



Memorandum

Date October 22, 1981

From Richard S. Monteith, M.P.H., Program Analyst, Program Evaluation Branch,
Family Planning Evaluation Division (FPED), Center for Health Promotion and
Education (CHPE)

Subject Foreign Trip Report (AID/RSSA): Honduras, 9/21-10/1/81--Evaluation of the
Asociación Hondurena de Planificación de Familia (AHPF) Community-Based
Distribution Program

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

SUMMARY

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SUMMARY

Performance of the Community-based Distribution Program since reorganization is mixed. While the number of distribution posts has increased by 59 percent from January to September, the number of active users served by the program decreased by 12 percent from the first quarter to the second quarter. Several factors account for the apparent decline in active users. Principal among these were the unavailability of program vehicles and funds to support field work for the first 4 months of the calendar year, and the failure of program personnel to follow program strategy in implementing the reorganized program. During my consultation, it was concluded that the original program strategy, with some changes, is both feasible and functional and will be implemented as planned.

Although the program just recently received a shipment of 252,000 cycles of Noriday oral contraceptives from Family Planning International Assistance (FPIA), low stock levels may quickly occur if certain conditions exist. Therefore, I recommend that 294,000 additional cycles be procured immediately for the program to meet current demand and fill the pipeline. NeoSampoon has been in short supply during the entire year. Approximately 5.5 million tablets would be required to meet estimated demand and to fill the pipeline.

Finally, I recommend that FPED consultants return to Honduras in January/February 1982 to evaluate the progress of the program.

I. PLACES, DATES, AND PURPOSE OF TRAVEL

Honduras, September 21-October 1, 1981, at the request of the Asociacion Hondurena de Planificacion de Familia (AHPF), USAID/Honduras, and AID/S&T/POP/FPSD, to evaluate the AHPF community-based distribution program. This consultation was provided by Richard S. Monteith, M.P.H., Program Evaluation Branch, Family Planning Evaluation Division (FPED), Center for Health Promotion and Education (CHPE), CDC. This travel was in accordance with the Resource Support Services Agreement (RSSA) between the Office of Population, AID, and FPED/CHPE/CDC.

II. PRINCIPAL CONTACTS

A. USAID/Honduras

1. Mr. John Massey, Director, Human Resources Division (HRD)

B. Asociacion Hondurena de Planificacion de Familia (AHPF)

1. Sr. Alejandro Flores, Executive Director
2. Sra. Gloria Mandragon, Director, Community-based Distribution Program (CBD)
3. Sra. Nelly Elizabeth Funez, Regional Supervisor, CBD
4. Sr. Roberto Flores, Regional Supervisor, CBD
5. Sr. Jose Nilo Lopez, Accountant

III. EVALUATION OF THE CBD PROGRAM

A. Program Performance

Program performance during the first 9 months of the calendar year is both encouraging and discouraging. On the one hand, the number of distribution posts increased from 437 in January to 693 in September, or an increase of 59 percent. On the other hand, despite this increase in distribution posts, the number of active users served by the program declined from 26,942 in the first quarter of the year to 23,762 in the second quarter (Table 1). This represents a 12 percent decrease in active users. As shown in Table 1, the greatest decrease in active users occurred in Region I. An increase rather than a decrease in active users was expected for Region III, since only a small number of posts were operational in this region before the program was reorganized, thus allowing more time for the mobile teams to establish new distribution posts.

Users of oral contraceptives account for almost all of the decline in active users (Table 2). However, the largest percentage decline in active users occurred among users of NeoSampoon. This is accounted for by the unavailability of this method during the first semester of the year.

The goal of the CBD program was to have 890 distribution posts operational by year's end and an active user population of 54,000 (see CDC Foreign Trip Report, Honduras, dated September 9, 1980); these goals may not be achievable. Several factors account for the apparent decline in active users from the first quarter to the second quarter. Vehicles purchased for the program did not become available until May (see CDC Foreign Trip Reports,

Honduras, dated April 6 and May 27, 1981). In addition, funds to support the travel costs of program personnel who could have used public transportation were also not available during the January-May period. Thus, existing distribution posts were not supervised or resupplied for 4 months and several distribution posts ran out of supplies, causing users and some distribution posts to drop out of the program.

A further explanation for the apparent decline in active users from the first quarter to the second quarter is that data for the second quarter for some distribution posts included only the months of May and June; the month of April was included in the first quarter's report. Thus, the number of active users for the first quarter were over-reported and subsequently under-reported for the second quarter. Even though this occurred, it is probably safe to say that there was no appreciable increase in active users from one quarter to another.

Although the delay in program implementation has been the major contributing factor to the slow growth of the program, other factors are also involved. These are discussed below.

B. Problems Observed

Failure to follow program strategy as originally planned and low stock levels of contraceptives were other major problems that I observed. Both resulted in the inefficient use of resources which, in turn, limited the amount of time available to the eight mobile teams to service existing distribution posts and to establish new ones. Examples of the failure to follow program strategy include:

1. Since May, the promoter/educators assigned to the mobile units have not worked independently of the administrators. Rather than working alone in communities promoting family planning, they basically have accompanied the administrators and, in some cases, acted as their "secretaries."
2. Some mobile teams have not worked their assigned routes efficiently. Rather than spending 5 days on the road servicing and establishing distribution posts, they return nightly to their homes. The result is increased gasoline consumption (gas costs \$2.07 per gallon) and lost time.
3. The mobile teams were required to submit reports on the status of each distributor they supervised to the central level. The plan was to report only aggregate data to higher administrative levels. The implication of this arrangement was that each administrative level would be responsible for the performance of the next lower administrative level. Submitting the reports mentioned above meant that less time was available to the teams to do field work.
4. With the reorganization of the CBD program, the control of the program was to become decentralized. Thus, the regional supervisors were to

become key individuals in managing and supervising the program in the field. Some of the supervisors did not recognize the scope of their work or exercise the authority and responsibility delegated to them; problems which should have been identified and resolved quickly were not.

5. Rotating funds established in each region to cover petty cash expenses, e.g., gasoline purchases, payment of per diem, and to give regional supervisors flexibility in managing their regions, proved to be too small. In addition, the funds were not replenished until 75 percent of the money in the fund was exhausted. Therefore, in some instances field work was halted because of lack of sufficient funds.

Low stock levels of contraceptive supplies also resulted in low program efficiency. Because of low stock levels, distribution posts were not issued a 4 months supply of each contraceptive type. Similarly, the mobile team and regional warehouses were not stocked with a 6-month supply. Thus, the mobile teams were required to visit their respective distribution posts monthly rather than quarterly, as planned. This resulted in increased gasoline consumption and a decrease in time to establish new distribution posts.

A shipment of 921,000 cycles of Noriday 1+50 and 252,000 cycles of Norminest donated by FPIA, which was scheduled to arrive in Honduras by sea on August 30, finally arrived on October 2. Mr. Steven Orr, FPIA, Miami, informed me in a telephone conversation on October 7, however, that all of the Norminest and 252,000 cycles of Noriday are consigned to the CBD program. Thus, the critical supply situation for the CBD program as far as orals are concerned is momentarily relieved. The balance of the Noriday shipment, or 669,000 cycles, is consigned to the yet-to-be implemented Commercial Retail Sales (CRS) program.

The supply situation with regard to orals, condoms, NeoSampoon, and contraceptive requirements for CY 1982 are discussed in Section IV of this report.

C. Reporting

During the evaluation, I encountered problems in the reporting of logistics data. Essentially, the mobile teams and the regional supervisors were not submitting separate reports on their respective supply status. These administrative levels were including their supply data in the aggregate reports, which makes it difficult to assess the supply status at each of these levels.

I also found that the administrators of the mobile teams lose valuable time in collecting data at distribution post level. The preparation of reports at this level is essentially done by the administrator without the participation of the distributors. The majority of the distributors are literate and intelligent and thus, capable in counting the number of users served and contraceptives dispensed during a reporting period. In addition most, if not all, are capable of keeping their tickler files up to date. If the distributors were allowed to perform these minor tasks and the administrators spot-checked their work, the amount of time an administrator spends at a given distribution post could be cut in half.

Quarterly reporting of user and supply data is almost 4 months behind because the mobile teams and urban promoters are not always taking advantage of their visits to the distribution posts to collect data and to resupply the posts. In other words, data for a given quarter are collected after the end of the quarter. If this policy continues, reports will always be late. I recommend that data be collected from posts once every 3 months. The 3-month period does not have to correspond to the standard 3-month quarter. Thus, over time each distribution post will have its own "quarter." If this recommendation is adopted, fluctuations will be observed in reported data from one quarter to another, e.g., the fourth quarter report for 1981 will show a decline in active users, but the report for the first quarter of 1982 will show an increase. Eventually, the fluctuations in the curve will flatten out.

D. Strategies to Establish New Posts

The rural population of Honduras is dispersed and, in some cases, inaccessible by road. Thus, there are not very many villages of substantial size (250 or more population) where it would be reasonable to establish distribution posts. CBD program officials recognize this fact and the fact that new strategies need to be developed to penetrate further into rural areas.

We discussed several alternatives, some of which are already being implemented in some areas. They include:

1. Existing distributors select "satisfied users" that live in remote villages to act as distributors. The existing distributors would be responsible to periodically supervise and to resupply the distributors living in the remote villages.
2. Distributors and promoters/educators attend MCH sessions conducted in MOH facilities to select women who live in remote areas to be distributors.
3. The CBD program coordinates with local MOH facilities to resupply MOH family planning users when it is more convenient for the user to do so.
4. Establish distribution posts in small stores that service dispersed rural populations. In addition, the storekeeper/distributor select women or men living in remote villages to act as distributors.

The CBD personnel who have begun to experiment with these alternatives are to be commended. However, additional efforts to serve remote populations need to be done.

E. Conclusions and Recommendations

Intensive meetings were held with CBD officials during my consultation. During these meetings, we concluded that the original program strategy is feasible and functional and could be implemented with a few modifications. Program officials also recognize that problems exist and understand that they need to be resolved for the program to succeed.

The changes made in program strategy were:

1. The three regional educator positions were eliminated, and a Central Educator position was developed.
2. The promoters/educators will be assigned to live and work for up to 60 days in towns not currently covered by urban promoters. In addition to establishing and supervising distribution posts in these towns, the educators will be responsible for establishing posts in nearby villages. After their work is completed in their assigned towns, they will move to other towns and repeat the process.
3. The counterpart administrator will assume the responsibility to resupply and supervise the posts that were created.

Agreement was also reached on the following items, most of which were included as part of the original program strategy.

1. The word "Distribuidos" will be added to Form DC2 to facilitate reporting of contraceptives issued by the administrators/educators to distributors.
2. Administrators, educators, and supervisors will submit two quarterly reports, as originally planned. One report will be on the contraceptive sales and/or supply status of the distributor or administrators/educators they supervise. The second report will be on their own supply status.
3. Distributors will be required to participate in the preparation of quarterly reports.
4. Distributors will be required to maintain their own tickler files.
5. Inventory Control Cards will be used at all levels.
6. Stock levels will be maintained at a maximum level of 4-months supply at distribution posts and 6-months supply at administrator/educator and regional levels.
7. Supply transactions, e.g., receipts and issues, will be recorded for the month in which they occur.
8. Data collection will occur at least once over a 3-month period rather than after the end of a calendar quarter. The 3-month period does not have to correspond to a standard calendar quarter.
9. The regional rotating funds should be increased to at least U.S.\$1,500, and the replenishment level should be reduced to 50 percent of funds on hand.
10. Regional supervisors will be more active in assisting their staff in programming their work and routes and in identifying unserved populations.

11. Educators who will be assigned to towns will dedicate the majority of their time to promoting family planning in unserved communities and in establishing new posts.
12. Number of posts served by administrators, educators, and supervisors will be routinely reported.
13. Supply imbalances at all program levels will be identified and corrected.
14. The number of posts served by administrators will be studied to correct imbalances and to more equitably distribute the workload. In addition, the workload between regions should also be studied.
15. When possible, public transportation should be used to transport contraceptive supplies from central to regional warehouses.
16. Equipment for program vehicles such as 25 gallon gas tanks, roof carriers, canvas covers, and "bush" tires should be purchased immediately. Funds are available in the current budget for this equipment.

To assist CBD program officials in organizing and improving field supervision, I recommend that USAID finance a 2 to 3 week consultancy by Sr. Rolando Sanchez. Sr. Sanchez, the Director of APROFAM's Direct Distribution Program in Guatemala, was successful in resupplying contraceptives to over 600 Guatemala MOH facilities with a field staff of four. Finally, I recommend that FPED/CHPE consultants return to Honduras in the first quarter of CY 1982 to monitor the progress of the CBD program and implementation of these recommendations.

IV. LOGISTICS

As mentioned earlier in this report, the supply situation for the CBD program became increasingly critical as the year passed, which affected the efficiency of the program. This was because a shipment of oral contraceptives scheduled to arrive in late August did not arrive until early October (actually, it should have been scheduled to arrive in June), and efforts to negotiate a "loan" of contraceptives from the MOH were unsuccessful.

The shipment included 252,000 cycles of Noriday 1+50 and 252,000 cycles of Norminest for the CBD program. An additional 669,000 cycles of Noriday was also received, but these contraceptives are consigned to the CRS program. The Noriday oral contraceptives consigned to the CBD program represent a 1-year's supply based on sales of this method during the first 6 months of 1981. Similarly, the 252,000 cycles of Norminest represent a 6-year's supply.

The CBD program will quickly experience low stock levels of Noriday if:

1. the number of active users of this method increases as expected;

2. all administrative levels of the program are stocked according to program policy;
3. current users of Noriday are reluctant or should not be switched to Norminest;
4. new oral contraceptive users prefer to use Noriday or should be prescribed Noriday rather than Norminest;
5. the CBD program cannot borrow from the Noriday stock consigned to the CRS program, and
6. a "loan" of Noriday cannot be negotiated with the MOH.

Medical epidemiologists contacted here at CDC and at AID/POP/W advise that current users of Noriday, who are happy with the method and who are not experiencing side effects, should continue with Noriday and not be switched to Norminest. They also advise that new users of oral contraceptives should begin with Noriday. Experience in Sri Lanka where Noriday was compared with Norminest shows better continuation rates and fewer pregnancies among women using Noriday. One of the major causes of pregnancy among new pill users is forgetfulness in taking their pills. When this occurs, Noriday--because of its higher dosage--provides better protection against pregnancy than Norminest.

Programmatic considerations also need to be taken into account. Although the majority of the distributors are literate, it is likely they would be confused with lengthy and complex instructions on when to prescribe one method over another. A less complicated program policy would be one that provides (1) for current users of Noriday who are not experiencing problems to continue with the method, (2) for all new users of orals to be prescribed Noriday, and (3) for women who experience problems with Noriday to be switched to Norminest.

Thus, Noriday should be the principal oral contraceptive of the CBD program. Based on current consumption rates of Noriday and the median between maximum and minimum stock levels established for all levels of the program, at least 420,000 cycles will be required to meet current demand and to fill the pipeline for the next 12 months. Thus, an additional 168,000 cycles of Noriday will be required. Of course, the program is expected to grow over the next 12 months during which new posts will be established and stocked. This will also effect the size of maximum and minimum stock levels maintained by administrative levels of the program. Therefore, I estimate that at least 546,000 cycles will be required to meet demand and to fill the pipeline over the next 12 months, or an additional 294,000 cycles.

NeoSampoon has been in short supply during the entire year. As of September 4, a zero balance on hand was recorded in the AHPF central warehouse. NeoSampoon is popular in Honduras, and the CBD program has demonstrated its popularity through sales. Currently, a shipment of 253,440 tablets for the program are being cleared through customs. This amount represents 2,112 Couple-Years of Protection. Prevalence figures on the use of NeoSampoon are currently not available. Even if they were available, they would not reflect actual demand, since NeoSampoon has never enjoyed the luxury of full supply.

Given a prevalence of 3 percent, a population of 725,000 women of fertile age (15-44), and a consumption rate of 120 tablets per year per couple, 2,707,200 tablets would be required just to meet demand. I feel that a 3 percent prevalence rate is realistic for Honduras, and recommend that twice the above quantity of NeoSampoon be procured for the program for the coming calendar year to determine real demand under conditions of full supply.

There is no apparent shortage of condoms for the CBD program. Currently, AHPF has 194,708 units on hand or approximately 7 year's supply, based on 1981 consumption rates.

V. FISCAL YEAR 1982 COMMUNITY-BASED DISTRIBUTION BUDGET

Mr. John Massey asked me to advise on a budget for the CBD program for the period November 1981-October 1982. The new budget calls for an AID contribution of U.S.\$376,411, or U.S.\$63,589 less than what was budgeted for the current program year, which is only 10 months in duration. If the cost of program vehicles is subtracted from this year's budget, next year's budget represents only a 3 percent increase. USAID should negotiate certain line items with AHPF, e.g., administrative costs, and require that some of the profits from the sale of contraceptives be used to cover program costs.



Richard S. Monteith, M.P.H.

TABLE 1

Number of Active Users, by Quarter and Region
AHPF Community-based Distribution Program
January-June 1981

<u>Quarter</u>	<u>Program</u>	<u>Region</u>		
		<u>I</u>	<u>II</u>	<u>III</u>
First	26,942	15,621	9,746	1,575
Second	23,762	13,185	9,012	1,565
Percent Change	-11.8	-15.6	-7.5	-0.6

TABLE 2

Percent Change in Active Users From First Quarter to
Second Quarter, by Method and Region,
AHPF Community-based Distribution Program
January-June 1981

<u>Method</u>	<u>Program</u>	<u>Region</u>		
		<u>I</u>	<u>II</u>	<u>III</u>
Orals	-11.6	-15.5	- 6.9	- 1.2
Condoms	- 8.9	-15.1	-12.7	+41.7
NeoSampoo	-37.2	-10.8	-53.2	-73.7
Foam, Cream	- 3.9	-50.6	+48.5	+40.0