17
Tel. (969) 23-232 - 31-986

NEIVA
Calle 6a. No. 6-47
Tel. (980) 25-831- 22-193

MEDELLIN
Calle 54 No. 43-47
Tel. (94) 39-33-82 – 39-95-64
39-50-82 – 39-30-84

CASTILLA (Medellín)
Carrera 68 No. 97-106
Tel. (94) 370-091

CALDAS (Antioquia)
Carrera 49 No. 49-15
Tel. (94) 780-874

RIONEGRO (Antioquia)
Carrera 48 No. 51-40
Tel. (94) 710-762

MONTERIA
Carrera 2a. No. 22-62
Tel. (9401) 29-19

PALMIRA
Carrera 26 No. 30-56
Tel. (931) 27-155 - 23-707

PASTO
Calle 16 No. 19-16
Avenida de Las Américas
Tel. (9301) 44-34

PEREIRA
Calle 17 No. 5-28
Tel. (961) 47-773 - 36-829

POPAYAN
Carrera 10 No. 4-78
Tel. (9399) 4387

SANTA MARTA
Calle 21 No. 6-14
Tel. (9501) 27-95

SINCELEJO
Carrera 20 No. 19-81
Tel (950) 21-885

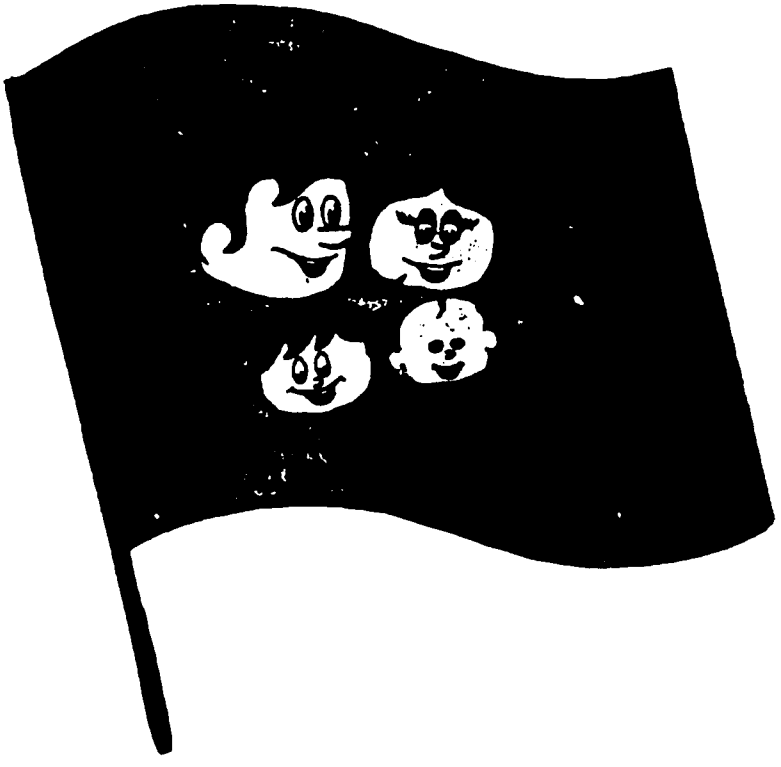
TULUA
Carrera 27 No. 30-16
Tel. (9319) 38-74

VALLEDUPAR
Carrera 12 No. 16-54
Tel. (957) 24-048

VILLAVICENCIO
Carrera 30 No. 41B-45
Tel. (9801) 34-48

BUSQUE LA BANDERITA VERDE

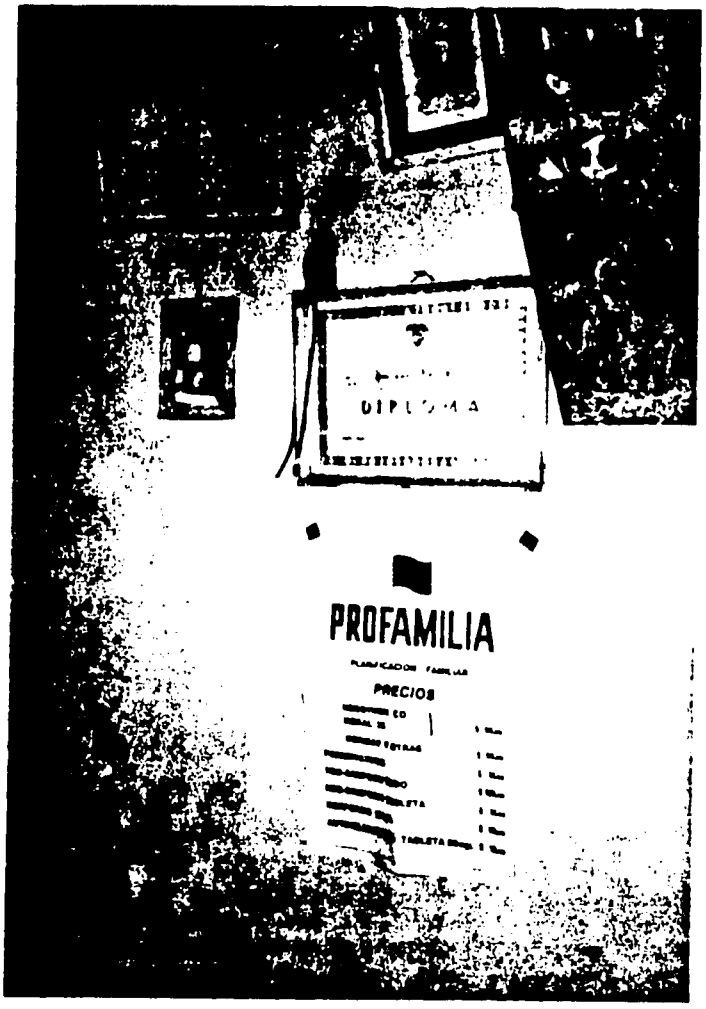
PROFAMILIA

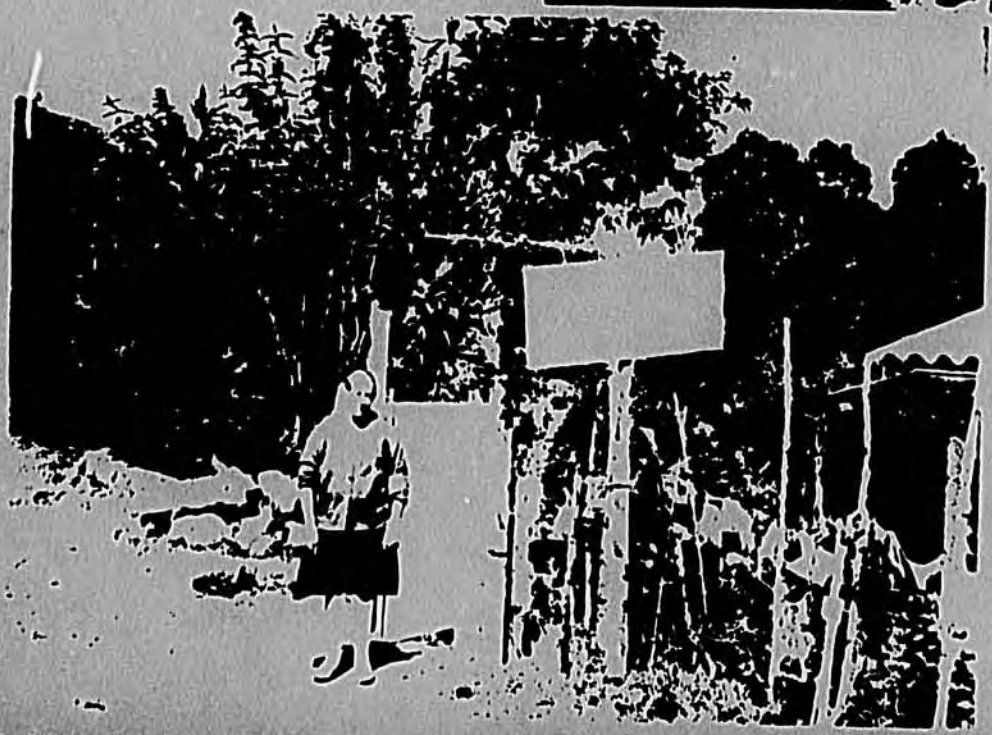


le orienta
y le sirve

APPENDIX 6

Photos of Distribution Posts


PROFAMILIA
PRECIOS



APPENDIX 7

Methodology and Data Analysis of the Cesar - Cauca Team Experiment

ESTUDIO SOBRE "EFICIENCIA DE DOS METODOS DE DISTRIBUCION COMUNITARIA DE ANTICONCEPTIVOS, EN LOS DEPARTAMENTOS DE CAUCA Y CESAR". COLOMBIA 1981

DISEÑO DE LA MUESTRA

LUIS CARLOS GOMEZ S.
Estadístico-Muestrista, Sociólogo
Enero de 1982

1. UNIVERSO DE ESTUDIO

Las mujeres en edad fértil (MEF), de 15 a 49 años, alguna vez en unión, residentes en 12 de los municipios del César y 12 del Cauca, conforman el universo del estudio sobre eficiencia de dos métodos de distribución comunitaria de anticonceptivos.

La tabla 1 presenta las estimaciones para 1981 de la población total y de las MEF objeto de la investigación, por zonas urbana (cabecera) y rural, de cada uno de los citados municipios. Los grupos control y experimental fueron constituídos previamente por las directivas del estudio. El concepto de intervención previa se refiere al desarrollo de actividades de planificación familiar con anterioridad a la fecha del estudio.

La máxima desagregación geográfica para efectos de inferencia de los resultados, se estableció a nivel de zona (urbana y rural), de cada grupo control o experimental, de cada departamento, lo cual significa ocho sub-universos de análisis rutinario.

2. TIPO DE MUESTRA

La muestra diseñada es probabilística, de conglomerados, estratificada y poliétápica.

Probabilística, dado que cada persona (MEF alguna vez en unión) del universo estudiado tiene una probabilidad conocida de selección superior a cero. Dicha probabilidad varía a nivel de las zonas urbana y rural de cada uno de los doce estratos definidos en el diseño (ver adelante).

De Conglomerados, constituídos por los municipios o Unidades Primarias de Muestreo (UPM), y por segmentos o grupos contiguos de hogares (Unidades secundarias), de tamaño promedio 10 en las zonas urbanas (cabeceras municipales) y 25 en las rurales. Las UPM son municipios en casi todos los casos. Por razones de cercanía, accesibilidad y contiguidad geográfica, y por causas operativas, en dos situaciones, la unidad primaria se constituyó juntando dos municipios. El tamaño de los segmentos fue en-

TABLA 1 - POBLACION TOTAL Y MEF (alguna vez en unión) RESIDENTES EN LOS MUNICIPIOS DEL UNIVERSO DEL ESTUDIO. PROYECCIONES A 1981

Depto.	Grupo	Municipio	Intervención previa	POBLACION TOTAL			M E F- UNIVERSO		
				Urbana	Rural	Total	Urbana	Rural	Total
Cauca	Control	Bolívar	SI	5.136	38.915	44.051	723	5.316	6.039
		Mercaderes	SI	5.609	18.611	24.220	789	2.570	3.359
		Patía	SI	8.067	15.682	23.749	1.073	2.004	3.077
		Balboa	Semi	2.437	11.885	14.322	314	1.343	1.657
		Almaguer	NO	1.756	8.461	10.317	227	1.032	1.259
		S.Sebastián	NO	615	5.028	5.563	80	738	818
	Experi-mental	El Tambo	NO	2.179	16.196	18.375	343	3.167	2.889
		La Vega	NO	1.944	11.530	13.474	288	1.567	1.855
		Puracé	NO	661	8.716	9.377	118	1.253	1.371
		La Sierra	NO	950	7.820	8.770	139	1.040	1.179
		Rosas	NO	1.009	7.365	8.374	141	917	1.058
		Sotará	NO	400	3.481	3.881	54	481	535
César	Control	Aguachica	SEMI	27.868	6.230	34.098	3.828	820	4.648
		Tamalameque	SI	3.029	25.047	28.076	342	3.410	3.752
		Río de Oro	SEMI	3.430	22.691	26.121	447	3.034	3.481
		Curumani	SEMI	14.036	8.614	22.650	1.824	1.120	2.944
		Pailitas	SEMI	6.254	3.714	9.978	923	548	1.471
		Gámarra	SEMI	5.401	5.422	10.823	704	721	1.425
		La Gloria	SEMI	2.632	4.984	7.616	328	718	1.046
		González	NO	1.259	5.124	6 383	154	494	648
	Experi-mental	El Copey	NO	15.810	24.124	39.934	1.910	3.131	5.041
		Chiriguaná	NO	6.683	18.815	25.498	823	2.408	3.231
		Robles	NO	6.483	17.289	23.772	785	2.030	2.815
		Chimichagua	NO	7.566	14.801	22.367	928	1.808	2.736

Notas : - Cuando la proyección de la cabecera disminuye en relación con el censo de 1973, se deja vigente esta población censal.

- En el Tambo, se incluye solamente dos sectores 22,23,y 24 de la zona rural, por razones, de orden público.

- Para la estimación de las MEF alguna vez en unión, se aplicó el factor " o.75 x hogar " suministrado por los directivos del estudio.

tablecido a partir de consideraciones de costo y precisión de resultados, deducidas de otras experiencias similares en Colombia (1).

Este tipo de muestra reduce sustancialmente los costos del trabajo de campo, a costa de un aumento razonable (en este caso) del error de muestreo.

Estratificada, por agrupación de las UPM en conjuntos homogéneos, aplicando los siguientes criterios principales : Departamento, al cual pertenece cada UPM, área control o experimental según la clasificación previamente establecida por las directivas del estudio, en función de sus objetivos, y tamaño de la UPM, procurando reunir unidades similares en cuanto al número de MEF en unión. La variable " intervención previa " también se tuvo en cuenta en el proceso de estratificación.

Se definieron tres estratos por cada área control y experimental, dentro de cada departamento (Ver Tabla 2). Resultaron en consecuencia 12 estratos a fin de optimizar la selección de otras tantas UPM. Aquellas UPM cuyo tamaño era aproximadamente similar al del estrato, se constituyeron en estratos, y su probabilidad de selección fue por lo tanto igual a 1. La probabilidad del resto de UPM se calculó en función de su número de MEF en unión dentro del estrato respectivo.

Polietápica, con tres etapas de selección :

a) De las UPM : seleccionado una de cada estrato, con probabilidad calculada en función del número de MEF en unión.

b) De los segmentos : seleccionado en cada uno de los ocho subuniversos de estudio, 25 en la zona urbana, de tamaño promedio 10 hogares, y 11 en la zona rural, de tamaño promedio 25, con probabilidad de selección calculada en función del número total de segmentos " existentes " en las zonas en cuestión.

c) De las MEF en unión : tomando el total de las residentes en cada uno de los hogares seleccionados, es decir, submuestreando con probabilidad 1 a este nivel.

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(1) Gómez L.C. y col. " Diseño de la Muestra ", Encuesta Nutricional en las áreas del Plan Nacional de Alimentación y Nutrición. Bogotá, 1979. (mimeo).

TABLA 2. ESTRATIFICACION DE LAS UNIDADES PRIMARIAS .- PROBABILIDADES DE SELECCION

Estrato	Depto.	Municipio	Area	Intervención Previa	MEF alguna vez en unión			Probabilidad
					Urbana	Rural	Total	
1	Cauca	Bolívar	Control	SI	723	5.315	6.039	1.00
2	Cauca	Almaguer	Control	NO	227	1.032	1.259	0.34
	"	S.Sebastián	"	NO	80	738	818	0.22
	"	Balboa	"	SEMI	314	1.343	1.657	0.44
					621	3.113	3.734	1.00
3	Cauca	Mercaderes	Control	SI	789	2.570	3.359	0.52
	"	Patía	"	SI	1.073	2.004	3.077	0.48
					1.862	4.574	6.436	1.00
4	Cauca	El Tambo	Exper.	NO	343	2.546	2.889	1.00
5	Cauca	La Vega	Exper.	NO	288	1.567	1.855	0.61
		La Sierra	"	NO	139	1.040	1.179	0.39
					427	2.607	3.034	1.00
6	Cauca	Puracé	Exper.	NO	118	1.253	1.371	0.46
	"	Rosas	"	NO	141	917	1.058	0.36
	"	Sotará	"	No	54	481	535	0.18
					313	2.651	2.964	1.00
7	César	Aguachica-Gamarra	Control	SEMI	4.532	1.541	6.073	1.00
8	César	Tamalameque	Control	SI	342	3.410	3.752	0.47
	"	Río de Oro-González	"	SEMI	601	3.258	4.129	0.53
					943	6.938	7.881	1.00
9	César	Curumani	Control	SEMI	1.824	1.120	2.944	0.54
		Pailitas	"	SEMI	923	548	1.471	0.27
		La Gloria	"	SEMI	328	718	1.046	0.19
					3.075	2.386	5.461	1.00
10	César	El Copey	Exper.	NO	1.910	3.131	5.041	1.00
11	César	Chiriguaná	Exper.	NO	823	2.408	3.231	1.00
12	Cesar	Robles	Exper.	NO	785	2.030	2.815	0.51
		Chimichagua	"	NO	928	1.808	2.736	0.49
					1.713	3.838	5.551	1.00

Nota : Para la estimación del número de MEF alguna vez en unión en 1981, se hicieron estimaciones sucesivas en el siguiente orden : (1°) Población urbana y rural a 1981, (2°) Hogares urbanos y rurales en 1981, (3°) MEF urbanas y rurales en 1981, aplicando el promedio MEF por hogar, urbano y rural, existente en 1973 en cada municipio y (4°) MEF urbano y rurales, en unión, en 1981, aplicando el promedio 0.75 x hogar, suministrado por las directivas del estudio.

3. MARCO DE MUESTREO

Lo conforman : a) las estimaciones a 1981 de población general y de MEF en unión de cada uno de los Municipios del Universo de estudio, realizadas a partir de los datos del censo de 1973 y de parámetros fijados por las directivas del estudio (promedio de MEF alguna vez en unión por hogar), y b) el material cartográfico y de recuento de hogares del censo de 1973, a nivel municipal y por sector mínimo de empadronamiento, facilitado por el Departamento Administrativo Nacional de Estadística (DANE).

4. TAMAÑO Y PRECISION DESEADA

La muestra debe, prioritariamente, permitir el análisis de cambios, en un período de un año o más, en el conocimiento y uso de métodos y servicios de planificación familiar, a nivel de 8 subgrupos o subuniversos de MEF alguna vez en unión, definidos en términos de departamento (Cesar y Cauca), área (control y experimental) y zona (urbana y rural).

Se estableció como requisito mínimo la identificación(a nivel de subuniversos) de diferencias, significativas estadísticamente, de 0.10 o más, entre dos proporciones P_1 y P_2, medidas en los tiempos 1 y 2 respectivamente, siendo $P_1 \geq 0.20$, con un nivel de confianza del 95% (probabilidad de acertar en la inferencia, $1 - \alpha$)

El cálculo del tamaño de muestra con base en las anteriores premisas es el siguiente :

$$n = \frac{N(P_1 Q_1 + P_2 Q_2)K}{N(\varepsilon_{P_1 - P_2}) + (P_1 Q_1 + P_2 Q_2)K}$$

En donde ,

N = Es el tamaño de cada subuniverso

El más pequeño : 1.083 MEF alguna vez en unión del área experimental, zona urbana, del Cauca.

El más grande : 13.003 MEF alguna vez en unión del área control, zona rural, del Cauca.

P_1 Proporción en la primera medición

Q_1 Proporción complementaria en la primera medición $(1-P_1)$

P_2 Proporción en la segunda medición.

Q_2 Proporción complementaria en la segunda medición $(1-P_2)$

$K =$ Son posibles valores del efecto de los conglomerados o efecto del diseño (deff), estimados a partir de múltiples experiencias en muestras probabilísticas de esta naturaleza, indispensables en la fórmula de tamaño de muestra arriba mencionada, para modificar la propia del muestreo aleatorio simple de elementos.

$ES_{P_1-P_2}$: Error estándar máximo admisible para la diferencia P_1-P_2, con un nivel de confianza del 95%, de tal forma que : $2(ES_{P_1-P_2}) = 0.10$

Tenemos entonces los tamaños de muestra (M) - de MEF en unión, necesarios para

M (Subuniversos)	K= efecto de diseño	
	1.3	1.4
1083	163	174
13003	190	204

Hogares de la muestra.

En base a lo anterior, y a un promedio de 0.75 MEF en unión por hogar, se decidió seleccionar para cada subuniversos urbano, un tamaño de muestra de 250 hogares, y para cada rural, 275 hogares. La perspectiva de una inferior cobertura de las entrevistas del estudio en la zona rural justificó el pequeño incremento en el tamaño de la muestra seleccionada en esta zona.

5. SELECCION DE LA MUESTRA

5.1. De Unidades Primarias

De cada uno de los 12 estratos, constituídos con los criterios señalados en la seccion 2., se seleccionó aleatoriamente como muestra representativa una unidad primaria de muestreo (UPM), con probabilidad proporcional al número de MEF alguna vez en unión.

Las UPM que por su tamaño constituyeron un estrato (estratos 1,4,7,10 y 11, de la tabla 2), tuvieron probabilidad 1, y formaron parte de la muestra por definición.

La Tabla 3 nos indica la muestra de unidades primarias y secundarias y las respectivas probabilidades de selección.

5.2. De Unidades Secundarias (segmentos)

Para cada zona (urbana y rural), de cada UPM, se seleccionaron independientemente los segmentos de la muestra señalados en la Tabla 3. La distribución de los segmentos, de cada zona, en las distintas UPM seleccionadas en un sub-universo, se hizo aproximadamente en función de la respectiva cantidad de MEF alguna vez en unión. A este nivel la probabilidad fue igual y resultó de la relación entre número de segmentos seleccionados y número de segmentos existentes (teóricos).

El procedimiento comprendió las siguientes etapas :

a- Cálculo del número de segmentos existentes (teóricos) en las sectores mínimos de empadronamiento del Censo Nacional de Población de 1973. Dichos sectores son manzanas en las zonas urbanas y áreas bien delimitadas (promedio de 100 hogares) en las zonas rurales.

Para la aproximación a valores enteros se aplicaron las siguientes clasificaciones :

Zona Urbana :

No. de Hogares por manzana	No. de Segmentos
5-14	1
15-24	2
25-34	3
⋮	

Zona Rural :

No. de Hogares por área	No. de Segmentos
13-37	1
38-62	2
63-87	3
88-112	4
113-137	5

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Tabla 3. (Bis) - Muestra de Unidades Primarias, Secundarias y probabilidades de selección.

Depto	Sub Universo	Area	Estrato	UNIDAD PRIMARIA Nombre	Probabilidad	Seg. Exist. Urb.	Seg. Exist. Rurales	MUESTRA UNIDADES SECUNDARIAS (SEGM) Urbanos No.	Urbanos Prob.	Rurales No.	Rurales Probabilidades
Cauca	1	Control	1	Bolivar	1.00	87	254	11	1/7.91	4	1/63.5
			2	Balboa	0.44	31	65	10	1/3.10	3	1/21.67
			3	Patia	0.48	99	99	29	1/3.41	4	1/24.75
	2	Experim.	4	El Tambo	1.00	35	136	16	1/2.19	3	1/45.33
			5	La Sierra	0.39	25	55	20	1/1.25	4	1/13.75
			6	Rosas	0.36	18	47	14	1/1.29	4	1/11.75
Cesar	3	Control	7	Aguachica Gamarra	1.00	411	112	26	1/15.81	3	1/37.33
			8	Rio de Oro González	0.53	77	152	6	1/12.83	4	1/38.00
			9	Pailitas	0.27	89	27	18	1/4.94	4	1/6.75
	4	Experim.	10	El Copey	1.00	139	96	22	1/6.32	4	1/24.00
			11	Chiriguaná	1.00	117	147	9	1/13.00	3	1/49.00
			12	Chimichagua	0.49	111	130	19	1/5.84	4	1/32.50

b- Cálculo de frecuencia acumulada de los segmentos teóricos.

c- Cálculo de intervalo de submuestreo, a nivel de zona y UPM, así :

$$\text{Intervalo} = \frac{\text{No. de Segmentos existentes}}{\text{No. de Segmentos a ser seleccionados.}}$$

d- Aplicación sistemática del intervalo sobre el listado ordenado de segmentos teóricos. Selección del primer segmentos de la muestra tomando un No. al azar entre 1 y el valor del intervalo de muestreo. Selección de los segmentos siguientes, sumando sucesivamente al 1er. No. seleccionado, el intervalo.

Como un sector de empadronamiento (manzana y área rural) tenía muchas veces más de un segmento teórico, en esta etapa lo que realmente se identificó fue el sector que contenía uno o más segmentos de la muestra.

e- Identificación en la cartografía de los sectores que contenían los segmentos de la muestra.

f- Partición de algunos de los sectores rurales grandes, cuya cartografía era lo suficientemente clara para permitir una subdivisión utilizando límites naturales,visibles, y asignación de una probabilidad a cada pedazo, en función de un supuesto No. de hogares. El criterio aplicado en este último procedimiento es la densidad de población de cada parte, deducida según la distancia de la cabecera municipal, la ubicación en función de las diferentes vías de comunicación, las características geográficas del terreno, y la cantidad de puntos de vivienda observados en la cartografía. La validez de este procedimiento ha sido verificada en diversas muestras con cubrimiento rural, la más reciente de las cuales es la de la " Encuesta PAN 1979 " (1)

g- Selección directa en el terreno, por los encuestadores, de los hogares propiamente tales, aplicando una fracción de submuestreo resultante de la relación entre número de segmentos seleccionados en la parte finalmente sorteada (usualmente 1) y el número de segmentos (teóricos) existentes en dicha parte. Para el efecto los encuestadores debieron recorrer minuciosamente la parte muestreada.

Las MEF alguna vez en unión de la muestra son todas las residentes en los hogares seleccionados.

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6. PROCEDIMIENTOS DE ESTIMACION

Son las instrucciones para el manejo de los datos básicos de la muestra y para la obtención de las estimaciones estadísticas requeridas.

6.1. Estimaciones insesgadas

A nivel de sub-universos y universo total. Dado que las probabilidades finales de seleccion (Tabla 4) varían en cada zona, por estrato, también son diferentes a nivel de sub-universos y del universo total, razón por la cual es necesario ponderar los datos básicos de cada Hogar y MEF de la muestra por el recíproco de la probabilidad final de selección ($1/f = F$), o por un factor equivalente.

La probabilidad final (f) de cada hogar y MEF es el producto de las probabilidades de la UPM (f_1) y del segmento (f_2) a los cuales pertenecen (Tabla 4).

La aplicación del recíproco de la probabilidad final ó factor de inflación (F), además de corregir el problema de las diferentes probabilidades, restituye a valores absolutos del universo de estudio, lo cual tiene gran utilidad práctica.

No obstante, si se desea trabajar con valores muestrales absolutos, la corrección por la diferente probabilidad se logra a través de un nuevo factor que resulta de la relación entre cada factor final de inflación y el promedio de dichos factores.

6.2. Fórmulas principales de estimación

Se utiliza la nomenclatura sugerida por Kish (2) para el muestreo de conglomerados desiguales.

6.2.1. A nivel de subuniverso

Y_u : Razón de estimación en el subuniversos u
(Se utiliza indistintamente para promedios y proporciones)

$$Y_u = \frac{\sum_{\alpha=1}^{a_u} \sum_{\beta=1}^{b_\alpha} \sum_{j=1}^{x_\beta} y_{\alpha\beta j} F_{\alpha\beta}}{\sum_{\alpha=1}^{a_u} \sum_{\beta=1}^{b_\alpha} \sum_{j=1}^{x_\beta} x_{\alpha\beta j} F_{\alpha\beta}}$$

(2) Kish, Leslie. "Survey Sampling", John Wiley and Sons, New York 1965, Chapter 6.

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Tabla 4. (Bis) - Probabilidades parciales, finales y factores de inflación.

	Probabilidades Parciales			Probabilidades finales		Factores Inflación	
Estrato	UPM f 1	Seg. Urb. f 2 u	Seg. Rur. f 2 R	Urbana f u	Rural f R	Urbana F U	Rural F R
1	1.00	1/7.91	1/63.5	1/7.91	1/63.5	8	63
2	0.44	1/3.10	1/21.67	1/7.05	1/49.2	7	49
3	0.48	1/3.41	1/24.75	1/7.1	1/51.6	7	52
4	1.00	1/2.19	1/45.33	1/2.19	1/45.3	2	45
5	0.39	1/1.25	1/13.75	1/3.2	1/35.3	3	35
6	0.36	1/1.29	1/11.75	1/3.6	1/32.6	4	33
7	1.00	1/15.81	1/37.33	1/15.8	1/37.3	16	37
8	0.53	1/12.83	1/38.00	1/24.2	1/71.7	24	72
9	0.27	1/4.94	1/6.75	1/18.3	1/25.0	18	25
10	1.00	1/6.32	1/24.00	1/6.3	1/24.0	6	24
11	1.00	1/13.00	1/49.00	1/13.0	1/49.0	13	49
12	0.49	1/5.84	1/32.50	1/11.9	1/66.3	12	66

$j = 1, 2, \ldots X_\beta$ son cada una de las MEF encuestadas en un segmento

$\beta = 1, 2 \ldots b_\alpha$ son los diferentes segmentos en la UPM

$\alpha = 1, 2 \ldots a_u$ son las diferentes UPM seleccionadas en el subuniverso u

$y_{\alpha\beta j}$ es el valor de la variable en la MEF j del segmento β, de la UPM α

$x_{\alpha\beta j}$ es la MEF j, del segmento β, de la UPM α.

$F_{\alpha\beta}$ es el factor final de inflación a nivel del segmento β de la UPM α, variable en las zonas urbanas y rurales

6.2.2. Para el conjunto del universo

$$Y = \frac{\sum_{u=1}^{u} \sum_{\alpha=1}^{a_u} \sum_{\beta=1}^{b_\alpha} \sum_{j=1}^{x_\beta} y_{u\alpha\beta j} \; F_{\alpha\beta}}{\sum_{u=1}^{u} \sum_{\alpha=1}^{a_u} \sum_{\beta=1}^{b_\alpha} \sum_{j=1}^{x_\beta} x_{u\alpha\beta j} \; F_{\alpha\beta}}$$

u = 1,2, ———, 8 son cada uno de los subuniversos.

7. CALCULO DE ERRORES DE MUESTREO

7.1. Para estimaciones a nivel de sub-universo

$es(r_u)$: Error estandar de la razón de estimación en el sub-universo u

Se propone utilizar el modelo propuesto por Kish para muestreo de conglomerados seleccionados sistemáticamente (Capítulo 6, Sección 6.5 c). Una excelente aproximación de los errores de muestreo puede obtenerse a partir de los segmentos estudiados.

La técnica de las posibles diferencias sucesivas, implica el establecimiento de las mismas de acuerdo con el orden de selección de los segmentos : 1°con 2°, 2°con 3°etc.

Entonces :

$$es(r_u) = \sqrt{\frac{\sum_{\alpha=1}^{a_u} b_\alpha}{\left(\sum_{\alpha=1}^{a_u}\sum_{\beta=1}^{b_\alpha} x_{\alpha\beta} F_{\alpha\beta}\right)^2 2\left(\sum_{\alpha=1}^{a_u} b_\alpha - 1\right)} \left[\sum_{g=1}^{\sum_{\alpha=1}^{a_u} b_\alpha - a_u} D_{yg}^2 (1-f_{\alpha\beta}) + r_u^2 \sum_{g=1}^{\sum_{\alpha=1}^{a_u} b_\alpha - a_u} D_{xg}^2 (1-f_{\alpha\beta}) - 2 r_u \sum_{g=1}^{\sum_{\alpha=1}^{a_u} b_\alpha - a_u} D_{yg} D_{xg} (\right.}$$

En donde, :

$$D_{yg} = \sum_{\alpha=1}^{a_u} \sum_{\beta=1}^{b_\alpha} y_{\alpha\beta} F_{\alpha\beta g}(g) - \sum_{\alpha=1}^{a} \sum_{\beta=1}^{b_\alpha} y_{\alpha\beta} F_{\alpha\beta}(g+1)$$

$\sum_{\alpha=1}^{a_u} b_\alpha = b_1 + b_2 + \cdots + b_{a_u}$ es el número de segmentos de las unidades primarias del sub-universo u .

$\sum_{\alpha=1}^{a_u} b_\alpha - a_u$ es el número de posibles diferencias sucesivas entre los segmentos, separando cada UPM

g : es el primer segmento de un par sucesivo

$g+1$: es el segundo segmento del citado par

7.2. <u>Para estimaciones a nivel del universo total</u>

El error de muestreo se calcula aplicando el modelo descrito antes, haciendo las diferencias y acumulaciónes sucesivas para el conjunto de segmentos de la muestra.

TERCERA ENCUESTA CAUCA - CESAR INFERENCIA DE RESULTADOS *PROPORCION DE TODAS LAS MUJERES QUE CONOCEN ME

AREA DE ANALISIS	VALOR OBSERVADO (ru)	ERROR DE MUESTREO (es_{ru})	LIMITES DE CONFIANZA DE Ru CON 95% DE SEGURIDAD		DIFERENCIA ENTRE PROPORCIONES	ERROR DE MUESTREO DE LA DIFERENCIA	INFERENCIA CON 95% D
			ru -2 (es_{ru}) INFERIOR	ru +2(es_{ru}) SUPERIOR	$\lvert r_1 - r_2 \rvert$	es $(r_1 - r_2)$= $es_{r_1} + es_{r_2}$	2 es $r_1 - r_2$
CESAR CONTROL	0.9667 = r_1	0.003202	0.960206	0.973104	0.0542	0.028991	0.056782
CESAR EXPERIMENTAL	0.9125 = r_2	0.025189	0.862122	0.962878			
CAUCA CONTROL	0.8231 = r_1	0.059199	0.704902	0.941298	0.0772	0.078819	0.151638
CAUCA EXPERIMENTAL	0.9003 = r_2	0.016720	0.86606	0.93374			
CESAR TOTAL	0.9486 = r_1	0.024238	0.911124	0.997076	0.0928	0.061921	0.123842
CAUCA TOTAL	0.8558 = r_2	0.037683	0.780134	0.931866			
CESAR URBANO	0.9725 = r_1	0.012921	0.967158	0.978142	0.0362	0.034349	0.068698
CESAR RURAL	0.9363 = r_2	0.031528	0.875244	0.999356			
CAUCA URBANO	0.9505 = r_1	0.028917	0.894666	1.018334	0.1044	0.072046	0.144092
CAUCA RURAL	0.8421 = r_2	0.043129	0.755842	0.928358			
TOTAL URBANO	0.9609 = r_1	0.007077	0.954746	0.983054	0.0716	0.052778	0.105556
TOTAL RURAL	0.8893 = r_2	0.045701	0.817598	0.960802			

TERCERA ENCUESTA CESAR - CAUCA INFERENCIA DE RESULTADOS *PROPORCION DE MUJERES EXPUESTAS QUE DIJIDEN ME

AREA DE ANALISIS	VALOR OBSERVADO * (r_u)	ERROR DE MUESTREO (es_r)	LIMITES DE CONFIANZA DE R_u CON 95% DE SEGURIDAD		DIFERENCIA ENTRE PROPORCIONES	ERROR DE MUESTREO DE LA DIFERENCIA	INFERENCIA CON
			$r_u - 2(es_{ru})$ INFERIOR	$r_u + 2(es_{ru})$ SUPERIOR	$\lvert r_1 - r_2 \rvert$	$es(r_1-r_2) = es_{r1} + es_{r2}$	$2\ es(r_1-r_2)$
CESAR CONTROL	0.9678= r_1	0.00759	0.95262	0.98298	0.0436	0.0311	0.0622
CESAR EXPERIMENTAL	0.9242= r_2	0.02351	0.87718	0.97122			
CAUCA CONTROL	0.8180= r_1	0.05082	0.71536	0.91964	0.0778	0.06722	0.13444
CAUCA EXPERIMENTAL	0.8958= r_2	0.01640	0.863	0.9286			
CESAR TOTAL	0.9531= r_1	0.019484	0.914132	0.992868	0.1025	0.057328	0.114656
CAUCA TOTAL	0.8506= r_2	0.037844	0.774912	0.926288			
CESAR URBANO	0.9683= r_1	0.004777	0.958746	0.977854	0.0231	0.028832	0.057664
CESAR RURAL	0.9452= r_2	0.024055	0.89709	0.99331			
CAUCA URBANO	0.9464= r_1	0.030419	0.885564	1.007236	0.1104	0.073789	0.147578
CAUCA RURAL	0.8360= r_2	0.043371	0.749258	0.922742			
TOTAL URBANO	0.9645= r_1	0.003692	0.957116	0.971884	0.0654	0.056932	0.113864
TOTAL RURAL	0.8991= r_2	0.053240	0.79252	1.00558			

(34)

TERCERA ENCUESTA CESAR -CAUCA INFERENCIA DE RESULTADOS *PROPORCION DE MUJERES EXPUESTAS- SABE EN DONDE LE DAN INFORMACION FAMILIAR

AREA DE ANALISIS	VALOR OBSERVADO (r_u)	ERROR DE MUESTREO (es_{r_u})	LIMITE DE CONFIANZA DE r_u CON 95% DE SEGURIDAD: $r_u - 2(es_{r_u})$ INFERIOR	$r_u + 2(es_{r_u})$ SUPERIOR	DIFERENCIA ENTRE PROPORCIONES $\lvert r_1 - r_2 \rvert$	ERROR DE MUESTREO DE LA DIFERENCIA $es(r_1 - r_2) = es_{r_1} + es_{r_2}$	INFERENCIA CON 95% DE SEGURIDAD $2\ es\ (r_1 - r_2)$
CESAR CONTROL	0.6937 = r_1	0.06434	0.57012	0.87738	0.0721	0.107452	0.215104
CESAR EXPERIMENTAL	0.7708 = r_2	0.043212	0.684376	0.857224			
CAUCA CONTROL	0.8620 = r_1	0.0525927	0.7566146	0.9673854	0.0073	0.1945187	0.3890374
CAUCA EXPERIMENTAL	0.8547 = r_2	0.1482547	0.5710406	1.1383594			
CESAR TOTAL	0.7230 = r_1	0.032133	0.658724	0.787276	0.1379	0.035719	0.071438
CAUCA TOTAL	0.8593 = r_2	0.0312546	0.8157428	0.9027572			
CESAR URBANO	0.8358 = r_1	0.035965	0.92327	0.84773	0.1721	0.074959	0.149918
CESAR RURAL	0.6637 = r_2	0.037974	0.525712	0.801688			
CAUCA URBANO	0.9219 = r_1	0.035726	0.850148	0.993352	0.0725	0.042353	0.084706
CAUCA RURAL	0.8494 = r_2	0.006627	0.836146	0.862654			
TOTAL URBANO	0.8507 = r_1	0.024961	0.801778	0.900622	0.1016	0.115944	0.231888
TOTAL RURAL	0.7421 = r_2	0.091583	0.560034	0.923266			

TERCERA ENCUESTA CESAR - CAUCA INFERENCIA DE RESULTADOS

*PROPORCION DE TODAS LAS MUJERES QUE CONOCEN LAS FUEN
INFORMACION DE PLANIFICACION FAMILIAR

AREA DE ANALISIS	VALOR OBSERVADO (r_u)	ERROR DE MUESTREO (es_r)	LIMITE DE CONFIANZA DE Ru CON 95% DE SEGURIDAD: $ru - 2\ (es_{ru})$ INFERIOR	$ru + 2\ (es_{ru})$ SUPERIOR	DIFERENCIA ENTRE PROPORCIONES $\lvert r_1 - r_2 \rvert$	ERROR DE MUESTREO DE LA DIFERENCIA $es\ (r_1 - r_2)$	INFERENCIA CON 9 $2\ es\ (r_1 - r_2)$
CESAR CONTROL	$0.6738 = r_1$	0.04322017	0.58735936	0.76024034	0.0828	0.0796771	0.1592143
CESAR EXPERIMENTAL	$0.7566 = r_2$	0.03639079	0.68398042	0.82[illegible]			
CAUCA CONTROL	$0.8125 = r_1$	0.09304249	0.62461530	1.00[illegible]	0.0624	0.10187399	0.2037477
CAUCA EXPERIMENTAL	$0.8749 = r_2$	0.00793155	0.8590369	0.8907631			
CESAR TOTAL	$0.7094 = r_1$	0.037464	0.671472	0.77328	0.1343	0.067116	0.134032
CAUCA TOTAL	$0.8367 = r_2$	0.029552	0.777896	0.894504			
CESAR URBANO	$0.7970 = r_1$	0.0218448	0.753104	0.840896	0.1491	0.084219	0.168438
CESAR RURAL	$0.6479 = r_2$	0.062571	0.523158	0.772842			
CAUCA URBANO	$0.9213 = r_1$	0.018210	0.8450[illegible]	0.977104	0.0975	0.053644	0.107288
CAUCA RURAL	$0.8238 = r_2$	0.035462	0.752916	0.894684			
TOTAL URBANO	$0.8191 = r_1$	0.036678	0.745744	0.892456	0.0921	0.122562	0.245124
TOTAL RURAL	$0.7270 = r_2$	0.085804	0.555232	0.898768			

TERCERA ENCUESTA CESAR - CAUCA INFERENCIA DE RESULTADOS *PROPORCION DE MUJERES EXPUESTAS - USO ACTUAL

AREA DE ANALISIS	VALOR OBSERVADO * (r_U)	ERROR DE MUESTREO (es_r)	LIMITES DE CONFIANZA DE r_U CON 95% DE SEGURIDAD $r_U - 2(es_{r_U})$ INFERIOR	$r_U + 2(es_{r_U})$ SUPERIOR	DIFERENCIA ENTRE PROPORCIONES $\lvert r_1 - r_2 \rvert$	ERROR DE MUESTREO DE LA DIFERENCIA $es_{(r_1 - r_2)} = es_{r_1} + es_{r_2}$ *	INFERENCIA CON 95 $2\ es_{(r_1 - r_2)}$ *
CESAR CONTROL	0.5623 = r_1	0.031229	0.501942	0.622758	0.0139	0.70176	0.140352
CESAR EXPERIMENTAL	0.5484 = r_2	0.040247	0.467916	0.629004			
CAUCA CONTROL	0.4683 = r_1	0.101524	0.265252	0.671348	0.0213	0.146457	0.292934
CAUCA EXPERIMENTAL	0.4896 = r_2	0.044943	0.399774	0.578426			
CESAR TOTAL	0.5576 = r_1	0.006038	0.545524	0.569676	0.0808	0.015874	0.031748
CAUCA TOTAL	0.4768 = r_2	0.009836	0.457128	0.496472			
CESAR URBANO	0.6135 = r_1	0.012229	0.564642	0.638158	0.0863	0.016001	0.032002
CESAR RURAL	0.5272 = r_2	0.004572	0.519056	0.537344			
CAUCA URBANO	0.6652 = r_1	0.009643	0.545914	0.684486	0.217	0.031222	0.062444
CAUCA RURAL	0.4482 = r_2	0.021579	0.405042	0.491358			
TOTAL URBANO	0.6225 = r_1	0.014718	0.572944	0.672056	0.128	0.05381	0.10762
TOTAL RURAL	0.4945 = r_2	0.039032	0.419436	0.572564			

FIGURES AND TABLES

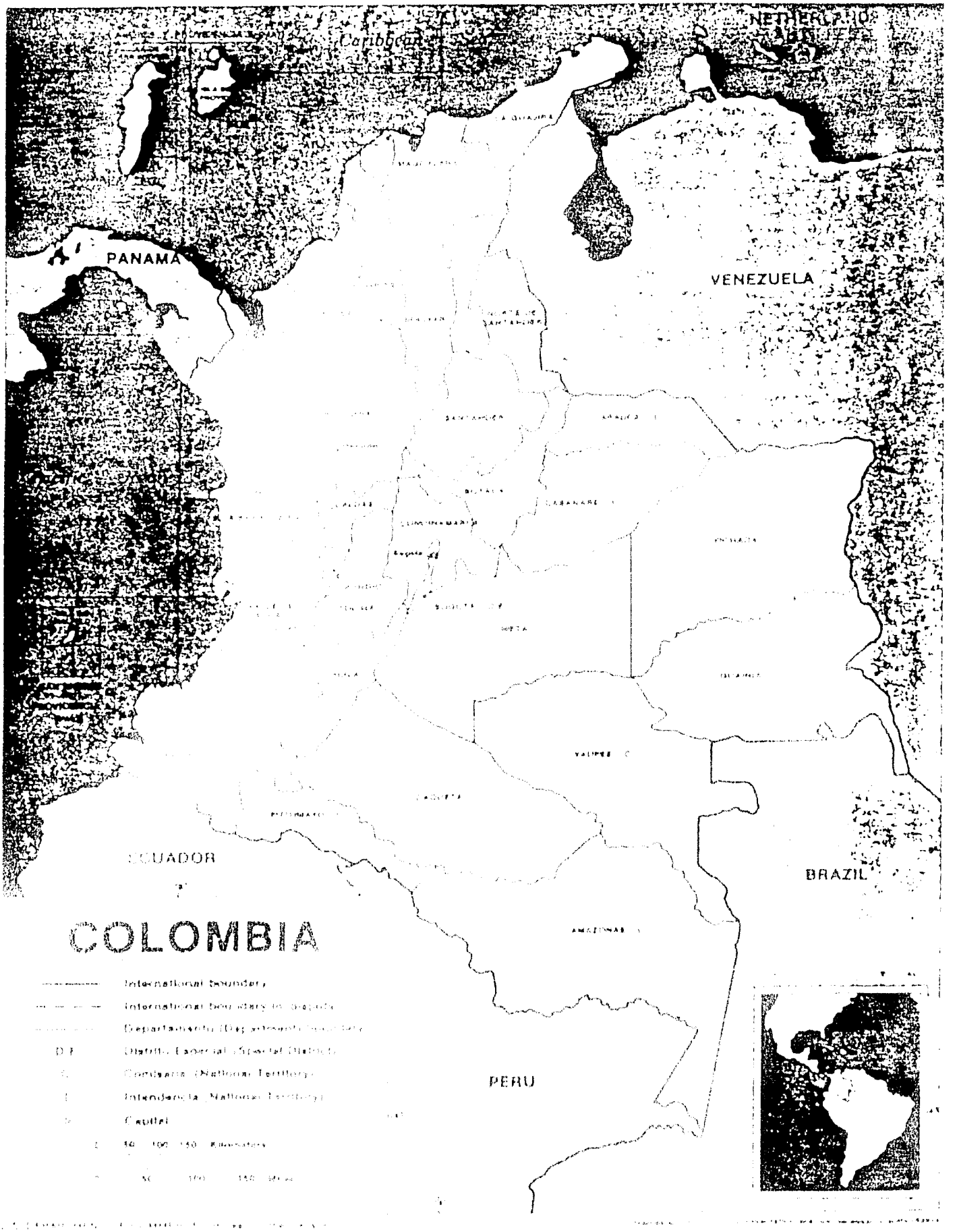
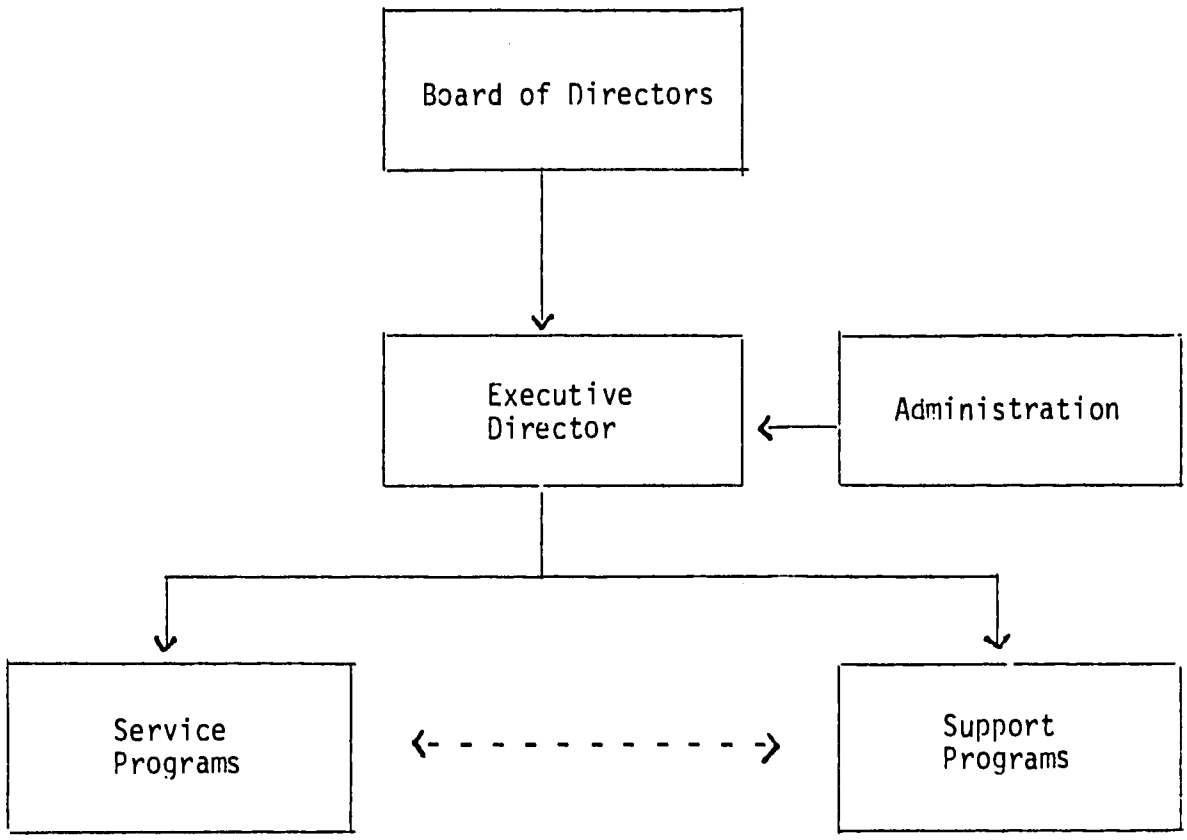

Caribbean
NETHERLANDS
PANAMA
VENEZUELA
ECUADOR
BRAZIL
PERU
COLOMBIA
International boundary
D.E.
Capital

FIGURE 2

ORGANIZATIONAL STRUCTURE OF PROFAMILIA



Clinical
Surgical
Community Based Distribution
Social Marketing

Information, Education and Communication
Evaluation and Research
Local Resources

FIGURE 3

CRITERIA FOR SELECTION OF CANDIDATES

FOR THE POSITION OF INSTRUCTOR

- Must identify with family planning.
- Have a positive attitude toward work in the community.
- Have a facility for verbal expression.
- Be creative and take initiative.
- Have the ability to speak to groups in public.
- Have the capacity to adapt and change.
- Have a good appearance.
- Be responsible.
- Be in good health and not pregnant.
- Be available with respect to hours and travel.
- Be married and between 30 and 40 years of age.
- Have a secondary school diploma in one of the following areas: Bachellor of Arts, Education, Social Promotion, Auxiliary Social Work, Auxiliary Nursing, or a minimum of four years of secondary education and complementary training in community development, nursing or social work.

FIGURE 4

FUNCTIONS AND ACTIVITIES OF THE INSTRUCTOR

Activities in IE&C

- Inform, motivate and train community leaders in family planning.
- Contact, select, motivate, train and evaluate persons in the community to be in charge of a distribution post.
- Inform, motivate and train persons and families in family planning, placing emphasis on those with limited economic resources.
- Publicize the availability of distribution posts and family planning clinics.
- Motivate users to utilize the services of the Profamilia clinics and make the corresponding referrals.
- Plan and present conferences, talks and courses on family planning to the different groups and institutions.
- Provide advice to individuals and groups which project a good image of Profamilia and collaborate in the achievement of its objectives.
- Inform each month the results of the work completed: IE&C activity, sales and inventory of methods.

Administration of the Community Program

- Visit the posts assigned quarterly, conduct the inventory, collect funds and resupply posts according to established procedures.
- Deliver the funds collected to the finance office.

- Prepare a monthly summary of sales and inventory of the distribution posts under her responsibility.
- Open distribution posts and make changes in their location should circumstances require.
- Take into account the general guidelines Profamilia has established for the incentive modality.
- Inform her immediate supervisor on a monthly basis of the administrative functioning and the program and make suggestions for program improvement.
- Insure that all the posts under her responsibility possess the necessary elements for their operation.
- Other tasks which her immediate supervisor assigns which are consistent with the objectives of this position.

FIGURE 5

INTEGRATED TIMETABLE OF OPERATIONS

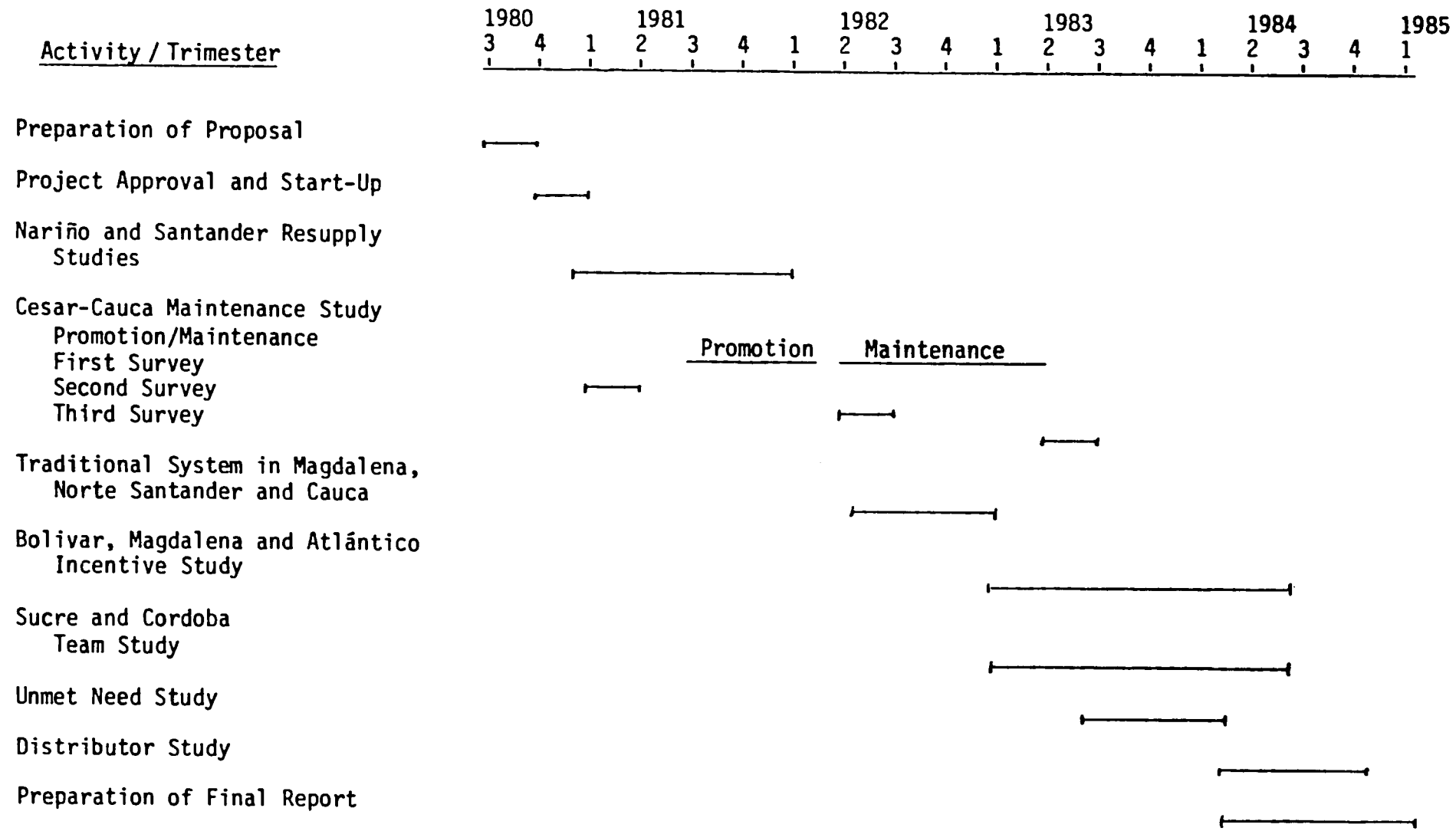


TABLE 1

SERVICE DELIVERY MODELS USED IN PROFAMILIA RURAL COMMUNITY DISTRIBUTION PROJECT

MODEL	PLACE	DATES	DATA AVAILABLE
Supply and Maintenance	Nariño and Santander	1980 - 1982	Service Statistics
Team and Instructor	Cesar and Cauca	1981 - 1983	3 Sample Surveys Service Statistics
Traditional Instructor	Magdalena, North Santander and Cauca	1982	Service Statistics
Incentive and Instructor	Cartagena, Bolivar, Santa Marta, Magdalena and Barranquilla, Atlántico	1983 - 1984	Service Statistics
Revised Team	Sincelejo, Sucre and Montería, Córdoba	1983 - 1984	Service Statistics

TABLE 2

SERVICE STATISTICS FROM OCTOBER 1, 1980 TO SEPTEMBER 30, 1981 FOR SANTANDER AND TO AUGUST 31, 1981 FOR NARIÑO

	Nariño[1]	Santander
Number of municipalities covered[2]	28	34
Number of distribution posts	63	72
Number of new acceptors	2,660	322
Number of contraceptives sold		
Orals (cycles)	13,766	6,928
Condoms (units)	17,807	6,998
Vaginal tablets	806	486
Educational activities		
Number of meetings	35	30
Number of household visits	1,905	1,916

SOURCE: Profamilia Service Statistics Reports, October 1, 1980, September 30, 1981.

[1]These statistics include the new maintenance experimental sites which at the time had no separate statistics.

[2]The number of municipalities covered and distribution posts established may vary from month to month. These totals are the numbers reported in August 1981.

TABLE 3

CONTRACEPTIVE PRACTICES OF CURRENT ORAL USERS ACCORDING TO DEPARTMENT, CESAR - CAUCA

I T E M	CESAR	CAUCA	TOTAL
USERS OF BOTH 21 AND 28 CYCLE			
Percent who could name the number of pills in her cycle.	96	95	96
USERS OF 21 CYCLE ONLY[1]			
Percent who wait correct number of days between cycles.	16	30	22
Percent who know what to do if do not menstruate after taking 21 pills.	10	16	12
Percent who take pill daily.	87	99	92
Percent who know what to do if forget to take a pill.	32	34	33
USERS OF 28 CYCLE ONLY[2]			
Percent who take pill daily.	87	100	88
Percent who know what to do if forget to take a pill.	26	38	26
[1] Total number of unweighted cases	46	52	98
Total number of weighted cases	167	125	292
[2] Total number of unweighted cases	65	9	74
Total number of weighted cases	262	19	281

SOURCE: First Survey César-Cauca, 1981.

TABLE 4

PERCENT OF CURRENT USERS WHO WERE INFORMED ABOUT CONTRACEPTIVE ALTERNATIVES AND SECONDARY EFFECTS

I T E M	CESAR	CAUCA	TOTAL
Percent who were informed of additional methods at time of adopting current method.	78	77	78
Of those who were informed of other methods, percent who were told about efficient methods.	71	85	75
Percent who were told before adopting a method that some methods might cause side effects.	66	25	65
Percent who have suffered secondary effects with current method.	23	31	25

SOURCE: First Survey César-Cauca, 1981.

TABLE 5

EXPERIMENTAL AND CONTROL MUNICIPALITIES OF CAUCA AND CESAR, ESTIMATED 1980 POPULATION FOR PROJECT SITES AND ESTIMATED NUMBER OF EVER MARRIED WOMEN 15 TO 49, BY PROJECT SITE

DEPARTMENT	GROUP	MUNICIPALITY	PREVIOUS SERVICE	TOTAL POPULATION[1]			WFA (EVER IN UNION)		
				URBAN	RURAL	TOTAL	URBAN	RURAL	TOTAL
Cauca	Control	Bolivar	Yes	5,136	38,915	44,051	723	5,316	6,039
		Mercaderes	Yes	5,609	18,611	24,220	789	2,570	3,359
		Patía	Yes	8,067	15,682	23,749	1,073	2,004	3,077
		Balboa	Some	2,437	11,885	14,322	314	1,343	1,657
		Almaguer	No	1,756	8,461	10,317	227	1,032	1,259
		S. Sebastián	No	615	5,028	5,563	80	738	818
		TOTAL							16,209
	Experimental	El Tambo	No	2,179	16,196	18.375	343	2,546	2,889
		La Vega	No	1,944	11,530	13.474	288	1,567	1,855
		Puracé	No	661	8,716	9.377	118	1,253	1,371
		La Sierra	No	950	7,820	8,770	139	1,040	1,179
		Rosas	No	1,009	7,365	8,374	141	917	1,058
		Sotará	No	400	3,481	3,881	54	481	535
		TOTAL							8,887
Cesar	Control	Aguachica	Some	27,868	6,230	34,098	3,828	820	4,648
		Tamalameque	Yes	3,029	25,047	28,076	342	3,410	3,752
		Río de Oro	Some	3,430	22,691	26,121	447	3,034	3,481
		Curumaní	Some	14,036	8,614	22,650	1,824	1,120	2,944
		Pailitas	Some	6,254	3,714	9,978	923	548	1,471
		Gamarra	Some	5,401	5,422	10,823	704	721	1,425
		La Gloria	Some	2,632	4,984	7,616	328	718	1,046
		González	No	1,259	5,124	6,383	154	494	648
		TOTAL							19,415
	Experimental	El Copey	No	15,810	24,124	39,934	1,910	3,131	5,041
		Chiriguaná	No	6,683	18,815	25,498	823	2,408	3,231
		Robles	No	6,483	17,289	23,772	785	2,030	2,815
		Chimichagua	No	7,566	14,801	22,367	928	1,808	2,736
		TOTAL							13,823

[1]SOURCE: Population projections based on 1973 census.

TABLE 6

HOUSEHOLD CHARACTERISTICS OF CESAR-CAUCA SAMPLE[1]

Characteristics	Description
Number of households visited	2,771
Average number of persons per household	5.3
Female	51%
Male	49%
Households with children	83.5%
Average number of children per household	4.1
Civil status of household head	
In union	78.6%
Separated	13.6%
Widow	7.8%
Age distribution (years)	
Less than 1	3.2%
1-4	11.6%
5-14	28.0%
15-49	45.7%
50-59	5.4%
More than 60	6.0%
Percent urban	70.8%

[1]No significant differences exist by region or experimental treatment. The data presented are based upon the household questionnaire from the second Cesar-Cauca survey.

TABLE 7

CHARACTERISTICS OF ALL EVER-MARRIED WOMEN BY INTERVENTION GROUP:
FIRST, SECOND AND THIRD SURVEYS IN CESAR AND CAUCA

ITEM	CESAR						CAUCA					
	CONTROL			EXPERIMENTAL			CONTROL			EXPERIMENTAL		
	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD
Mean age	30.3	30.1	30.4	31.1	31.2	31.4	30.8	31.2	31.9	33.2	32.3	33.7
Mean number of years of formal education	2.7	2.8	3.0	2.9	2.9	3.3	2.9	2.9	3.0	2.7	3.0	3.3
Mean number of live births	4.1	4.0	4.9	4.9	4.7	5.2	4.0	4.7	4.5	4.6	4.1	4.3
Exposure status (%)												
Currently pregnant	15	14	14	16	14	11	10	9	8	11	8	10
Widowed, divorced, separated	13	18	12	11	18	15	17	24	27	12	19	16
Couple sterilized	5	5	10	12	13	12	7	8	14	6	9	8
Other impairment	0	2	0	0	0	1	1	1	0	0	1	0
Reported fecund	67	61	64	61	55	59	65	58	51	71	63	66
Number of unweighted cases	507	620	351	283	496	171	300	623	172	214	570	165
Number of weighted cases	20357	14251	28620	9659	11300	11552	10487	11300	12302	5055	11335	7764

TABLE 8

PERCENTAGE OF CURRENTLY MARRIED FECUND WOMEN WHO KNOW OF CONTRACEPTIVE METHODS BY AGE, NUMBER OF LIVE BIRTHS, LEVEL OF EDUCATION AND PLACE OF RESIDENCE: FIRST, SECOND AND THIRD SURVEYS IN CESAR AND CAUCA

ITEM	CESAR						CAUCA					
	CONTROL			EXPERIMENTAL			CONTROL			EXPERIMENTAL		
	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD
All	97	99	95	98	98	91	80	98	82	73	99	90
Age	93	95	71	88	91	79	79	91	44	65	99	100
15-19	93	95	71	88	91	79	79	91	44	65	99	100
20-24	98	99	96	100	98	94	89	100	78	66	100	95
25-29	98	100	96	100	100	100	91	100	100	77	97	100
30-34	95	99	98	100	98	100	71	100	91	70	100	100
35-39	99	100	100	97	100	89	83	100	99	78	100	94
40-44	100	100	97	100	96	80	60	94	94	74	95	77
45-49	94	93	100	94	100	92	75	95	52	75	100	76
Number of live births												
0	89	95	79	100	85	81	78	88	64	35	100	78
1	97	99	85	89	100	84	82	99	69	67	100	94
2	100	100	100	89	100	92	87	96	73	77	100	100
3	93	99	94	96	94	100	78	100	98	65	100	100
4	96	100	97	100	100	100	82	100	88	68	100	77
5 +	99	98	99	98	100	91	74	99	85	78	97	87
Education												
None	93	97	92	97	94	90	73	100	68	58	94	58
1-2	98	97	96	97	99	84	73	98	76	71	100	85
3-4	99	100	93	96	100	88	80	96	87	75	98	95
5	98	100	97	100	99	100	91	100	96	92	100	100
more than 5	100	100	100	100	100	100	98	100	100	80	100	100
Place of residence												
Urban	96	100	97	98	98	97	92	100	93	83	100	100
Rural	98	97	94	98	98	90	77	97	80	72	99	89
Number of cases												
Unweighted	436	483	305	250	387	139	256	464	124	187	453	140
Weighted	17700	11458	25126	8566	9226	9624	8605	8588	8920	4442	6741	6512

TABLE 9

PERCENTAGE OF CURRENTLY MARRIED FECUND WOMEN WHO KNOW OF CONTRACEPTIVE METHODS ACCORDING TO SPECIFIC METHODS: FIRST, SECOND AND THIRD SURVEYS IN CESAR AND CAUCA

ITEM	CESAR						CAUCA					
	CONTROL			EXPERIMENTAL			CONTROL			EXPERIMENTAL		
	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD
No Method	3	2	1	2	2	0	20	2	4	27	1	1
Oral	96	96	99	98	96	98	78	89	87	73	97	96
IUD	75	76	86	80	81	91	51	73	78	54	87	79
Condom	59	61	69	60	69	77	22	52	53	19	60	52
Suppository	72	69	75	82	80	84	42	53	54	25	55	44
Sterilization												
Female	90	90	95	96	94	99	68	90	83	57	92	86
Male	30	25	35	21	26	33	16	20	19	9	25	22
Rhythm	53	41	52	42	49	68	19	39	46	12	47	52
Withdrawal	42	28	32	32	33	47	12	40	39	9	41	33
Injection	88	88	91	92	91	95	61	76	78	45	73	56
Other	5	7	10	6	7	27	1	3	2	0	5	3
Numer of cases												
Unweighted	436	483	305	250	387	139	256	464	124	187	453	140
Weighted	17700	11458	25126	8566	9226	9624	8605	8588	8920	4442	6741	6512

TABLE 10

PERCENTAGE OF CURRENTLY MARRIED NON-PREGNANT FECUND WOMEN WHO ARE CURRENTLY USING CONTRACEPTION (INCLUDING STERILIZATION) BY AGE, NUMBER OF LIVING CHILDREN, LEVEL OF EDUCATION AND TYPE OF RESIDENCE: FIRST, SECOND AND THIRD SURVEYS IN CESAR AND CAUCA

ITEM	CESAR						CAUCA					
	CONTROL			EXPERIMENTAL			CONTROL			EXPERIMENTAL		
	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD
All	50	44	57	36	48	55	37	51	47	24	54	49
Age												
15-19	32	23	18	19	22	40	35	54	5	29	72	68
20-24	60	43	59	46	42	48	38	60	54	39	44	63
25-29	55	58	66	33	56	70	50	47	51	15	60	42
30-34	63	49	64	41	77	82	52	58	52	30	74	42
35-39	59	56	68	38	48	61	23	70	71	17	66	70
40-44	28	48	59	47	38	44	22	38	54	16	49	51
45-49	19	15	37	35	31	28	18	18	7	25	34	28
Number of live births												
0	16	15	22	-	3	-	11	48	19	-	2	33
1	38	53	38	21	38	68	39	62	19	20	42	55
2	61	52	78	50	60	58	42	48	53	38	56	62
3	60	50	62	41	43	57	31	65	69	26	73	68
4	61	39	59	49	59	46	51	37	48	19	59	45
5	49	43	60	36	51	55	32	48	45	22	53	39
Education												
None	40	28	50	24	40	32	21	40	48	14	36	40
1-2	47	47	55	25	45	60	23	54	32	19	51	40
3-4	61	48	60	45	54	46	43	37	54	27	58	58
5	58	59	54	48	59	69	55	71	65	32	67	76
more than 5	54	66	69	61	53	82	68	76	69	57	61	48
Place of residence												
Urban	56	53	61	49	46	64	61	67	68	51	73	66
Rural	48	32	56	34	49	52	31	44	43	21	51	47
Numer of cases												
Unweighted	363	200	257	208	164	119	228	251	112	163	279	124
Weighted	14719	9449	21154	7061	7697	8308	7568	7535	7942	3891	6058	5710

TABLE 11

PERCENTAGE DISTRIBUTION OF CURRENT USERS ACCORDING TO TYPE OF METHOD BEING USED: FIRST, SECOND AND THIRD SURVEYS IN CESAR AND CAUCA

METHODS	CESAR						CAUCA					
	CONTROL			EXPERIMENTAL			CONTROL			EXPERIMENTAL		
	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD
Artificial	84	84	87	90	90	87	97	68	78	79	60	54
Oral	48	43	37	29	40	36	43	22	13	13	17	21
IUD	10	14	10	5	2	11	16	9	11	29	11	6
Condom	2	2	5	3	0	0	3	0	2	0	4	7
Suppository	4	5	7	5	6	5	3	2	1	0	4	0
Sterilization	14	18	24	45	38	32	27	25	47	33	22	20
Injection	6	2	4	3	4	3	5	10	4	4	2	0
Natural	16	16	13	10	10	13	3	32	22	21	40	46
Rhythm	8	7	5	5	6	5	3	8	11	8	13	30
Withdrawal	4	9	3	0	4	5	0	24	11	13	25	16
Other	4	0	5	5	0	3	0	0	0	0	2	0
TOTAL	100	100	100	100	100	100	100	100	100	100	100	100

TABLE 12

THE PERCENT OF ALL EVER MARRIED WOMEN WHO NAMED A SPECIFIC SOURCE FOR FAMILY PLANNING SERVICES: FIRST, SECOND AND THIRD SURVEYS IN CESAR AND CAUCA

SOURCE	CESAR						CAUCA					
	CONTROL			EXPERIMENTAL			CONTROL			EXPERIMENTAL		
	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD
No place	59	35	30	68	28	24	63	18	19	60	13	13
Health services	27	32	31	46	38	44	41	58	51	39	79	60
Drugstore	17	40	23	12	38	13	7	27	16	4	14	15
Profamilia	22	13	20	12	17	17	6	23	12	9	28	18
Physician	6	3	7	8	3	4	5	22	6	1	8	2
Other	11	1	5	7	0	1	7	3	1	6	4	2
Total number of unweighted cases	507	620	351	283	496	171	300	623	172	214	570	165
Total number of weighted cases	20357	14251	28620	9659	11300	11552	10487	11335	12302	5055	8361	7764

TABLE 13

THE PERCENTAGE DISTRIBUTION OF CURRENT USERS BY SOURCE OF MOST FREQUENT CONTRACEPTIVE SERVICE OR SUPPLY SOURCE:
FIRST, SECOND AND THIRD SURVEYS IN CESAR AND CAUCA

SOURCE	CESAR						CAUCA					
	CONTROL			EXPERIMENTAL			CONTROL			EXPERIMENTAL		
	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD
MOH	21	22	14	28	19	17	66	33	34	69	41	49
Drugstore	30	53	49	37	49	44	10	33	30	6	24	40
Profamilia	21	14	16	9	23	29	2	15	15	11	20	11
Physician	12	10	9	13	2	10	21	18	11	3	6	0
Other	16	1	12	13	6	0	1	1	10	11	9	0
Percent total	100	100	100	100	100	100	100	100	100	100	100	100
Number of cases												
unweighted	163	142	108	48	89	38	86	147	27	39	137	29
weighted	6568	3033	8604	1498	2059	2678	2171	2036	1296	614	1275	1056

TABLE 14

THE PERCENTAGE DISTRIBUTION OF ORAL USERS BY SOURCE OF SUPPLY ACCORDING TO INTERVENTION GROUP: FIRST, SECOND AND THIRD SURVEYS IN CESAR AND CAUCA

SOURCE OF SUPPLY	CESAR						CAUCA					
	CONTROL			EXPERIMENTAL			CONTROL			EXPERIMENTAL		
	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD
Health services	20	12	31	25	19	52	72	27	10	55	36	36
Drugstore	44	68	28	51	43	22	12	37	45	3	33	42
Profamilia	20	16	24	11	29	26	3	26	27	34	23	22
Physician	4	3	8	13	2	0	13	9	18	8	3	0
Other	12	1	9	0	7	0	0	1	0	0	5	0
Number of cases												
Unweighted	90	88	53	26	64	19	51	87	13	12	63	18
Weighted	3657	1974	4260	803	1563	1468	1372	1115	542	134	626	692

TABLE 15

THE PERCENTAGE DISTRIBUTION OF STERILIZED WOMEN
BY SOURCE OF OPERATION ACCORDING TO INTERVENTION DEPARTMENT

SOURCE OF OPERATION	CESAR			CAUCA		
	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD
Ministry of Health	64	75	78	48	62	71
Profamilia clinic	13	13	8	5	9	5
Private clinic	16	11	14	36	27	23
Other	7	1	0	11	2	1
Percent total	100	100	100	100	100	100
Number of cases						
Unweighted	68	112	64	44	150	49
Weighted	2433	2275	4606	1103	1984	2798

TABLE 16

PERCENT DISTRIBUTION OF CURRENTLY MARRIED FECUND WOMEN ACCORDING TO PATTERN OF USE: FIRST, SECOND AND THIRD SURVEYS IN CESAR AND CAUCA

PATTERN OF USE	CESAR						CAUCA					
	CONTROL			EXPERIMENTAL			CONTROL			EXPERIMENTAL		
	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD	FIRST	SECOND	THIRD
Current users	42	37	48	31	41	47	33	45	42	21	49	43
Former users	23	18	26	33	18	21	9	26	14	14	16	24
Never have used	35	45	26	36	41	32	58	29	44	65	35	33
Total	100	100	100	100	100	100	100	100	100	100	100	100
Number of cases												
Unweighted	436	484	305	250	387	139	256	464	124	187	453	140
Weighted	17700	11458	25126	8566	9226	9624	8605	8588	8920	4442	6741	6512

TABLE 17

NUMBER OF NEW ACCEPTORS BY METHOD ACCORDING TO AREA

APRIL 1 TO SEPTEMBER 30, 1982

AREA	NUMBER OF COUNTRIES	NUMBER OF POSTS	NUMBER OF NEW ACCEPTORS				TOTAL
			ORALS	CONDOMS	VAGINALS	STERILIZATIONS	
Cesar Maintenance	13	97	464	191	77	322	1054
Magdalena/Bolivar Experimental	7		22	8	2	154	186
Magdalena/Bolivar Promotion	14		577	105	87	51	820
Sub-total	34		1028	284	143	527	2060
Cauca Maintenance	14	72	2240	1505	121	130	3996
Cauca Experimental	12	13	1769	505	56	73	2403
Cauca Promotion	7		736	464	68	102	1370
Sub-total	33		4850	2078	226	305	7769
TOTAL	67		5878	2362	369	832	9829

SOURCE: Profamilia Service Statistics.

TABLE 18

NUMBER OF CONTRACEPTIVES SOLD BY METHOD AND AREA

APRIL 1 TO SEPTEMBER 30, 1982

A R E A	NUMBER OF CONTRACEPTIVES SOLD			
	ORAL (CYCLES)	CONDOMS (UNITS)	VAGINAL TABLETS (BOX OF 12)	NEO-SAMPOON (20 TUBES)
Cesar Maintenance	15,318	6,829	594	272
Magdalena/Bolivar Experimental	782	773	15	18
Magdalena/North Santander Promotion	12,121	7,756	320	129
Sub-total	28,221	15,358	929	419
Cauca Maintenance	7,161	4,424	326	69
Cauca Experimental	2,976	647	52	23
Cesar Promotion	2,661	1,283	84	18
Sub-total	12,798	6,354	462	110
TOTAL	41,019	6,354	1,391	529

SOURCE: Profamilia Service Statistics.

TABLE 19

COST PER COUPLE YEAR PROTECTION AND COST PER NEW ACCEPTOR BY AREA FOR THE PERIOD APRIL 1, 1982 TO SEPTEMBER 30, 1982 (US DOLLARS)

I T E M	MAINTENANCE		EXPERIMENTAL		TRADITIONAL	
	Cesar	Cauca	Bolivar/ Magdalena	Cauca	Magdalena N. Santander	Cauca
Total Costs	11,338	11,340	10,540	14,384	15,935	11,244
Number years of protection[1]	5,396	2,283	1,999	1,159	1,712	1,543
Cost CYP	2.10	4.97	5.27	12.41	9.31	7.29
Number of new acceptors	1,054	3,686	186	2,403	820	1,370
Cost per new acceptor	10.76	3.08	56.67	5.99	19.43	8.21

[1]Includes orals, IUDs, condoms, vaginals and female sterilization. For each method the following years were assigned: 13 cycles = 1 year; 100 units of condoms = 1 year; 100 units of vaginals = 1 year; 1 sterilization = 12.5 years.

SOURCE: Profamilia Service Statistics.

TABLE 20

PROFILE OF WOMEN WITH UNMET NEED FROM THE SECOND SURVEY COMPARED TO ALL WOMEN IN CESAR - CAUCA SAMPLE

	Cesar - Cauca Sample (n = 2309) %	Women with Unmet Need (n = 58) %
% Urban	70.8	34.5
Mean age (± SD)	31 ± 9	37 ± 9
Mean years of formal education (± SD)	3.0 ± 2	2.5 ± 1
Mean number of live births (± SD)	4.5 ± 3	7.3 ± 4

TABLE 21

CHARACTERISTICS OF HOUSEHOLDS AND THE COMMUNITY OF THE UNMET NEED SAMPLE

Households [1]	%		%
Living room	69	Cement floor	47
Separate bedrooms	60	Dirt floor	41
Radio	79	Electricity	46
Television	22	Piped water	41
Toilet or latrine	60	Drainage/services	22
Cook with wood	71	Garbage collection	10

Community [1]	%		%
Primary school	72	Health Promotor	35
Secondary school	36	Health Post	45
Bank	35	Health Center	39
Rural credit union	47	Hospital	21
Telecommunications	57	Pharmacy	45
Airport	24	Profamilia distribution post	53
Physician in residence	35		
Dentist in residence	35		

[1] The figure reported represents the percentage of households or community with the characteristic .

TABLE 22

PERCENTAGE OF WOMEN AND MEN WITH UNMET NEED WHO KNOW OF CONTRACEPTIVE METHODS

Method	Women % (n = 58)	Men % (n = 58)
Orals	93.1	41.4
Condoms	62.1	24.1
I U D	79.3	12.1
Sterilization:		
Female	96.6	29.3
Male	25.9	6.9
Injection	82.8	13.8
Vaginals	65.5	17.2
Rhythm	46.6	19.0
Withdrawal	51.7	10.3
Breastfeeding	72.4	--
Others	6.9	8.6

TABLE 23

PERCENTAGE OF WOMEN AND MEN REPORTING PREVIOUS USE OF CONTRACEPTIVE METHODS

Method	Women % (n = 58)	Men[1] % (n = 58)
Orals	29.3	20.7
Condoms	1.7	6.9
I U D	1.7	1.7
Injection	1.7	-
Vaginals	5.2	3.4
Rhythm	1.7	1.7
Withdrawal	3.4	3.4
Other	5.2	1.7

[1] Includes perceived use by spouse.

TABLE 24

REPORTED FREQUENCY OF AND SATISFACTION WITH SEXUAL RELATIONS IN UNMET NEED SAMPLE

Item	Women % (n = 58)	Men % (n = 58)
Frequency		
Daily	3.4	1.7
3 - 6/week	19.0	5.2
1 - 2/week	34.5	24.1
1 - 3/month	22.4	50.0
less than 1/month	5.2	1.7
Never	13.8	3.4
Other	1.7	13.8
Satisfaction with relations		
Personal	72.4	91.4
Spouse	94.8	89.3

TABLE 25

REASONS FOR NOT CURRENTLY WANTING ANOTHER CHILD
IN UNMET NEED SAMPLE

Reasons	Women[1] % (n = 49)	Men % (n = 48)
Economic burden	49.0	44.9
Too old	30.6	14.6
Have sufficient children	0	18.8
Children require too much attention	16.3	0
To provide a better life for existing children	0	12.5
Religious fears	0	6.3
Difficult to work and care for children	4.1	0
Other	0	2.1

[1] Nine women and ten men could not answer this question.

TABLE 26

OPINIONS OF IMPORTANT REFERENCE GROUPS ON THE USE OF FAMILY PLANNING IN UNMET NEED SAMPLE

Item	Women % (n = 58)	Men % (n = 58)
Perceived opinion of spouse[1] regarding use of family planning		
In favor	43.9	36.6
Indecisive	2.4	9.8
Not interested	14.6	36.6
Against	39.0	17.1
Percent of groups in favor of family planning		
Friends	65.5	51.6
Parents	58.6	48.3
Community	51.7	55.2
Church	10.3	15.5

[1] Only for couples who do not talk about family planning (n = 41).

TABLE 27

DESCRIPTION OF THE REVISED TEAM AND INCENTIVE PROJECT AREAS ON THE ATLANTIC COAST

Area	Centers	Number of Municipalities	Area (Km^2)	1973[1] Population	Approximate no. of women of fertile age
Incentives	3	48	34,709	1,902,553	266,357
Team	2	41	35,227	1,042,451	145,943
TOTAL:	5	99	69,936	2,945,004	412,300

SOURCE: 1973 Census.

TABLE 28

CHARACTERISTICS OF INSTRUCTORS IN THE PROFAMILIA COMMUNITY DISTRIBUTION PROGRAM

Characteristics	Team (n = 5)	Incentive (n = 6)
Median age at start of project	27	30
Sex	1 male, 4 females	6 females
Median months of experience with Profamilia	18	18
Number of posts under responsibility	328	387
Transportation	jeep, bus	bus

SOURCE: Profamilia Service Statistics.

TABLE 29

IE & C ACTIVITIES IN TEAM AREAS BY SEMESTER:

MONTERIA AND SINCELEJO

Activity	1 Semester 1983	2 Semester 1983	1 Semester 1984	Total
Distributors trained	428	379	409	1,216
Conferences given	502	557	603	1,662
Attendance: adults	17,989	18,718	19,820	56,527
youths	5,289	4,724	6,358	16,371
Household visits	3,895	1,704	1,445	7,044
Persons visited	6,195	2,872	2,836	11,903
Persons motivated for sterilization	1,108	1,011	664	2,783

SOURCE: Profamilia Service Statistics.

TABLE 30

IE & C ACTIVITIES IN INCENTIVE AREAS PER SEMESTER:

BARRANQUILLA, CARTAGENA, AND SANTA MARTA

Activity	1 Semester 1983	2 Semesters 1983	1 Semester 1984	Total
Distributors trained	157	286	328	771
Conferences given	294	388	721	1,403
Attendance: adults	5,029	8,427	13,838	27,294
youths	787	1,258	2,946	4,991
Household visits	3,458	3,203	5,130	11,791
Persons visited	4,459	5,563	7,424	17,446
Persons motivated for sterilization	2,388	3,899	2,971	9,253

SOURCE: Profamilia Service Statistics.

TABLE 31

PRODUCTION OF SERVICES BY THE PROFAMILIA TEAM PROGRAM FOR 1982 - 1984 IN MONTERIA AND SINCELEJO

Method / Year	1982		1983		1984
	1 Semester	2 Semester	1 Semester	2 Semester	1 Semester
Orals (cycles)	49,359	54,938	47,386	51,168	58,595
Condoms (units)	12,468	14,242	12,821	14,148	16,887
Vaginal suppositories (units)	9,984	14,300	13,905	9,658	15,709
Female sterilization	1,234	1,995	2,278	2,660	2,144
Couple year of protection	19,447	28,949	32,387	37,424	31,633
% Difference between semesters		+48.9%	+11.9%	+15.6%	-15.5%

SOURCE: Profamilia Service Statistics.

TABLE 32

PRODUCTION OF SERVICES BY THE PROFAMILIA INCENTIVE PROGRAM FOR 1981 - 1984 IN BARRANQUILLA, CARTAGENA AND SANTA MARTA

Method / Year	1982		1983		1984
	1 Semester	2 Semester	1 Semester	2 Semester	1 Semester
Orals (cycles)	55,802	58,294	73,680	94,597	100,642
Condoms (units)	16,984	21,683	31,987	38,101	37,072
Vaginal suppositories (units)	1,544	4,056	2,663	32,942	38,506
Female sterilization	1,806	1,105	1,085	1,751	1,274
Couple years of protection	27,053	18,554	19,577	29,865	24,422
% Difference between semesters		-31.4%	+5.5%	+52.6%	-18.2%

SOURCE: Profamilia Service Statistics.

TABLE 33

INCENTIVES IN U.S. DOLLARS PAID[1] PER SEMESTER IN THE PROFAMILIA COMMUNITY PROGRAM DURING 1983-1984 IN SANTA MARTA, BARRANQUILLA AND CARTAGENA

Product	1983 1 Semester	%	1983 2 Semester	%	1984 1 Semester	%	TOTAL	%
Orals	379	69.4	1,382	75.3	1,607	75.4	3,728	74.1
Condoms	183	17.2	234	12.8	225	10.6	642	12.8
Vaginal suppositories	86	8.1	117	6.4	134	6.3	337	6.7
Antihelmintics	57	5.3	101	5.5	164	7.7	322	6.4
TOTAL	1,065		1,834		2,130		5,029	

[1] Incentive value per unit in Colombian pesos: Orals $3.00, condoms $1.00, vaginal suppositories, i.e. Norforms (12/box) $0.20 and Neo-Sampoon (20 tubes per unit) $0.50, antihelmintics $0.50.

SOURCE: Profamilia Service Statistics.

TABLE 34

PERCENT OF ACHIEVEMENT RELATIVE TO GOALS IN TEAM AND INCENTIVES

CBD CONDITION 1983 - 1984

Reporting Period	Team %	Incentives %
1 Semester 1983		
Orals	-11	+5
Condoms	-1	+33
Vaginal Suppositories	+11	+715
Antihelmintics	+355	+734
2 Semester 1983		
Orals	-4	+34
Condoms	+9	+59
Vaginal Suppositories	-23	+884
Antihelmintics	+452	+1171
1 Semester 1984		
Orals	+11	+43
Condoms	+30	+55
Vaginal Suppositories	+26	+1033
Antihelmintics	+441	+1951

[1]The goals per semester for the incentive conditions were: 70,500 cycles of orals, 24,000 condoms, 3,726 units of vaginals and 1,500 tablets of antihelmintics. For the team condition the departmental goals per semester were: 53,000 cycles of orals, 13,000 condoms, 12,500 vaginal suppositories and 3,000 antihelmintics.

SOURCE: Profamilia Service Statistics.

TABLE 35

EXPENDITURES BY ITEM FOR TEAM AND INCENTIVE STRATEGY ZONES USED TO CALCULATE COST PER CYP (U.S. DOLLARS) (18 MONTHS)

Item	Team[1]	Incentive
I Personnel (salary and benefits)		
A Regional Coordinator	7,233	7,233
B Supervisors	1,455	1,455
C Instructors	20,273	40,545
D Team	16,493	-
Subtotal	45,454	49,233
II Project expenses (travel and per diem)		
A Regional Coordinator	2,392	2,392
B Supervisors	1,354	1,354
C Instructors	11,734	23,467
D Team	10,234	-
E Incentives	-	5,029
Subtotal	25,714	32,242
III PROFAMILIA overhead (15%)	10,675	12,221
Grand Total (I,II,III)	81,843	93,696

[1]The cost for instructors in the team condition was covered by PROFAMILIA's own funds and corresponds to the salary, benefits and expenses for three promotors for 18 months. The cost of sterilization is included in part of the analysis of cost-effectiveness and was estimated at US$37.00 per operation, although sterilization services were not paid by the Council award.

TABLE 36

COUPLE YEARS OF PROTECTION PROVIDED BY TEAM AND INCENTIVE INTERVENTIONS AND THE ASSOCIATED COST (US$ 1984)

Strategy	Total CYP for 18 mo. period	Total Cost[1]	Cost Effectiveness per CYP
Team			
with sterilization	101,444	343,068	3.38
without sterilization	12,919	81,843	6.34
Incentive			
with sterilization	73,864	245,766	3.32
without sterilization	19,291	93,696	4.86

[1] When sterilizations are included, their cost is estimated at US$37.00 each. The total cost of sterilizations was approx. $262,034 for 7,082 sterilizations in the team condition and $152,070 for 4,110 sterilizations in the incentive condition.

TABLE 37

COVERAGE OF CBD DISTRIBUTORS STUDY

Item	No.	%
Total number of distribution posts	3,452	
Interviews programmed	616	17.8
Ratio of posts visited which were no longer operative	60/616	9.7
Posts not found due to problem of the address	7	-
Posts where the manager was absent	17	-
Interviews incomplete	1	-
Interviews completed, sample fraction	531	15.4
Coverage (interviews completed/ existing posts)	531/556	95.5

TABLE 38

DESCRIPTION OF POSTS IN THE CBD DISTRIBUTOR SAMPLE (n = 531)

Characteristic	%
Located in urban areas	86.6
Place of sale:	
Private home	36.8
Small store	44.8
Other commercial site	18.4
Displays Profamilia sign	78.7
Displays price list	65.2
Have Profamilia publications	53.9
Displays Profamilia poster	29.8
Place contraceptives in showcase	13.9

TABLE 39

CHARACTERISTICS OF CBD DISTRIBUTORS

Characteristic	Description
Mean age (± SD)	40 ± 10
Marital status:	
In union	75.9%
Separated/Widow/Divorced	12.6%
Single	11.5%
Years of education (± SD)	6 ± 3
Distributors with children	87.8%
Mean number of children (± SD)	4 ± 3
Previous use of contraceptives	75.9%
Current use of contraception	53.7%
Years of experience as distributor (± SD)	4 ± 3
Receive assistance from family members in sales	61.0%

TABLE 40

CHARACTERISTICS OF TRAINING AND PROMOTION FOR CBD DISTRIBUTORS

Item	%
Year distributor received last formal training	
1984	58.0
1983	14.5
1982	5.8
Prior to 1981	7.6
Never received formal training	14.1
Techniques used for promotion in the community (multiple response)	
Household visits	9.3
Group meetings	9.1
Personal contacts	36.4
Do not promote	52.0
Distributors who refer couples for additional services	
I U D	68.4
Sterilization	71.4
Other methods	41.6

TABLE 41

CBD DISTRIBUTOR'S KNOWLEDGE OF THEMES PRESENTED IN THE CBD DISTRIBUTOR'S MANUAL

Items	Description
Total number of items	31
Mean level of items correct (± SD)	20 ± 4
Mean percentage of items correct	64.5%
Quartiles (range 1 - 29)	
1 - 8 correct	2.3%
9 - 16 correct	16.9%
17 - 24 correct	64.6%
25 - 29 correct	16.2%

TABLE 42

ITEMS WITH HIGHEST AND LOWEST PERCENTAGE OF CORRECT RESPONSE BY CBD DISTRIBUTOR

Highest	%	Lowest	%
When one should take the pill	98.3	Five counterindications for orals	29.4[1]
Number of relations per condom	95.5	Explanation of what is vasectomy	45.4
Number of relations per vaginal tablet	92.3	Recommendation for methods during lactation	48.4
Appropriate moment to insert tablet	91.9	What to do if forget to take an oral	49.2
Presence of menstruation following sterilization	90.0	Which days of the cycle are fertile	49.5
Capacity to have children following sterilization	89.1	When to begin new cycle of 28 orals	49.9

[1] Mean correct of five items, range of individual items was 7.3 - 50.8%

TABLE 43

SALES PER DISTRIBUTION POST DURING THE PREVIOUS SEMESTER
(APRIL - SEPTEMBER, 1984)

Item	Description
Posts selling contraceptives	100%
Mean couple years of protection sold (± SD)	14 ± 24
Range of CYP per post	0 - 367
Posts selling Pirantel	41.8%
Mean sales of Pirantel (±SD)	23 ± 52
Range of sales per post	0 - 485
Posts selling oral rehydration salts	4.7%
Mean sales of oral rehydration (± SD)	0.3 ± 3
Range of sales per post	0 - 55

SOURCE: Profamilia Service Statistics.