

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
CENTER FOR DISEASE CONTROL

B# 25633

TO : William H. Foege, M.D.
Director, Center for Disease Control
THROUGH: Philip S. Brachman, M.D.
Director, Bureau of Epidemiology (BE)

DATE: May 11, 1978

FROM : Program Analysts, Program Evaluation Branch (PEB)
Family Planning Evaluation Division (FPED), BE

SUBJECT: Resource Support Services Report: Evaluation of the Direct Distribution
of Contraceptive Materials Project (DDP), Guatemala; April 18-26, 1978

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SUMMARY

During the period April 18-26, 1978, an FPED/CDC team assisted the Asociacion Pro-Bienestar de la Familia de Guatemala (APROFAM) in the analysis of data from an evaluation of APROFAM's Direct Distribution of Contraceptive Materials Project (DDP) and the family planning program of Guatemalan Ministry of Public Health (MSP), to which the DDP provides logistics support. This support is provided in 2 ways, one with APROFAM providing supplies directly to MSP health centers and posts (DDP-supplied), and the other in which APROFAM provides supplies to MSP area warehouses where they are then distributed to the clinics (Warehouse-supplied). Because of alleged methodological irregularities surrounding the evaluation, the results of the evaluation can only be generalized with extreme caution. With this reservation in mind, the evaluation shows that the DDP is achieving its objective of stocking and maintaining family planning supplies in MSP clinics. In addition, the results of the evaluation suggest that, in terms of contraceptive stocks on hand, availability of family planning services to the public and use of DDP forms and reporting, the performance of DDP-supplied clinics may be superior to that of area warehouse-supplied clinics. The problems of the program were identified to be in the areas of data collection and reporting and program evaluation and management. In general, we recommend that DDP management

consolidate the program it has developed to date, giving particular attention to the reporting system and data requirements needed for the management of the program. Specific recommendations include:

- 1) Based on program performance, adjust maximum and minimum stock levels in the clinics to 12 and 6 months, respectively.
- 2) Extend the time for the promoters to complete their rounds. If this and recommendation 1 are adopted, they will allow the promoters to make more non-resupply visits to the clinics and to spend more time in the clinics for the purpose of providing assistance in data management and program development.
- 3) Streamline the reporting system by: combining some forms; eliminating data requirements from others; ensuring that DDP forms are used universally in the program; consolidating files for individual clinics; and changing reporting requirements from monthly to quarterly.

I. PLACES, DATES, AND PURPOSE OF TRAVEL

Guatemala, April 18-26, 1978, at the request of USAID/Guatemala, AID/POP/LA and AID/POP/FPD, to provide technical assistance to the Asociacion Pro-Bienestar de la Familia de Guatemala (APROFAM) in the analysis of data from the evaluation of the Direct Distribution of Contraceptive Materials Project (DDP) and the Guatemalan Ministry of Public Health (MSP) family planning program. This consultation was provided by Richard S. Monteith and Jack L. Graves, Program Analysts, CDC/BE/FPED. This travel was in accordance with the Resource Support Services Agreement (RSSA) between the Office of Population, AID, and CDC/BE/FPED, and was made in conjunction with a trip to El Salvador where Mr. Monteith provided technical assistance to the Instituto Salvadoreno del Seguro Social in the analysis of maternal and child health statistics.

II. PRINCIPAL CONTACTS

A. USAID/Guatemala

1. Scott Edmonds, Population Officer

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

1. Dr. Roberto Santiso, Executive Director
2. T.S. Maria Antonieta Pineda, Chief, Evaluation Unit
3. Sr. Fernando Montalban, Evaluation Unit
4. Srita. Maritza Vasquez Gutierrez, Evaluation Unit

III. BACKGROUND

The 1977 Program Agreement (PROAG) between USAID/Guatemala and the Asociacion Pro-Bienestar de la Familia de Guatemala (APROFAM) called for a year-end evaluation of APROFAM's Direct Distribution of Contraceptive

Materials Project (DDP) and the family planning program of the Guatemalan Ministry of Public Health (MSP) to which the DDP provides logistics support. In October 1977, an FPED/CDC team provided technical assistance to APROFAM in a general evaluation of the DDP, which mainly consisted of a review of DDP records maintained in Guatemala City. The results of that evaluation showed that the program had progressed since its initiation in July 1976, as evidenced by a steady growth in active users, contraceptives distributed, money collected, visits to MSP clinics, and contraceptives issued to MSP clinics. However, during that evaluation, problems were detected in the collection and analysis of data for the evaluation and management of the program (see CDC Resource Support Services Report: Guatemala, dated November 28, 1977). Since the October 1977 evaluation did not focus specifically on individual clinics, the end-of-year evaluation called for in the 1977 PROAG was intentionally designed to investigate the status of the program at the clinic level, and to provide data that would complement the data obtained in the October evaluation. In November 1977, with the assistance of FPED/CDC, a questionnaire was developed, and a 10% stratified random sample of MSP health centers and posts participating in the DDP was selected for study. The questionnaire was field-tested during March 6-11, 1978, and the actual field work was conducted by APROFAM's evaluation unit from March 27 through April 14, 1978. The purpose of the consultation reported here was to assist APROFAM evaluation personnel in the analysis of the data.

IV. LIMITATIONS OF THE DATA

Before presenting the findings of the evaluation, a brief discussion of the data is warranted. The sample design was meant to be representative of all MSP clinics (centers and posts) participating in the DDP as of October 1977. However, due to alleged methodological irregularities the data collected during the evaluation may be biased: it was reported that DDP personnel visited some of the sample clinics immediately prior to the conduct of the evaluation. DDP personnel participated in the design of the questionnaire and were also knowledgeable of the clinics included in the sample. If, in fact, clinics in the sample were visited and received special treatment, the results of the evaluation can only be generalized with extreme caution. In addition, if some or all of the sample clinics received special treatment, the actual performance of clinics, in general, must be interpreted as probably being below that which was found in the evaluation and reported here.

Although the possibility exists that the data were biased, and because the alleged irregularities have not been documented, the data were analyzed as a teaching exercise for APROFAM evaluation personnel. Under normal circumstances, we would be hesitant to analyze data that may have the possibility of being compromised. Thus, discussion of the data and results that appear on the following pages of this report is presented as though there were no bias in the data. However, in doing so we advise the reader

to exercise caution in drawing hasty conclusions, since the findings may have serious implications for individuals participating in the DDP. If it is contemplated to make management decisions on the basis of a particular finding and the data is considered questionable, we recommend that the data set in question be validated by revisiting some of the sample clinics or other clinics which were not in the sample, to collect additional data before a decision is made.

We recognize the difficulties of establishing and adhering to strict study controls in "in-house" evaluations. In the case of the DDP evaluation, it was almost impossible for DDP personnel not to have prior knowledge of the scope and content of the evaluation. It may not be possible to repeat the evaluation under stricter controls. However, it is our hope that this evaluation has been a learning experience for APROFAM personnel, and that the application of acceptable methodological procedures will be observed in future evaluations.

V. FINDINGS OF THE EVALUATION

A. Characteristics of Clinics in Sample

Forty-three MSP health centers and posts were selected in the sample. However, the family planning programs of only 39--14 health centers and 25 health posts--were evaluated (see Table 1). For the 4 health posts, for which data were not obtained, the following reasons were cited: absence of the person in charge of family planning at the time of the evaluation (San Juan Bautista and El Teocinte); unavailability of horses or mules to travel to the health post (Pueblo Nuevo); and an undeveloped family planning program (El Duranzo). Table 1 also shows that of the 39 clinics evaluated, 21 of the clinics receive their family planning supplies directly from APROFAM (DDP-supplied clinics), while 18 are supplied through an area warehouse (area warehouse-supplied clinics).

As stated above, a 10% stratified random sample of MSP health centers and posts participating in the DDP was selected for study. The proportion of sample clinics that were health centers and health posts was 32.6% and 67.4%, respectively. This is comparable to the proportion of all clinics that are currently participating in the DDP that are health centers (31.5%) and health posts (68.5%). However, a comparison of the sample clinics with all clinics in the program by source of supply shows that the clinics which receive their supplies directly from APROFAM were under-represented (53.8% vs. 65.3%), and area warehouse-supplied clinics were over-represented (46.2% vs. 34.7%). This raises the possibility that the differences presented in this report between the sample DDP and area warehouse-supplied clinics might be due to this discrepancy. However, standardizing the totals in Tables 2 and 5 by type of clinic did not seem to effect the differences found between DDP and area warehouse-supplied clinics. Standardized totals are presented in these tables for purposes of comparison.

As Table 2 shows, 20 (51%) of the MSP clinics that were evaluated had provided family planning services prior to the initiation of the DDP. (Readers are reminded that the MSP initiated a family planning program in 1968 and by June 1976, just before the DDP began, services were available through 126 MSP health centers and posts.) As expected, a greater proportion of health centers had had prior family planning services. Table 2 also shows that a larger proportion of these clinics receive their family planning supplies directly from APROFAM than through an area warehouse (57% vs. 44%).

The DDP started in July 1976 and, therefore, the maximum time that any clinic could have participated in the program at the time the evaluation data was gathered was 21 months. Table 3 shows that the average time of participation in the program for the health units studied was 8.6 months; two-thirds of them have been in the program less than one year. This reflects the fact that the DDP was expanding rapidly in 1977 and is a relatively new program in most of the health units it serves. We feel that some of the problems of the DDP relate to short participation by these health units.

B. Availability of Family Planning Services

Tables 4-6 present data on the availability of family planning services in the study clinics. Table 4 shows that 25 or 64% of the study clinics do not have special hours programmed during which family planning services are provided; that is, services are available during the 44 hours these clinics are open during the week to the public. One clinic in this group does not provide any services except referral to a nearby health center.

The different types of services provided by these clinics are also analyzed in this table. For the purpose of analysis the services were categorized as contraceptive resupply (Metodo), family planning information and education (Info.), appointments (Cita), medical examination (Examenes), and none (Ningun). As the table shows, the majority of the clinics provide contraceptive resupply and informational services during the hours they are open to the public. However, only 12 of the clinics provide medical examinations, and 10 of these clinics are health posts. This finding is surprising since it would seem more likely that physicians who perform these examinations would be assigned to health centers than to health posts, which raises questions on the quality of the data that was reported to the evaluators.

The data in Table 5 show that 14, or 26%, of the study clinics have special hours during which family planning services are provided. The table also shows that a higher proportion of health centers than health posts, and a higher proportion of DDP-supplied than area warehouse-supplied clinics have special hours. Table 6 shows that 3 of the clinics do not provide services

outside of the special hours programmed for family planning. However, of the 11 that do, the majority resupply users and provide information, but only 2 clinics provide medical examinations, which probably reflects the unavailability of trained personnel in the clinics for this purpose.

C. Training, Use of Forms, and IE & C Materials

In Table 7, data on the number of trained personnel working in the study clinics and the type of training they received are presented. Two broad categories of training are identified: clinical training in family planning, which is defined to include training in the examinations related to the prescription of contraceptives and the medical control of patients, and administrative training which refers specifically to the training conducted by APROFAM for MSP personnel participating in the DDP. The most striking finding from this analysis is that fully two-thirds of the study clinics do not have any trained family planning clinicians on their staff. This finding was viewed by Dr. Santiso as being unusually high, and he questioned its reliability since APROFAM has been involved in training MSP personnel for many years. He also felt that some of the MSP personnel interviewed during the evaluation may not have understood the question asked of them and thus, responded incorrectly, a possibility to which we concede. However, we feel that the finding is plausible. Prior to the initiation of the DDP, family planning services were available through only 126 MSP facilities; presently, approximately 500 MSP health centers and posts provide these services. It is unlikely that personnel working in MSP facilities without family planning services prior to the initiation of the DDP would have received clinical training in family planning and, for that matter, it is not likely that all MSP personnel working in clinics which had family planning services received this type of training. In addition, some trained personnel could have been transferred to other services, resigned, etc. Table 2 showed that only 51% of the study clinics provided family planning services prior to the DDP, and since the number of training sessions in clinical aspects of family planning conducted by APROFAM has not increased appreciably since June 1976, it is thus plausible that two-thirds of the clinics would not have personnel trained in the clinical aspect of family planning care.

On the other hand, Table 7 also shows that APROFAM's efforts to train MSP personnel in the administration of family planning programs has been successful. Only 15% of the clinics reported that they have not received the administrative training currently being conducted by APROFAM. This number should decrease after APROFAM completes its training program next month.

Personnel in the clinics were asked if their clinic had received a medical family planning supervisory visit from MSP supervisors during the last 6 months. Personnel in only 4 clinics reported that they had.

Table 8 is an attempt to document the use and correct use of the DDI' forms in the MSP clinics. Five forms are used in the clinics:

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- 1 - Inventory Control Card
- 2 - Appointment Card (Tickler File)
- 3 - Patient Receipt Form
- 4 - Monthly Report
- 5 - Requisition Form

The data collected on the use of the DDP forms is of questionable quality. Two factors lead us to this conclusion.

1. APROFAM personnel, who actually conducted the field evaluation, were not fully knowledgeable of the forms used in the DDP nor in their correct use. For this reason, the data collected on Form 1 (Inventory Control Card) was not included in the analysis (unknowingly, the evaluators evaluated the wrong Inventory Control Card, which had been incorrectly implemented in the clinics).

2. Inconsistencies in the data. Several examples could be presented to demonstrate the inconsistencies; however, the following 3 examples will suffice to make our point:

- a. Data collected on active users suggests that there are approximately 19,000 active users in the MSP family planning program. However, data collected on dispensation of oral contraceptives, the principal contraceptive in the program suggests that there are only 7,500 active users in the program. These data are in contrast to the estimate of 24,551 average monthly couple-months of protection made during the previously mentioned October 1977 evaluation.
- b. Based on data from the evaluation, the average monthly number of cycles of oral contraceptives dispensed to users during the last 6 months and the average number of active users per clinic can be calculated. Assuming that the majority of the users are oral contraceptive users, and taking into account the fact that an oral contraceptive user requires 13 cycles per year, the statistics on the average number of active users and cycles dispensed should be comparable. They were not in every case. Overall, the average number of active users per clinic was calculated to be 38, and the average number of cycles dispensed was sufficient for 43. For area warehouse-supplied clinics, the disparity was even greater: the averages were calculated to be 12 and 25, respectively.
- c. In the past, many clinics reported active users as the number of patients who visited the clinic during the month. This practice is probably continuing. One of the questions asked was the health unit's definition of "active user" and many different definitions were given, none of which were expressed in terms of elapsed time since last clinic visit.

Keeping in mind the reservations we have about the data, Table 8 suggests a differential in the performance of clinics supplied directly by APROFAM and those supplied by area warehouses. The data suggest that more DDP-supplied clinics are using more forms and using them correctly than area warehouse-supplied clinics. Although not every clinic is using the forms correctly, the data suggest that the periodic visits of the APROFAM promoters have some effect on the quality of the data reported by the clinics. Conversely, the data show that for those clinics that are supplied from an area warehouse, there is a lower probability that the forms will be used at all, not to mention used correctly. This is particularly the case with forms 4 and 5 (Monthly Report and Requisition Form, respectively). The apparent non-use of the requisition form in clinics supplied by area warehouses is due, in part, to the absence of the APROFAM-supplied form for that purpose. We identified this problem during our February 7-18, 1977 consultation and recommended then "that DDP forms be used universally in the project at all levels and that provisions be made to print these forms for use in the field" (see p. 16, CDC Resource Support Services Report: Guatemala, dated April 26, 1977). We reiterate the same recommendation in this report.

In Table 9, data on the availability of information, education, and communication (IE & C) materials in the clinics are presented. Almost every clinic (37) had at least 1 family planning poster visible to the public. However, a smaller number of clinics (26) had family planning pamphlets available for distribution to potential or actual users of contraception. Little difference on these parameters existed between DDP- and area warehouse-supplied clinics.

D. Contraceptive Supplies

Tables 10-13 address the question of contraceptive supplies on hand in the clinics and issues made by APROFAM to the MSP. Table 10 shows the number of clinics that have ever dispensed contraceptives by type of contraceptive. All but one of the clinics have dispensed orals (97.4%) and the great majority condoms (74.4%), the 2 major contraceptives in the program, but less than 45% of the clinics have ever dispensed the other methods of contraception, i.e., Neosampon, injections, and IUDs. However, the data show that most health centers have dispensed every contraceptive except injections. In comparing DDP-supplied clinics with area warehouse-supplied clinics, a higher proportion of the former have ever dispensed the different methods available in the program than the latter. This finding suggests that clinics, which receive their commodities directly from APROFAM, may have been better supplied than those which are supplied through the area warehouses. This finding is supported by Table 11, which distributes the clinics by the type of contraceptives on hand at the time of the evaluation. However, in comparing Table 10 with Table 11, it can be seen that more clinics have ever distributed IUDs and

injections than the current number of clinics that have these commodities on hand in their inventories. The differential may be due to the lack of trained personnel in the clinics to prescribe or dispense these commodities, the willingness of the clinics to stock these commodities, or the lack of incentive for the promoters to promote IUDs in the clinics, since their dispensation to users does not generate a commission for the promoters. According to Dr. Santiso, the vaginal tablet, Neosampon, and the injection, Deproprovera, are regarded, like orals and condoms, as principal contraceptives in the program. However, both Tables 9 and 10 serve to point out that issues of these commodities to the clinics have been uneven and have not received the emphasis Dr. Santiso feels they should.

Table 12 shows actual stock levels of the different contraceptives on hand in the clinics at the time of the evaluation. Notable in this table are the clinics with no or small stock levels of condoms, Neosampon, and injections, and an almost universal stockout of IUDs in all of the clinics. Without reliable data on monthly dispensation of oral contraceptives and condoms by the clinics to users, it is impossible to determine if adequate maximum stock levels of these contraceptives are being maintained by the clinics. However, the stock levels of oral contraceptives found in Salama, Quezaltepeque, Concepcion Las Minas, Montufar, Nahauala, and Anguiater-Frontera appear to be too low to be representative of either adequate maximum or minimum stock levels of 12 and 6 months, respectively.

Table 13 shows the average number of contraceptives by type of contraceptive on hand in the clinics at the time of the evaluation. This table suggests that DDP-supplied clinics maintain higher stock levels for each type of contraceptive in their inventories than area warehouse-supplied clinics. Unless area warehouses can respond immediately to emergency request for commodities, it is likely that the clinics they supply are at greater risk of running out of supplies than DDP-supplied clinics. The low stock levels in the area warehouse-supplied clinics also indicate that these clinics have to be supplied more frequently than DDP-supplied clinics, a process which increases the administrative costs of supplying these clinics.

During the evaluation, an attempt was made to document the time required to process requests for supplies, i.e., from the date a request is made by the clinics to the date of delivery of supplies. Because of poor record-keeping at the clinic level, data were available on only 16 requests for supplies, and of these 16, the date of the request and date of delivery were the same for 9 requests. Two conditions would make this possible: the promoter filled the request on the spot, or clinic personnel requested and picked up their supplies on the same day from the DDP office in Guatemala City. Data were available on only 3 requests made by area warehouse-supplied clinics, and the relevant dates revealed same-day service. In short, there was not enough data available from the evaluation to make a meaningful analysis.

Therefore, data from the DDP central files were examined. No attempt was made to select a random sample of requests and shipping invoices. The results of this analysis are presented in Table 14. In the top panel data are presented on the amount of time to process a request from date of request to date of delivery. The average time to process requests from area warehouses was 14 days. The average time to process requests from health centers and posts, which receive their supplies directly from APROFAM, was greater--19 days. In the middle and bottom panels it can be seen that the time from the date of preparation of shipping invoices to the date of delivery accounts for the majority of the time required to process requests. For those clinics with high minimum stock levels, we feel that the time found to process requests is acceptable. However, for those clinics with low inventory levels or stockouts for certain commodities, i.e., condoms, Neosampoon, and injections, these times are not acceptable.

E. Acceptor Reporting

Table 15 is a composite of different performance indicators by type of health clinic and source of supply. Because the evaluation results suggest that records have been maintained poorly in the clinics and, because the APROFAM evaluators were unable to identify and correct errors in the records during the evaluation, we feel that the data presented in this table, with the possible exception of the data on average stock levels in the clinics, should be interpreted with extreme caution. Keeping this disclaimer in mind, Table 15 suggests that the performance of DDP-supplied clinics may be better than that of area warehouse-supplied clinics on every performance indicator. In addition, if the summary statistic on the average number of admissions (2.7) is correct by a factor of $\pm 10\%$, the average annual number of new acceptors incorporated in the program would range from 14,580 to 17,820 acceptors per year (using 500 MSP clinics as the base number of clinics participating in the DDP). Although these estimations are modest, given the number of clinics participating in the DDP they are encouraging, as they demonstrate that couples will use contraceptives if they have access to them. In Table 2 we saw that 49% of the clinics did not provide family planning services prior to the DDP. Thus, the DDP may take credit for making services available for 7,144 to 8,732 couples annually ($.49 \times 14,580$ and $.49 \times 17,820$), given the currently monthly admission rate.

Since the beginning the DDP monthly reporting by the clinics has been a problem, both in terms of the quality of data reported and lack of reporting. During our October 23-28, 1977 consultation with the DDP, we reported that the percent of clinics submitting monthly reports from January through August 1977, had increased from 41% to 55% (see CDC Resource Support Services Report: Guatemala, dated November 28, 1977). During the present evaluation it was found that the frequency of reporting by the clinics had continued to improve. As Table 16 shows, 65.7% of the

required monthly reports were submitted by the clinics during the July 1977-February 1978 period. However, during the December 1977-February 1978 period, the rate declined to 59.5%. Table 16 also shows that a higher proportion of DDP-supplied clinics submitted the required number of monthly reports than did area warehouse-supplied clinics, and that the decline in reporting during the December 1977-February 1978 period was due primarily to the failure of area warehouse-supplied clinics to submit their monthly reports.

F. Miscellaneous

The evaluation design called for an analysis of the individual accounts of the study clinics and the number and frequency of visits made by the promoters to the clinics. Because of the unavailability and/or unreliability of data on these parameters, it was impossible to do these analyses.

The unavailability of data on the individual clinic accounts found during the evaluation is due primarily to the failure of area warehouse-supplied clinics and the area warehouses that supply them to maintain records; 18 of the 39 study clinics receive their supplies through an area warehouse. For the DDP-supplied clinics, the unavailability of data can be explained by poor or non-existent filing practices. We feel that periodic audits of the clinic and area warehouse accounts should be a standard operating procedure of the DDP. To a certain extent this is being done at the DDP central office where monthly reports are prepared on the status of the accounts of the individual clinics and area warehouses (see Exhibit 1 for a sample report). However, notably absent from these reports is the value of the commodities the clinics and warehouses have in their inventories. Without this information, it is impossible to audit the individual accounts and to detect irregularities. Thus, the DDP accounting system is not being used as a management tool as it can and should be.

VI. DISCUSSION AND RECOMMENDATIONS

Keeping in mind the limitations of the data, the evaluation shows that the DDP is achieving its objective of stocking and maintaining family planning supplies in MSP clinics. This is supported by program data on issues made to all MSP facilities since the initiation of the DDP, which is presented in Table 17. This table shows that issues of different contraceptives to the MSP during 1977 exceeded* issues made during the first 7 months of the DDP (June-December 1976), when they are annually adjusted.

*Fewer units of vaginal treatments were distributed in 1977 than during the first 7 months of project when the latter issues are annually adjusted. However, when Neosampoon is treated separately, issues of this contraceptive during 1977 exceed the annual adjusted issue for 1976.

Data from the evaluation also suggest that the performance of DDP-supplied clinics may be superior to that of area warehouse-supplied clinics on several different parameters. This may be due to the periodic visits of the DDP promoters to the MSP health centers and posts for the purpose of resupply. Although the main purpose of the promoters' visits are to resupply the clinics, it appears that to some degree the visits may also serve to motivate MSP clinic personnel to provide higher quality family planning services than clinics that receive their supplies through an area warehouse.

The problems of the program remain in the area of data collection and reporting and program evaluation and management. In making this statement, we recognize the barriers confronting DDP personnel in serving an organization (MSP) that is not always cooperative or appreciative of the support it receives from APROFAM. Nevertheless, in part, the DDP staff can and should be held accountable for some of the deficiencies found in the program during this evaluation: for example, the data suggest that priorities established for the program, i.e., rapid expansion of the program, have not always corresponded to the program components requiring the most and immediate attention, such as the reporting system. On the other hand, some of the data, as well as interviews with 3 of the 4 promoters, suggest that the DDP has not always received all of the support it needs from the MSP and APROFAM to implement and sustain family planning services in MSP clinics.

From the evaluation and from previous observations of the DDP, we feel that the program has progressed to a point where serious consideration should be given to redefining the objectives of the DDP and the role of the promoters. Heretofore, the attention of the program has been on establishing family planning services in MSP clinics and providing the necessary logistics support in order to sustain them. For the most part, the DDP has been successful in this effort and, presently, the development of new contraceptive outlets is currently being broadened to include municipal pharmacies. In addition, it was reported that the DDP is beginning to provide logistics support to APROFAM's various community-based distribution programs. Before expanding the program base to which the DDP must provide logistics support, we recommend that DDP management focus on consolidating the DDP-supported MSP program it has developed to date, giving particular attention to the reporting system and data requirements needed for the management of the program, which includes the maintenance of adequate inventory levels at all sites. In this light, we offer the following recommendations for APROFAM's consideration:

1. Based on program performance, establish maximum and minimum stock levels in the clinics for each item of supply that is equivalent to 12 and 6 months, respectively. The implication of this recommendation is that the promoters will only have to visit the clinics 2 times a year for the purpose of resupply instead of monthly.

2. Given the adoption of the recommendation outlined above, extend the time for the promoters to complete their rounds to approximately 8 to 10 weeks. This will allow the promoters to make more non-resupply visits to the clinics and to spend more time in the clinics to provide assistance in data management and program development. A corollary to this recommendation is that clinics experiencing the most problems should be identified and visited first.
3. In health areas and clinics, where it is clear that inputs beyond those of the promoters are needed to implement or sustain a family planning program, APROFAM should mobilize its various resources to diagnose the problems and provide the necessary technical assistance to resolve them. This may include procuring and distributing family planning literature, the showing of movies, implementing IE & C activities, and providing training to MSP personnel.

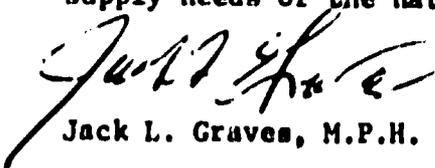
Regardless of APROFAM's inputs, in the final analysis the viability of the MSP family planning program can be sustained or improved upon only if the MSP adopts an active role in the management and supervision of its own program. Therefore, we recommend that steps be taken to increase the MSP's responsibility for the program.

4. In order to improve the DDP record system, we recommend that:
 - a) APROFAM negotiate with the MSP on the redesign of the receipt form (Recoleccion Diaria) and the monthly report, both of which should require data only on number of new admissions and active users by method, and units of contraceptives dispensed. Presently, both forms provide for the reporting of terminating users by reason for termination, data which is poorly reported, if at all, and never processed.
 - b) Serious consideration be given to changing the reporting requirements from monthly to quarterly.
 - c) The current requisition form and shipping invoice used in the DDP should be combined into one form. This would reduce paperwork, simplify filing, and facilitate the processing of orders.
 - d) The DDP, at the central level, should consolidate the files on each clinic or area warehouse in the program into individual folders. In addition, the promoters should carry with them at all times a duplicate set

of records which correspond to the clinics and areas in their network. This will provide for better control of the program, as well as facilitate its evaluation.

- e) The forms used in the DDP should be used universally throughout the program. Presently, the majority of the DDP forms are not utilized in the health areas that supply their own clinics.
5. Data from this evaluation and previous observations of the DDP suggest that the DDP accounting system is in disarray. We recommend that the accounting system be audited in detail and if the situation warrants it, close all current clinic and area accounts and begin anew. A corollary to this recommendation is the need to establish guidelines, standards, and sanctions for the accounting system.

Although, at the time of the evaluation, the DDP had been in operation for 21 months, it should be considered as a new program. The primary objective of the program was to supply contraceptives to all appropriate health units in the MSP. This objective appears to have been reached. The DDP must now adjust to this situation and take steps to assure that adequate stock levels are established and maintained in the health units. APROFAM also considers the promotion of contraceptive use in rural Guatemala as one of its goals. This goal will surely be defeated if rural Guatemalans, who have become motivated to use contraceptives, find that they are not continuously available. It is for this reason that we have so strongly recommended that the DDP record system be fully implemented and brought up to date. The information in this system is vital to program planning in order to insure that the contraceptive and other supply needs of the national family planning program are met.


Jack L. Graves, M.P.H.


Richard S. Monteith, M.P.H.

Attachments

APPENDIX A

Table Headings in English

- TABLE 1 - MSP Health Units in the Sample, By Source of Supply and Type of Health Unit, Guatemala, March - April, 1978
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T A B L A # 1

Unidades de Salud en la Muestra* por Fuente
de Suministros y Tipo de Unidad de Salud
Guatemala. Marzo - abril 1978

<u>Tipo de</u> <u>Unidad de Salud</u>	<u>Fuente de Suministros</u>		
	<u>Total</u>	<u>PDD</u>	<u>Area</u>
Centro de Salud	14	7	7
Puesto de Salud	25	14	11
Total	39	21	18

La Muestra se hizo tomando 43 centros y puestos de salud del Ministerio de Salud Pública. No fué posible obtener datos de los siguientes puestos y centros:

1. San Juan Bautista: No se encontraba la encargada del Programa
2. Pueblo Nuevo: No se pudo llegar por falta de bestia.
3. El Teocinto: No se encontraba la encargada
4. El Durazno: No hay programa completo, pues solo tiene papelería.

T A B L A # 2

Unidades de Salud que tenían Servicios de Planificación Familiar

Antes del Inicio del PDD, por fuente de

Suministros y Tipo de Unidad de Salud

Guatemala, Marzo - abril 1978

<u>Tipo de Unidad de Salud</u>	<u>Fuente de Suministros</u>		
	<u>Total</u>	<u>PDD</u>	<u>Area</u>
Centro de Salud	9 (64.3%)	6 (85.7%)	3 (42.9%)
Puesto de Salud	11 (44.0%)	6 (42.9%)	5 (45.4%)
Total	20 (51.3%)	12 (57.1%)	8 (44.4%)
Standardized Totals	(50.3%)	(57.4%)	(44.5%)

NOTA: El Porcentaje entre paréntesis indica el porcentaje del total de Centros y Puestos de Salud en la Muestra que tenían programa de Planificación Familiar antes del P.D.D.

T A B L A # 3

Unidades de Salud por Número de Meses que han Participado en el PDD y por Tipo de Unidad y Fuente de Suministros Guatemala, Marzo-Abril 1978

Tipo de Unidad y Fuente de Suministros	No. Total de Unidades	Porcen taje	Unidades de Salud Meses Participando en PDD					Tiempo Promedio en PDD (meses)					
			1 - 6		7 - 12		13 - 18		19 - 24		descu nocido		
			No.	%	No.	%	No.		%	No.	%	No.	%
1. PDD													
Centros	7	100.0	1 (14.3)	3 (42.9)	0 (0.0)	0 (0.0)	3 (42.9)					7.3	
Puestos	14	100.0	6 (42.9)	4 (28.6)	3 (21.4)	0 (0.0)	1 (7.1)					6.9	
2. AREA													
Centros	7	100.0	1 (14.3)	2 (28.6)	1 (14.3)	2 (28.6)	1 (14.3)					12.2	
Puestos	11	100.0	2 (18.2)	6 (54.5)	1 (9.1)	0 (0.0)	2 (18.2)					9.1	
3. TOTAL													
Centros	14	100.0	2 (14.3)	5 (35.7)	1 (7.1)	2 (14.3)	4 (28.6)					10.2	
Puestos	25	100.0	8 (32.0)	10 (40.0)	4 (16.0)	0 (0.0)	3 (12.0)					7.8	
4. TOTAL													
PDD	21	100.0	7 (33.3)	7 (33.3)	3 (14.3)	0 (0.0)	4 (19.0)					7.0	
Area	18	100.0	3 (16.7)	8 (44.4)	2 (11.1)	2 (11.1)	3 (16.7)					10.3	
5. GRAN TOTAL													
	39	100.0	10 (25.6)	15 (38.5)	5 (12.8)	2 (5.1)	7 (17.9)					8.6	

NOTA: La suma de los porcentajes no siempre da el 100.0 % por el redondeo.

TABLE 4

Unidades de Salud que no tienen horas Especiales Programadas para Planificación Familiar, por Tipo de Servicio Disponible y Tipo de Unidad y Fuente de Suministros.

Guatemala, Marzo - Abril, 1978

<u>Tipo de Unidad y Fuente de suministros</u>	<u>Unidad de Salud</u>					<u>No. Total de Unidad</u>
	<u>Tipo de Servicio</u>					
	<u>Método</u>	<u>Info.</u>	<u>Citas</u>	<u>Exámenes</u>	<u>Ningún</u>	
1. <u>PDD</u>						
Centros	2	1	2	2	0	2
Puestos	8	8	6	6	0	9
2. <u>AREA</u>						
Centros	4	4	0	0	1	5
Puestos	9	9	4	4	0	9
3. <u>TOTAL</u>						
Centros	6	5	2	2	1	7
Puestos	17	17	10	10	0	18
4. <u>TOTAL</u>						
PDD	10	9	8	8	0	11
Area	13	13	4	4	1	14
5. <u>GRAN TOTAL</u>	23	22	12	12	1	25

T A B L A # 5

Unidades de Salud que tienen Horas
Especiales programadas para Planificación
Familiar por Fuentes de Suministros y Tipo de Unidad
de Salud, Guatemala, Marzo-Abril 1978

<u>Tipo de</u> <u>Unidad de Salud</u>	<u>Fuente de Suministros</u>		
	<u>Total</u>	<u>PDD</u>	<u>Area</u>
Centro de Salud	7 (50.0%)	5 (71.4%)	2 (28.6%)
Puesto de Salud	7 (28.0%)	5 (35.7%)	2 (18.2%)
TOTAL	14 (35.9%)	10 (47.6%)	4 (22.2%)
Standardized Total	(34.9%)	(47.8%)	(21.0%)

NOTA: El porcentaje entre paréntesis indica el porcentaje del total de Centros y Puestos de Salud en la muestra, que tienen horas especiales para Planificación Familiar.

T A B L A # 6

Unidades de Salud que tienen horas especiales para Planificación Familiar que prestan Servicios de Planificación Familiar en horas no Programadas, por tipo de Servicio y Tipo de Unidad y Fuente de Suministros. Guatemala, marzo-abril 1978

<u>Tipo de unidad y fuente de suministros</u>	<u>Unidad de Salud</u>					No. Total de unidad
	<u>Tipo de Servicio</u>					
	<u>Método</u>	<u>Info.</u>	<u>Citas</u>	<u>Exámenes</u>	<u>Ningún</u>	
1. <u>PDD</u>						
Centros	4	2	3	1	1	5
Puestos	4	4	0	0	1	5
2. <u>AREA</u>						
Centros	0	0	0	1	1	2
Puestos	1	2	0	0	0	2
3. <u>TOTAL</u>						
Centros	4	2	3	2	2	7
Puestos	5	6	0	0	1	7
4. <u>TOTAL</u>						
PDD	8	6	3	1	2	10
Area	1	2	0	1	1	4
5. <u>GRAN TOTAL</u>	9	8	3	2	3	14

T A B L A # 7

Unidades de Salud, por Personal Adiestrado en Aspectos
Clínicos y Administrativos y por Tipo de Unidad
y Frente de Suministros

Guatemala, Marzo- Abril 1978

<u>Tipo de Unidad y Fuente de Su ministros</u>	<u>No. Total de Unidades</u>	<u>Unidades con personal adiestrado</u>							
		<u>En Aspectos Clínicos</u>				<u>En Aspectos Administrativos</u>			
		<u>Porcen taje</u>	<u>Ningún</u>	<u>1</u>	<u>> 1</u>	<u>Porcen taje</u>	<u>Ningún</u>	<u>1</u>	<u>> 1</u>
1. PDD									
Centros	7	100.0	4 (57.1)	2 (28.6)	1 (14.3)	100.0	1 (14.3)	1 (14.3)	5 (71.4)
Puestos	14	100.0	10 (71.4)	4 (28.6)	0 (0.0)	100.0	3 (21.4)	9 (64.3)	2 (14.3)
2. AREA									
Centros	7	100.0	5 (71.4)	1 (14.3)	1 (14.3)	100.0	0 (0.0)	2 (28.6)	5 (71.4)
Puestos	11	100.0	7 (63.6)	3 (27.3)	1 (9.1)	100.0	2 (18.2)	7 (63.6)	2 (18.2)
3. TOTAL									
Centros	14	100.0	9 (64.3)	3 (21.4)	2 (14.3)	100.0	1 (7.1)	3 (21.4)	10 (71.4)
Puestos	25	100.0	17 (68.0)	7 (28.0)	1 (4.0)	100.0	5 (20.0)	16 (64.0)	4 (16.0)
4. TOTAL									
PDD	21	100.0	14 (66.7)	6 (28.6)	1 (4.8)	100.0	4 (19.0)	10 (47.6)	7 (33.3)
Area	18	100.0	12 (66.7)	4 (22.2)	2 (11.1)	100.0	2 (11.1)	9 (50.0)	7 (38.9)
5. GRAN TOTAL	39	100.0	26 (66.7)	10 (25.6)	3 (7.7)	100.0	6 (15.4)	19 (48.7)	14 (35.9)

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T A B L A # 8

Unidades de Salud, por Número de Formas del PDD usadas en las
Unidades y Número de Formas Usadas Correctamente, y Por Tipo
de Unidad y Fuente de Suministros
Guatemala, Marzo - Abril 1978

Tipo de Unidad y Fuente de Su- ministros	UNIDADES DE SALUD													No. Total de Unidades	
	a						Prome- dio	a					Prome- dio		
	Formas Usadas					1 ^b		Formas Usadas Correctamente							
	1 ^b	2	3	4	5		Total		1 ^b	2	3	4	5	Total	
1. PDD															
Centros	*	6	6	7	4	23	3.3	*	6	6	2	4	18	2.6	7
Puestos	*	12	13	11	9	45	3.2	*	9	12	5	4	30	2.1	14
2. AREA															
Centros	*	3	7	5	1	16	2.3	*	2	4	1	1	8	1.1	7
Puestos	*	9	9	8	3	29	2.6	*	6	8	3	3	20	1.8	11
3. TOTAL															
Centros	*	9	13	12	5	39	2.8	*	8	10	3	5	26	1.9	14
Puestos	*	21	22	19	12	74	3.0	*	15	20	8	7	50	2.0	25
4. TOTAL															
PDD	*	18	19	18	13	68	3.2	*	15	18	7	8	48	2.3	21
Area	*	12	16	13	4	45	2.5	*	8	12	4	4	28	1.6	18
5. GRAN TOTAL															
	*	30	35	31	17	113	2.9	*	23	30	11	12	76	1.9	39

NOTA A: Las Formas Incluyen:

1. Tarjeta de Control de Existencia
2. Tarjeta de control de citas
3. Recolección Diaria
4. Informe Mensual
5. Pedidos

NOTA B: No fué posible evaluar el uso correcto de la tarjeta de control de existencia. Ya que después de la Evaluación, nos dimos cuenta que la forma número uno, que se evaluó no es la que se debe usar.

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T A B L A # 9

Unidades de Salud, por Disponibilidad de Afiches
y Folletos al Público, y por Tipo de Unidad
y Fuente de Suministros
Guatemala, Marzo-abril 1978

<u>Tipo de Unidad y Fuente de Su ministros</u>	<u>Unidades de Salud con</u>		<u>No. Total de Unidades</u>
	<u>Afiches a la Vista</u>	<u>Folletos Disponibles</u>	
1. <u>PDD</u>			
Centros	7	5	7
Puestos	13	11	14
2. <u>AREA</u>			
Centros	7	2	7
Puestos	10	8	11
3. <u>TOTAL</u>			
Centros	14	7	14
Puestos	23	19	25
4. <u>TOTAL</u>			
PDD	20	16	21
Area	17	10	18
5. <u>GRAN TOTAL</u>	37	26	39

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T A B L A # 10

Unidades de Salud, por Métodos Anticonceptivos
que han distribuido, y por tipo de unidad y Fuente
de Suministros

Guatemala, Marzo - abril 1978

Tipo de Unidad y Fuente de Su- ministros	UNIDADES DE SALUD Métodos que han distribuido							No. Total de Unidades
	Pastilla	Condón	DIU	Neo- Serpón	Espuma, Jalea, Crema.	Inyección	Ningún	
1. PDC								
Centros	7 (100.0)	6 (85.7)	6 (85.7)	6 (85.7)	6 (85.7)	5 (71.4)	0 (0.0)	7
Puestos	14 (100.0)	13 (92.9)	0 (0.0)	5 (35.7)	5 (35.7)	3 (21.4)	0 (0.0)	14
2. AREA								
Centros	6 (85.7)	3 (42.9)	2 (28.6)	2 (28.6)	2 (28.6)	1 (14.3)	1 (14.3)	7
Puestos	11 (100.0)	7 (63.6)	0 (0.0)	3 (27.3)	2 (18.2)	3 (27.3)	0 (0.0)	11
3. TOTAL								
Centros	13 (92.9)	9 (64.3)	8 (57.1)	8 (57.1)	8 (57.1)	6 (42.9)	1 (7.1)	14
Puestos	25 (100.0)	20 (80.0)	0 (0.0)	8 (32.0)	7 (28.0)	6 (24.0)	0 (0.0)	25
4. TOTAL								
PDC	21 (100.0)	19 (90.5)	6 (28.6)	11 (52.4)	11 (52.4)	8 (38.1)	0 (0.0)	21
Area	17 (94.4)	10 (55.6)	2 (11.1)	5 (27.8)	4 (22.2)	4 (22.2)	1 (5.6)	18
5. GRAN TOTAL								
	38 (97.4)	29 (74.4)	8 (20.5)	16 (41.0)	15 (38.5)	12 (30.8)	1 (2.6)	39

NOTA: Los porcentajes entre paréntesis, indican el porcentaje del total de centros y Puestos de Salud; que han distribuido los diferentes métodos de Planificación Familiar.

T A B L A # 11

Unidades de Salud, por Métodos Anticonceptivos en Existencia, al momento de la Evaluación y por Tipo de Unidad y - Fuentes de Suministros, Guatemala, Marzo - Abril 1978

Tipo de Unidad y Fuente de Su ministros.	UNIDADES DE SALUD							No. Total de Unidades
	Métodos en existencia				Espuma, Crema, Jales →			
	Pastilla	Condón	DIU	Neo-Sempón	Inyección	Ningún		
1. PDD								
Centros	7 (100.0)	6 (85.7)	0 (0.0)	6 (85.7)	5 (71.4)	1 (14.3)	0 (0.0)	7
Puestos	14 (100.0)	13 (92.9)	3 (0.0)	6 (42.9)	5 (35.7)	1 (7.1)	0 (0.0)	14
2. AREA								
Centros	6 (85.7)	3 (42.9)	1 (14.3)	1 (14.3)	1 (14.3)	1 (14.3)	1 (14.3)	7
Puestos	11 (100.0)	6 (54.5)	0 (0.0)	3 (27.3)	2 (18.2)	2 (18.2)	0 (0.0)	11
3. TOTAL								
Centros	13 (92.9)	9 (64.3)	1 (7.1)	7 (50.0)	6 (42.9)	2 (14.3)	1 (7.1)	14
Puestos	25 (100.0)	19 (76.0)	0 (0.0)	9 (36.0)	7 (28.0)	3 (12.0)	0 (0.0)	25
4. TOTAL								
PDD	21 (100.0)	19 (90.5)	0 (0.0)	12 (57.1)	10 (47.6)	2 (9.5)	0 (0.0)	21
Area	17 (94.4)	9 (50.0)	1 (5.6)	4 (22.2)	3 (16.7)	3 (16.7)	1 (5.6)	18
5. GRAN TOTAL	36 (97.4)	28 (71.8)	1 (2.6)	16 (41.0)	13 (33.3)	5 (12.8)	1 (2.6)	39

NOTA: El porcentaje entre paréntesis, indica el porcentaje del total de centros y Puestos, de Salud que tienen existencia de métodos anticonceptivos.

TABLA # 12

La existencia de Anticonceptivos en las Unidades de Salud al momento de la Evaluación

Guatemala, Marzo - abril 1978

Tipo de Unidad y Fuente de suministros	No. de unidades de Anticonceptivos en Ex.						Tipo de Unidad y Fuente de Suministros.	No. Unidades de Anticonceptivos en Existencia.					
	Pastilla	condón	DIU	Neo-Sampón	Espuma, Crema, Jales Iny.			Pastilla	Condón	DIU	Neo-Sampón	Espuma, Crema, Jales Iny.	
1. BDO CENTRO							3. APEA CENTRO						
Pereles	4770	1440	-	40	95	-	Sub-Centro B	-	-	-	-	-	-
Santa Caterina Pita	620	-	-	20	10	-	Tacaná	1723	-	79	-	-	-
Guerralesque	269	98	-	16	20	-	Santa Terés La U.	516	132	-	8	6	-
Salavá	135	160	-	1	10	20	El Yuncador	97	-	-	-	-	-
Totenicozón	1700	181	-	8	-	-	Nehualá	8	56	-	-	-	-
Mulitá	600	288	-	10	6	-	10. Julio	221	-	-	-	-	-
Ant. Guatemala	1370	660	-	49	31	-	San Martín Dil.	60	36	-	-	-	13
2. BDO PUESTOS							4. AREA PUESTOS						
Ariosa	472	266	-	8	6	-	El Tejar	56	144	-	3	-	-
Cabello Blanco	418	216	-	10	11	-	Cuytenango	82	-	-	-	-	-
Osere	214	144	-	-	-	-	Semuc	72	-	-	-	-	-
Cotenzuela	903	354	-	6	6	-	Nuevo Progreso	96	132	-	-	-	-
Comcep. Los Pinos	42	24	-	-	-	-	Godínez	46	144	-	-	3	-
Entre Ríos	564	108	-	-	4	-	Purulhá	64	62	-	5	10	1
Ayerzo	54	126	-	9	-	1	Agua Escondida	57	144	-	9	-	-
Jocotenango	175	432	-	5	8	-	El Edén	48	-	-	-	-	-
Ciudad Vieja	459	246	-	5	6	-	Azulco	48	-	-	-	-	1
Membrer	64	108	-	-	-	-	Las Arzuconas	43	69	-	-	-	-
Río Blanco	98	86	-	-	-	-	Anguetú-Fontera	16	-	-	-	-	-
Apocotón	210	-	-	-	-	-							
Sorchi	90	132	-	-	-	-							
Santiago Agrícola	218	48	-	-	-	-							

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T A B L A # 13

Número Promedio de Métodos Anticonceptivos en Existencia
al momento de la Evaluación, por método y Tipo de Unidad
y Fuente de Suministros, Guatemala, Marzo - abril, 1978

Tipo de Unidad y fuente de Su- ministros,	Promedio de métodos en existencia						No. Total de Unidades
	Pastilla	Condón	DIU	Neo- Sempón	Espuma, Crema, Jales	Inyección*	
1. PDD							
Centros	1201 (7)	407 (6)	0 (0)	22 (7)	23 (6)	3 (1)	7
Puestos	207 (14)	165 (13)	0 (0)	3 (6)	3 (5)	- (1)**	14
2. AREA							
Centros	375 (6)	32 (3)	11 (1)	1 (1)	1 (1)	2 (1)	7
Puestos	57 (11)	64 (6)	0 (0)	2 (3)	2 (2)	- (2)**	11
3. TOTAL							
Centros	828 (13)	219 (9)	6 (1)	12 (8)	12 (7)	2 (2)	14
Puestos	186 (25)	121 (19)	0 (0)	2 (9)	2 (7)	- (3)**	25
4. TOTAL							
PDD	618 (21)	246 (19)	0 (0)	9 (13)	10 (11)	1 (2)	21
Area	181 (17)	52 (9)	4 (1)	1 (4)	1 (3)	1 (3)	18
5. GRAN TOTAL	416 (38)	156 (28)	2 (1)	6 (17)	6 (14)	1 (5)	39

NOTA: * La inyección no se tomó por dosis, ni por frasco de 10 dosis.

NOTA: El guión significa que la cantidad es menor que uno, pero mayor que cero.

NOTA: El número entre paréntesis, significa la cantidad de unidades de salud, que tienen anti-
conceptivos en existencia.

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T A B L A # 14

Unidades de Salud Seleccionados por
Número de días requeridos para pro-
cesar pedidos por destinación de los
Suministros

1. Pedido - Recibo

<u>D E S T I N O</u>	No. de días Promedio	rango	Unidades de salud		
			D I A S		
			< 10	10 - 20	> 20
Bodega del área	14.0	6-34	3	4	2
Centro/puestos	19.1	7-37	2	7	6

2. Pedido - Envío

<u>D E S T I N O</u>	No. de días Promedio	rango	Unidades de Salud		
			D I A S		
			< 5	5 - 10	> 10
Bodega del área	5.2.	0-12	4	3	2
Centro/puestos	6.5	0-20	5	8	2

3. Envío - Recibo

<u>D E S T I N O</u>	No. de días Promedio	Rango	Unidades de Salud		
			D I A S		
			< 10	10 - 20	> 20
Bodega del área	9.2	3-23	7	1	1
Centro/Puestos	12.5	2-35	9	4	1

NOTA:

Datos tomados del archivo del PDD y No de la encuesta.

T A B L A # 15

Número Promedio de Usuarías Activas, Admisio-
nes por mes, ciclos de pastillas entregados durante
los últimos 6 meses y promedio de pastillas en existencia
y meses promedio de pastillas disponibles por tipo de uni-
dad de Suministros. Guatemala, Marzo-abril 1978

<u>Tipo de Unidad y Fuente de Su- ministros</u>	<u>No. Prome- dio de U- suarías - Activas</u>	<u>No. Prome- dio de Ad- misiones por mes</u>	<u>Promedio de Ciclos ent- gados durante los últimos 6/m</u>	<u>Promedio de pasti- las en exi- tencia.</u>	<u>Meses pro- medio de pastillas disponibles</u>
1. <u>PDD</u>					
Centros	216	14.5	125	1281	10
Puestos	25	2.1	16	287	18
2. <u>AREA</u>					
Centros	22	2.3	58	375	7
Puestos	8	0.6	7	57	8
3. <u>TOTAL</u>					
Centros	105	5.7	97	828	9
Puestos	16	1.4	12	186	15
4. <u>TOTAL</u>					
PDD	66	4.5	56	618	11
Area	12	1.3	25	181	7
5. <u>GRAN TOTAL</u>	38	2.7	43	416	10

NOTA: Este nota incluye datos solo de las unidades de salud, que informaron.

T A B L A # 16

Porcentaje de los informes mensuales
debidos que fueron enviados por las unida-
des de Salud e APROFAM

-- Guatemala, (Julio/77- febrero/78)
Guatemala, Marzo-Abril 1978

Tipo de Unidad y <u>Fuente de Suministros</u>	<u>Porcentaje de Unidades de salud reportando</u>	
	<u>Julio/77 - Feb/78</u>	<u>Dic./77 - Feb/78</u>
1. <u>PDD</u>		
Centros	85.7	81.0
Puestos	71.6	71.8
2. <u>AREA</u>		
Centros	44.6	23.8
Puestos	59.5	53.3
4. <u>TOTAL</u>		
Centros	65.2	52.4
Puestos	66.0	63.8
4. <u>TOTAL</u>		
PDD	77.1	75.0
Area	53.1	41.2
5. <u>GRAN TOTAL</u>	65.7	59.5

T A B L A # 17

Anticonceptivos Entregados por APROFAM al Ministerio de Salud Pública

1971 - 1977

<u>Anticonceptivos</u>	<u>1971</u>	<u>1972</u>	<u>1973</u>	<u>1974</u>	<u>1975</u>	<u>1/1-5/31 1976</u>	<u>6/1-12/31 1976¹</u>	<u>1977</u>
Pastillas	122,587	161,260	114,605	265,472	275,977	129,138	172,905	298,588
Condomes	3,099	3,561	8,927	15,528	26,795	57,773	49,464	112,638
DIU	685	426	1,049	1,650	2,937	1,330	955	2,401
Tratamientos Vaginales ²	36	32	2	189	4,508	256	4,903	6,135
Depo-Provera ³	3,216	2,062	3,050	4,897	3,250	1,240	2,415	7,990
C-file	-	-	-	-	729	146	157	-

NOTAS:

¹ Las fechas corresponden a los primeros 6 meses del PDD.

² Incluye cremas, espumas, jales y tabletas.

³ Número de dosis.

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EXHIBIT 1

INFORME SEPTIEMBRE

AREAS DE SALUD	Tot. Generado 40% 31/8-77	(-) Equipo Septiembre	40% Disponible 30/9-77	Cuenta Corriente 30/9-77
Jefatura Quetzaltenango	278.65	-	347.77	2,064.50
P.S. San Mateo	6.48	-	6.48	20.71
C.S. San Juan Ostuncalco	11.58	-	11.58	-
C.S. Palestina de Los Altos	-	-	-	35.00
C.S. Coatepeque	54.70	154.00	- 77.30	73.00
II Jefatura Sacatepéquez	470.70	-	655.24	1,698.18
II P.S. San Fco. Zapotitlán	-	-	-	247.50
C.S. Escuintla	114.77	-	114.77	788.55
C.S. Palín	57.22	-	57.22	3.15
P.S. Sipacate	17.78	-	22.65	27.05
C.S. Nueva Concepción	63.55	-	63.55	197.50
C.S. La Democracia	127.70	-	163.56	65.90
C.S. Sta. Lucía Cotzumalguapa	77.12	-	77.12	242.70
C.S. Tiquiate	113.25	-	145.25	627.65
P.S. Cerro Colorado	3.98	-	5.78	34.05
C.S. Puerto San José	144.77	-	144.77	831.90
P.S. Siquinalá	5.30	-	5.30	22.75
P.S. La Comera	3.75	-	6.27	32.25
P.S. Istapa	0.66	-	0.66	23.70
P.S. Los Angeles	0.36	-	2.14	16.25
P.S. Las Cruces	-	-	1.44	18.00
P.S. Texcuaco	-	-	0.40	20.60
P.S. Chontel	-	-	0.18	30.15
P.S. Obrero	-	-	-	37.60

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