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Subject Foreign Trip Report (AID/RSSA) - Brazil, August 29, 1981 to September 16, 1981

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Director, Centers for Disease Control
Through: Horace G. Ogden, Director, CHPE *HGO*

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SUMMARY

BEMFAM's community-based distribution program (CBD) has achieved considerable success during its 6 years of operation in Pernambuco. The 1980 MCH/Family Planning Survey demonstrated a prevalence of contraceptive use of 7.5 percent of married women using the CBD program--a respectable achievement, especially since the CBD program offered only oral contraceptives at that time. Essentially, the initiation phase of the program has been completed, and the program is solidly entrenched in the state. We feel that the program is in transition from the initiation phase to a maintenance phase and that BEMFAM should consider a restructured program for this new phase. We recommend that BEMFAM and Pathfinder consider reducing program staff at the state level,

resupplying posts on a quarterly basis, performing selective supervision, eliminating stipends for municipal physicians, and creating a program to train and supply private and public sector physicians.

In Alagoas the CBD program is being integrated into the State Health Department. The integration of the CBD program should be considered an important accomplishment of one of BEMFAM's goals. This integration should be closely monitored as a means of developing a model for integration in other states. However, this integration is part of an overall reform of the Health Department and is far from completed.

We feel that BEMFAM should define its objectives for integration, keeping in mind the long range role of BEMFAM in Alagoas. We suggest that BEMFAM consider community education, the training of public and private physicians, and technical assistance to the Health Department as part of its future, independent role in Alagoas. We feel that the Department does not have the resources to absorb these functions at this time. BEMFAM and the Health Department should also define a specific written plan for integration, including a timetable.

Logistics has been one of the CBD program's strong points. BEMFAM should monitor carefully the Health Department's logistics performance. If necessary, a consultation by an outside group such as CDC may be necessary to improve the Department's logistics capability. Additional recommendations for both Alagoas and Pernambuco appear on pages 18-20 of the report (Section VI).

I. PLACES, DATES, AND PURPOSE OF TRAVEL

Rio de Janeiro, August 29-30 and September 12-16, 1981; Recife, September 1-7, 1981; Maceio, September 8-10, 1981; and Salvador, September 11, 1981, at the request of USAID/Brazil, and AID/POP/FPSD, and AID/POP/LA to: 1) provide technical assistance to the Sociedade Civil Bem-Estar Familiar de Brasil (BEMFAM), the IPPF affiliate, and the Pathfinder Fund in evaluating the community-based distribution programs in Alagoas and Pernambuco States. Travel was performed in accordance with the Resource Support Services Agreement (RSSA) between the Office of Population/AID/Washington and CDC/CHPE/FPED.

II. PRINCIPAL CONTACTS (See Appendix A.)

III. INTRODUCTION

Since 1978, the Pathfinder Fund has financed community based distribution (CBD) programs in the states of Pernambuco and Alagoas. These programs are directed by the Sociedade Civil Bem Estar Familiar no Brasil (BEMFAM), the IPPF affiliate, in collaboration with the State Health Department. Prior to negotiating the renewal of this grant for calendar year 1982, Pathfinder requested an evaluation of the project to determine future needs of the program and whether the program is operating as efficiently as possible. The evaluation team included Mark Oberle of FPED/CDC and Maria de Tanco, a Pathfinder consultant, in coordination with Dr. Jose de Codes, the Pathfinder country representative in Brazil.

Although Pathfinder's funding of the project began in 1978, BEMFAM's CBD programs in these states actually began in 1975*. Until 1980, the program included oral contraceptives only. Starting in 1980, the CBD program began to offer condoms, Emko and NeoSampoon in addition to orals. All contraceptives are distributed free of charge. Both states have a coordinating headquarters staffed by a state coordinator, an education adviser, a communication adviser, an evaluation adviser, and various aides and administrative staff. A team of field supervisors provides monthly supervision to distributors, all of whom are either volunteers or paid by municipal governments, unions, or private organizations other than BEMFAM. In addition, volunteer educators promote family planning through lectures, fairs, and other activities. We will describe each of these job categories in separate sections.

Our overall impression of the CBD program in these states is quite positive. Family planning is widely accepted and supported by community leaders: mayors, legislators, union leaders. The 1980 Pernambuco Family Planning/MCH survey demonstrates a reasonable level of contraceptive use: 41 percent of women in union in Pernambuco were using a family planning method, and 22 percent of married women have used the CBD program at some time**. As of July 1980, the CBD program provided services for 7.5 percent of married women in the state. All of these women were using orals. Of all users of oral contraceptives, 59 percent obtained their contraceptives from the CBD program--86 percent in the rural areas of the state.

Because the program offered only orals, by 1980 some 5.5 percent of women in union, or one-fourth of all program clients, had dropped out of the CBD program but were using methods from other sources. Of these program dropouts, 44 percent have had surgical sterilization, a method not offered by the program. In addition, 8.8 percent of married women have used the program in the past but are no longer contracepting. Of these women, 58 percent are not using contraceptives because they desire pregnancy, are subfecund, or are not sexually active. About half of the remaining 42 percent specified pill side-effects as their reason for discontinuation.

*Gorosh M., John Ross, Walter Rodrigues, and Jose Maria Arruda. 1979. Community-based distribution in Rio Grande do Norte, Brazil--a case study of a CBD program. International Family Planning Perspectives 5(4):150.
Rodrigues Walter. 1979. Family planning--A basic and essential activity in maternal-child health programs. Sociedade Civil Bem-Estar Familiar no Brasil. Rio de Janeiro, Brasil.

**Rodrigues Walter, Jose Maria Arruda, Leo Morris, and Barbara Janowitz. 1981. Pesquisa Sobre Saude Materno-Infantil e Planejamento Familiar No Estado do Pernambuco. Sociedade Civil Bem-Estar Familiar no Brasil e Faculdade de Medicina, UFPE (Relatorio Preliminar).

In 1978 and 1979 both CBD programs reached a peak both in terms of new acceptors and active users (Tables 1 and 2). Both measures have subsequently declined, as have the number of cycles of oral contraceptives distributed (Table 3). Preliminary data from the first half of 1981 suggest that the program may achieve only half of its targeted distribution of 1,566,000 cycles of oral contraceptives. Program staff suggest that the reasons for the decline in new acceptors and active users include the previous lack of alternative methods, contributing to a low continuation rate, and frequent switches of oral contraceptive formulations because of procurement problems.

Follow-up of program drop outs has not proven to be productive. However, BEMFAM's administrator claims to have resolved the contraceptive procurement problem: orals can now be purchased locally, thus guaranteeing a regular flow of supplies. By August 1981, alternative methods became available at all distribution posts. It is still too early to measure the impact of these new methods on active user rates; data from the first regions to stock the methods is still quite preliminary (Table 4). However, the decline in new acceptor rates may have been reversed--Alagoas reported 24 percent fewer new acceptors in January 1981 than in January 1980 but June 1981 showed a 2.6 percent increase compared with June 1980 (Table 5). Using data from the 1980 contraceptive prevalence survey, it is estimated that 176,000 women who are non-users of contraception, were in need of family planning services in Pernambuco. Of these women, 50,000 are concentrated in Greater Recife. A comparison of service statistics with population data (Tables 6-7) suggests that coverage in the Recife area (Region I) could be improved, especially in lower socioeconomic areas. Because women in need of family planning services cannot be estimated by region within each state, we calculated the average number of women in union per distribution post as a crude measure of coverage. Most regions in both states contained a population of between 1,000 and 3,400 women in union per distribution post (Table 6). However, Region 1 (Recife) contains 8,896 women in union per distribution post, in part because of greater accessibility to private sources in Recife. Another way to look at coverage is the percentage of women in union reported as active in the CBD program. In Region 1, only 3.1 percent of women in union were using the program, whereas all other regions in both states reported a prevalence of 5.3 to 15.8 percent of women in union. The CPS estimated 50,000 women in need of services in Recife, primarily in poor neighborhoods. The Pernambuco program plans to open 40 new posts in the Recife Metropolitan area by the end of this year. By year's end Pernambuco will have approximately 380 posts, the first major increase in posts since 1979.

The number of posts to be opened in Alagoas is not clear at the present time. BEMFAM is in the process of transferring responsibility for supervision and administration of distribution posts to the State Department of Health. Contraceptives in four of the five regions of the state will be distributed only through government health facilities. In these regions the non-medical distribution posts will be closed, and state medical units not currently included under BEMFAM's CBD program will be supplied with contraceptives. BEMFAM's Alagoas coordinator estimates that 290 state health facilities will ultimately provide contraceptive services, but the timetable for this integration is still vague. A casualty in this integration will be communities currently served by non-medical posts but lacking a state medical facility.

In brief, both programs reached a peak in active users and new clients in 1978-79. Several changes in the program will probably improve performance: reliable procurement of contraceptives, an increase in distribution posts, and the availability of three barrier methods as alternatives to oral contraceptives. However, it is too early to judge the results of these changes because all three have occurred in the second half of 1981. We believe that the program has passed its initial stage of development and some changes in program structure may be appropriate now that the program has matured.

IV. PERNAMBUCO

A. Distribution Posts.

The distribution posts in Pernambuco which we had the opportunity to visit had a considerable number of new and subsequent users. The distributors were well organized and the majority were highly motivated toward their work. Although there are advantages to locating distribution posts in well-known community locations backed by community organizations, in order to have the confidence of the community, one of the most successful posts which we visited was in the home of a distributor, who happened to be a community leader. The number of posts has increased from 54 in 1975 to 342 in June 1981. There were an average of 208 active users per distribution post. This average varies by region. Recife is the region with the least program coverage and the greatest number of women in union per post. Region IX has the least number of women in union per post but the greatest program coverage. However, the suggestion of an inverse correlation between program coverage and the number of women per post is not borne out in closer analysis ($r_s=0.299$). By year's end BEMFAM expects to open 40 additional posts. These new posts will be concentrated in lower socioeconomic areas of Recife.

PERNAMBUCO

B. Logistics

The logistics system in Pernambuco is one of the CBD program's strong points. Supplies are shipped from Rio to the Recife warehouse on a monthly basis. The warehouseman sends supplies to each of the regional supervisors by bus, or else the supervisors themselves pick up needed supplies on a monthly basis. Supervisors resupply distributors monthly, with the aim of maintaining a 3-month reserve. New clients receive one cycle of orals, one can of Emko, one tube of NeoSampoon, or 12 condoms. At 3-month intervals subsequent clients receive 3 cycles of orals, 2 tubes of NeoSampoon, 2 cans of Emko, or 36 condoms.

Until one year ago, the CBD program offered only orals. Alternate (barrier) methods were introduced in three regions of the state late last year, and throughout the state at all distribution posts as of August 1981.

The chief logistics problems for BEMFAM have been the government's general restrictions on importation of foreign commodities and donor restrictions on local procurement. Logistics problems became acute in the second and third quarters of this year, when supplies of orals ran dangerously low. In

July/August, only 1.5 months' supply of orals (99,206 cycles) were available in the state and regional warehouses. However, the Pernambuco program reacted appropriately--it limited resupply clients to one cycle of orals rather than three. Of the ten distribution posts we visited, all had at least some oral contraceptives. Only one was out of stock of NeoSampoon and condoms, but, in fact, the distributor at this post had been particularly successful. She had just received her first shipment of barrier methods and ran out the day of our visit. Without prior data on usage rates for the barrier methods, it would be difficult to avoid occasional problems such as this. However, the distributor had not contacted her supervisor to request an emergency resupply.

Although usage rates for alternate methods are not yet available, the state and regional warehouses had on hand 168,000 condoms, 2,287 tubes of NeoSampoon, and 1,639 cans of Emko. Judging from the popularity of NeoSampoon reported by distributors, BEMFAM should monitor the drawdown of NeoSampoon stocks with extra care to avoid possible statewide shortages.

The procurement picture overall has improved. According to BEMFAM's administrator in Rio, they can now purchase orals locally as needed. BEMFAM will also be able to import barrier methods through Rio Grande do Norte's state government. Limited supplies of NeoSampoon available from donor agencies may still restrict availability of vaginal suppositories.*

BEMFAM's current strategy of resupplying distributors on a monthly basis is quite appropriate for the initiation phase of a program. During the maintenance phase of the program, we believe that logistics can be handled more efficiently on a quarterly basis, by two persons in two vehicles. These two persons could resupply distributors and pick up service statistics, thus freeing supervisors for other tasks described below.

C. Medical Sector

The 1981 Pathfinder grant includes funds for one state medical supervisor and eight regional medical supervisors. In theory, 152 municipal physicians receive a stipend of Cr\$ 3,000 (about U.S. \$27) per month to attend patients with complications or contraindications. In fact, many of these municipal physician stipends were not actually utilized in 1980. Nevertheless, the system has received some criticism because very few patients require a physician referral--1,280 clients in all of 1980. Unlike the state medical supervisor, the regional medical supervisors do very little supervising. These are, in part, political jobs, related to private physician support for the program, but it is apparently not possible to terminate these jobs at the

*Two anecdotes on NeoSampoon are worth mentioning here. Several distributors claimed that clients prefer NeoSampoon in tubes rather than plain foil packs. For future procurements of NeoSampoon, BEMFAM should evaluate the acceptability of the packaging. Distributors also reported frequent client complaints of burning sensation with NeoSampoon. The distributor's manual discusses this only as a possible side effect. The manual should instruct distributors to anticipate this by telling new clients that NeoSampoon often produces a feeling of warmth.

moment. We recommend that the regional medical supervisor posts currently vacant not be filled, and that the remaining positions be abolished by attrition. We also recommend that the municipal physician stipends be abolished. In place of these direct payments, we recommend that an organized program of continuing medical education be offered in the state. A systematic program of seminars, educational materials, and contraceptive supplies for both public and private sector physicians is a much more productive use of these funds than the current stipend system. We would like to suggest that the state medical supervisor as well as an administrative and medical officer from BEMFAM/Rio visit the private physician program in Colombia (SOMEFA), or some comparable project, to study the organization of such a program.

D. Evaluation

The program in Pernambuco has one of the most complete and accurate service statistics systems in any CBD program anywhere. Distributors fill out a three-part form for each new acceptor. Part A of the form remains with the distributor. Part B is forwarded to the state evaluation sector, and the client keeps Part C as an appointment and identification card. The distributor maintains a monthly list of subsequent visits, with each client's name, number, and the type and amount of contraceptives received. Supervisors collect the monthly list of subsequent visits and Part B of the new client form and hand these over to the state evaluation sector.

Each month the two people in Pernambuco's evaluation sector tabulate new and subsequent visits by distributor, region, and method. Some of these tabulations are unnecessary. For instance, for each distribution post, the evaluation sector has to add new and subsequent visits to obtain a total number of visits by method for each month (Controle do movimento III, Total de atendimento). Calculation of total visits by post does not add anything to the basic information needed. Supervisors can just as easily review the monthly trends of new and subsequent visits independently.

Tabulations of commodities also include unnecessary information. For each distributor, region and state, contraceptives distributed are divided into new and subsequent clients ("Relatorio tecnico mensal," and "unidade por metodos V"). This commodity information can then be checked against the number of new and subsequent visits reported. Now that contraceptive procurement is relatively assured and regular supplies should be available, it is unnecessary to require such precision. Instead, as a gross check, commodities actually distributed can be compared to the number expected on the basis of the count of users. In other words, for 1 month, the oral contraceptives distributed (based on inventory) should equal the number of new acceptors, plus three times the number of revisits by continuing users of orals.

The "B" part of the new user form is used for two purposes. The demographic characteristics of the new users are tabulated and forwarded to Rio. Subsequently, after every month, the evaluation sector must search the list of subsequent visits, and record visits made by any client in a 10 percent sample selected for follow-up. This compilation is designed for the calculation of continuation rates and requires many hours of work each month.

However, it is not clear whether this information has ever been utilized. More importantly, no one in the field was aware of any practical usefulness of this follow-up study. There has, at least, not been any feedback to the field of results. If BEMFAM wants to continue this follow-up, a smaller sample would require less work. If a larger sample is desired, the original information is always available as a sampling frame and can be compiled when it is clear that it will be utilized. An active dialogue between state coordinators, supervisors, and the national evaluation unit may further reduce paperwork currently involved in the CBD program. By reducing its work load it will be possible to limit the evaluation sector in Pernambuco to one person.

E. Supervision

Supervision should be considered in two stages. The first is supervision by the state coordinator to the regional field supervisors. The second stage of supervision is by the field supervisors to volunteer distributors and educators. Supervision of distribution posts by field supervisors is performed monthly covering for each post. During the visit, the supervisor collects service statistics: the new user cards and the list of clients seen for subsequent visits during the previous month. She also takes an inventory and resupplies the distributor with appropriate forms, educational pamphlets, and contraceptives. Finally, she visits the mayor, other authorities, the volunteer educators, and the municipal physician. From the physician she collects the monthly summary of patients seen for contraceptive complications and/or contraindications.

Currently, the program has 10 supervisors, a reduction from 14 earlier this year. The reduction in field supervisors has required a change in BEMFAM's regional divisions, a process which is still under development. On the average, each supervisor attends 16.4 municipios, and an average of 34.2 distribution posts (without counting the new posts to be established later this year).

The field supervisors also spend 3 working days each month attending a state-wide program meeting in the Recife headquarters. As a result of this monthly meeting, supervisors have only 16 work days in the field--an average of 2.2 distribution posts to be visited each work day. Because supervisors must travel by public transportation and must spend one to four hours of each distributor visit reviewing service statistics and taking inventory, the supervisors have little time left for other supervisory activities and promotion of family planning in the community. When we asked the three supervisors whom we met how much time they were able to spend in educational activities they replied that they were able to spend very little time on education.

Currently, the supervisor must carry an average of three boxes of oral contraceptives plus other contraceptive methods to each post, a voluminous load to carry on public transportation. Contraceptive supplies would weigh even more if the supervisor had to supply posts on a quarterly rather than a monthly basis. We feel that a supervisor should be relieved of the responsibility of resupplying distributors, and if possible the task of collecting service statistics. She could then dedicate herself to a brief supervision of each post, including discussion of the previous month's

service statistics. Additional time would be available to visit local authorities, coordinate information with local journalists, and work more effectively with community educators. This supervision should not be performed on a rigid monthly schedule, but rather selectively according to the requirements and problems of each distributor. On the average each supervisor could handle 30 municipios, visiting an average of 10 municipios each month. Dr. Jim Foreit, of Columbia University, is assisting BEMFAM in a trial of selective supervision in the state of Piaui. The lessons learned in this trial should prove of use in Pernambuco. The combination of selective supervision and a separate team of supply personnel, would make it possible to reduce the number of supervisors from 10 to approximately 8.

Currently the state coordinator supervises the field supervisors primarily at the monthly program (staff) meeting in Recife. In addition, the coordinator has programmed one visit per year to each supervisor in her region. During the general staff meeting in Recife, each sector (education, communications, evaluation) meets with each supervisor to review the previous month's activities. For example, the evaluation sector spends 2 hours with each supervisor reviewing exhaustively the file for each distribution post to assure the accuracy of the information and discuss secular trends. In addition, during the monthly meeting the supervisors discuss their experiences with each other, and in some cases receive retraining. This system has the advantage of permitting frequent exchanges of ideas and experiences, and the possibility of retraining. However, the monthly meetings take time away from other tasks, and, in fact, do not permit the personnel in the state office the opportunity to detect problems as they occur in the field. We feel that it would be preferable to have only four supervisory meetings per year which would allow the state coordinator and other office staff the opportunity to visit the field more frequently on a systematic basis. This schedule would permit the state office to observe the program in the field, utilize the supervisor's time more effectively, and permit the state coordinator more frequent contact with local community leaders.

Currently the supervision of the CBD program is excessively specialized. Supervision of education and communication activities could probably be combined into a single coordinated activity.

F. Communications

BEMFAM's CBD programs have two separate sections for education and communication managed by two different persons. In Pernambuco the communications sector is run by a woman with a degree in social communications. Her activities include three projects:

- (1) She writes a regular CBD program newspaper. Each state published a monthly newspaper printed on fine paper, and containing basically local program and political news and general information on family planning. Approximately 5,000 copies are distributed by the supervisors to program volunteers, authorities, leaders of various community groups, and physicians. The newspaper is designed to stimulate interest among persons who are collaborating with the program. Some \$6,817.00 was programmed for the newspaper in

Pernambuco in 1981. We think that BEMFAM should consider a national (or regional) newspaper produced in Rio de Janeiro on simple stationary with one page of local news for each state. This approach would lower the unit cost of printing, permit the interchange of ideas among states, and may provide even more prestige to the local news when covered by a national publication.

- (2) The communicator produces one-half of a weekly radio program. She prepares 15 minutes of local news and replies to questions (she receives approximately 30 letters monthly). Unfortunately, on most of the radio stations the program is broadcast between 6:00 and 6:30 a.m. on Sunday mornings. During visits to 10 distribution posts we asked distributors if they regularly listened to the program or recommend it to their clients. Generally, they do not.
- (3) The communicator also prepares press releases and answers questions from the press. In general, we did not detect much coordination between the field supervisor, the communications and education advisors, and the distributors and educators in the field. We feel that BEMFAM should consider integrating the communications and education sectors in order to target these activities to priority areas.

G. Education and Training

For BEMFAM, education is one of the more important aspects of the CBD program, and is carried out at several levels. First, the state coordinating office has an education advisor and an auxiliary who are in charge of training educators and supervising their activities. They currently conduct talks in factories and schools and prepare a "week of the family" event in various municipalities,. The education advisor had a difficult time explaining to us what the intended message of her educational program was. She had not reviewed the IE&C data from the CBD evaluation surveys conducted in four northeast states in 1980. BEMFAM has suggested a regional workshop for the coordinators, medical advisors, and advisors at the state level from the four states included in the Northeast CBD evaluation survey conducted in 1980 and Piaui in 1979 to learn how to interpret and apply the results of the surveys. Such a workshop may assist the education advisor in designing specific objectives for the education program.

The second level of educational activities is the field supervisor, but on average, her activities consist of only two planned talks per month. If the supervisor were not required to resupply distribution posts, she would have more time available for participation in educational activities.

Finally, at the community level the voluntary educator is the person in charge of educational activities. She has only five talks programmed per month and is supposed to make home visits, but does not have any specific goal for home visits. Since March, 127 educators have been trained or retrained in Pernambuco. Currently, 57 percent of the municipios have at least one educator, with coverage being similar in all 14 regions except Regions 1, 2, and 8. The activity level of the educators has dropped dramatically from 3.5 talks per educator in 1979 to 1.1 talks per educator in 1981 per month.

It is important for the education advisor to reassess the educational activities and develop a specific educational initiative aimed at the low-income community. In addition to information about the program, the educational activity should address the fears of contraception detected by the CBD evaluation/contraceptive prevalence survey. In addition, it is important to coordinate the activities of the volunteer educators, the radio program, and the field supervisors.

H. Personnel

As of September 1981, the Pernambuco CBD program employed 35 personnel, not including the 164 municipal physicians. Of these 35 employees, only 10 are field supervisors. Personnel costs constitute 70.7 percent of the budget; however, this percentage is somewhat misleading because the budget does not include the cost of contraceptives. In accordance with the recommendations discussed above, we would suggest the following minimum staff (29) remain in the CBD program:

- 1 Coordinator
- 1 Administrator
- 2 Advisors in education, communications and training
- 1 Evaluation auxiliary
- 8 Field supervisors
- 2 Field supervisors, for resupply visits
- 1 Medical supervisor
- 5 Regional medical supervisors (not to be replaced)
- 1 Secretary
- 2 Typists
- 2 Drivers
- 1 Warehouseman
- 1 Janitor
- 1 Office clerk

Pathfinder should require a rigorous justification of any additions to this minimum staff for the CBD program.

V. ALAGOAS

A. Integration Process

In January 1981, the State Secretary of Health decided to integrate BEMFAM's community-based distribution program into the Health Department. This integration is consistent with a general policy of eliminating categorical programs, and decentralizing decision-making from the State Office to the five health regions. As a consequence of the widespread reform of the Health Department, family planning will become a routine part of the MCH program.

The concept of integration is the result of a long process of negotiation between BEMFAM and the State Health Department. Initially, the Secretary of Health was not very favorable towards family planning. Although the Secretary has recently changed his position to favor family planning, other members of the Health Department still oppose distribution of oral contraceptives without physician supervision. Accordingly, the Health Department will require users

of oral contraception to be seen by a physician at every 3-month visit. In effect, this restricts health posts to the distribution of barrier methods. The Health Department is also opposed to the use of IUDs.

Many of BEMFAM's staff members in the state office coordination were assigned by the Secretary of Health, and some receive part of their salary from the Health Department. The State Coordinator is an employee of the Department of Health and receives part of his salary from BEMFAM. He is new to family planning and received practical training in family planning in Rio de Janeiro and Rio Grande do Norte. The BEMFAM Northeast Regional Coordinator also spent 2 months working jointly with him in Alagoas. Nevertheless, the State Coordinator claims that he has not received adequate training in family planning. He is, in fact, not highly motivated towards family planning and even less toward CBD. Despite his training, he does not feel capable of advising the Secretary of Health on family planning. Two other new persons in the program are the Medical Supervisor and the Communications Advisor, both of whom were selected by the Secretary of Health. BEMFAM's State Office is viewed by the Health Department as an anomaly within the new structure of the Department. With the exception of epidemiology, most other vertical programs do not maintain a separate office. The former program heads are now advisors in the Department's planning and evaluation unit. For the moment, BEMFAM state coordination is assuming that it will be abolished and its functions absorbed by the Health Department. Alternatively, however, BEMFAM may have an independent role as an advisor to the Health Department in community education and in the training and supplying of public and private physicians.

The following steps are planned in the integration of the family planning program. Meetings are planned in each of the regions to discuss the family planning program with a physician representing each health center. Supposedly after these meetings, each physician will return to his unit and inform the other staff members of the nature of the program. Although meetings have taken place, it appears that very little communication has gone on between physicians attending the meetings and the remainder of the staff of health centers.

Although a training program in contraceptive technology was planned for the medical staff, BEMFAM was unable to provide resources for this training program. However, BEMFAM's Acting Director told us that some year-end funds may be available for this training. In addition, BEMFAM supervisors continue to provide on the job training for state regional supervisors.

When BEMFAM distribution posts are passed to the Department of Health, household posts will be closed, and the patients' records transferred to the nearest Health Department facility. The BEMFAM evaluation system will be integrated into the Secretary of Health's overall information system. This step is planned for the month of October. Integration of the logistics system is still only partial. BEMFAM maintains a separate warehouse for contraceptives in Maceio, and Health Department vehicles transport supplies from Maceio to the regional warehouses.

Although these steps in integration have been outlined, there is currently no time table for implementing the integration. BEMFAM reports that the Secretary of Health had originally agreed to complete integration by the first quarter of 1982.

B. Distribution Posts

The Secretary of Health in Alagoas plans to incorporate family planning into essentially all units of the health system--health posts, health centers, mixed units, and regional hospitals. However, health posts, which do not have physicians, will only be able to distribute barrier methods. The BEMFAM State Coordinator told us that the Health Department has 295 units of which approximately 290 will contain family planning eventually. As of September, only 98 Health Department units had family planning health activities (34 percent).

The Health Department only provides services in four of the five regions of Alagoas, the remaining region being under the control of a federal agency known as Special Public Health Service (FSESP). BEMFAM will continue to work in the FSESP region using the same approach as in Pernambuco, except that 25 municipal physicians will still be paid 3,000 cruzeiros per month to consult on patients with contraceptive complications and contraindications.

C. Logistics

Contraceptives for Alagoas are shipped monthly from Rio to BEMFAM's Maceio warehouse. The four regions covered by the Health Department pick up supplies and carry them to the department's warehouses. State supervisors then resupply distributors. The only logistics role for BEMFAM under integration is maintaining the central warehouse and resupplying the FSESP region (essentially Region III).

The performance of the logistics system in Alagoas has been poor, but we lacked the time to pinpoint its problems. As of August, all distribution posts had received alternate methods of contraception. However, the state-wide shortage of orals reached its nadir in August. Despite rationing, 3 out of 15 distribution posts whose records we examined were out of stock of oral contraceptives at the end of August. During the week of our visit, a shipment from Rio remedied the pill shortage, but only at the central level. No orals were yet available at the one regional warehouse we visited, and stocks of other methods were low (68 cans of Emko, 600 condoms, and the equivalent of 145 tubes of NeoSampoon).

At the distributor level, we visited six posts. Orals were available in all of them; but two posts lacked Emko and one post had run out of both Emko and condoms. The shortage of orals may be attributed to the nationwide procurement problem, and the shortage of Emko and condoms to the recent introduction of alternate methods. However, although the region we visited reportedly had the best team of state supervisors, the supervisors did not have a clear methodology for resupplying posts. The state supervisors claim to leave a "reserve" at every post but do not have an established reserve goal. As part of training for State supervisors, BEMFAM should teach

supervisors to calculate contraceptive requirements, with the aim of maintaining a 3-month reserve in each post. Supervisors should also be instructed to have distributors contact them for emergency supplies if stocks get low.

The usefulness of BEMFAM's separate contraceptive warehouse in Alagoas is doubtful. The state health department claims that adequate warehouse space is available, but the department might request BEMFAM to pay for an additional warehouseman to handle contraceptives. We feel that the BEMFAM warehouse could be integrated with the state warehouse now, and the current warehouseman's job eliminated. Contraceptives could be shipped directly from Rio to the state warehouse. The FSESP municipios (Region III) could be supplied either from the state warehouse, or from Recife. The BEMFAM state coordinator could check on the state and regional warehouses periodically to assure adequate stocks and timely shipments. The only situation justifying a separate BEMFAM warehouse would be a large distribution program to private physicians. If such a distribution program were implemented, it may be difficult for a state warehouse to supply private physicians, or for Recife to provide timely shipments.

In summary, although current shortages of commodities in Alagoas may be attributable to forces beyond local control, BEMFAM must work closely in training state supervisors if adequate supplies are to be maintained. In addition, we feel that the BEMFAM warehouse in Maceio is currently not necessary. Each of the five regions in Alagoas is semi-independent, and we were able to visit only one of the regional headquarters. Thus we could not determine the extent of the logistics problem. A more thorough evaluation of the logistics problem by CDC or a similar agency would be helpful to assist the State Health Department in this aspect of integration.

D. Medical Sector

Alagoas has a part time medical supervisor and no regional medical supervisors. During 1981, some 70 municipal physician positions were included in the program. With integration, the stipend system for municipal physicians is being eliminated, except for the 25 municipal physicians in the FSESP municipios (essentially Region III). The actual expenses for the stipends in 1982 will be less than \$15,000--only 40 percent of the 1980 expenditure of \$37,502 for stipends. At this time, BEMFAM personnel do not feel that it is politically possible to restrict the stipend program further. However, we would urge its termination at the earliest possible time.

Instead of direct payments to physicians, we suggest regular seminars and the distribution of educational and contraceptive materials, as we proposed for Pernambuco. This activity should be organized in a systematic program for physicians in both the public and private sectors.

Unfortunately, BEMFAM's state medical supervisor is a part-time employee with major clinical responsibilities in a maternity hospital. Her hours are not flexible enough to permit the extensive travel that might be required in an expanded medical program. If a physician training and supply program is begun, an additional full or part time physician may be required.

E. Evaluation

Currently, Alagoas' evaluation sector operates in much the same way as Pernambuco's. Starting in October, the Health Department will combine information systems from all categorial programs into a single information system operated by the state. Only total counts of new and subsequent family planning visits by method will be available. Although the Superintendent of Health suggested that BEMFAM pay personnel expenses to help analyze data, the actual expense of tabulating the data is small. We would not recommend supporting such a position.

An alternative role for BEMFAM's evaluation unit might be to sample records in health facilities to obtain continuation rates and characteristics of new acceptors. However, the Superintendent of Health has insisted that family planning will now be one of many routine services. Unless the Health Department indicates that some operational decision would be made on the basis of this information, we would not recommend continuing full-time evaluation personnel in Alagoas.

F. Supervision

Supervision of family planning activities will become the responsibility of the State Health Department (SHD) supervisors in each of the four health regions controlled by the Department. These supervisors have received a short practical course in public health, and are traveling with the current BEMFAM supervisors to supervise jointly the CBD distributors and to learn BEMFAM's supervision process. In fact, much of the family planning supervision is still being carried out by BEMFAM personnel. One reason for this is that the SHD supervisors have their hands full with supervision of other program areas. Also, BEMFAM's statistics system is viewed as complicated, and the SHD supervisors do not feel any need to learn the system because it will be abandoned in October when the State's information system takes over from the BEMFAM system. Another possible explanation is that the physicians in the Department of Health have not been trained in contraceptive technology and thus are still not really involved in the program. Although we visited the best organized of the four health regions, the supervisors' basic knowledge of family planning was deficient. Nevertheless, the supervisors felt that they did not require any specific training in family planning.

Once the new information system is implemented, and the physicians and supervisors trained, the Health Department's regions will absorb the family planning program. The supervisors in the fourth region, which we visited, feel that they will be able to assume complete responsibility for the program by December. In Region III where FSESP operates, supervision can be provided by one supervisor who would only have 15 municipios and about 25 posts, substantially less than the average supervisory responsibility in Pernambuco at the moment. Ultimately this supervision could be provided on a selective basis.

Once integration is completed, it is unclear whether the SHD would be interested in having BEMFAM provide any sort of supervision in the field in the four regions under SHD control. However, we feel that each region could well require one BEMFAM supervisor to provide informal liason with the Department of Health and to supervise the voluntary educators.

As in Pernambuco, the State Coordinator is currently supervising the regional BEMFAM supervisors by means of monthly staff meetings in Maceio. The integration process will render these meeting of little use. We feel that instead of monthly meetings, the Coordinator should rely heavily on field visits, with the aim of not only supervising BEMFAM personnel, but also observing the process of integration, providing technical assistance to the State's regional supervisors, detecting problems, and collaborating with the regions in opening new health department posts. In fact, the Coordinator is not supervising the regions regularly. In the last 3 months his field trips were limited:

<u>June</u>			
2 days	Palmeira dos Indios	Region 2	
1 day	Arapiraca	Region 2	
1 day	União das Palmaras	Region 5	
<u>July</u>			
1 day	Penedo	Region 3	
2 days	Palmeira y Santana	Region 4	
<u>August</u>			
1 day	Penedo	Region 3	
6 days	Piaçabuçu	Region 3	

The reason for such infrequent field visits was that the Coordinator felt his field visits were unnecessary because not all health center physicians had received the training that had been planned (training had been postponed until year's end) and that family planning was not a priority for the Department of Health. Nevertheless, as our one brief visit to six health posts demonstrated, a field trip is extremely useful in detecting problems and drawing attention to the problems of family planning.

G. Communications

The communications advisor position in Alagoas is occupied by the Health Department's press officer. Although he is listed in the original budget as a full time BEMFAM employee he works only part time at BEMFAM. He claimed to be receiving a full time salary from each organization.

His activities are the same as the communications advisor in Pernambuco, except for press contacts. The radio program is scheduled for 7:00-7:30 a.m. on Saturdays in Maceio--a much more appropriate hour than in Recife. A listener survey performed for Maceio's radio stations by IBOPE (a public opinion marketing survey group) reported that 12.5 percent of households interviewed had listened to the program in June--more than any other program at that hour. Since the communicator began working for BEMFAM 4 months ago, the number of radio stations carrying BEMFAM's program in Alagoas increased from two to four.

Alagoas' newspaper is much less successful. The last issue was published in February. The communications advisor claimed that he had sent the March issue to Rio for approval and printing in June, but had still not received it. The role of the newspaper in an integrated official program should be evaluated carefully. A technical bulletin on contraceptive technology aimed at medical personnel and/or a national newspaper may be far more useful.

The radio program should continue as an activity of BEMFAM independent of the Health Department once integration is complete. However, BEMFAM will probably not require a full time employee for this activity.

H. Education

As in Pernambuco, the educational activities in Alagoas are carried out by three levels.

At the level of the state coordination, there is an education advisor, who, unfortunately was on vacation during our visit. However, the state coordinator told us that the education advisor is currently working on a plan for integrating general health education in Region I and is trying to coordinate several other institutions involved in health education in the community.

Second, the supervisors are providing health education talks, but as in Pernambuco, the supervisors have little time for this activity.

Third, the volunteer health educators are decreasingly active in Alagoas. The number of health educators as well as the number of talks have decreased. In January there were 51 educators, but in June there were only 23 active educators. Except for the month of June the average number of talks per educator has remained relatively constant, as seen in the following table.

<u>Month</u>	<u>No. of Educators</u>	<u>No. of Talks</u>	<u>Average No. of Talks/Educator</u>
January	51	117	2.3
February	51	114	2.3
March	34	77	2.2
April	33	73	2.2
May	27	65	2.4
June	23	45	1.9

It is very doubtful that family planning education will be absorbed by the Health Department, since the Department essentially has no health education activities. BEMFAM should continue in the future to utilize their voluntary health educators, but it is important to emphasize the importance of the field supervisors. Once the Health Department has absorbed the supervisory role of BEMFAM, the field supervisors will only have health education as a major responsibility except in Region III

I. Personnel

One of the objectives of BEMFAM in developing the integration of family planning services into the Health Department is to be able to reduce operational costs to a level which the Health Department can absorb. In Alagoas this objective of integration is about to be realized and the personnel of BEMFAM's state coordination can be reduced to a minimum team necessary to develop those BEMFAM activities to be continued after integration is completed in Alagoas. This minimum team would be:

1 Technical coordinator
1 Medical supervisor (or full time equivalent)
1 Education advisor
1 Secretary
4 Field supervisors
1 Quarter-half time accountant
Part time communications advisor for radio programs

It is important to emphasize that the timing of program reductions should be congruent with the integration process. BEMFAM, Pathfinder, and the Health Department will have to cooperate carefully to achieve a smooth transition.

VI. SUMMARY OF RECOMMENDATIONS

A. Pernambuco

BEMFAM's community-based distribution program (CBD) has achieved considerable success during its 6 years of operation in Pernambuco. The 1980 MCH/Family Planning survey demonstrated a prevalence of 7.5 percent of married women using the CBD program--a respectable achievement, especially since the CBD program offered only oral contraceptives at that time. Essentially, the initiation phase of the program has been completed, and the program is solidly entrenched in the state. We feel that the program is in transition from the initiation phase to a maintenance phase and that BEMFAM should consider a restructured program for this new phase. We would like to offer the following recommendations for consideration by BEMFAM and Pathfinder:

1. Logistics: BEMFAM should consider resupplying posts on a quarterly rather than a monthly basis. We suggest two drivers with two vehicles to distribute supplies and collect service statistics. This would free supervisors for other tasks described below.
2. Supervisors: Eight supervisors should be available to provide supervision on a selective rather than a monthly basis. We suggest that supervisors also emphasize educational activities during these visits.
3. Coordinator: The state coordinator should emphasize systematic and regular field visits to work with regional supervisors. The state-wide supervisors' staff meetings should be reduced from one per month to one per quarter.
4. Evaluation: The evaluation sector's work can be reduced by eliminating two non-essential forms and possibly reducing the number of clients in the follow-up sample. By establishing a dialogue between state program managers and BEMFAM/Rio, it may be possible to reduce paperwork to the minimum necessary for operational decisions, and thus reduce the state evaluation sector to one person.

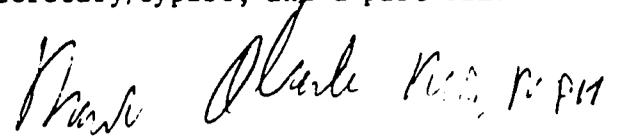
5. Regional Medical Supervisors: The three vacant medical supervisor positions should not be filled, and the remaining medical supervisor posts should be eliminated through attrition.
6. Municipal physicians: Municipal physician stipends should be eliminated.
7. Training and supplies for the physicians: Instead of direct payments to physicians, we suggest regular seminars and the distribution of contraceptive and educational materials. This activity should be organized in a systematic program for physicians in both the public and the private sector.
8. Program Norms: Now that alternative methods are available, BEMFAM should reevaluate program norms such as the age limit for pill users. In addition, supervisors should emphasize to distributors the importance of maintaining pill users on the same formulation.
9. Communications: The communication and education activities should be integrated into one sector.
10. Program Newspaper: BEMFAM should consider a single national newspaper, with one page devoted to each state's local news.
11. Administration: Administrative and support personnel should be reduced to one administrator, one secretary, one typist, two drivers, one watchman, and one janitor.
12. State program personnel should discuss and interpret the 1980 contraceptive prevalence survey for use in program policy.

B. Alagoas

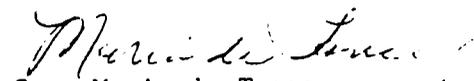
The integration of the CBD program into the Department of Health should be considered an important accomplishment of one of BEMFAM's goals. This integration should be closely monitored as a means of developing a model for integration in other states. However, this integration is part of an overall reform of the Health Department and is far from completed.

1. Goals: BEMFAM should define its objectives for integration keeping in mind the long range role of BEMFAM in Alagoas. We suggest that BEMFAM consider community education, the training of public and private physicians, and technical assistance to the Health Department as part of its future, independent role in Alagoas. We feel that the Department does not have the resources to absorb these functions at this time.
2. Timetable: BEMFAM and the Health Department should negotiate a specific written plan for integration, including a timetable.
3. State coordinator: The coordinator should devote more time to direct technical assistance in each region, in order to assure a smooth transition in the field.

4. Supervisors: Once integration is achieved, one supervisor only should be required for each region, to coordinate education activities (except in the FSESP region where supervisory responsibility will continue).
5. Financial: BEMFAM should take this opportunity to reduce operational costs so that funds can be reallocated to other program areas
6. Evaluation: Once the Health Department's new information system is installed, the Department should assume responsibility for service statistics. No full time BEMFAM staff are required.
7. Logistics: The BEMFAM warehouse should be eliminated. Supplies for the Health Department should be shipped directly to the Department's warehouse from Rio. Supplies for the FSESP municipios can be shipped either from the Department's warehouse or from Recife. A consultation by an outside group such as CDC may be necessary to improve the Department's logistics capability.
8. Education: As in Pernambuco, the education and communication sectors should be combined and these activities coordinated by a single advisor.
9. Medical: As in Pernambuco, government and private physicians require training in contraceptive technology, as well as educational materials and supplies. An additional physician may be required at least part time.
10. Administrative: Administrative and support staff for BEMFAM's Alagoas operation should consist of only one secretary/typist, and a part time administrator.



Mark W. Oberle, M.D., M.P.H.



Sra. Maria de Tanco, *ph*
Pathfinder Consultant

APPENDIX A

PRINCIPAL CONTACTS

Rio de Janeiro/BEMFAM

Dr. Walter Rodrigues, Executive Secretary
Dr. José Maria Arruda, Technical Advisor
Sra. Carmen Gomes, Coordinator, Planning Dept.
Sr. Márcio Ruiz Schiavo, Coordinator, Information Dept.
Dr. Abel Soza Leão, Medical Dept.
Dr. José Milare, Administrator
Dr. Jim Foreit, Columbia University Advisor

Salvador/Pathfinder Fund

Dr. José S. deCodes, Country Representative

Maceio/BEMFAM

Dr. Dario João de Mendonça Bernardes, State Technical Coordinator
Reginaldo Araujo Ribeiro, Administrator
Dra. Glaucia Maria de Sá Palmeira, Medical Advisor
José Regis Barros Cavalcante, Communications Advisor
Dayse Monteiro da Silva, Evaluation Advisor

Maceio/Other

Dr. Ubiratan Pedrosa Moreira, Superintendent, State Health Dept.
Antonia Lucia Silvestre, Distributor, Tabuleiro Dos Martins
Dr. Carlos Cavalcante, Director, Tabuleiro Dos Martins
Maria Mascarenhas Costa, Distributor, Sta. Luzia do Norte
Dra. Vera Lucia Elias Rodrigues, Region IV Director
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Eliane Gomes Costa, Supervisor
Marly Mayia Lemos, Supervisor
Esmerina Dausas Wanderley, Supervisor
Dr. Stamar Lisboa, Batalha Health Center
Dr. Maria da Silva Santos, Batalha Health Center
Dr. Ezechias da Rocha, Major Isidoro Hospital

Pernambuco/BEMFAM

Dra. Denise Z. P. Barbosa, BEMFAM Regional Coordinator
Dra. Maria Vilma de Oliveira, State Technical Coordinator
João Francisco Regis de Andrade, Administrator
Dr. José Marcos Ionas Pereira Barbosa, State Medical Supervisor
Aldamara de Souza Costa, Education Advisor
Maria Edileusa Calado, Evaluation Advisor
Nadja de Moura Carvalho, Communications Advisor
Sra. Valderéz Rangel de Souza, Supervisor, Region II, Olinda
Dr. Hugo Siquiera, Medical Supervisor
Iracilda Guedes Galindo, Supervisor, Region X
Dr. Gercino Cordeiro, Municipal Physician, Alagoinha

Pernambuco/Other

Maria do Carmo Vasoncelos, Olinda, Health Center Claudio Gueiros Leite
Mirian Zuleide Felix da Silva, Recife, Creche Luluzinha
Dr. Ernando Alves de Carvalho, Secretary of Health, Pernambuco
Maria Helena de Lima, Igarassu, Municipal Health Post
Dr. Clovis Lacerde Leite, Mayor, Igarassu
Dr. Luis Coelho, Filho, Municipal Health Officer, Arcoverde
Aureo Bradley, Mayor, Arcoverde
Aurenita Soares de Sousa, Municipal Health Post, Arcoverde
Maria de Fatima Brito, Health Post, Santa Ramos
Emelia Dedil, Health Post, Santa Ramos
Brasilino Baia de Lima, Mayor, Alagoinha
Creunice Almeida Galindo, Distributor, Alagoinha
Genesia Teixeira Freitas, Pousado de Perpetuo Socorro, Alagoinha
Sandra Mergulhao, Distributor, Pesqueira
Dra. Paula Frassinette Amaral, Crazada Femenina do Pesqueira
Fernando Alboquerque, Secretary of Labor, Pernambuco
Maria Fatima de Arruda, Supervisor, Region VIII
Manoel Marcos Chagas Aroucha, Filho, State Legislator
Severino Almeida, Filho, State Legislator
Alcir Marreiros Teixeira, State Legislator
Jose de Assis Pedrosa, State Legislator
Luis Heraclio do Rego Sobrinho, State Legislator

TABLE 1

Active Users
 CBD Program, Pernambuco and Alagoas States, Brazil
 1975-1981

	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>1981</u>
Pernambuco							
Recife	(*)	(*)	(*)	9.840	8.099 ^a	5.986	5.222
Other Regions	(*)	(*)	(*)	80.130	82.456	81.543	68.073
Total	24.593	66.220	75.793	89.970	90.557	87.529	73.295
Alagoas	6.873	17.834	9.171	18.665	21.619	18.262	17.520

*Estimate for December for 1975-80 and June for 1981.
 (*)=Data not available

Note: Source - BEMFAM Department of Evaluation

TABLE 2

New Users
CRD Program
Pernambuco and Alagoas States, Brazil
1975-1981

	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>1981*</u>
Pernambuco							
Recife	(*)	(*)	(*)	10.359	4.374	2.950	1.375
Other Regions	(*)	(*)	(*)	55.037	50.303	36.170	17.360
Total	18.141	37.940	64.156	65.396	54.677	41.120	18.735
Alagoas	4.940	10.615	8.615	8.520	18.800	14.211	6.532

*Jan-June, 1981

(*)=Data not available

Note: Source - BEMFAM Department of Evaluation

TABLE 3

Oral Contraceptives Distributed (Cycles)
 CBD Program
 Pernambuco and Alagoas

	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>1981*</u>
Pernambuco							
Recife	(*)	(*)	(*)	155.871	154.292	56.334	24.281
Other Regions	(*)	(*)	(*)	671.957	710.976	713.721	311.127
Total	542.290	239.474	571.265	827.828	865.268	770.055	335.408
Alagoas	14.427	53.894	77.053	154.867	198.217	183.000	81.292

*Jan.-June, 1981

(*)=Data not available

Note: Source - BEMFAM Department of Evaluation

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TABLE 4

Barrier Methods Distributed
 CBD Program
 Pernambuco and Alagoas

	<u>Condom (Units)</u>		<u>Foam (Cans)*</u>		<u>NeoSampoon (Tablets)</u>	
	<u>1980</u>	<u>1981</u>	<u>1980</u>	<u>1981</u>	<u>1980</u>	<u>1981</u>
Pernambuco						
Recife	82	3,216	-	22	1,000	2,812
Other Regions	-	11,404	-	205	6,756	16,621
Total	82	14,620	-	227	7,756	19,433
Alagoas						
	260	18,141	-	-	13,992	14,244

*January-June, 1981

Note: Source - BEMFAM Department of Evaluation

TABLE 5

New Users by Month
CBD Program, Alagoas State, Brazil
Jan-June, 1980 and 1981

	<u>1980</u>	<u>1981</u>	<u>% Change</u>
January	1,670	1,271	-23.8,
February	1,204	1,160	- 3.7
March	1,387	1,001	-27.8
April	1,090	1,056	-31.0
May	1,108	1,087	- 2.0
June	933	957	+ 2.5

Note: Source - BEMFAM Department of Evaluation

TABLE 6

Average Number of Women in Union per Distribution Post
By Region, Pernambuco State, Brazil
June, 1981

<u>Region</u>	<u>Number of Women in Union</u>	<u>Number of Posts</u>	<u>Average Number of Women in Union Per Post</u>
I	169,016	19	8,896
II	62,806	32	1,962
III	111,362	33	3,375
IV	79,381	29	2,737
V	59,269	27	2,195
VI	53,359	22	2,425
VII	49,241	20	2,462
VIII	63,677	37	1,721
IX	30,911	30	1,030
X	41,861	25	1,674
XI	33,344	26	1,282
XII	34,536	19	1,817
XIII	30,816	17	1,813
XIV	42,543	16	2,659
Total	862,400	352	2,450

TABLE 7

Percentage of Women in Union Active in CBD Program
by Region, Pernambuco State, Brazil
June 1981

<u>Region</u>	<u>Women in Union</u>	<u>Active CBD Users</u>	<u>% Coverage</u>
I	169,016	5,277	3.1
II	62,806	8,814	14.0
III	111,362	13,052	11.7
IV	79,381	6,726	8.5
V	59,269	4,322	7.3
VI	53,359	3,999	7.5
VII	49,241	4,876	9.9
VIII	63,677	6,932	10.9
IX	30,911	4,898	15.8
X	41,861	6,061	14.4
XI	33,344	2,571	7.7
XII	34,536	NA	NA
XIII	30,816	2,573	8.3
XIV	42,543	3,245	7.6
Total	862,400	73,346	8.5

TABLE 8

Total Number of CBD Posts
Pernambuco and Alagoas

	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>1981</u>
Pernambuco							
Recife	(*)	(*)	28	14	14	19	19*
Other Regions	(*)	(*)	243	276	307	315	323*
Total	54	68	271	290	321	334	342*
Alagoas	43	97	126	175	185	164	163**

*June, 1981

**May, 1981

(*)=Data not available

Note: Source - BEMFAM Department of Evaluation

TABLE 9

Percentage of Women in Union Active in CBD Program
By Region, Alagoas
June 1981

<u>Region</u>	<u>Women in Union*</u>	<u>Active CBD Users</u>	<u>% Coverage</u>
I	88,094	4,698	5.3
II	54,976	2,846	5.2
III	38,648	2,373	6.1
IV	45,785	3,904	8.5
V	50,007	3,950	7.9
Total	277,510	17,771	6.4

*To estimate women in union, the proportion of women currently in union in the 1980 Pernambuco Contraceptive Prevalence Survey was applied to the 1980 Alagoas census population totals for each region.

TABLE 10

Average Number of Women in Union per Distribution Post
by Region, Alagoas
June 1981

<u>Region</u>	<u>Women in Union*</u>	<u>Number of Posts</u>	<u>Average Number of Women in Union Per Post</u>
I	88,094	47	1,874
II	54,976	28	1,963
III	38,648	25	1,546
IV	45,785	325	1,430
V	50,007	31	1,613
Total	277,510	163	1,703

*To estimate women in Union, the proportion of Women currently in union in the 1980 Pernambuco Contraceptive Prevalence Survey was applied to the 1980 Alagoas census population totals for each region.