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The Pathfinder Fund

Long-Term Strategy for Brazil
FY 90–94

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FY 90-94

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EXECUTIVE SUMMARY

A. Introduction

"The magnitude of the projected demand for family planning services in the twenty-first century, the limited resources that will be available, and the changing environment in which services will be delivered, will all require a major reassessment of population assistance strategies by both donor agencies and national governments." [1]

In preparation for the changing environment of the coming decade, The Pathfinder Fund has developed a five-year strategy for its work in Brazil. Pathfinder has defined Brazil as a priority country for the Latin American region and the strategy is the organization's plan for addressing the resource and programmatic challenges which confront the delivery of family planning services in that country. Pathfinder has supported family planning activities in Brazil for over a decade and today is a leading international population donor in the country. However, the decreasing resources available for Latin America, the increasing number of women of reproductive age, the move toward more long-acting methods in "mature" [2] countries, the growing concern for the quality of family planning services, and the desire to achieve maximum impact for the dollars invested led Pathfinder to reassess current strategies and programs in Brazil.

The development of a five-year strategy involved collaboration with AID/Washington and Brazil, cooperating agencies, international donors, and Brazilian family planning organizations. This document will describe the strategy through nine sections: Introduction, Environmental Analysis, Family Planning Institutional Analysis, Problem Identification, Pathfinder Five-Year Goals for Brazil, Pathfinder Country Strategy, Specific Objectives, Workplans for FY 90-94, and Pathfinder Inputs.

B. Strategy Process Overview

A six-person team made up of staff members from Pathfinder field and headquarters offices and an external consultant with expertise in strategic planning developed the strategy. Each step in the strategy development process will be described in more detail within the appropriate section. The major steps of the process included:

- definition of methodology
- data collection and analysis
- team review of issues
- problem identification
- development of responses to problems
- definition of goals
- analysis of strategic options and priorities
- resource projections
- creation of program-specific workplans
- identification of financial, technical, and commodity inputs

C. Fiscal Years (FY) 86-89 Performance

Pathfinder's program in Brazil has been used for such activities as:

Integration of a family planning curriculum in medical schools which has included the development of a family planning manual for professors of medical and nursing schools, sponsorship of national professional meetings, and training of medical students and doctors.

Young adult reproductive health care through support of the first hospital-based postpartum family planning services for this group, sponsorship of the major household surveys of adolescents in collaboration with the Centers for Disease Control and other organizations, sex education training for teachers which was subsequently replicated, other service models for young adults.

Service provision in the Northeast region of Brazil primarily with *Sociedade Civil Bem Estar Familiar no Brasil* (BEMFAM), implemented through the public sector health network.

Service delivery through the national network of health maintenance organizations (HMOs) via the integration of family planning with their ongoing health services.

Institutional development through core support and technical assistance to private voluntary organizations (PVOs) such as *Associação Brasileira de Entidades de Planejamento Familiar* (ABEPF) and *Centro de Estudos e Pesquisas Clovis Salgado* (CEPECS).

Commodities grants resulting in 492,652 couple-years-of-protection (CYPs).

Technical assistance provided to grantees in the areas of clinical training, income generation and sustainability, quality of care, logistics, curriculum development, service delivery management, adolescent programs, and strategic planning.

As a result of this support, Pathfinder/Brazil has achieved the following:

- A total of 542,426 CYPs were provided through projects and commodities grants. In 1988, Pathfinder support contributed .03% to national contraceptive prevalence.
- A total of 981 health and family planning professionals were trained through project-related activities.
- Seventeen travel and training grants were provided through the Cooperative Agreement Washington (CAW)/add-ons and forty-two through the Cooperative Agreement Brazil (CAB).
- Cost per CYP has decreased from $56.30 in FY 86 to $4.70 in FY 89.

Pathfinder portfolio management indicators demonstrate the following:

- Forty-seven projects were supported by CAW/add-on and six were funded by CAB.
- Numbers of CAW/add-on projects committed each year dropped from eighteen in FY 86 to ten in FY 89.
- Over half of CAW/add-on projects lasted between one and two years.

- CAW allocations for Brazil have dropped from $600,000 in FY 88 to $400,000 in FY 89.

- CAW commitments have decreased from $795,201 in FY 86 to $334,000 in FY 89.

- Average cost per project has increased from $14,649 in FY 86 to $64,763 in FY 89.

- Average cost for service delivery projects for the same period has increased from approximately $13,000 to $100,000.

D. Comparative Advantage in Brazil

- Based on FY 88 commitments, Pathfinder is the largest AID-funded family planning donor in Brazil, after International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR).

- The Pathfinder Country Representative, Dr. José de Codes, and his Brazilian staff enhance project development and management by bringing to the process their knowledge of family planning, language skills, sensitivity to culture, and contacts among the family planning community.

- Since Pathfinder opened its Brazil office over a decade ago, it has played an important role in the identification of new family planning providers and the creation of a positive family planning environment with support from physicians and other health providers, political groups, feminist groups, and others.

- Pathfinder's expertise in Brazil includes curriculum development in medical schools, adolescent fertility programs, and large-scale commodities distribution.

- Pathfinder works closely with AID/Brazil and collaborates with other cooperating agencies.

- The Brazil office draws upon Pathfinder's many years of experience in Latin America.

E. Environmental Analysis

As part of the strategic planning process, Pathfinder carried out a comprehensive environmental analysis of Brazil so that the organization could efficiently and effectively exercise its comparative advantage. The analysis summarized below is based on the 1986 national Demographic Health Survey (DHS), adolescent fertility surveys of 1988 and 1989 conducted in Salvador and São Paulo, and other sources.

This overview highlights the following important characteristics of family planning use in Brazil:

- Brazil is the largest country in Latin America with more than 144 million people, approximately one-third of the region's population.
- Contraceptive prevalence is 66% with modern methods at 57%, classifying Brazil as a "mature" country.
- Some health indicators such as infant mortality (63) and maternal mortality (87-154) are worse than those of other "mature" countries.
- The prevalence of modern methods in the Northeast region is 44% (only receiving "consolidation" classification).
- The national total fertility rate (TFR) is 3.53.
- The TFR in the Northeast region is 5.23, while in the rural areas of the region it increases to 7.07.
- The national age-specific fertility rate (ASFR) for all age groups have declined since 1966 except for that of 15-19 years olds, which has increased.
- The quality of family planning services and information is characterized by: two-thirds of female sterilizations performed in conjunction with caesarian sections, misuse of oral contraceptives, low intrauterine device (IUD) and barrier method use, and a high abortion ratio, estimated at 1.67 abortions per live birth.
- Almost eighty percent of contraceptive use is made up of two methods, pills and female voluntary surgical contraception (VSC).
- Government pill price regulations and reimbursement policies of the Social Security System regarding clinical family planning methods narrow the choice of methods available.

- Despite efforts to integrate family planning into the national public health system, services are generally not available through this sector.

- Social Security and other public and private hospitals and doctors are the primary sources of female VSC.

- Pharmacies are the major provider of oral contraceptives.

- Some state health systems in the Northeast offer family planning. Municipal health systems are often more receptive to family planning than other levels of the public health system. As national and state services are decentralized to the local level, municipal health systems in the Northeast will play an important role in service delivery.

- BEMFAM cooperative programs with the public sector in the Northeast are an important contributor to prevalence in that region.

F. Family Planning Institutional Analysis

As part of the data gathering process, an analysis was made of seven key Brazilian institutions which have in the past, or could in the future, collaborate as grantees for Pathfinder projects. Information provided was analyzed and evaluated to determine the potential role of each in the implementation of the five-year strategy. The organizations which were analyzed included ABEPF, *Associação Brasileira de Medicina de Grupo* (ABRAMGE), BEMFAM, CEPECS, *Centro de Pesquisas e Assistência Integrada à Mulher e à Criança* (CPAIMC), *Federação Brasileira das Sociedades de Ginecologia e Obsetrícia* (FEBRASGO) and the Odebrecht Foundation.

G. Problem Identification

Although numerous family planning problems exist in Brazil, the team identified four major problems which Pathfinder could address, given its resources and expertise. Causes for each problem area, outlined below, and obstacles to their resolution were analyzed.

The first problem identified was that of low contraceptive prevalence in the Northeast region relative to the rest of Brazil. Causes of this problem include lack of access to information and services; limited number of trained family planning providers; overreliance on pills and female VSC; political resistance to family planning; inadequate information, education, and communication (IE&C) materials; commodities shortages; low educational and income levels.

The second problem area is inadequate family planning services quality. The major causes of the poor quality of family planning use are concentration of method mix on only two methods; little use of the IUD and other methods; routine performance of sterilizations after caesarian sections in Social Security hospitals; mass distribution of pills through pharmacies; and Social Security reimbursement policies.

The third problem is the increasing adolescent fertility rate. Causes of this problem include changing norms regarding sexual behavior; lack of comprehensive, widespread sex education which focuses on attitudinal change and family planning services; lack of access to age-appropriate information and services.

The minimal impact of family planning PVOs on contraceptive prevalence relative to the commercial sector and to public hospitals was identified as the fourth and final problem area. The causes of this problem include the limited ability of any one PVO to influence prevalence due to the enormous size of the country; continued duplication of the same clinical model without attempting innovative approaches; mass distribution of pills through pharmacies which has bypassed PVOs; female VSC primarily carried out in public hospitals; weak managerial capacity among some PVOs especially in strategic planning, sustainability, and management information systems (MIS); insufficient collaboration with the public sector to maximize scarce resources; limited attention paid by the PVOs to sustainability and the impact of their activities.

H. Possible Pathfinder Responses

The long-term strategy must address the obstacles to family planning services to the extent that resources and institutional capacity permit. Following the definition of problems, causes, and obstacles, the team generated a long list of Pathfinder's possible responses to these problems. The advantages and disadvantages of each response were identified and compared with other options. Particular emphasis was placed on Pathfinder's comparative advantage.

The team confronted the following questions:

How can Pathfinder help overcome the problem of low prevalence in the Northeast?

How can Pathfinder help improve the quality of family planning services?

How can Pathfinder address the problem of high adolescent fertility?

How can Pathfinder improve the institutional capacity of family planning PVOs?

Seven strategic program options were generated in response to the problem of low prevalence in the Northeast. The four options which resulted in the largest number of "pros" and fewest number of "cons" were: (1) Support PVOs in promoting IUD insertion along with other temporary methods in municipal health centers in the Northeast; (2) Provide IUD insertion services along with other methods in postpartum wards of public hospitals in the Northeast; (3) Provide commodities grants with special emphasis on the Northeast; and (4) Support the inclusion of family planning to services provided by HMOs.

The problem of family planning quality produced three strategic program options. Two of these options yielded the most positive outcomes: (1) Increase IUD use as a component of method mix by establishing a training center for IUD insertions, complemented by a marketing program through the Brazilian manufacturer of IUDs; and (2) Promote an environment responsive to positive changes in the policies of the Social Security System to include family clinical planning methods as a reimbursable cost.

The problem of high adolescent fertility produced nine possible strategic options, three of which were the most advantageous: (1) Establish a hospital-based, postpartum program in the Northeast; (2) Provide school-based sex education, combined with preparation of training materials and instruction for professors in university schools of education; and (3) Explore the feasibility of distributing condoms through commercial channels (small stores) to young adults, accompanied by promotion.

The improvement in the institutional capacity of PVOs was primarily addressed through an analysis of Pathfinder's ongoing core support commitments; (1) The current commitment to CEPECS will be honored as well as Pathfinder's three-year commitment to ABEPF; (2) Continued support for service delivery through financial obligations and technical assistance will assist local PVOs to move toward sustainability; and (3) Travel and training activities, efficiently administered through a single grant, will support the implementation of the new strategy.

I. Pathfinder Five-Year Goals in Brazil

The next step in the strategy development process was the development of goals for Pathfinder's program in Brazil. It should be noted that the goals listed below are a product of the previous problem identification activity as well as the process described in the next section. During the FY 90-94 period, Pathfinder will contribute resources and technical assistance to the following:

- Pathfinder will increase contraceptive prevalence by supporting family planning services and dissemination of information in the Northeast region.

- Pathfinder will improve the quality of family planning services through improvements in the method mix by increasing knowledge and use of the IUD in the Northeast. Additionally, Pathfinder will promote changes in reimbursement policies of the Social Security System for clinical family planning methods.

- Pathfinder will provide barrier methods through small commercial outlets in the Northeast to decrease the fertility rate of women 15 to 24 years of age. Also, Pathfinder will increase postpartum family planning services in the Northeast region.

- Pathfinder will assist two PVOs in increasing their financial sustainability by providing technical assistance and core support.

J. Pathfinder Strategy

The strategy team developed a set of criteria for evaluating the possible responses to the four major family planning problems outlined in part nine. The following list defines, in order of magnitude, the specific criteria based on the Pathfinder goals.

High Priority

1. Impact measured by CYPs
2. Quality services (defined as access to a range of methods)

Medium Priority

3. Service to low prevalence areas
4. Potential for leveraging of Pathfinder resources
5. Contribution to program and institutional sustainability
6. Consistency with Pathfinder comparative advantage

Lower Priority

7. Services to hard-to-reach populations (culturally and/or demographically)
8. Potential for widespread replicability
9. Avoidance of duplication with other cooperating agencies
10. Measurability of impact
11. Effort required by headquarters and field offices
12. Consistency with expertise of Pathfinder/Brazil

The nine strategic options were evaluated using the above twelve criteria which were weighted according to priority. Each option was attributed a ranking to represent the extent to which it met the criteria. Each option's ranking was subsequently crossed with each weighted criterion and subsequently scored. The results of the analysis are seen in Section VI. The provision of the IUD and other methods through municipality health centers, HMOs, and postpartum wards received the highest scores.

Although each of the options was considered to be important, it would be unrealistic to undertake them all due to the limited resources available. Current commitments consume approximately one-third of A.I.D. resources available through FY 91. Therefore, new strategy will gradually be phased in as these current commitments are honored.

As current commitments under the CAW are completed, Pathfinder will adopt a new strategy with five central program emphases for the period FY 90-94:

Increase Access to High-Quality Services and Education

- Pathfinder will increase the access to temporary family planning methods and information, with emphasis on the IUD, in the Northeast. Programs can be achieved in cooperation with PVOs such as BEMFAM and with municipal governments and community organizations.

Continue Expansion of HMO Program

- Pathfinder will concentrate on continued family planning services and education with emphasis on clinical methods. Efforts should be coordinated through local HMOs in cooperation with ABRAMGE and PROMEDICA, a leading HMO located in the Northeast. Special attention will be given to low-income industrial and agro-industrial workers.

Improve Availability of Family Planning to Postpartum Women

- Pathfinder will improve the availability of family planning services and education to postpartum patients in public hospitals in the Northeast. The effort will focus on both adult and adolescent women and will offer all temporary methods including the IUD for appropriate clients.

Increase Support for Training and Promote Change in Reimbursement Policies

- Pathfinder will augment support to the obstetric-gynecological community for family planning through the training of physicians and medical students in IUD insertion and VSC; train private doctors in IUD insertion and quality of care issues which will be complemented by the marketing of locally-produced IUDs in cooperation with the Brazilian manufacturer; and work with FEBRASGO to promote changes in *Instituto Nacional de Assistência Médica e Previdência Social* (INAMPS, the Social Security System) policies to include family planning clinical methods, including VSC, as a reimbursable cost.

Commodities Distribution and Marketing to Young Adults

- Pathfinder will continue commodity support to family planning providers through technical assistance in logistics, MIS, and commodity grants and couple these efforts with pilot initiatives in the marketing and distribution of barrier methods to young adults through small shops in the Northeast.

K. Specific Objectives

Through the implementation of the above strategic program areas, during the FY 90-94 period, Pathfinder will:

- Achieve 587,420 CYPs through project-related activities
- Provide 844,640 CYPs through commodities grants
- Serve 285,172 new family planning users
- Train 1,603 health and family planning professionals
- Provide fifteen percent of all project-related CYPs and fifty percent of commodity grant CYPs through the IUD
- Provide institutional support to two family planning PVOs

L. Program Workplans FY 90-94

The following information is a summary of each strategic program area. Discussions about follow-up implementation issues have already begun within Pathfinder and with AID/Washington and Brazil.

Family Planning Including IUDs through Northeast Health Centers

Description:	All temporary methods, including the IUD, will be provided through the collaborative programs between BEMFAM and the public sector. The program will begin in the larger municipalities where the probability for success is greater, and then move to the smaller municipalities. Special IUD referral units will be established. Pathfinder will support clinical training, program administration and supervision, MIS, commodities, and evaluation. IE&C materials principally directed at women with low educational levels will be adapted from those already available from Program for Appropriate Technology in Health (PATH). An IE&C and counseling strategy will also be developed. It is expected that this program will see an increase in IUD use from 0.0% to 5.8% of the method mix.
Sustainability Plan:	Collaboration will be sought with the United Nations Fund for Population Activities (UNFPA). Pathfinder will leverage its resources through the public sector which will provide its infrastructure, personnel, and referral system.
Evaluation:	Baseline and follow-up data will be collected from service statistics on the number of users and CYPs, user profile, and method mix. The project staff will include a data collection specialist.
Technical Assistance:	MIS, commodities, IE&C, clinical management, clinical training
Outputs:	190,689 CYPs, 114,823 new users, 300 persons trained, increase in IUD use from 0.0% to 5.8% of method mix
Funding Needs:	$661,000

Family Planning through HMOs

Description: Pathfinder will continue to support training, supervision, technical assistance, and commodities for the implementation of family planning services and education in a total of 48 HMOs through ABRAMGE. In addition to providing primarily clinical methods such as the IUD and female VSC, this program will demonstrate to the HMOs the cost-effectiveness of incorporating family planning into their ongoing health services. It is anticipated that this program will be replicated by the HMOs themselves once Pathfinder funding ends.

Sustainability Plan: Program costs reflect an increasing proportion of expenses assumed by the HMOs themselves: Pathfinder will provide support to each HMO for only two years at a lesser amount the second year.

Evaluation: Baseline and follow-up data will be obtained from service statistics. Criteria for evaluation will include the number of participating HMOs, geographic area served, population covered, method mix, CYPs, and cost-effectiveness.

Technical Assistance: MIS, evaluation, clinical training

Outputs: 194,462 CYPs, 58,750 new users, 403 persons trained, 48 HMOs in the program, 30% decrease in annual cost to Pathfinder per HMO

Funding Needs: $258,000

Family Planning to Postpartum Women in the Northeast

Description: Pathfinder will support training, IE&C materials, commodities, and technical assistance to participating public hospitals in the Northeast. The IUD and all temporary methods will be made available. This program will focus on both adult and adolescent clients. Pathfinder's support will extend for three years in decreasing amounts each year as the hospitals themselves assume costs. By the end of five years, an expected 30% of the adult method mix will be attributable to the IUD.

Sustainability Plan: Participating hospitals will absorb the total costs by the end of the funding period, which is what has occurred among hospitals previously supported by Pathfinder. The hospitals themselves will contribute their staff, infrastructure, and equipment.

Evaluation: The program will collect service statistics data to measure the CYPs achieved, contraceptive use among adolescents, and increase in the use of IUDs.

Technical Assistance: Evaluation, clinical management, clinical training

Outputs: 150,037 CYPs, 111,599 new users, 20% of whom are young adults, 200 persons trained, increase in IUD use from 20% to 30% of adult method mix.

Funding Needs: $565,000

Physician Training and Promotion of Improved Clinical Family Planning Policies

Description: Three components will make up this program including (1) The training of physicians in the Northeast in IUD insertion and quality of care issues at selected medical school sites in the region. This component will subsequently be complemented by collaboration with the Brazilian manufacturer of IUDs which will market the method to the trained physicians; (2) The training of medical students and physicians in VSC and IUD insertion, supporting national professional meetings, and providing commodities support; and (3) Working with FEBRASGO to influence changes in the current system of reimbursement for family planning clinical methods in the Social Security System. This component will be carried out as part of FEBRASGO's plans to expand its role as an advocate of high-quality family planning care. The new FEBRASGO president resides in Salvador, Bahia, also the site of Pathfinder/Brazil, which should facilitate the implementation of this component.

Sustainability: The IUD training activity will include a cost-recovery component through training fees charged to physicians. IUDs will be sold to the trained doctors by the local manufacturer and training costs have the potential to ultimately be absorbed by the manufacturer.

Evaluation: The FEBRASGO medical school curriculum implementation and exchange program, which Pathfinder pioneered in Brazil, will be evaluated in year one. Evaluation criteria include number of participating medical schools, number of physicians trained, and number of trainees currently providing family planning. The sales of IUDs in the marketing component will be monitored to determine the CYPs produced.

Technical Assistance: Evaluation, clinical training, marketing

Outputs: 52,042 CYPs, 630 physicians trained, progress toward policy changes

Funding Needs: $468,000

<u>Commodities Distribution and Marketing to Young Adults</u>

Description: Pathfinder will continue providing commodities to Brazil through CPAIMC as a national distribution center, identifying new Northeast institutions which could serve as commodities reception centers, and distributing commodities to providers currently able to receive them. A workshop in early FY 91 will train warehouse storekeepers with technical assistance by headquarters and field staff. Finally, a study will be carried out to assess the feasibility of marketing foaming tablets and condoms to young adults through small shops in the marginal urban zones of the Northeast. SOMARC's collaboration will be sought when appropriate.

Sustainability: The grantee agency will generate income from the distribution and marketing of contraceptives to young adults.

Evaluation: Pathfinder will monitor the trained storekeepers to determine the extent to which they use the training received. A system which monitors contraceptive sales in the small shops will also be implemented.

Technical Assistance: MIS, commodities, marketing

Outputs: 844,640 CYPs, 65 persons trained, commodities distribution centers in the Northeast.

Funding Needs: $543,000

M. Pathfinder Inputs

Financial Resources

The financial projections were developed based on lower CAW allocations compared to previous years, as well as the availability of add-on funds. The FY 90 allocation was unusually low due to the potential for significant estimated deobligated funds from exchange gains. The FY 86-89 allocations dropped from $600,000 to $400,000. The projections for FY 91-94, therefore, show a downward trend compared to the FY 86-89 period. These amounts reflect Pathfinder's designation of Brazil as a priority country in Latin America and that these resources are necessary to demonstrate a measurable positive impact on contraceptive use in Brazil. Pathfinder anticipates that the following resources will be available from USAID for FY 90-94:

TABLE 1
PATHFINDER FINANCIAL RESOURCES FOR BRAZIL
(THOUSANDS $)

Fiscal Year	1990	1991	1992	1993	1994
CAW Allocation	180	300	400	350	250
Add-ons	160	160	250	250	250
Est. Deobligations*	204	100	--	50	101
Total	544	560	650	650	601

*primarily from currency devaluations

A total of just over three million dollars from CAW and add-on funds is expected to be programmed in Brazil over the next five years. This amount includes current commitments (including ABEPF) as well as a gradual phasing in of the new strategy. However, a number of preliminary activities related to the implementation of the strategy have begun and it is expected that most programs will have begun by the fall of 1990.

Technical Assistance

A total of 22 person-months of technical assistance is being planned for the duration of the five-year strategy. This figure is in addition to routine monitoring and supervision visits by Pathfinder/Brazil which occur at least twice yearly to each project. The technical assistance will be provided by Pathfinder headquarters and field staff and with outside consultants contracted as needed. Each project will include a technical assistance workplan. Targeted areas include clinical training, commodities management, MIS, evaluation, clinical management, marketing, financial management, and sustainability.

Evaluation and Monitoring

A comprehensive program evaluation system will be developed during the design phase and will be implemented at the beginning of each new project. Every project will include the collection of baseline data against which to measure performance. Depending on the project, the data will be collected from existing service statistics, small area surveys, client interviews, and other sources. Data collection will be carried out by project staff with assistance from Pathfinder, or occasionally external consultants.

A yearly evaluation of the Pathfinder/Brazil strategy will be conducted. At the end of each fiscal year, a document will be prepared reporting on portfolio management indicators, person-months and nature of technical assistance provided, performance of individual projects, performance of programs against annual country objectives, lessons learned, and plans for the coming fiscal year. In addition, the headquarters and field offices will carry out annual updates of the country strategy so that the document remains a useful tool to enable Pathfinder to focus its resources and expertise to achieve maximum impact.

I. INTRODUCTION

SECTION HIGHLIGHTS

- *Summary of Pathfinder's Accomplishments*
- *Description of Pathfinder's Comparative Advantage*
- *Rationale and Methodology for Strategic Planning*
- *Stages in the Strategic Planning Process*

A. Pathfinder Accomplishments in Brazil

1. Family Planning in Medical Schools

For the last ten years, Pathfinder/Brazil has initiated and fostered the implementation of a family planning curriculum in medical schools in Brazil. This program has achieved its goal to institutionalize the teaching of family planning theory and clinical practice to medical students, interns, and residents. The program included the following activities:

- Promotion of training and services in five medical schools (linked to hospital-based family planning services) in the states of Bahia, Alagoas, Pernambuco, Paraná, and Paraíba during fiscal years (FY) 86-89.

- Provision of information, education, and communication (IE&C) materials and commodities once medical schools assumed the costs of training and services at the conclusion of the project.

- Development and dissemination of a family planning manual for professors of medical and nursing schools which was written with the goal of improving the quality and consistency of family planning teaching. In addition to its use within Brazil, the curriculum is being utilized in other Latin American countries and in Africa.

- Assistance with the organization of national professional meetings for obstetricians-gynecologists sponsored by the *Federação Brasileira das Sociedades de Ginecologia e Obstetrícia* (FEBRASGO).

2. Young Adult Reproductive Health Care

Pathfinder is recognized as the pioneer and leader of support for services and education for young adults in Brazil. Pathfinder support and assistance have included the following:

- Support of the first hospital-based postpartum family planning programs for young adults in Brazil.

  Both services and education have been provided in hospitals in the Northeast states of Bahia and Recife. Due to increased demand for services by adult women, the program was expanded to cover this group. The young adult program has been used as a model for similar services in Mexico and Colombia and has continued even though Pathfinder assistance has concluded.

- Support for a variety of other health models for young adults.

  These models have included, in the past, integrated health care programs, sex education in schools, service referrals, and family planning linked to job and literacy training.

- Expansion of sex education training for teachers throughout the country.

  Assistance includes the preparation of educational training materials as well as the replication of this training. A special focus is placed on increasing knowledge and behavioral change by emphasizing reproductive health and responsible parenthood.

- Provision of support for a series of household surveys of adolescents carried out in Salvador, São Paulo, Recife, and Rio de Janeiro and for a secondary analysis of the national demographic health survey (DHS) data.

  Technical assistance been provided by Dr. Leo Morris of the Centers for Disease Control (CDC). In FY 90, Pathfinder will support one national and four regional conferences to disseminate the survey findings to service providers and researchers.

- Co-sponsorship with the Odebrecht Foundation of the first Brazilian meeting on young adult reproductive health.

  This meeting, by bringing service providers and adolescents themselves together, was the first of its kind to highlight young adult needs.

- Continuation of support, with private funds, for the promotion of sex education and service delivery as well as the development of video tapes.

  This effort, undertaken in collaboration with the Odebrecht Foundation, has specifically targeted young adults.

3. Family Planning Services in the Northeast and Other Areas

Pathfinder has provided support and technical assistance to the International Planned Parenthood Foundation's (IPPF) affiliate, *Sociedade Civil Bem Estar Familiar no Brasil* (BEMFAM), for the delivery of services in the Northeast region. Starting in FY 86, Pathfinder worked in the states of Maranhão and Sergipe and then transferred to Alagoas and Rio Grande do Norte. Pathfinder assists with supervision, training, commodities, technical assistance, and IE&C materials. This support is implemented primarily through the state and municipal public sector infrastructure, but is also offered through private organizations.

Pathfinder also supports the national health maintenance organizations (HMO) association for the purpose of integrating family planning with their ongoing health services. Sixteen HMOs currently participate in the program which has great potential for sustainability and replicability as well as high impact on contraceptive use.

4. Institutional Support

Pathfinder has provided core support and technical assistance to key Brazilian private voluntary organizations (PVOs) and individuals:

- For many years Pathfinder has supported *Associação Brasileira de Entidades de Planejamento Familiar* (ABEPF) in the implementation of specific projects. These include the Technical Information Center which disseminates information on family planning issues appearing in the Brazilian press. In coordination with Family Planning Management Training Program (FPMT), Pathfinder is now aiding ABEPF to increase its long-term institutional sustainability.

- *Centro de Estudos e Pesquisas Clovis Salgado* (CEPECS) is currently receiving core support from Pathfinder. Pathfinder is collaborating with Enterprise to enable CEPECS to create an income-generating clinic which will underwrite the costs of CEPECS' clinic network.

- With private funds, Pathfinder has given core support to a feminist organization, *Coletivo Feminista*. This organization continues to provide family planning services and training that emphasize quality of care and client-responsiveness.

- A total of 981 professionals were trained through project related activities; 17 travel and training grants were provided with Cooperative Agreement Washington/add-on (CAW) funds and 42 through the Cooperative Agreement Brazil (CAB).

5. Logistics/Commodities Management

Pathfinder has provided 492,652 couple-years-of-protection (CYPs) during FY 86-89 through commodity grants. Through support to *Centro de Pesquisas e Assistência Integrada à Mulher e à Criança* (CPAIMC), commodities are currently distributed to family planning providers. In FY 89, Pathfinder conducted a commodities workshop to strengthen the skills of Brazilian family planning providers in logistics management.

6. Contribution to National Prevalence

Pathfinder/Brazil has achieved 542,426 CYPs through commodities grants and project activities. In 1988, Pathfinder support contributed .03% to national contraceptive prevalence.

7. Technical Assistance Capacity

Pathfinder has given technical assistance to family planning PVOs, medical schools, hospitals, feminist organizations, and the public sector health network. Technical assistance areas have included clinical training, income generation and sustainability, quality of care, logistics, curriculum development, service delivery management, adolescent programs, and strategic planning.

8. Policy

Primarily with private funds, Pathfinder has played an important role in fostering a positive environment for family planning. A three-pronged approach was implemented which included the following:

- In collaboration with the RAPID Project/Futures Group, Pathfinder funded and gave technical assistance to *O Segundo Brasil* for a series of papers prepared by leading Brazilian social scientists on the effects of population growth; sponsored meetings on the links between population and the economic, labor, and health sectors; and developed population briefing sheets for political leaders.

- With private funds, during the preparation of the new Brazilian Constitution, Pathfinder supported a media campaign and provided technical assistance to parliamentarians to document the importance of including family planning as a constitutional right. This right was subsequently added to the Constitution.

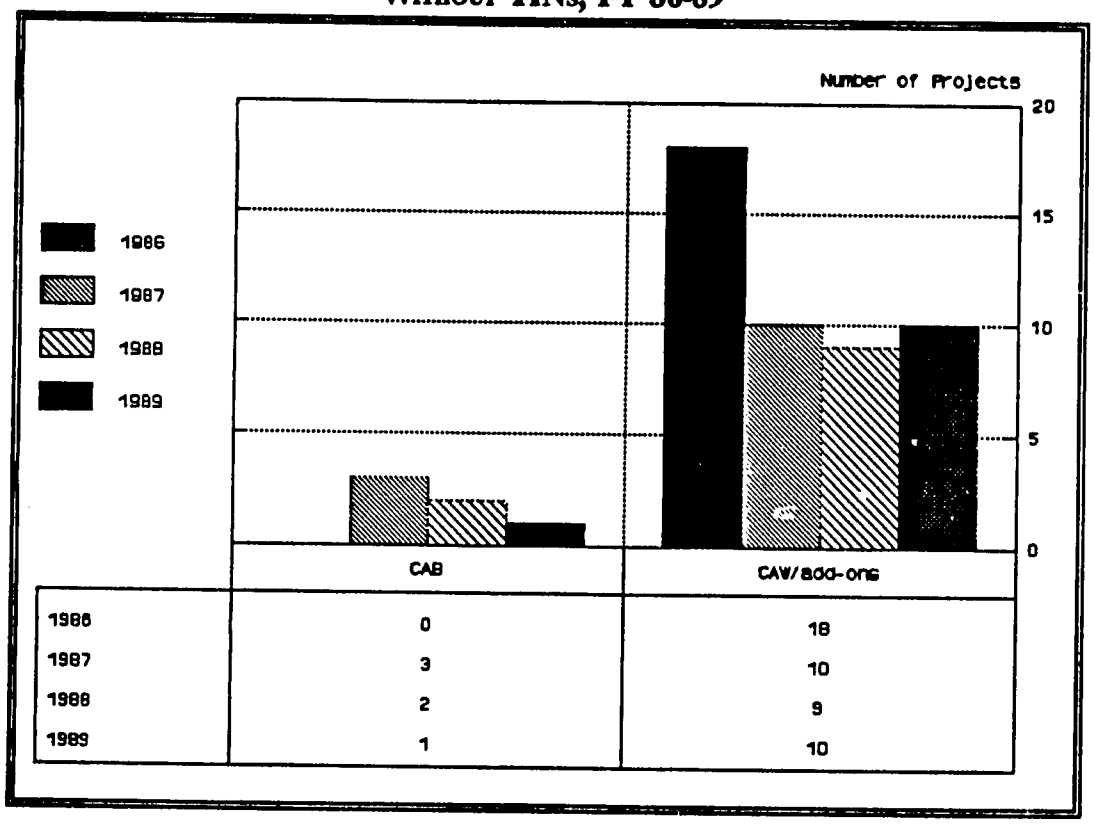
- Pathfinder has worked with feminist groups which have played a significant role in improving the quality of family planning offered in Brazil. These activities have included support for the first feminist family planning clinic and the first national feminists' meeting on family planning.

B. Summary of Pathfinder Performance FY 86-89

1. Number, Duration and Type of Projects

During the period FY 86-89, Pathfinder/Brazil committed a total of 53 projects, not including travel and training grants (TINs), from all Agency for International Development (A.I.D.) funding sources.

Table 1
Number of Projects by Funding Source
Without TINs, FY 86-89



	CAB	CAW/add-ons
1986	0	18
1987	3	10
1988	2	9
1989	1	10

77

Forty-seven (89%) were attributable to CAW and add-ons and six (11%) to CAB. The number of individual projects committed each year with CAW/add-on funds reflects the trend toward fewer numbers of projects. There is a decrease from eighteen in FY 86 to ten in FY 89.

TABLE 2
NUMBER OF PROJECTS COMMITTED BY FUNDING SOURCE
WITHOUT TINS, FY 86-89

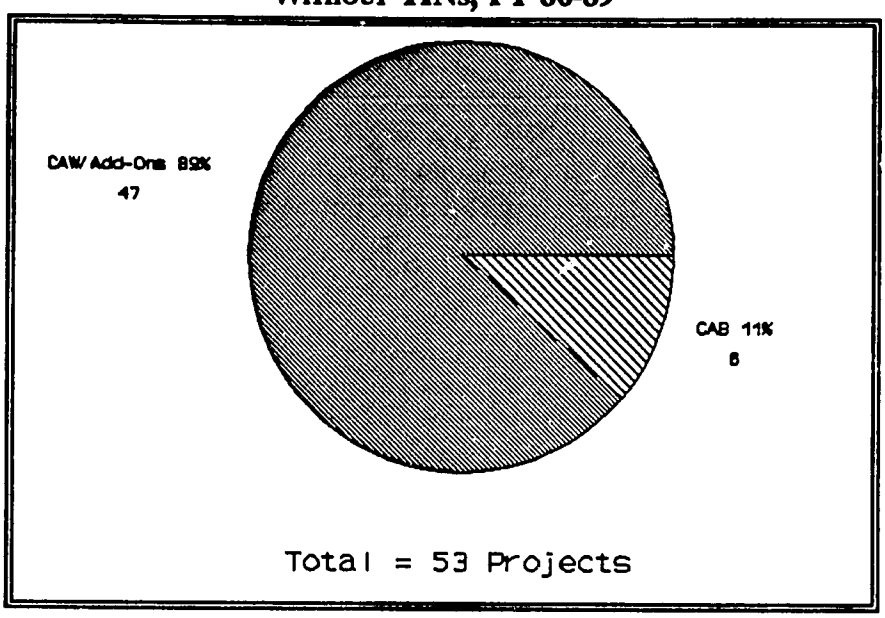


TABLE 3
TREND IN NUMBER OF ANNUAL PROJECTS COMMITTED
CAW/ADD-ONS, WITHOUT TINS, FY 86-89

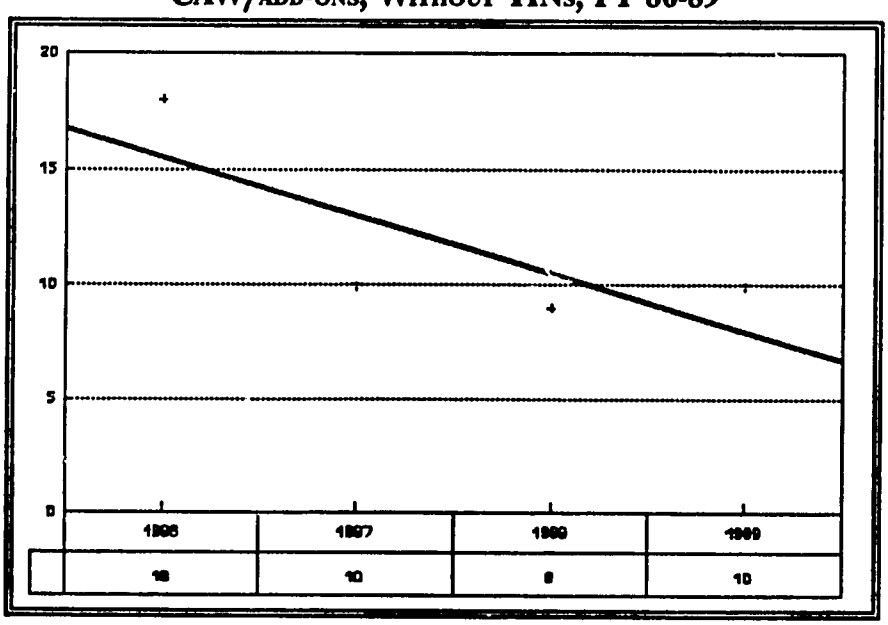


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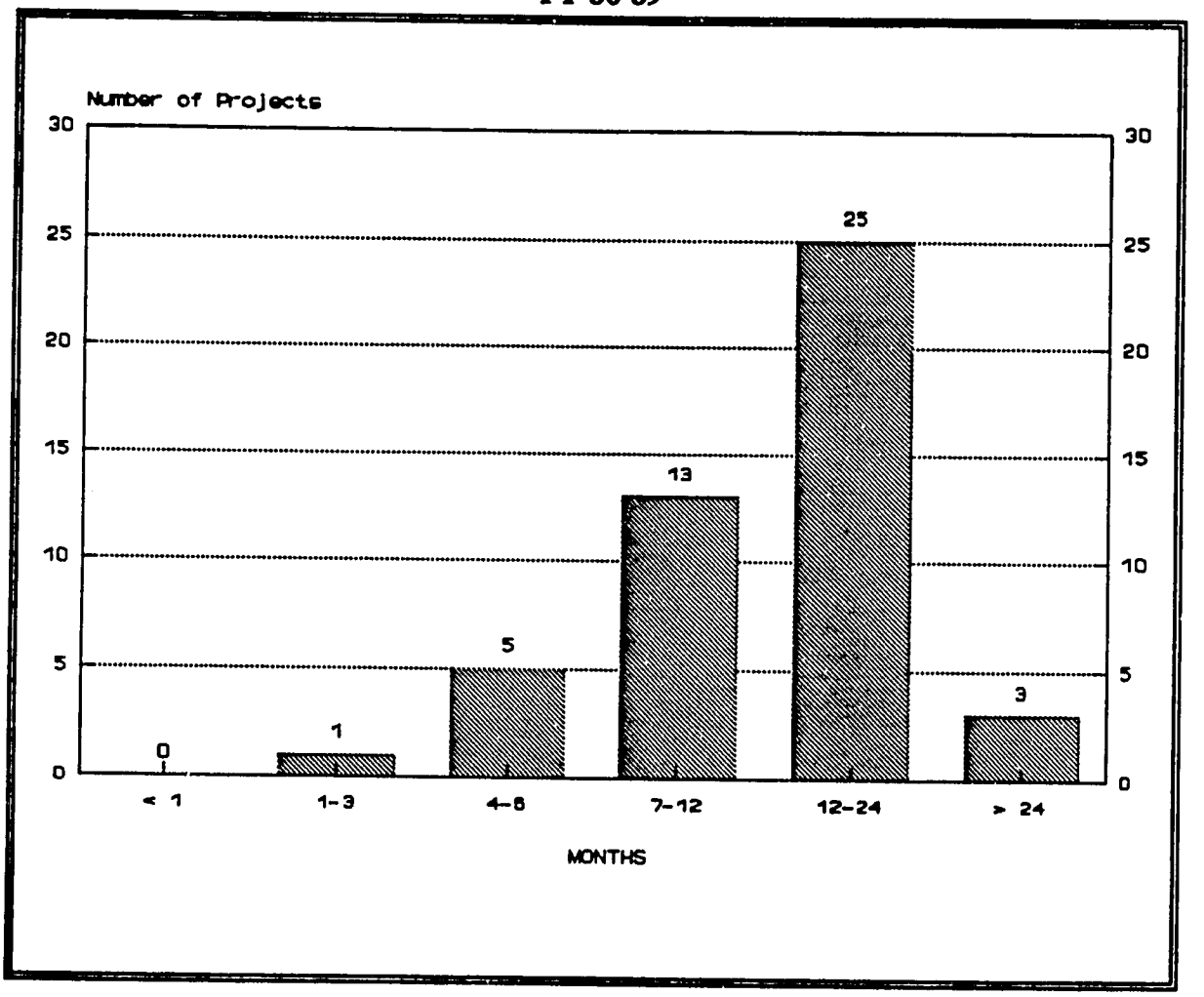
Table 4 portrays the duration of projects committed from CAW/add-on funds during the period. Over one-half of projects were one to two years in length and three were longer than two years.

TABLE 4
DURATION OF CAW/ADD-ON PROJECTS
FY 86-89



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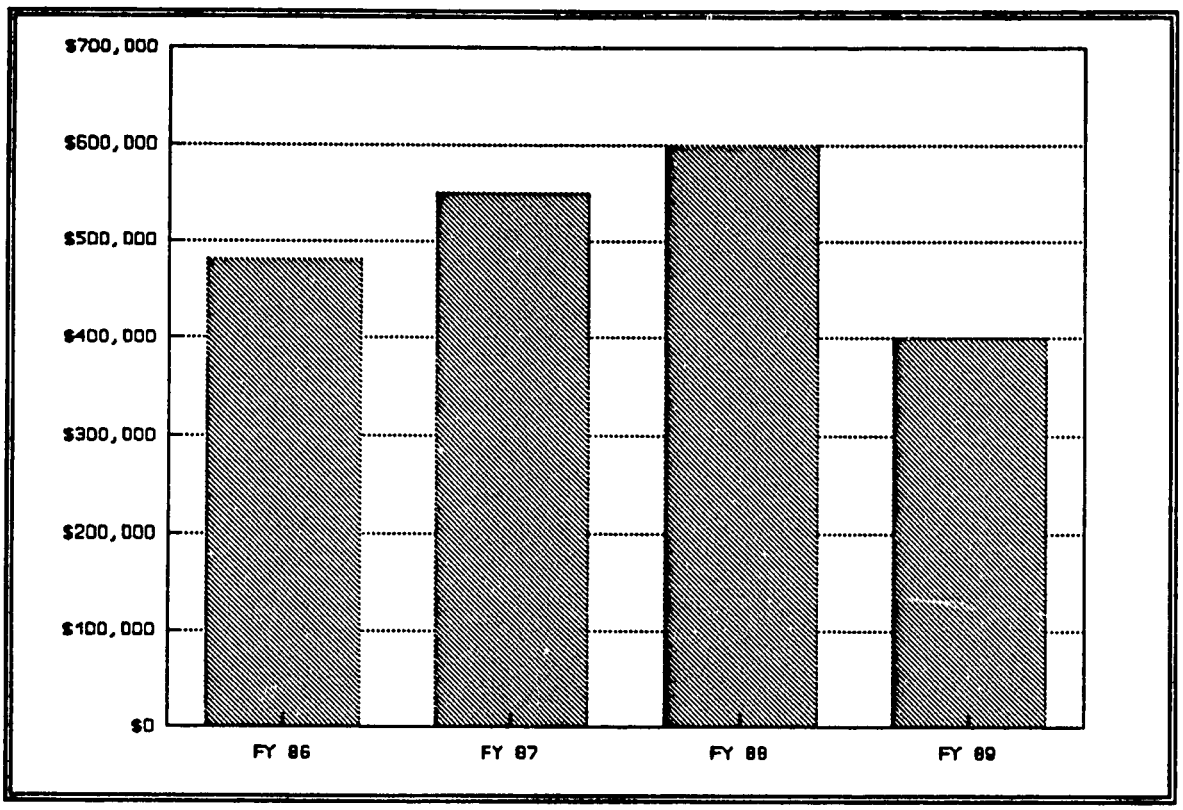
2. Financial Overview

The annual Brazil CAW allocations, as shown in Table 5, reflect the decreasing amount of funds available for Latin America. From a peak of $600,000 in FY 88, the allocation for FY 89 dropped to $400,000.

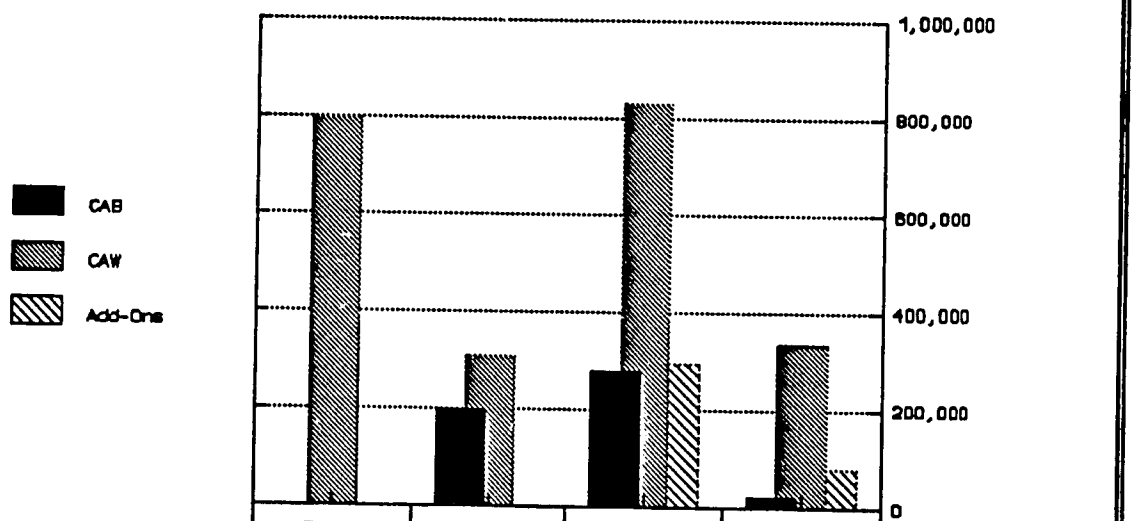
TABLE 5
ANNUAL BRAZIL CAW ALLOCATIONS
FY 86-89



28

As can be seen in Table 6, CAW commitment amounts totalled just over $2.2 million for the FY 86-89 period and add-on amounts were almost $375,000. The amount committed from the CAW allocation shows a downward trend, from just under $800,000 in FY 86 to $334,000 in FY 89. It should be noted that the FY 88 commitment included a large two-year commodities distribution project with a smaller young adult component with CPAIMC, in the amount of $546,000. The annual CAW commitment amount has declined 58% between FY 86 and FY 89. A total of $498,000 has been committed from the CAB which concludes in December 1989.

TABLE 6
ANNUAL COMMITMENTS*
BY FUNDING SOURCE, FY 86-89



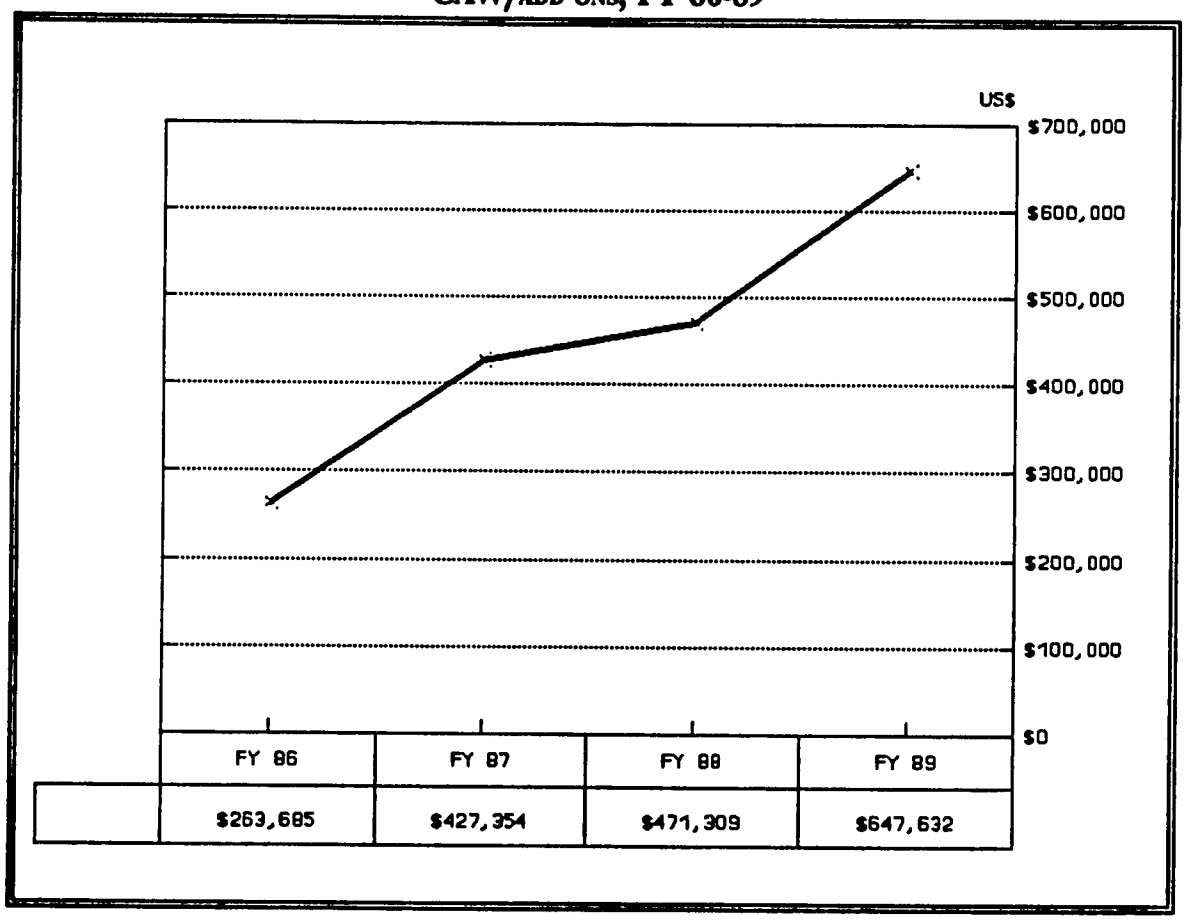
	FY 86	FY 87	FY 88	FY 89	
CAB	0	197,097	277,250	23,704	498,051
CAW	795,201	307,444	827,869	334,060	2,264,574
Add-Ons	0	0	295,009	79,600	374,609
	795,201	504,541	1,400,128	437,364	3,137,234

(*)Commitment=Cash+Commodit.+Bulk+Inkind

27

Disbursements to CAW and add-on projects are seen in Table 7. An increase during the period is due to the fact that projects committed in a given fiscal year could have received disbursements in as many as three fiscal years, depending on the project duration and the commitment month. Any decrease in annual commitment amount may take several years to be reflected in decreasing disbursement amounts. It should be noted that the disbursement amount for FY 86 was especially low. This is due to a large project which was committed but subsequently ended early without significant disbursements.

TABLE 7
ANNUAL DISBURSEMENT AMOUNT
CAW/ADD-ONS, FY 86-89



	FY 86	FY 87	FY 88	FY 89
	$263,685	$427,354	$471,309	$647,632

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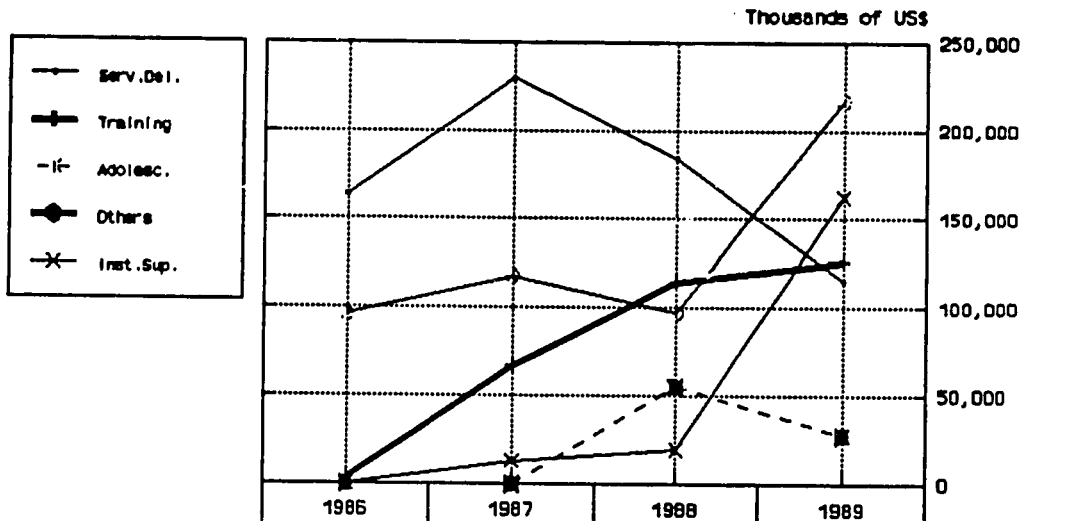
Table 8 demonstrates the type of project based on disbursements. Thirty-three percent of disbursements were made to service delivery projects. Twenty-nine percent were for "other" projects which include research and evaluation, IE&C, and administrative projects such as office equipment purchases, and commodities distribution.

TABLE 8
DISBURSEMENTS BY TYPE OF PROJECT
CAW/ADD-ON, FY 86-89



	1986	1987	1988	1989	
Serv.Del.	163,940	229,360	183,855	115,254	692,409
Training	3,705	67,058	114,785	125,863	311,411
Adolesc.	0	0	55,695	27,720	83,415
Others	96,292	117,752	97,209	216,639	523,892
Inst.Sup.	0	13,182	19,764	162,156	195,102
	263,937	427,352	471,308	647,632	1,810,229

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Table 9 highlights the average cost of CAW/add-on projects which is about $38,000 over the four-year period while for CAB projects it is approximately $32,000. The trend for increasingly larger projects is shown during the same period (Table 10) from an almost $15,000 average cost per project in FY 86 to an almost $65,000 average in FY 89 for CAW/add-on projects.

TABLE 9
AVERAGE PROJECT COST BY FUNDING SOURCE
FY 86-89

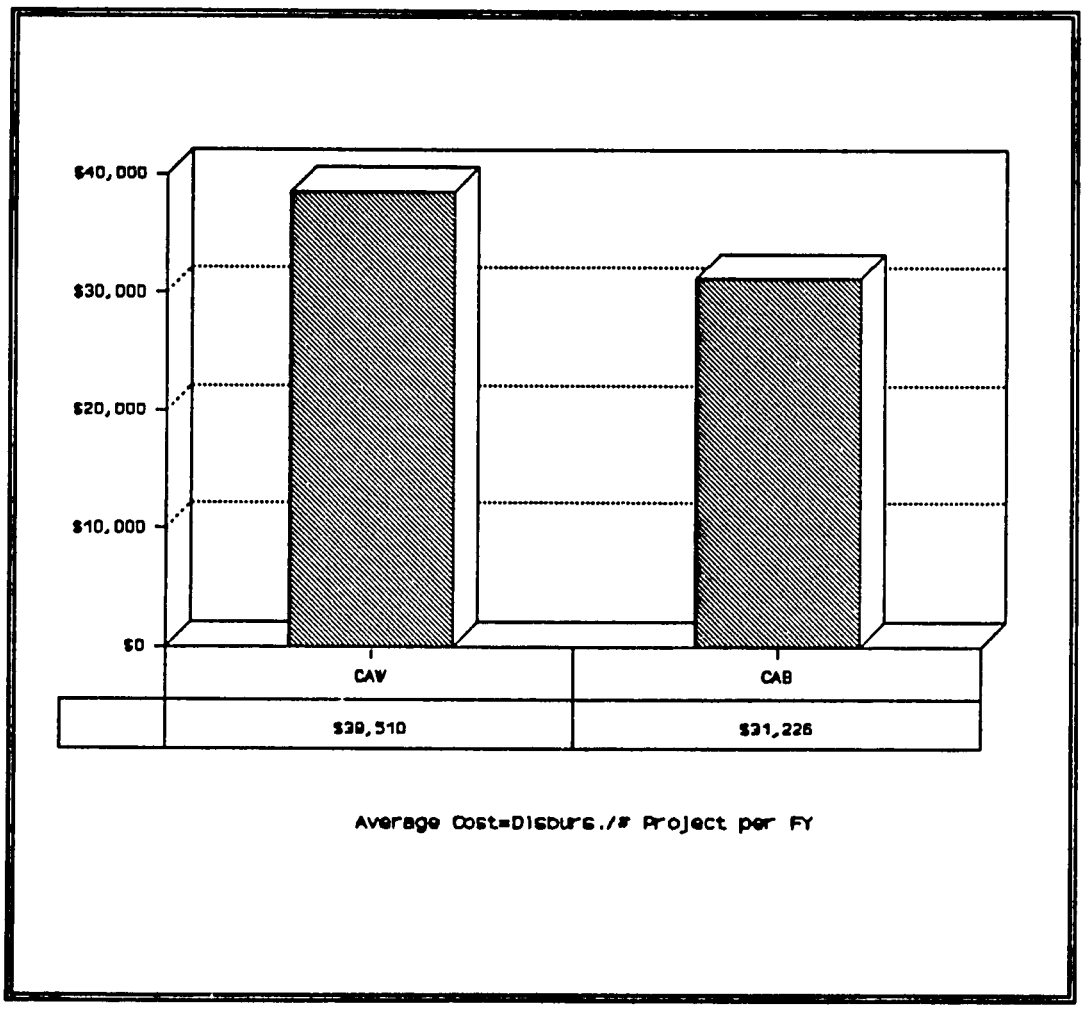
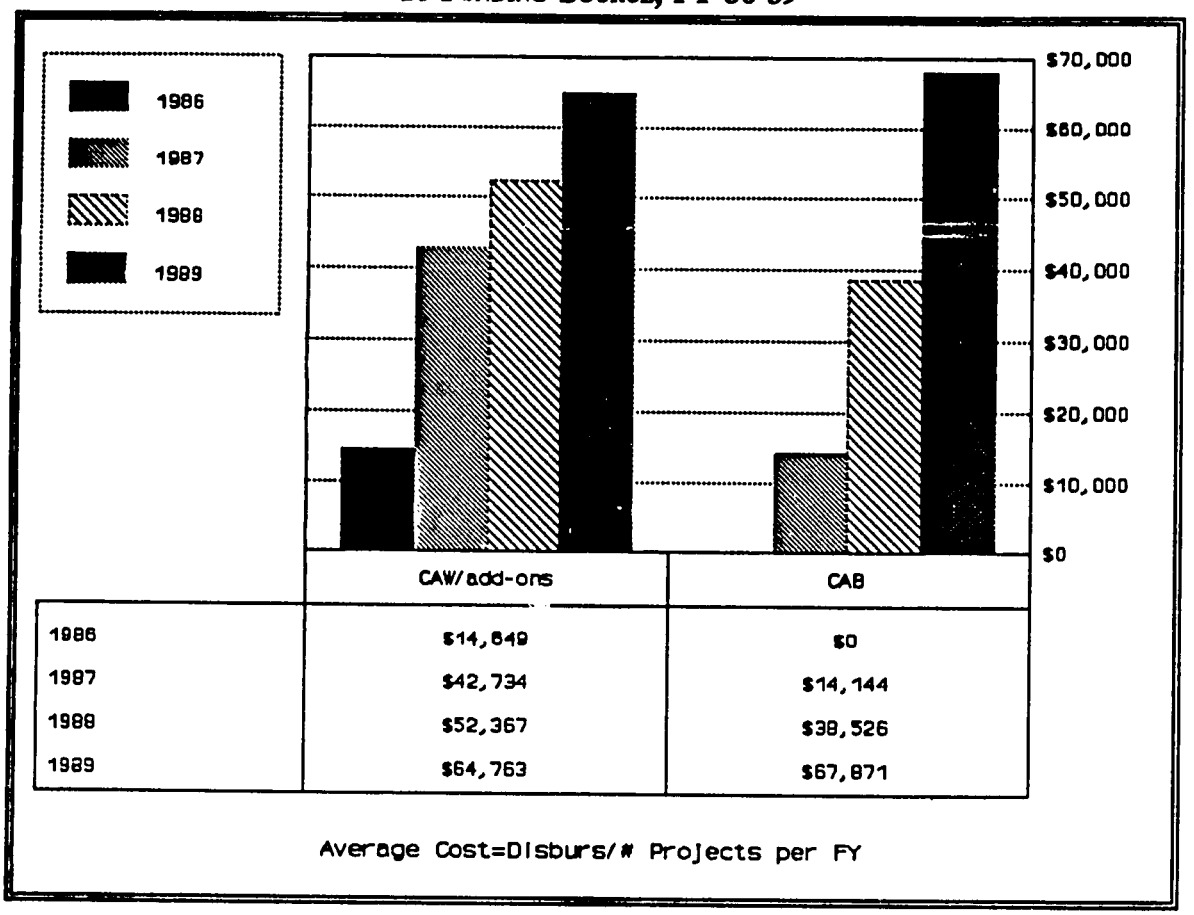


TABLE 10
ANNUAL PROJECT COST
BY FUNDING SOURCE, FY 86-89



The average cost by type of project for the period shows that institutional support projects have the highest average cost, followed by adolescent projects (Table 11). These institutional support projects represent those providing core support to PVOs such as ABEPF. Adolescent projects in Latin America are frequently more expensive than service delivery and education to adults due to the difficulties of reaching this age group. Table 12 shows that the annual average cost of most types CAW/add-on projects increased during FY 86-89. Service delivery average project cost rose from approximately $13,000 in FY 86 to $100,000 in FY 89.

Table 11
Average Cost of CAW/add-on Projects
By Type of Project, FY 86-89

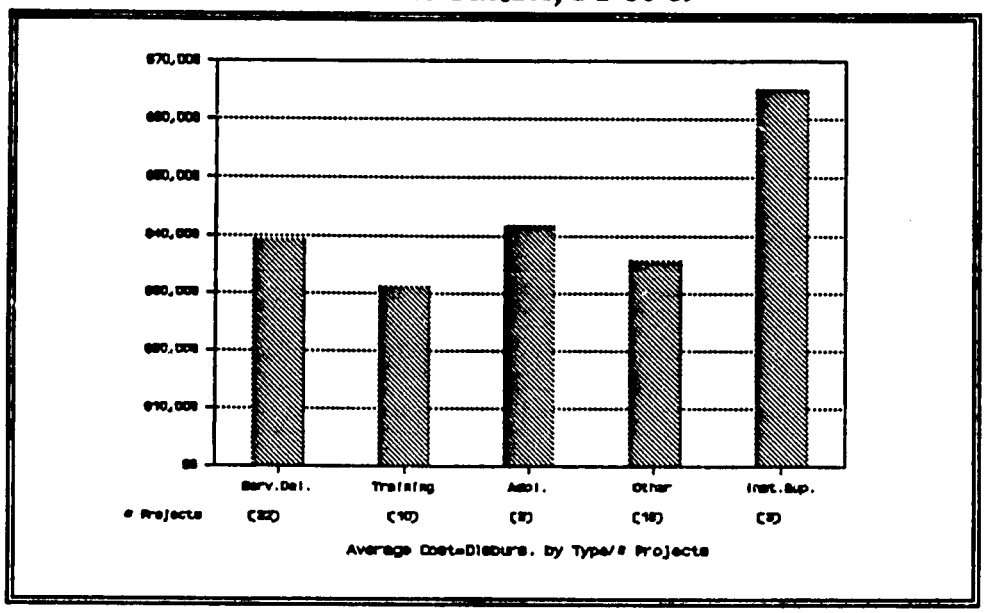
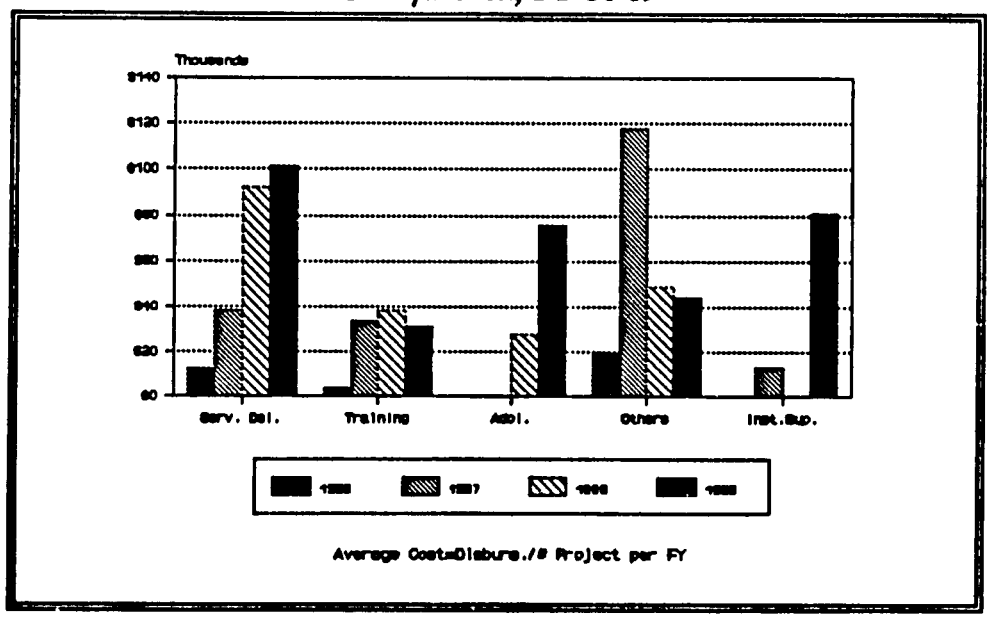


Table 12
Average Annual Cost by Type of Project
CAW/add-on, FY 86-89



3. Outputs

A total of 542,426 CYPs, as seen in Tables 13 and 14, were produced through projects and commodities grants in Brazil. Pathfinder doubled its output of project-related CYPs from FY 88 to FY 89. Pathfinder is currently updating and improving its data collection system and it is probable that CYPs related to projects are underreported.

TABLE 13
CYPs ACHIEVED THROUGH COMMODITY GRANTS
FY 86-89

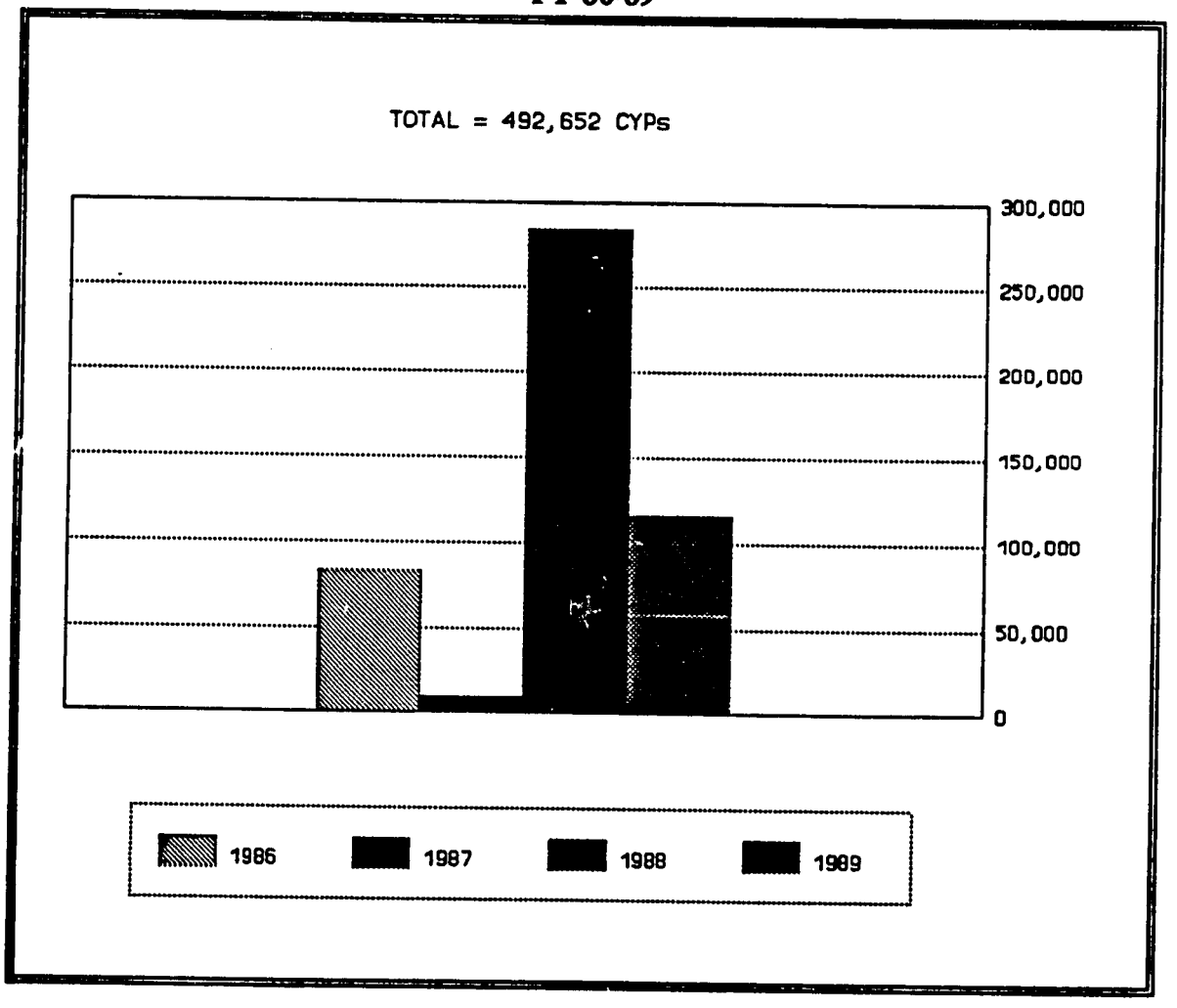
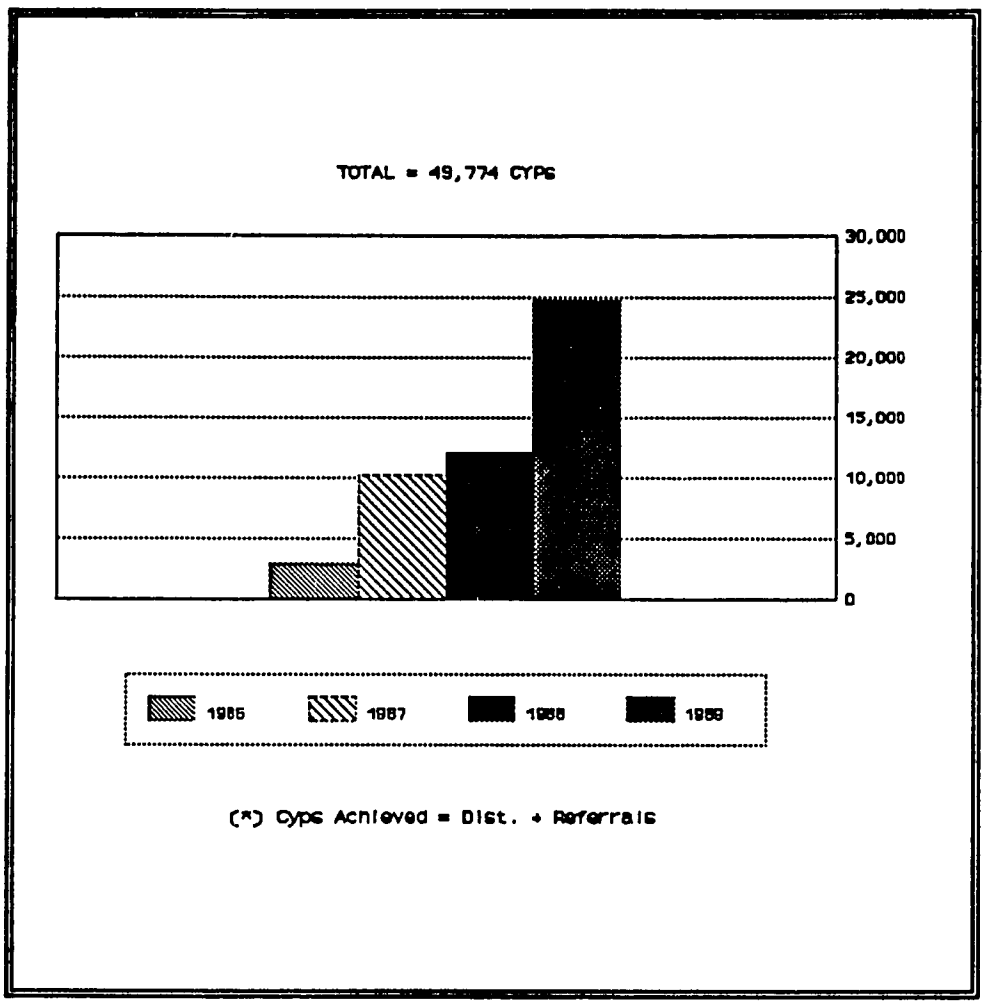
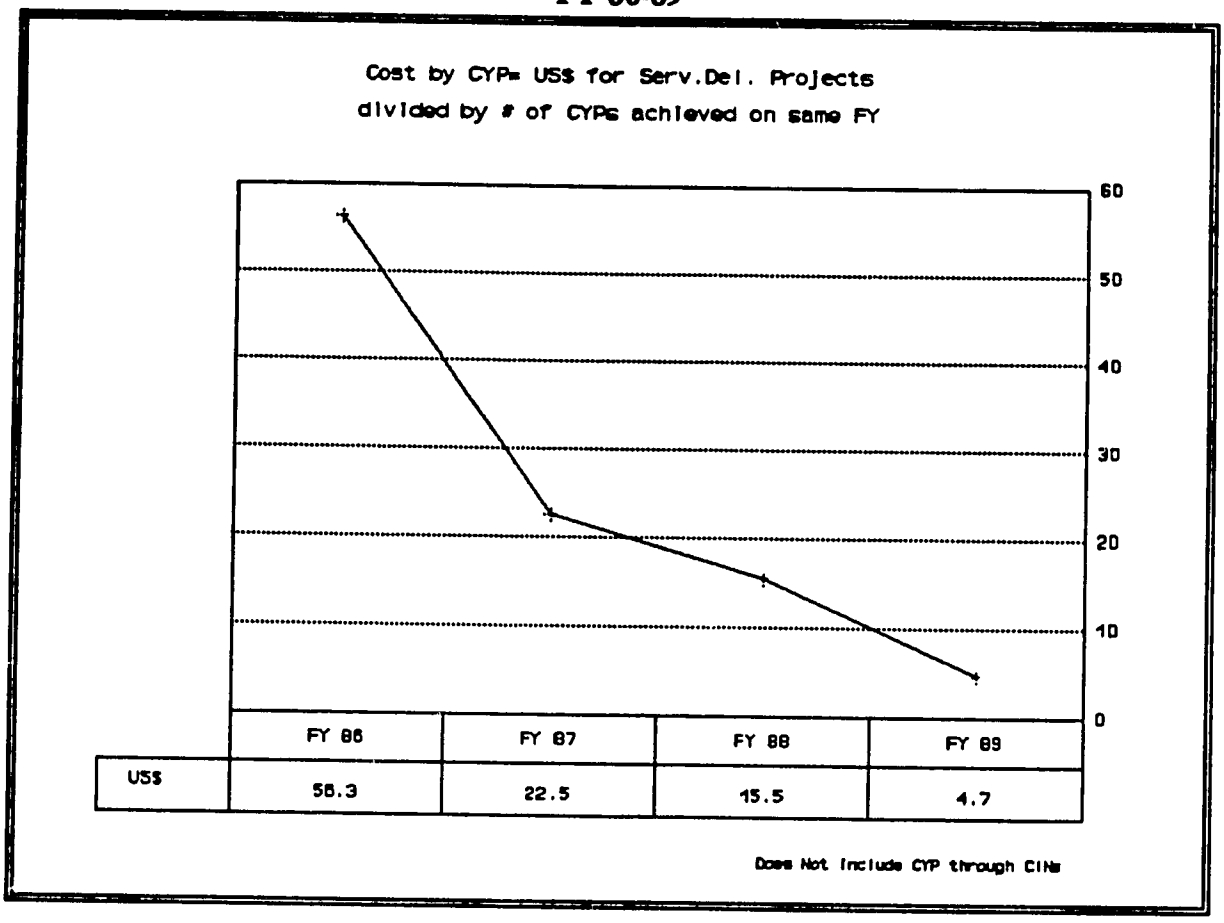


TABLE 14
CYPs ACHIEVED* THROUGH PROJECT ACTIVITIES
FY 86-89



Cost per CYP has declined in Brazil from $56.30 to $4.70 over the four-year period, a 92% decrease, (Table 15). The FY 89 cost per CYP is comparable to the figure for the Latin American region as a whole. This dramatic decline is due to the doubling of project-related CYPs between FY 88 and FY 89 and a decrease in disbursements for service delivery projects. The lower disbursement is a result of the lower number of service projects committed that year, two compared for example, to twelve in FY 86.

TABLE 15
COST PER CYP FOR SERVICE DELIVERY PROJECTS
FY 86-89



C. Pathfinder's Comparative Advantage in Brazil

Pathfinder's unique characteristics have made it a leader among USAID-funded family planning donors in Brazil. Its comparative advantage includes the following:

- Pathfinder's Brazil office opened in 1979. During those ten years, it has played an important role in the identification of new family planning providers and has assisted in the creation of a positive image in Brazil among the medical community, other health providers, political groups, and feminists.

- Pathfinder is the largest USAID-funded family planning donor in Brazil (after IPPF/WHR) in funds committed in FY 88.

- Pathfinder's Country Representative, Dr. José de Codes, is a Brazilian obstetrician-gynecologist. He and his local staff bring their language skills, sensitivity to culture, and contacts among the family planning community to facilitate Pathfinder's work in Brazil.

- Pathfinder/Brazil monitors, supervises, coordinates and evaluates projects, and responds to project and commodities requests with speed and efficiency. Rapid response systems organized between Pathfinder's Boston and Brazil offices facilitate travel and training grants and small projects.

- Pathfinder/Brazil works in close cooperation with AID/Brazil for efficient program implementation.

- Pathfinder has developed considerable experience in a variety of areas. The organization is acknowledged as the leader in the implementation of family planning curriculum in medical schools, adolescent fertility programs, and commodities management.

- The Brazil office draws upon Pathfinder's many years of regional experience in Latin America. Recent continuing education of the local staff has included workshops in proposal development and evaluation.

- Pathfinder's long-standing contacts with physicians and feminists have facilitated its ability to respond to opportunities for program development.

- Pathfinder coordinates extensively with other cooperating agencies such as Management Sciences for Health (MSH) and John Snow, Inc. (Enterprise and Family Planning Logistics Management Projects (FPLM)) in providing project and technical assistance support.

D. Rationale for Strategic Planning

To meet the challenges of the 1990s, Pathfinder carried out a long-range strategic planning process during the second half of 1989. Strategic planning is essential in an organization as its environment becomes increasingly complex. In Brazil, family planning providers are faced with new opportunities and challenges as shifts in the policy environment take place, as HMOs play a more important role, and as changes occur in the priorities of large international donors.

For Pathfinder, which seeks to contribute to the availability of quality family planning information and services to underserved populations in Brazil, the periodic development of strategic plans is essential. In order to maximize effectiveness, Pathfinder's strategic plan includes:

- A clear definition of Pathfinder's goals in Brazil in relation to the needs of the population and the comparative advantage of the institution.

- The evaluation of a broad range of strategic options for meeting these goals, and the selection of those options that utilize resources most effectively and efficiently. An inevitable result of this process is greater geographic and programmatic focus and a clear justification for each element of the strategy.

- The development of measurable objectives and the establishment of a monitoring and evaluation schedule. The result is an increased capacity to gauge progress in program implementation and to determine the results of those programs in relation to the goals.

In addition, the development of a strategic plan will:

- Enhance the ability of the organization to systematize its internal decision-making processes.

- Increase the capacity to provide technical assistance to grantee agencies in areas such as institutional development, program development and implementation, and sustainability.

- Respond to the need to maximize Pathfinder's resources to yield the greatest impact.

E. Methodology

The methodology for developing this five-year plan was based upon (1) information gathering to ensure data-heavy analysis; (2) a clearly-defined analytic process, made up of discrete stages; and (3) a highly interactive dynamic among the strategy team in which differences in assumptions and criteria were openly discussed.

The chart below portrays the process by which the strategy was developed. Each stage of the process is identified followed by a description of the activities undertaken to complete the stage.

STAGE	ACTIVITY
Preparation	A country strategy format was developed in collaboration with Pathfinder's offices in Boston, Brazil, and Colombia and was reviewed with AID/Washington. Team members included rep. from PF/Boston and Brazil and the Regional Office in Bogotá. An outside consultant with expertise in strategic planning and management was the sixth team member.
Data Gathering	Using the format as a guide, the strategy team gathered data from a variety of sources. This process included visits to the Centers for Disease Control, AID/Washington, IPPF/WHR and MSH. Phone discussions were carried out with cooperating agencies such as AVSC, DA, and the Futures Group. Financial and programmatic data were obtained from Pathfinder's database and project files. In-country work included field visits to AID/Brasilia and major grantees.
Review of Major Themes and Issues	Though all team members were familiar with the major issues, this review was intended as a way of unifying the team (which met together for the first time in Brazil at this point) and to establish the parameters for information sharing.
Information Sharing	Five types of information were shared: (a) background on PF/Brazil and its accomplishments to date; (b) demographic and health indicators of Brazil; (c) the political situation in Brazil and implications for family planning programs; (d) the role of international donor programs; and (e) an analysis of the local institutions that were visited in the the data-gathering stage.
Problem Identification	Each team member was asked to identify the five major problems facing family planning in Brazil. The causes of each problem were also discussed, as were potential obstacles.
Responses to Problems	The purpose of this open discussion was to generate as many creative ideas as possible on ways to overcome problems. Attention was paid to Pathfinder's comparative advantage in addressing these problems.
Goals and Objectives	General goals were formulated in response to the problems identified and for each goal, a number of specific objectives, with measurement indicators, were developed. As part of this process, a list of specific criteria for the selection of strategic program areas was developed.
Strategic Options and Priorities	Based upon the responses previously suggested, a list of strategic options was defined and submitted to a test by by the criteria. What emerged was a ranking of weighted averages and an indication that some options should be given higher priority than others.
Resource Projection	Available resources were projected for two periods: first, for the fifteen months through FY 91, covering the period remaining in the current cooperative agreement with Washington, and second, for the three years of FY 92-FY 94.
Work Plan	As a result of the analyses conducted in previous stages, five strategic options were selected. Each of these, now in the form of programs, was defined in terms of specific objectives and targets, grantee, financial resources and technical assistance required, and indicators for evaluation.
Financial and Human Resource Plan	The data from the work plan were then used to determine the needed Pathfinder inputs as well as the requirements for the monitoring and evaluation of the country program.

II. ENVIRONMENTAL ANALYSIS

SECTION HIGHLIGHTS

- *Demographic and Family Planning Analysis*
- *Political Environment and Family Planning Context*
- *Role of International Population Donors*

A. Analysis of Brazilian Demographic Data

The following section is an overview of Brazil based on data from the 1986 DHS and adolescent fertility surveys carried out in Salvador and São Paulo, which were published in 1988 and 1989.

1. Country Highlights

General and Family Planning Use

- Brazil is the largest country in Latin America with more than 144 million people, approximately one-third of the region's population.
- Health indicators such as infant mortality rates are worse than those in other advanced developing countries in Latin America.
- Contraceptive prevalence is 66% with modern methods at 57%; the national TFR is 3.53.
- The prevalence of modern methods is considerably lower in the Northeast region and stands at 44%. The Northeast TFR is 5.23, while that of the rural areas of the region is 7.07.
- The adolescent (ages 15-19) fertility rate is increasing compared to the declining rates of other age groups.

Quality of Family Planning Use

- Family planning quality is a problem because two thirds of female sterilizations are performed after caesarian sections; oral contraceptives are misused; intrauterine device (IUD) use is almost nonexistent; and there are an estimated 1.67 abortions per live birth.
- Almost eighty percent of contraceptive use is concentrated on just two methods, pills and voluntary surgical contraception (VSC).
- Major factors affecting family planning quality are: government price regulations for pills leading to widespread distribution of the method, and policies of the Social Security System prohibiting reimbursement for clinical family planning methods.

- Improper use of orals is a major reason leading to a high prevalence of unsafe abortions.

Family Planning Providers

- Despite some initial efforts, family planning is generally not offered through the national public health system.

- Although the Social Security System does not provide family planning, through their reimbursement policies, it has become the major provider of female VSC. Private hospitals and doctors are important providers as well.

- Pharmacies are the major provider of oral contraceptives.

- Some state health systems in the Northeast offer family planning, primarily in cooperation with BEMFAM. As national and state services decentralize to the local level, municipal health systems will play a more important role in service delivery.

- BEMFAM cooperative programs with the public sector in the Northeast are an important contributor to prevalence in that region.

2. Demographic Overview

Brazil is a country with a 1988 estimated population of 144 million people, a 19% increase since 1980. It is the largest country in Latin America with almost one-third of the region's population. Table 1 highlights 1988 and 1989 estimates of important population, economic and health characteristics.[3]

TABLE 1
DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS OF THE BRAZILIAN POPULATION

POPULATION STATISTICS	
Population	144,000,000
Crude birth rate (per 1,000 pop.)	28
Crude death rate (per 1,000 pop.)	8
Rate of natural increase	2%
Doubling time at existing rate	65 years
Total fertility rate	3.5
Percent of population in rural areas	27%
Percent of population in urban areas	73%
GNP per capita	$1,640
CRITICAL HEALTH INDICATORS	
Infant mortality (per 1,000 live births)	63
Maternal mortality (per 100,000 live births)	87-154
Expectation of life at birth	65 years
Percent of population with access to safe water	76%
Percent of babies born with low birth weight	9%

Based on modern contraceptive prevalence (57%), Brazil is classified as a "mature" developing country. However, health indicators portray a nation with the health status typical of a much less developed country. According to the 1986 DHS, the national infant mortality rate (IMR) has dropped from 99 to 76 during the period 1976-1986, although it is well above the average for Latin America. However, marked urban-rural differentials exist. The 1986 urban IMR was 61, a decrease from 95 for 1976.

More significantly, though, in rural areas there has been virtually no decline in the IMR between 1976-1986. The 1986 rate stands at 106. This figure is comparable to much less developed countries in Latin America, such as Haiti and Bolivia.[4]

According to Table 2, the national TFR is 3.53 although marked urban-rural, regional, and educational level differences exist. Rural TFR is 5.04 while that of the most underdeveloped region, the Northeast, for example, stands at 5.23. The Northeast TFR is almost double that of other regions. The TFR for Brazilian women with no education is three times that of women with more than primary level education.[5]

TABLE 2
TFR AND MEDIAN NUMBER LIVE BIRTHS
(BY AGE, URBAN-RURAL, AND EDUCATION LEVEL)
PERCENT, 1986

				Region*						No	<		>
	Brazil	Urban	Rural	Rio	SP	S	CW	NE	NCW	Educ	Prim	Prim	Prim
Total Fertility Rate													
1983-86	3.53	3.04	5.04	2.63	2.90	2.76	3.13	5.23	3.64	6.49	5.09	3.14	2.54
1980-82	4.29	3.51	6.43	2.71	3.48	3.68	3.78	6.48	4.04	6.95	5.67	4.24	2.99
Median number of children born live to women between 40-44	4.67	4.04	6.45	3.11	3.90	4.56	4.08	6.34	5.22	6.85	5.66	3.95	2.80

* Refer to Annex IV for table legend

Contraceptive Knowledge, Use and Source of Methods

Nationally, knowledge and use of modern[6] contraceptives are characteristic of a country with a "mature" contraceptive use. Virtually all women in union know of the existence of at least one contraceptive method.[7]

TABLE 3
KNOWLEDGE AND USE OF METHODS AMONG WOMEN IN UNION
PERCENT, 1986

Method	Knows Method	Ever Used	Currently Using
Pill	99.6	72.5	25.2
IUD	67.1	2.4	1.0
Female Sterilization	95.4	26.9	26.9
Male Sterilization	55.9	0.8	0.8
Condom	86.5	23.4	1.7
Injectables	57.5	2.7	0.6
Rhythm	77.2	21.0	4.0
Withdrawal	70.3	28.5	5.0
Any of the Above	99.9	86.3	65.8

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The most popular methods are female sterilization (27%), pills (25%), and rhythm and withdrawal (9% combined). Almost 80% of contraceptive use is attributable to pills and female VSC. It is important to note that for a variety of historical reasons, such as publicity about the Dalkon shield, risks associated with IUD use, and lack of governmental approval for this method until 1983, the IUD is virtually unused.

Contraceptive prevalence of women in union varies significantly between the Northeast region and other regions. In 1986, the rate stood at 74% in the metropolitan area of São Paulo while it was 53% in the Northeast region. Forty-seven percent of Northeast women in union are not current users. The Northeast region's family planning use would be classified as in the "consolidation" phase, in contrast to Brazil as a "mature" country because the modern prevalence in the Northeast is 44%. Rural-urban differentials exist as well with almost 70% of urban women in union using a method while only 57% of rural women contracept (Table 4).* However, even among the *favelas* (slum areas) of São Paulo and Rio, prevalence exceeds 60%. Although Brazil, as a whole, is almost 70% urban, the Northeast region is only 60% urban.

The percentage of sterilized women does not vary by educational level, while marked differences are seen by parity. Almost sixty-one percent of women with no children are not using any contraceptive method.

TABLE 4
DISTRIBUTION OF WOMEN IN UNION, 15-44, CURRENTLY USING SOME METHOD OF CONTRACEPTION
PERCENT, 1986

	% Using Some Method	Female Sterlz	Pill	With	Rhythm	Condom	Male Sterlz	Others	% Not Using Any Method	Total	Number of Cases
Brazil	65.8	26.9	25.2	5.0	4.3	1.7	0.8	2.0	34.2	100	3,471
Urban	69.3	30.1	25.1	3.8	4.7	1.9	1.1	2.5	30.7	100	2,515
Rural	56.7	18.3	25.2	8.0	3.0	1.1	0.3	0.8	43.3	100	956
Rio *	70.9	33.0	25.5	2.9	5.4	1.8	0.2	2.0	29.1	100	365
SP	73.5	31.4	24.3	6.7	3.3	3.1	2.4	2.2	26.5	100	756
South	74.4	18.3	41.0	7.7	3.1	1.7	0.4	2.1	25.6	100	700
CW	63.7	25.7	23.5	2.7	6.5	2.0	0.8	2.5	36.3	100	538
NE	52.9	24.6	17.3	4.3	4.5	0.5	0.2	1.6	47.1	100	913
NCW	62.1	42.0	12.4	2.4	2.9	0.5	0.5	1.4	37.9	100	199
No Educ	47.3	23.8	13.5	6.3	1.5	0.7	0.0	1.4	52.7	100	344
< Prim	58.6	26.0	21.2	7.0	2.5	1.1	0.0	0.9	41.4	100	990
Prim	69.9	29.5	26.2	6.1	4.4	1.7	0.5	1.5	30.1	100	710
> Prim	73.3	26.9	30.3	2.7	6.1	2.4	1.8	3.1	26.7	100	1,427
0 Child	39.1	0.2	25.5	4.2	5.2	2.1	0.4	1.5	60.9	100	227
1 Child	59.5	3.4	41.4	4.3	5.4	2.4	0.0	2.6	40.5	100	711
2 Child	71.2	23.6	28.8	5.2	5.5	2.3	2.3	3.5	28.8	100	910
3 Child	77.3	47.6	19.1	4.1	3.2	0.9	0.7	1.7	22.7	100	658
4+ Child	63.9	39.4	13.9	6.1	2.7	1.0	0.2	0.5	36.1	100	965

* Refer to Annex IV for table legend

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The most frequent sources for female sterilization are private doctors, clinics, and the *Instituto Nacional de Assistência Médica e Previdência Social* (INAMPS, the Social Security System). Pills and condoms are most often obtained through pharmacies. Seventy-one percent of methods are obtained through the private sector as seen in Table 5.[9]

TABLE 5
SOURCE OF CONTRACEPTIVES
PERCENT, 1986

Source	Pill	Female Sterilization	Condom	Other Clinic Method	Other Method	Total
Government Hospital	0.4	9.9	0.0	11.8	0.0	7.0
State Health System	2.8	0.1	0.0	2.4	4.0	2.0
Social Security Clinic	0.3	45.3	0.0	6.5	0.0	20.0
Private Doctor/Clinic	1.3	42.0	0.0	68.9	0.0	22.0
Pharmacy	92.7	0.0	98.6	1.1	90.2	45.0
Other	2.4	2.6	1.4	9.3	5.8	4.0
Total	100	100	100	100	100	
Number of Cases	1,002	1,016	63	74	44	2,199

The Ministry of Health (MOH) hospitals and the state and municipality health centers play a limited role nationally in the provision of methods. In the Northeast region, however, where pill use makes up 17% of the prevalence rate, about 15% of pill users obtain their method from the State Ministry of Health centers versus less than 3% nationally (Table 6)[10]. This is due to the cooperative family planning programs in the Northeast between BEMFAM and the state health sector.

TABLE 6
DISTRIBUTION OF USERS OF THE PILL AND FEMALE STERILIZATION
PERCENT, 1986

METHOD SOURCES	REGION*					
	Rio	SP	South	CW	NE	NCW
THE PILL						
Government Hospital	0.7	0.0	0.0	0.0	2.0	0.0
State Health System	0.7	0.0	0.4	0.0	14.6	1.5
Social Security Clinic**	0.7	0.8	0.0	0.6	0.0	0.0
Private Doctor/Clinic	0.7	3.2	0.8	0.6	1.0	1.5
Pharmacy	92.9	94.4	95.8	96.2	80.9	97.1
Other ***	4.3	1.6	2.9	2.5	0.0	0.0
Total	100	100	100	100	100	100
Number of Cases	116	211	325	142	176	32
FEMALE STERILIZATION						
Government Hospital	5.7	0.0	2.9	3.6	29.8	8.1
State Health System	38.6	58.5	44.7	40.5	41.2	40.1
Social Security Clinic**	49.4	39.5	49.5	52.4	27.7	50.2
Private Doctor/Clinic	5.1	0.0	0.0	0.0	0.0	0.0
Pharmacy	1.3	2.0	2.9	3.6	1.4	1.5
Total	100	100	100	100	100	100
Number of Cases	130	248	139	150	256	94

* Refer to Annex IV table legend
** Includes INAMPS
*** Includes private institutions, parent/friends, other

Sterilization as a Contraceptive Method

Twenty-seven percent of all contracepting women in Brazil have been sterilized, making it the most popular method. The median age of sterilization nationally is 31.4 years, although 16% of sterilized women undergoing the procedure were less than 25 years of age. Approximately one-quarter of sterilizations were performed on women with two or fewer children. User profiles of sterilized women denote marked differences in the Northeast and North-Central-West regions compared to the country as a whole.

For the North-Central-West region, contraceptive prevalence is comparable to national levels at 62%. However, female sterilization accounts for 42% of this prevalence. In contrast, other regions of the country have sterilization rates which range from 18% to 33%. Of this very high proportion of females sterilized in the North-Central-West, almost one-third are less than 25 years of age. However, the parity distribution of women sterilized in this region is comparable to those in other regions of the country (Table 7).[11] What these data suggest is that a large portion of women in this region begin their child-bearing early, space their births close together, and then are sterilized.

TABLE 7
PROFILE OF STERILIZED WOMEN
PERCENT, 1986

	REGION*						
	TOTAL	Rio	SP	South	CW	NE	NCW
Year of Sterilization							
Prior to 1975	7.1	7.6	6.8	11.6	7.7	2.8	11.7
1975-1977	9.0	8.9	6.8	11.6	12.5	6.6	11.7
1978-1980	19.1	19.6	20.4	21.4	16.7	15.2	25.9
1981-1983	33.3	32.3	36.7	31.1	34.5	34.3	24.9
1984-1986	31.5	31.6	29.2	24.3	28.6	41.2	25.9
Total	100	100	100	100	100	100	100
Age at Sterilization							
<25	16.1	15.8	14.3	9.7	8.3	20.8	30.5
25-29	23.8	27.2	25.2	21.4	24.4	19.0	31.0
30-34	37.7	36.7	39.5	47.6	41.1	32.5	28.9
35-39	18.7	18.4	15.6	18.4	23.8	22.5	8.6
40+	3.7	1.9	5.4	2.9	2.4	5.2	1.0
Total	100	100	100	100	100	100	100
Median Age	31.4	31.0	31.4	32.4	32.1	31.6	28.1
Duration of Marriage							
<5 Years	16.8	26.0	15.0	12.6	13.1	15.6	23.9
5-9 Years	34.5	34.8	40.8	27.2	31.6	33.2	36.6
10-14 Years	29.2	26.0	27.9	36.9	34.5	25.3	27.4
15-19 Years	15.1	12.0	10.2	19.4	19.0	19.0	8.6
20 + Years	4.5	1.3	6.1	3.9	1.8	6.9	3.6
Total	100	100	100	100	100	100	100
Children at Sterilization							
0-1	3.9	2.5	4.1	5.8	3.0	4.2	3.0
2	22.7	41.8	21.8	14.6	20.2	17.3	29.4
3	33.1	31.6	40.1	37.9	36.9	23.5	29.4
4+	40.3	24.0	34.0	41.8	39.9	55.0	38.1
Total	100	100	100	100	100	100	100
Number of Cases	1,016	130	248	139	150	256	94

*Refer to Annex IV for table legend

In the Northeast region, the modern prevalence rate is forty-four percent. Twenty-five percent of prevalence is made up of female sterilization, comparable to the proportion nationally. The median age at sterilization is also comparable to national figures. However, the parity of Northeast women who are sterilized is markedly higher than the country-wide parity. Fifty-five percent have four or more children compared to forty percent nationally.

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Quality of Family Planning Use

At least three major issues characterize the poor quality of family planning use in Brazil. These issues are sterilizations following caesarian sections, misuse of oral contraceptives, and under-utilization of the IUD.

TABLE 8
TIMING OF STERILIZATION IN RELATION TO LAST CHILD BIRTH
PERCENT, 1986

Time of Sterilization	TOTAL	REGION Rio	SP	South	CW	NE	NCW
ALL BIRTHS							
At birth							
Caesarian	63.8	65.8	71.4	75.7	61.9	53.6	53.8
Vaginal	8.4	3.2	6.8	0.0	11.3	11.8	18.3
< 11 Months after birth	9.7	10.8	4.1	7.8	8.3	15.6	12.2
12+ Months after birth	18.1	20.2	17.7	16.5	18.4	19.0	15.7
Total	100	100	100	100	100	100	100
Number of Cases	1,016	130	248	139	150	256	94
ONLY HOSPITAL BIRTHS							
At birth							
Caesarian	72.1	75.9	80.5	95.4	72.8	57.1	60.2
Vaginal	11.2	4.8	8.0	0.0	13.0	15.8	27.7
< 11 Months after birth	9.2	9.6	4.6	2.3	5.4	18.5	6.0
12+ Months after birth	7.5	9.6	6.9	2.3	8.7	8.7	6.0
Total	100	100	100	100	100	100	100
Number of Cases	559	68	147	59	82	163	40

* Refer to Annex IV for table legend

Almost two-thirds of sterilizations are carried out following caesarian section deliveries (Table 8).[12] Brazil has one of the highest caesarian section rates in the world, and presently stands at almost 32%. Regional differences are noticeable with 43% of deliveries in São Paulo performed by caesarian section versus 19% in the Northeast (Table 9)[13].

TABLE 9
DISTRIBUTION OF BIRTHS BY CAESARIAN SECTION
PERCENT, 1986

REGION	Births by Caesarian Sections
Brazil	31.6
Urban	35.3
Rural	20.5
Rio de Janeiro	43.2
Sao Paulo	43.2
South	29.3
Central East	34.4
Northeast	18.6
North-Central-West	37.0
No Education	19.1
< Primary	20.2
Primary	27.4
> Primary	43.3

Oral contraceptives are widely available through pharmacies at low prices. Their misuse is one of the major factors contributing to the extremely large number of illegal abortions performed. Brazil has one of the world's highest abortion ratios. The World Health Organization (WHO) estimates that five million abortions are performed annually vs. three million births.

The IUD is virtually unutilized in Brazil due, in part, to only recent governmental approval of the method, negative publicity about the Dalkon shield, and opposition to the IUD by left-wing political groups, the Roman Catholic Church, and feminist organizations. Over the last four years, however, mass media coverage of the past controversies has been quite limited.

B. Young Adult Fertility

Brazil is fortunate to have available a significant body of information on adolescent fertility. This section is based on recent household surveys of young adults (15-24 year olds) in Salvador and São Paulo as well as a secondary analysis of the 1986 DHS.[14,15,16] It should be noted that the household surveys do not take into consideration the characteristics of sex education courses offered, such as quality, duration, teaching methodology, and type of trainers. Therefore, it is difficult to make assessments about the reasons for differences in reproductive behavior between those young adults receiving a course and those not receiving one.

Adolescent Reproductive Behavior Highlights

- Fifty percent of young adults have received a sex education course through school, pre-marital classes, youth clubs, and social centers.
- Participation in sex education did not affect the average age of first intercourse.
- National data indicate that half of methods used at first intercourse are rhythm or withdrawal. Salvadoran women (Northeast region) receiving a sex education course were more likely to use a contraceptive method at first intercourse than those not receiving a course (32% vs. 17% respectively).
- The majority of sex education courses are not linked to services and therefore, it is difficult to evaluate them in terms of contraceptive use.
- Knowledge of pills and condoms is over 95%.
- The age-specific fertility rate (ASFR) for all age groups has declined since 1966 except for that of 15-19 year olds, which has increased.
- Oral contraceptives are the most common method used by young women.
- Sources of contraceptives for young adults in Salvador are: pharmacies (66%), private hospitals and physicians (13%), and public hospitals (7%).
- Pregnancies among young adults are frequently unintended and undesired.

1. Young Adult Profile

The profile described below will help Pathfinder to better target young adult needs. For example, a significant portion of young adults neither work nor study which presents a major challenge to designing programs to reach this group.

Education

- Approximately half of the adolescent population has not completed six years of education.
- Twenty-seven percent of women in Salvador and thirty percent in São Paulo have not completed the second level of education, comparable to seventh and eighth grade in the U.S.

- Neither the São Paulo nor the Salvador survey demonstrates large differences in educational levels between men and women. In Salvador, however, the percentage of women and men not finishing the early years of primary school is slightly higher for females (14% vs. 9% respectively).

Marital Status

- While the vast majority of young adults are single, 25% of women and 10% of men are married.

- The proportion who are still single, defined as those neither married nor living with a partner, remains high, even when only the 20-24 year old group is considered. Fifty-six percent of women in São Paulo and sixty percent of women in Salvador are single.

Economic Activity

- Male-female differences are noticeable in the area of economic activity, especially among the 20-24 year age group. The percentage of men who work is approximately 50% in Salvador and 63% in São Paulo. On the other hand, the percentage of women who work is 31% in Salvador and 35% in São Paulo.

- Almost 25% of 15-19 year old women in São Paulo and 14% in Salvador report neither studying nor working. This percentage increases to 38% for 20-24 year old women in both locations.

Socio-Economic Status and Family Structure

- The Salvador survey shows that 50% of young women and 55% of young men fall into the poor or very poor socio-economic category. Another 33% are considered lower middle-class.

- In Salvador, about one-third of the young adults surveyed live in a nuclear family structure. The second and third most common arrangements are with one or both parents and other relatives (19%) and with relatives alone (11%).

- More women than men (13% vs. 3% respectively) live in their own nuclear family, reflecting the younger age at which women marry. A larger percentage of women than men (13% vs. 1% respectively) live with non-relatives. Young women domestic workers account for a substantial proportion of this difference.

2. Sex Education and its Impact

Participation in Sex Education

Approximately one-half of the young adults who participated in household surveys in Salvador and São Paulo indicated that they had received a sex education course. Sex education included a class, a series of classes, or counseling related to reproductive health. In Salvador, a significant proportion of young men and women (39%) received a course at school. The surveys measured knowledge about subjects that had actually been covered in a sex education course. For example, the surveys reveal that awareness of sexually transmitted diseases is higher among those who received information about the topic in a course.

Impact of Sex Education

There are only slight differences in knowledge levels about modern contraceptives between those who have participated in a course and those who have not. The primary reason for this low discrepancy is that overall awareness levels of methods are already very high. For example, in Salvador, knowledge of condoms, pills, and female sterilization among the 15-24 year old population is 97%, 96%, and 88% respectively. Comparable percentages in São Paulo also hold true. It should be noted that knowledge of the less common methods nevertheless does increase with a sex education course.

Awareness of a modern contraceptive method is defined as recognition of a method as it is named by an interviewer and/or an adolescent being able to name a method without prompting. More detailed information, for example, on how a given method is used is not measured and would probably result in much lower knowledge levels.

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Participation in a sex education course does not appear to affect the average age of the onset of premarital sexual activity. In Salvador and São Paulo, the average age for women is 17.2 and 16.8 years respectively; for males, 15.0 and 14.7 years. However, those women receiving a course are more likely to use a contraceptive method at first intercourse than those not having a course, 32% vs. 17% respectively in Salvador. Nationally, almost 15% of young women used a method at first intercourse although almost half of these methods were rhythm or withdrawal. The figure was higher in Salvador where 23% percent used a method at first intercourse.

On the other hand, the courses taken by the male survey participants in Salvador do not demonstrate an impact on contraceptive use at first sexual intercourse. This is due to the fact that males begin their sexual activity at an earlier age and they may not have had an opportunity to receive a course before their first sexual encounter.

3. Adolescent Fertility, Contraceptive Use and Source of Method

Age-Specific Fertility Rate

Since 1966, the ASFR for all women of reproductive age (WRA) has declined except among the 15-19 year old cohort.[17] The ASFR for women 15-19 years old in Salvador is 57, and 139 for 20-24 year olds.

TABLE 10
DISTRIBUTION OF AGE-SPECIFIC FERTILITY RATE*
1966-1986

	Years Prior to Survey			
Age	0-4 (1981-86)	5-9 (1976-81)	10-14 (1971-75)	15-19 (1966-71)
15-19	80.6	80.9	86.2	76.6
20-24	199.2	220.3	223.3	251.0
25-29	189.3	213.5	247.9	276.1
30-34	140.7	175.1	206.8	--
35-39	89.9	124.9	--	--
40-44	43.3	--	--	--

* Age-specific fertility is measured in births per 1,000 women per year in each age group.

The high adolescent fertility rate may be due to a variety of factors: the small percentage of couples contracepting at first intercourse, use of traditional methods (withdrawal and rhythm) at first intercourse, improper use of oral contraceptives, and method failure, especially in the cases of condoms and vaginal tablets.

Sexual Activity

Slightly more than one-third of all females from both surveys have had premarital intercourse. Of the single group that has had premarital sex, approximately 43% of women in Salvador are currently sexually active, defined as intercourse within the last month. The vast majority (65%-72%), of those currently sexually active single women in Salvador and São Paulo used contraception at the last intercourse. There are no differences in contraceptive use between male and female young adults in the 20-24 year old age group. (Table 11).[18]

TABLE 11
CURRENT CONTRACEPTIVE USE AMONG MARRIED ADOLESCENTS IN SALVADOR
PERCENT

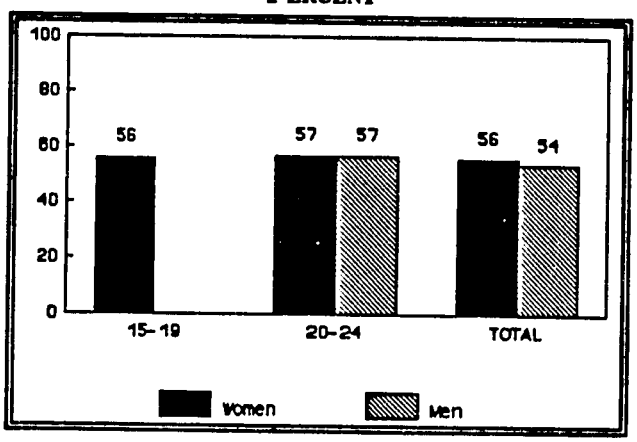
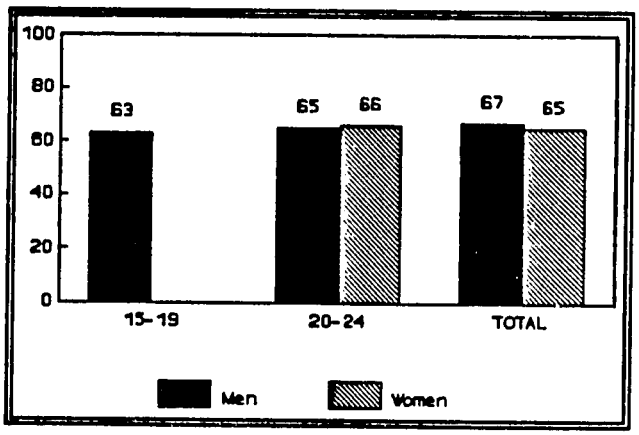


TABLE 11A
CURRENT CONTRACEPTIVE USE AMONG UNMARRIED ADOLESCENTS IN SALVADOR
PERCENT



These prevalence figures must be viewed in light of the nature of single adolescent sexual activity. Those who have had premarital intercourse but are not currently sexually active may be less likely to use contraceptives due to their sporadic sexual activity.

According to the Salvador survey, oral contraceptives are the most popular method among young adults: 66% of Salvadoran young single women who contracept use pills compared to 25% of contracepting women nationally. Among contracepting single women in Salvador, condoms (16%), and vaginal tablets (8%) are the next most common methods. Young Salvadoran married women who use a modern method show the following distribution: pills (55%), injections (11%), and condoms (8%).

Although survey data are not available, PVOs such as BEMFAM report an increased demand for condoms among young couples. The high incidence of Acquired Immune Deficiency Syndrome (AIDS) in Brazil and the extensive publicity about the disease most likely contribute to higher condom demand.

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The most common sources of methods for young adults in Salvador are pharmacies (66%), private doctors and hospitals (13%), and public hospitals (7%).

In Salvador, 53% of babies born to the 15-24 age group were conceived out-of-wedlock, vs. 34% nationally. It is possible that a large percentage of these pregnancies were undesired and unplanned. In Salvador, almost 60% of single women and 36% of all women who got pregnant reported that the pregnancy was unintended. These same figures are seen nationally as well. Additionally, only a small percentage (8%) of adolescents in Salvador wanted to become pregnant at their first intercourse.

C. The Northeast Region of Brazil[19,20,21,22]

This section is based on data obtained from the 1986 DHS, a secondary analysis of DHS data on the Northeast and state DHS surveys carried out between 1979-82.

Regional Highlights

- The educational level of WRA is low, especially in rural areas. Eighty-six percent of rural women have less than six years of education while twenty percent have no education at all.

- The TFR of the Northeast is 5.23, substantially higher than the national rate of 3.53. Rural Northeast TFR is 7.07 compared to 5.04 nationally, and for women with no education the TFR is 8.31 in the Northeast and 6.49 nationally.

- Young adult fertility rates are very high: 100/1,000 for 15-19 year olds and 260/1,000 for 20-24 year olds.

- The desire for no additional children indicates the potential for increased contraceptive use in the region. Currently, married WRA who want no more children range from 21% for those with no children to 61% of women with 5+ children. In rural areas, 86% of women with 4+ children desire to cease childbearing.

- Knowledge of female sterilization and pills (over 90%) is high among both rural and urban women.

- Modern prevalence for the region is 44%, although variations occur from state to state.

- Female sterilization and pills are the two most popular methods. IUD use is virtually non-existent.

- Over one-half of sterilized women have four or more children.
- Although the majority of sterilizations occur after caesarian sections, the caesarian section rate is much lower in the Northeast compared to the country as a whole.
- The public sector is a more important service provider in the Northeast than in other regions.
- The current decentralization of the state health system to the municipalities may open the door to increased family planning at that level in the Northeast.
- BEMFAM, working through the municipal and state health services, is the major single provider by far in the Northeast. These health centers represent virtually the only public sector provision of temporary methods in the Northeast.
- The largest number of family planning outlets are located in the states of Alagoas, Pernambuco, Rio Grande do Norte, Ceará, and Paraíba.
- Bahia, with the region's largest population, and Sergipe are the two most underserved states, based on number of municipal, state, and BEMFAM clinic outlets per population.

Population in the Northeast States

The Northeast region of Brazil includes the states of Maranhão, Piauí, Ceará, Rio Grande do Norte, Paraíba, Pernambuco, Alagoas, Sergipe, and Bahia. The 1980 population of the region represents almost one-third of the total population of the country. The two largest states are Bahia and Pernambuco with half the region's population. The Northeast is approximately 60% urban and 40% rural in contrast to the country as a whole which is 70% urbanized. The Northeast is the poorest and most underdeveloped region of Brazil.

Profile of Northeast Women

The educational level of women in the region is low: 12% of WRA have had no education and almost half have had less than 6 years of schooling. In the rural areas, 86% of women have had less than 6 years of education and 20% have had none.

Fifty-eight percent of WRA are married or living with a partner. A larger percentage of rural women (68%) than urban women (51%) live with a spouse or partner. Rural women marry or live with a partner at a younger age than their urban counterparts. For example, 47% of 20-24 year old urban women live with a partner or spouse while 65% of rural women of this age fall into the same category.

In the Northeast region, almost 70% of births take place in hospitals, the majority of those in public facilities.

The TFR of the Northeast region has decreased since 1980. During the period 1980-82, the TFR was 6.48 while during 1983-86, it dropped to 5.23. However, the TFR for Brazil as a whole, for the later period, is 3.53. Rural-urban TFR differentials in the Northeast exist: 7.07 for rural areas vs. 4.05 for urban areas. For women with no education, the TFR stands at 8.31. This figure is particularly important given the sizeable proportion of women in the region with no education (12%), especially in rural areas (20%).

The ASFR for the Northeast are markedly higher than for the nation as a whole. Particularly notable are the ASFR for young women, 15-19 year olds at 100 and 20-24 year olds at 260. The ASFR for 15-19 year old women in rural areas stands at 130 while that of 20-24 year old women, 330.

Contraceptive Knowledge and Use

In the urban areas of the Northeast, there is almost universal knowledge of the pill and female sterilization among WRA. The next most acknowledged methods are rhythm (84%), condoms (67%), and injectables (67%). Only 59% of urban women know of the IUD, about the same percentage as know of withdrawal. In rural areas, there is almost as widespread an awareness of the pill and female sterilization but knowledge levels drop sharply with other methods. Rural women demonstrate lower awareness of the rhythm method, injectables, and condoms, 59%, 58%, and 56% respectively. Additionally, just 28% of rural women know of the IUD.

TABLE 12
METHOD MIX FOR NORTHEAST USERS
1986

METHOD MIX	%
Female Sterlization	24.6
Pill	17.2
Rhythm	4.5
Withdrawal	4.3
Condom	0.5
Other	1.8
Total	52.9

According to the national DHS, overall contraceptive prevalence in the Northeast is 53% compared to 65% nationwide.[23] However, when modern methods are considered, the rate is 44%.

TABLE 13
DISTRIBUTION OF CONTRACEPTIVE METHODS DETERMINED BY NORTHEAST STATE DEMOGRAPHIC SURVEYS

State/ Country	*Year*	*VSC*	*Pills*	*IUD*	*Rhythm*	*Condom*	*Withdrawal*	*Vaginal Methods*	*Other*	*Contraceptive Prevalence*	*Total*
Piauí	1979	15.4	1.0	–	2.6	–	2.5	–	0.3	30.9	21.8
Rio Grande/N	1980	17.4	17.9	0.3	6.0	0.7	3.4	1.4	–	47.0	47.1
Pernambuco	1980	18.9	12.5	0.6	3.5	0.7	3.6	1.7	–	41.4	41.5
Paraíba	1980	15.7	14.3	–	6.6	0.2	5.7	0.6	–	43.2	43.1
Bahia	1980	11.7	9.6	0.5	–	1.4	3.2	0.9	0.3	31.1	27.6
Piauí	1982	19.6	9.6	–	2.2	0.8	2.0	–	0.8	35.0	35.0
Brazil	1986	26.9 *	25.2	–	4.3	1.7	5.0	–	2.0	65.8	65.1
		0.8 **		***							

* Women ** Men *** Included in other

Within the Northeast region there are marked differences in contraceptive use. Table 13[24] provides the most up-to-date individual state data on distribution of contraceptive methods. In the state of Bahia, modern prevalence in 1980 was 28% while in Pernambuco the rate was 34% in the same year. Comparing the distribution of contraceptive methods by region, Piauí and Bahia have the lowest modern contraceptive prevalence rates in the Northeast at 22% and 28% respectively.

Source of Contraceptive Methods

The sources of contraceptive methods differ in the Northeast compared to the rest of Brazil. Pharmacies account for almost all of the sources of pills nationwide, while 81% of Northeast pill users obtain their cycles from pharmacies and 15% from state health posts. The use of these posts by the local population can be attributed to the cooperative programs between BEMFAM and the State Ministries of Health in the region as well as to the low income levels of residents which reduces access to the commercial sector.

Rural-urban differences also exist in the provision of female sterilization. Almost one-half of urban sterilized women in the Northeast obtain their procedure through the Social Security System, while 37% of rural women obtain theirs through private doctors and hospitals. Government hospitals are the second most common source for sterilization: 28% in urban areas and 38% for rural areas.

Profile of Sterilized Women of Reproductive Age in the Northeast

Sterilization is the most popular method in the Northeast. The average age of sterilization is 31.6 years, about the national average. One-fifth of sterilized WRA had the procedure at less than 25 years of age. The parity of sterilized women is higher than the rest of Brazil, in that 55% of sterilized women have four or more children. The Brazilian pattern of sterilizations following caesarian section occurs with 56% of urban sterilizations and 48% of rural sterilization. However, 19% of all hospital births in the Northeast are caesarian, a much lower figure than the nation as a whole.

Family Planning Service Providers in the Northeast

The public sector plays a greater role in the delivery of family planning services to the estimated eight million WRA in the Northeast region than in the rest of Brazil. For example, fifteen percent of pill users obtain their cycles from state health posts in contrast to less than one percent nationally.

BEMFAM has focused its efforts in the Northeast through clinics and *convenios*, or agreements, with state and municipal governments. Currently, BEMFAM's ten clinics serve about 80,000 new users annually. BEMFAM has approximately 140 *convenios* with state and local governments to provide IE&C materials, training, contraceptives, monitoring, supervision, and technical assistance to the public sector health posts. Pathfinder currently supports BEMFAM's work in the states of Rio Grande do Norte and Alagoas. The state governments in Maranhão and Paraíba are currently implementing maternal and child health (MCH) family planning programs with funds from the United Nations Fund for Population Activities (UNFPA).

These cooperative services have the advantage of leveraging private resources to maximize their impact through the utilization of the public sector infrastructure. In addition, these programs are virtually the only ones in which the impact of the family planning PVO sector is reflected in prevalence rates. *Sistem Unificado de Saúde* (SUDS, the decentralization of the national health system) is now being implemented and may be perceived as a positive development for family planning. Municipal governments are often more receptive to the integration of family planning services into their health programs than state level systems.

The difficulties of the current *convenio* strategy include the concern that the signing of individual agreements may prove to be cumbersome to BEMFAM. Additionally, opposition to family planning services still exists among some state-level health systems.

The following chart depicts the number of service outlets supported by the various family planning PVOs in the Northeast. The outlets include individual physicians who are ABEPF affiliates, state or municipal health posts and clinics supported by agreements with BEMFAM, and HMOs of various sizes affiliated with ABRAMGE, and individual BEMFAM clinics. It is reasonable to assume that the state and municipal outlets, followed by BEMFAM's own clinics, serve the largest number of users. Although data on population covered by each outlet are not available, these figures present a general overview of coverage in the Northeast.

Table 14
Number of Family Planning Service Outlets by Northeast State

ALAGOAS — Population: 2.4 million Municipalities: 97

	Municipal	State	Own	Private	Affiliate	TOTAL
BEMFAM	67	346	0	24	0	437
ABEPF	0	0	0	0	0	0
ABRAMGE	0	0	0	0	0	0
Total	67	346	0	24	0	437

BAHIA — Population: 11.7 million Municipalities: 367

	Municipal	State	Own	Private	Affiliate	TOTAL
BEMFAM	62	0	1	12	0	75
ABEPF	0	0	0	0	12	12
ABRAMGE	0	0	0	0	3	3
SUDESCO	4	0	0	0	0	4
Total	62	0	1	12	15	94

CEARA — Population: 6.4 million Municipalities: 164

	Municipal	State	Own	Private	Affiliate	TOTAL
BEMFAM	220	0	3	92	0	315
ABEPF	0	0	0	0	14	14
ABRAMGE	0	0	0	0	1	1
Total	220	0	3	92	15	330

MARANHAO — Population: 5.1 million Municipalities: 132

	Municipal	State	Own	Private	Affiliate	TOTAL
BEMFAM	16	0	0	53	0	69
ABEPF	0	0	0	0	1	1
ABRAMGE	0	0	0	0	1	1
Total	16	0	0	53	2	71

PARAIBA — Population: 3.2 million Municipalities: 171

	Municipal	State	Own	Private	Affiliate	TOTAL
BEMFAM	224	0	0	56	0	280
ABEPF	0	0	0	0	6	6
ABRAMGE	0	0	0	0	0	0
Total	224	0	0	56	6	286

PERNAMBUCO — Population: 7.3 million Municipalities: 167

	Municipal	State	Own	Private	Affiliate	TOTAL
BEMFAM	212	0	0	131	0	343
ABEPF	0	0	0	0	3	3
ABRAMGE	0	0	0	0	1	1
Total	212	0	0	131	4	347

PIAUI — Population: 2.6 million Municipalities: 116

	Municipal	State	Own	Private	Affiliate	TOTAL
BEMFAM	189	0	0	2	0	191
ABEPF	0	0	0	0	5	5
ABRAMGE	0	0	0	0	0	0
Total	189	0	0	2	5	196

R.G. DO NORTE — Population: 2.3 million Municipalities: 151

	Municipal	State	Own	Private	Affiliate	TOTAL
BEMFAM	307	0	1	35	0	343
ABEPF	0	0	0	0	0	0
ABRAMGE	0	0	0	0	0	0
Total	307	0	1	35	0	343

SERGIPE — Population: 5.1 million Municipalities: 132

	Municipal	State	Own	Private	Affiliate	TOTAL
BEMFAM	16	0	0	0	0	16
ABEPF	0	0	0	0	0	0
ABRAMGE	0	0	0	0	0	0
Total	16	0	0	0	0	16

D. Political Environment and Family Planning Context

1. Section Highlights

- Brazil currently ranks in the world's top ten economies in terms of gross domestic product.
- The 1988 inflation rate was over 1,000%.
- Brazil has a very high degree of inequality in income distribution especially in the Northeast.
- Brazil has the largest external debt of all developing countries. Debt swap is currently not offered by the government.
- U.S. assistance to Brazil is classified as an advanced developing country program with limited resources.
- Organized family planning programs did not begin until 1965 with services and education offered by BEMFAM.
- Integration of the health programs of the MOH's Social Security System is currently underway as well as decentralization of services to the state and municipal levels.
- Public health dollars are primarily earmarked for curative medical care.
- Efforts in the 1970s and 1980s to implement public sector family planning programs have not been successful. Family planning was not an issue in the recent presidential campaign.
- While the government does not openly and directly support family planning, price regulations and policies have led to a predominant use of pills and female sterilization.
- Government policies and unintended subsidies have led to a high proportion of female sterilizations performed after caesarian sections.
- Oral contraceptives are available over-the-counter at very low cost due to government price regulations.
- The very high illegal abortion rate has contributed to a high maternal mortality rate.

2. General Discussion of Economic and Political Environment[25]

Brazil's economy ranges in complexity from the industries of São Paulo, Latin America's largest and most modern industrial complex, to trading posts on the Amazon River. Industrial development has been, in the past, concentrated in the southeastern states of Rio de Janeiro, São Paulo, and Rio Grande do Sul, but is now expanding to include the Northeast and far west. Brazil currently ranks in the world's top ten economies in terms of gross domestic product.

Following the 1964 coup, the Brazilian Government focused on two major economic goals: high gross domestic product (GDP) growth rates and control of inflation. By 1968, economic stabilization had succeeded enough to warrant an expansionist policy, especially focusing on industrial growth. The growth was financed through heavy foreign borrowing. In the 1970s, the sharp rise in oil prices, unprecedented increase in interest rates, and the plummeting of the commodities market brought the Brazilian economy to a virtual standstill. For years now, Brazil has been fighting an inflationary spiral exemplified in yearly inflation increases from forty percent in 1978 to over one thousand percent in 1988.

Even during the years of relative prosperity, however, not all of Brazil benefited equally. Low industrial wages allowed handsome profits but did little to improve the lot of the urban worker, especially in the Northeast region. Officially, the government's position was that only through sustained high industrial growth could there be improvements in regional imbalances. The already high degree of inequality in income distribution continued to increase, especially in the Northeast.

Private commercial banks, official export credit agencies, the World Bank, and the Inter-American Development Bank (IDB) replaced U.S. bilateral assistance programs as major sources of financing for development projects. As a result, the country's foreign debt rose rapidly and today is the largest of any developing country: U.S. $130 billion. About one-fourth is held by U.S. banks. In fact, debt service is a major part of Brazil's balance of payments. Although Brazil has agreed to swap a very small and insignificant part of its debt for equity, creditors and the Brazilian Government have suspended debt refinancing until the new president is sworn in during March of 1990.

As Brazil's domestic economy has grown and diversified, the country has become increasingly involved in international politics and economics. It presently is a member of the General Agreement on Tariffs and Trade (GATT), the International Monetary Fund (IMF), the Group of 77, the World Bank, and the IDB. The United States is Brazil's most important commercial partner.

In view of Brazil's economic development and its increased ability to obtain loans and technical assistance from private and multilateral sources, U.S. assistance programs were phased out in the 1970s. The A.I.D. bilateral program was terminated at the time

Brazil declined to sign the non-proliferation of nuclear power agreement. Currently, A.I.D. maintains a small advanced developing country program that emphasizes cooperation in science, technology, and family planning, and responds to endemic disease, emergencies, and natural disasters.

3. The Politics and History of Family Planning

Historical Background

Organized family planning programs are relatively new in Brazil. Demographic studies and research done before the mid-sixties indicate that information and contraceptive services were very limited. Traditional contraceptive methods such as periodic abstinence and withdrawal were common and abortion was often used to terminate unwanted pregnancies.

In 1965, BEMFAM began to provide contraceptive information and services. Institutional efforts were promoted through a network of affiliated clinics established in urban areas in 16 of 27 states. The first community-based distribution programs (CBD) in the country were also established by BEMFAM in Rio Grande do Norte in 1973. Other CBD programs followed in Pernambuco, Paraíba, Alagoas, Piauí, and Ceará in cooperation with the Secretariats of Health in these states.

Basic health programs are the responsibility of the MOH. The government is active in a program to integrate the curative and preventive health subsystems of INAMPS with that of the MOH. Eventually, both types of services will be decentralized, first to the state health secretariats, and thereafter, to health districts within each state.

Eighty-five percent of public health budgets are set aside for curative hospital care. The remaining 15% is devoted to all forms of public health, such as communicable disease control and occupational health. The government's present policies place relatively little emphasis on public education to encourage better health habits such as anti-smoking campaigns, family planning, and improved diet.

The Brazilian Government's policies toward family planning have been very fluid since Brazil's reluctant participation in the 1974 Bucharest Conference on Population. The government's public stand, however, has not reflected its actions. In 1974, the MOH attempted to implement a family planning program which was undermined by pressures from the Church and the political left. Then, in 1979, in his inaugural speech, President Figueiredo announced the need for a family planning program. However, during his five year tenure, he achieved very little. *Programa de Assistência Integral à Saúde da Mulher* (PAISM), created in the early 1980s, to improve access to family planning and other health care for women, has fallen behind schedule in implementation.

In 1988, Brazil promulgated a new constitution that covers a wide range of issues such as human rights, women's rights, education, divorce, and family planning. There have been many groups involved in lobbying for the implementation of constitutional laws that will affect the population issue. Despite the fact that the right to family planning is now constitutionally guaranteed, the government has no population policy. Presidential elections were held in November and December 1989. The winner comes from a center-right coalition, that is, as yet, ambiguous about its strategy toward family planning. It is also becoming evident that city-level government entities are the most favorable to family planning. This is due, in part, to direct social and political pressures from constituents.

Although the public sector has established a network for family planning, it is slow and inefficient. It is difficult to calculate their achievements since they tend to under-report services provided. Commodities distribution has proven to be the best way to monitor family planning services in this sector.

Government Stands on Methods

The criteria for performing sterilizations have changed since the Ethical Code addressed the issue in 1984. However, sterilization continues to be controversial. INAMPS officially does not provide for sterilizations, but is responsible for an unintended federal subsidy for female sterilization provided under the medical cover of caesarian sections. This method represents 27.2% of contraceptive use in the country. Almost two-thirds of female sterilizations in Brazil are performed in public hospitals and reimbursed under other surgical procedures.

In the last twenty years, regulations on the sale of drugs, including oral contraceptives have been relaxed to the extent that pills are available over the counter at low cost due to price regulations by the government.

NORPLANT contraceptive implants have not been approved for use and the IUD was approved in 1983.[26]

In 1987, FEBRASGO's National Committee on Human Reproduction recommended that the Ministry of Health implement tighter controls on injectables and restrict their distribution to very specific cases.

Abortion, although illegal, is ten times the rate of the U.S. where it is legal. Women from the upper middle socio-economic class have access to clinics or private medical facilities where illegal abortions are provided in relatively safe conditions. Women from the lowest socio-economic segments, on the other hand, have been forced to obtain abortions through lay midwives. These disadvantageous conditions have largely contributed to very high maternal mortality and morbidity rates in the country. The 1983 maternal mortality rate was 78 per 100,000[27]. The death rate is primarily due to hemorrhages, infections, and uterine perforations. With MOH approval of prostaglandin for the treatment of peptic ulcers, poor women have begun to use the drug as abortifacients. The result has been a decrease in the rate of postabortion infections but many women are now using it as a contraceptive method.

Medical School Teaching Environment

Pathfinder has had a long-standing program to implement family planning curricula in medical schools. Therefore, the following description attempts to assess the training and teaching environment in Brazilian medical schools, and identify future technical assistance needs.

There are 75 medical schools in Brazil. They are unequally distributed throughout the country according to demographic density, and socio-economic development of each state and their municipalities. The state of São Paulo has the highest number of medical schools followed by Minas Gerais, Rio Grande do Sud, and Rio de Janeiro. All the other states in the Northeast have at least one or two medical schools located in their capital cities. Most of the schools belong to federal, state or private (most of those Catholic) universities.

The quality of teaching varies widely in the country depending on the availability of resources. The State University of São Paulo has three of the most important medical schools in the country, which are located in the cities of Ribeirão Preto, Campinas, and São Paulo. The medical schools in São Paulo are the leaders in medical training for Brazil, have a large number of qualified professors, offer a good residency training program, and have a solid post-graduate program which receives trainees from all over the country.

The federal universities are located in each state capital in the country, all of which have a medical school, and offer residency training in affiliated teaching hospitals.

Catholic and independent private schools are smaller and often are located in small cities of the interior. Most of them do not have a permanent staff of professors. Instead, they rely on well known physicians or professors from the major schools who will teach their students on a part time basis. All medical schools utilize hospitals from the Social Security and state network for the practical training of their students.

Medical schools affiliated with hospitals or clinics are well suited to offer family planning training, if family planning has been incorporated into the curriculum. Medical schools with family planning curricula can be found in the states of Bahia, Alagoas, Pernambuco, Paraná, and Paraíba.

The quality of teaching in the medical schools depends on the above-mentioned factors and, above all, on the dedication and seriousness of their faculty. Many professors receive a very low salary, almost symbolic, in small schools and profit either from the prestige or the satisfaction of performing high quality teaching.

E. Role of International Population Donors

1. USAID Country Strategy

<u>Strategy for USAID Population Assistance in Brazil</u>

In order to maximize the reduced funds available, USAID currently focuses its family planning efforts on the following areas:

- Areas with low contraceptive prevalence in the Northeast region, the state of Minas Gerais and the *favelas* of Rio de Janeiro and São Paulo
- Groups with low contraceptive prevalence such as young adults and males
- Quality of family planning services through training and expanding targeted IE&C programs
- Sustainability of PVO programs
- Coordination of cooperating agencies working in Brazil
- Increased use of market opportunities and private enterprise

The A.I.D. Central Office of Population and the Latin America/Caribbean (LAC) Regional Bureau have had a long history of support for Brazilian population activities. Since 1986, USAID funding support for Brazil is as follows:[28]

TABLE 15
USAID POPULATION FUNDING
BRAZIL, 1986

FISCAL YEAR	FUNDING**
1986	$7,545,000
1987	6,707,000
1988	5,640,000
1989	5,939,000 *
Total	$25,831,000

* Does not include $430,000 in LAC funds
** Includes in-country costs, overhead, travel, and equipment

Between FY 87 and FY 88, there was a decrease of over one million dollars in S&T/POP support to Brazil. This drop was especially notable in the family planning services area.

USAID is also focusing its efforts on improved impact as a result of the dollars spent in Brazil. Impact may include increases in prevalence among the target population, improvements in method mix or replication of a particular service model. Impact of family planning services will be documented by data.

Strategies for individual cooperating agencies should have a clear focus, defining targeted population groups and the geographic areas in which services will be supported. Cooperating agencies will avoid duplication of efforts through coordination of activities.

A focus on financial sustainability will include linkages between local PVOs and the public sector, income generation through client fees or local fund-raising, improvements in management, and efficiency of programs. Programs with limited potential for client-generated income, such as those that service adolescents, should focus on increased local support, diversification of funding support and potential for replication of the service model.

Finally, A.I.D.'s strategy will include an emphasis on improved project portfolio management by individual cooperating agencies: fewer, larger projects for multiple years of funding, and fewer numbers of grantees.

2. Cooperating Agencies/Contractors Supporting Family Planning Services in Brazil

A total of ten cooperating agencies/contractors (including Pathfinder) spent a total of $4.677 million in USAID funds to support family planning service delivery in FY 88. After IPPF/WHR, Pathfinder was the largest single donor in that year.[29]

TABLE 16
COMMITMENTS BY USAID-SUPPORTED DONORS, FY 88
(THOUSANDS $)

Agency	$(000)
IPPF (Matching)	2474
Pathfinder	736
FPIA	394
AVSC	368
DA	285
Futures/SOMARC	222
JHPIEGO	79
JSI/Enterprise	56
MSH	51
JHU-PCS	12
Total	4,677

The following charts summarize the activities of the ten organizations: their grantees, nature of programs funded, and geographical focus (Table 17). More detailed information on each organization is found in Annex I.

The analysis of options in Section VI included an assessment of the program areas Pathfinder could support without duplicating any other cooperating agency/contractor. This assessment included:

- Review of the geographic areas already supported by cooperating agencies.
- Evaluation of Pathfinder's strengths and expertise *vís-á-vís* those of other cooperating agencies.
- Identification of gaps in support to particular geographic areas or target populations.
- Identification of areas of potential collaboration with other cooperating agencies.

TABLE 17
A PROFILE OF COOPERATING AGENCIES

	COOPERATING AGENCIES									
Location	FPIA	DA	SOMARC	JHPIEGO	AVSC	JHU/PCS	JSI	IPPF	MSH	PF
Rio	▲	▲		▲	▲		▲	▲	▲	▲
Sao Paulo					▲	▲	▲			▲
South	▲							▲		
Central	▲									
Northeast	▲	▲	▲	▲	▲	▲	▲	▲		▲
North-Central-West										▲

	COOPERATING AGENCIES/Contractors*									
Grantees	FPIA	DA	SOMARC	JHPIEGO	AVSC	JHU/PCS	JSI	IPPF	MSH	PF
ABEPF		▲			▲	▲	▲		▲	▲
BEMFAM	▲	▲		▲			▲	▲	▲	▲
CEPECS	▲									▲
CPAIMC	▲	▲		▲			▲		▲	▲
CAEMI		▲								
CLAM	▲									
PROPATER					▲	▲	▲			
O SEGUNDO			▲							
Hospitals					▲				▲	▲
CNBL	▲				▲					
Pharmacies			▲		▲					
Programs	FPIA	DA	SOMARC	JHPIEGO	AVSC	JHU/PCS	JSI	IPPF	MSH	PF
CBD-services							▲	▲		▲
Training	▲	▲		▲	▲			▲	▲	▲
Sustainability	▲				▲		▲		▲	▲
Technical Asst.		▲			▲			▲	▲	▲
Management		▲							▲	▲
Medical		▲		▲	▲					▲
Institution Bld	▲	▲			▲				▲	▲
Commodities										▲
Mass Media			▲			▲				
IE&C	▲						▲	▲		▲
Social Marketing			▲				▲	▲	▲	
Research				▲		▲	▲			▲
Young Adults		▲								▲

*Currently supporting service delivery in Brazil

3. Major Non-U.S. Population Donors[30]

The United States is the single largest bilateral donor of population funds to Brazil. The major non-U.S. donors are UNFPA, the World Health Organization/Pan-American Health Organization (WHO/PAHO), and IPPF/London.

UNFPA

- UNFPA's fifteen million dollar grant during 1985-89 to the Government of Brazil (GOB) supports maternal child health/family planning training, equipment, contraceptives, and other service components.

- UNFPA and the GOB are currently discussing a new grant for twenty million dollars for 1990-95. The new government elected at the end of 1989 will negotiate the final plan. PAHO will serve as the executing agency.

- The draft plan extends MCH/family planning activities among the public network with possible priority areas in the north and Northeast regions and some large cities.

- UNFPA currently provides assistance directly to a few selected states and municipalities in the Northeast and North-Central-West regions.

World Health Organization

- WHO has provided $1.7 million to Brazilian organizations during the period 1972-1987 for social and biological research, institutional strengthening, and contraceptives.

- PAHO grants to the national and state ministries of health have mainly supported evaluation and research in MCH programs and travel and training for population professionals, which total $1.2 million in the period 1986-1989.

IPPF/London

- IPPF/London provided approximately one million dollars to BEMFAM in 1988 for family planning service delivery.

Other Donors

- The Ford Foundation, Rockefeller Foundation, and International Development Research Center (IDRC) provide support primarily for various research activities; the Japanese Organization for International Cooperation in Family Planning (JOICEFP) funds some service delivery programs.

III. FAMILY PLANNING INSTITUTIONAL ANALYSIS

SECTION HIGHLIGHTS

- *Overview of Seven Brazilian Institutions*
- *Services Offered by Each Institution*

Institutional Overview

The following seven institutions have in the past, or could in the future, collaborate as grantees for Pathfinder projects. Information obtained through background materials and interviews with each organization was analyzed and evaluated to determine the potential role of each in the implementation of the Pathfinder strategy. A brief description with key findings about each of the institutions follows. A more detailed analysis is located in Annex III.

ABEPF

ABEPF is a unique umbrella organization which is comprised of 155 private family planning providers nationwide. While this position permits opportunities for political representation, it imposes limitations, particularly in the financial area. ABEPF initially played a key role in the consolidation and distribution of resources, but that role has steadily diminished since fewer resources are available and affiliates themselves have become more sophisticated in developing proposals and approaching potential funders. The political representation role may become more important in the future, but would require a larger membership and a greater willingness to take risks.

Other ABEPF services, such as publications and training, may ease existing financial burdens, but uncertainty remains as to whether they can be marketed at full cost. A three-year plan, which is being partially funded by Pathfinder, is guiding ABEPF's current activities. During the first year of Pathfinder core support, ABEPF has made major progress in improving its administrative and financial systems.

ABRAMGE

ABRAMGE, the industrial association of HMOs, is well-positioned to reach large numbers of company employees. It is a sustainable alternative to the public health system and provides high quality service. A major limiting factor is that HMOs do not reach the informal and underemployed sectors, which are among the poorest and most underserved client groups of Brazil.

Pathfinder currently supports the incorporation of family planning into the health services of sixteen HMOs. One of Pathfinder's goals is to demonstrate the cost-effectiveness of offering family planning so that costs are assumed by the HMOs themselves, with subsequent replication of the model. Furthermore, Pathfinder is presently supporting one of its strongest ABRAMGE members, PROMEDICA, which is an active promoter of family planning in the Northeast.

BEMFAM

The BEMFAM, the IPPF affiliate, is a strong service provider among PVOs and is the only one to have any visible impact on regional prevalence in the Northeast. However, this impact appears minuscule when compared to commercial channels and hospitals. BEMFAM is a solid institution that has, in recent years, largely overcome its autonomous image and has forged relationships with many municipalities and community groups.

One of BEMFAM's strengths in the Northeast is the distribution of condoms among sexually active adolescents. However, its institutional capacity to recover costs is limited and the organization depends upon large infusions from IPPF to cover its core budget. Pathfinder currently funds collaborative programs between BEMFAM and the public health systems in two Northeast states and provides assistance for surveys in adolescent fertility. In order to streamline its operations and to prevent stockouts, BEMFAM is working to strengthen its systems for commodities management, particularly in the area of projections and inventory controls.

CEPECS

CEPECS has essentially replicated, on a state level, what BEMFAM has done on a regional level in the Northeast. Like BEMFAM, CEPECS provides supervision and commodities to a network of health posts who, in turn, serve as referral points to a central clinic. One of CEPECS' strengths is that it has been effective, through this model, in serving poor client groups.

In order to attain financial sustainability , the organization will have to overcome many obstacles. In this respect, the pilot clinic project in Belo Horizonte being undertaken with Pathfinder and Enterprise support is interesting and should be closely monitored. The key test for CEPECS is whether it can provide, with the assistance of a new administrator, the necessary entrepreneurship to ensure the success of the pilot clinic.

CPAIMC

CPAIMC is a major service provider in the *favelas* of Rio de Janeiro where it is believed that pockets of low-prevalence populations exist. Its integrated health model provides a broad range of needed services to its clients as well as training for family planning professionals. Its geographic focus on a high prevalence area, Rio de Janeiro, is both a strength and a limitation since it leads to a more efficient use of resources but, at the same time, constricts potential impact.

CPAIMC's capability to generate income as well as its overall organizational management are currently being examined by donor agencies. Presently, with Pathfinder support, it is a leading importer and distributor of commodities and carries out a young adult program.

FEBRASGO

FEBRASGO, the national professional society of obstetricians and gynecologists, has been very active in the organization of special events, the publication of a professional journal, and the coordination of working groups in diverse fields such as ethics, research, and membership requirements. Pathfinder has given resources and technical assistance to FEBRASGO in the preparation of a teaching manual for medical students as well as the implementation of family planning in medical school curricula.

FEBRASGO's strengths include its national credibility and its access to medical schools. Future plans for the organization will place special attention on the improvement of quality of care.

Odebrecht Foundation

The Odebrecht Foundation, sponsored by one of Brazil's largest construction companies, is a private foundation that has fostered health and education programs for adolescents. It is a well managed PVO that has selected a viable project, the Liceo Program, to test its innovative approaches. Concurrently, it is also beginning to facilitate a more favorable policy environment for family planning.

The Odebrecht Foundation has focused its service efforts in Salvador where its vocational school produces videos and materials on health and family planning. Pathfinder's assistance for this project with private funds is the support of clinical and educational activities.

The following chart, Table 1, summarizes the programs offered by each institution.

TABLE 1
INSTITUTIONAL AND PROGRAMMATIC ANALYSIS

SERVICES	*BEMFAM*	*ABEPF*	*CEPECS*	*CPAIMC*	*ABRAMGE*	*FEBRASGO*	*Odebrecht*
Clinic	Δ		Δ	Δ	Δ		Δ
CBD	Δ		Δ				
Sex Education	Δ	Δ					Δ
Markets	Δ						
IE&C	Δ	Δ	Δ				Δ
Research	Δ						
Training	Δ	Δ					Δ
Technical Assistance	Δ	Δ					
Commodity Distribution	Δ			Δ	Δ		
Policy/Representation	Δ	Δ			Δ	Δ	
Coordinating		Δ					
Adolescent	Δ			Δ			Δ

There are many other institutions in Brazil that provide support for family planning services. These include CLAM, CAEMI, and PRO-PATER. Contributions are also made by hospitals such as Sofia Feldman in Belo Horizonte, pharmacies, and local producers of contraceptives such as PROMED. All were considered as potential future collaborators in the design of the Pathfinder strategy.

IV. PROBLEM IDENTIFICATION

SECTION HIGHLIGHTS

- *Analysis of Major Problems Facing Family Planning and Their Causes*
- *Identification of Potential Obstacles*
- *Possible Pathfinder Responses to Problems*
- *Pros/Cons of Responses*

A. Four Major Problems, Their Causes, and Obstacles to Resolution

Although numerous family planning problems exist in Brazil, the team identified four major problems which Pathfinder could address, given its resources and expertise.

1. Relatively low contraceptive prevalence in the Northeast and in northern Minas Gerais

Problems

- Modern contraceptive prevalence in the Northeast is low (44%) relative to national prevalence (57%).
- The TFR in the Northeast is 5.23 compared to the national rate of 3.53. In rural areas of the region, the rate is 7.07. Among the 12% of women with no education, it is 8.31.

Causes

- Lack of access to information and services.
- Few family planning providers exist in the Northeast. Virtually the only public sector provision of temporary methods is through the BEMFAM cooperative programs with the public sector. Additionally, the commercial pharmacy network is not as widespread or accessible in the Northeast as in other parts of the country. The problem is exacerbated by lower income levels in the Northeast which limit access to private providers.
- Concentration of method mix on two methods, VSC (permanent) and pills (temporary).
- Political resistance to family planning exists in some areas.
- Inadequate and inappropriate IE&C materials, particularly for rural illiterate women and young adults.
- Logistical problems and commodities shortages caused by the inaccessibility of the region.
- Low educational and income levels which are correlated with low contraceptive use. Furthermore, the income distribution in the region is more skewed than in the rest of Brazil.

2. Inadequate family planning services and contraceptive quality

Problems

- Sterilizations are routinely performed in conjunction with caesarian sections.
- Misuse of oral contraceptives probably leads to high incidence of illegal abortion.
- Use of the IUD and the diaphragm and other barrier methods is very low.

Causes

- Method mix is concentrated on two methods, pills and VSC.
- Underutilization of the IUD which is the result of a controversial history of the method in Brazil. The IUD is shrouded by past negative publicity from the media, the Church, and other sectors all of which were aggravated by the Dalkon shield disaster; provider bias against and lack of access to the method; preference of doctors to insert IUDs in their private offices rather than in public facilities; the lack of correct information about the method; only recent federal approval of the method; and the lack of reimbursement by the Social Security System for insertions.
- Scant low use of the diaphragm is caused by lack of physician training in insertion; unwillingness of providers to educate clients about correct use; lack of client information about the method; cultural bias against touching the genital area; and the high cost of imported diaphragms and spermicides.
- Limited use of barrier methods due to questionable quality of locally produced condoms; no local production of any form of spermicides.
- Routine performance of sterilizations after caesarian sections in Social Security hospitals. When done in combination, the procedure is reimbursable to the physician and hospital. However, VSCs are not paid for by Social Security on a stand-alone basis. Consequently, the caesarian section rate in Brazil is one of the highest in the world and is directly related to increased maternal risks and costs. Even in the Northeast, where caesarian section rates are comparable to those in the U.S., a large percentage of caesarian sections performed are in conjunction with tubal ligations.

- Inexpensive cost of pills (due to generalized governmental price regulations of drugs) has led to mass distribution through pharmacies which bypasses medical consultation.

3. **Increasing fertility rates among adolescents**

Problems

- The ASFR for 15-19 year old women is the only rate to have increased since 1966.
- Fertility rates for 15-19 and 20-24 year old women in the Northeast are especially high relative to the rest of Brazil.

Causes

- Changing societal norms regarding sexual behavior.
- Inadequate comprehensive, widespread sex education which focuses on attitudinal change and information on contraceptives and services.
- Lack of access to age-appropriate information and services.

4. **Minimal impact of family planning PVOs on contraceptive prevalence relative to the commercial sector and to public hospitals**

Problems

- Impact of PVOs on prevalence is only seen in Northeast where BEMFAM cooperative programs with the state public sector programs are a source of oral contraceptives.

Causes

- Limited ability of any one PVO to influence prevalence due to the enormous size of the country.
- Continued duplication of the same clinical model without attempting innovative approaches.

- Mass distribution of pills through pharmacies has bypassed PVOs.
- Performance of female VSCs in conjunction with caesarian sections are primarily carried out in Social Security and other public hospitals.
- Inadequate managerial capacity among some PVOs, especially in strategic planning, sustainability, and MIS.
- Insufficient collaboration with the public sector in the provision of resources and technical assistance for the purpose of maximizing scarce resources.
- Limited attention is paid by the PVOs on sustainability as well as to the impact of their activities.

B. Summary of Problems, Causes, and Obstacles

The following chart summarizes the four major family planning problems described in this section, the causes of these problems, and the obstacles to resolving these problems.

LOW PREVALENCE IN NE

Causes

- Lack of access
- Few family planning providers
- Concentration on only two methods
- Political resistance
- Inappropriate IE&C materials
- Logistical problems and commodity shortages
- Low education and income levels

Obstacles

- Untrained providers
- Inefficient commodity systems
- Poor service infrastructure
- Inappropriate IE&C materials
- PVOs unable to effectively leverage resources

CONTRACEPTIVE QUALITY

Causes

- Concentration on only two methods
- Underutilization of the IUD
- Provider bias against IUD and diaphragm
- Limited use of barrier methods
- Social Security policy
- Misuse of oral contraceptives

Obstacles

IUD

- Position of Church
- False beliefs about IUDs
- Provider bias/lack of training
- Private doctors prefer to insert in own offices
- Protectionism against IUD importation

VSC

- INAMPS reimbursement policy
- Legal restrictions on sterilizations

Pills

- Uneducated clientele
- High turnover of pharmacy staff
- Provider lack of knowledge

HIGH ADOLESCENT FERT.

Causes

- Changing norms regarding sexual behavior
- Lack of sex education focused on attitudinal change and services
- Lack of access to age-appropriate information and services

Obstacles

- Lack of contraceptive information
- Services do not target adolescents
- Untrained providers
- Inaccessibility of services
- Adolescents not in school/not working difficult to reach

LOW IMPACT OF PVOs

Causes

- Limited ability of any one PVO
- Continued duplication
- Mass distribution of pills
- Female VSCs performed in public sector
- Inadequate managerial capacity in MIS, strategic planning, and sustainability
- Insufficient collaboration with the public sector
- Limited emphasis placed on sustainability

Obstacles

- Inadequate skills and resources to collaborate with the public sector
- Lack of local resource inputs
- Ill-conceived missions of some PVOs
- Inefficient use of scarce resources
- Lack of entrepreneurial orientation

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C. Identification of Common Obstacles

A number of common obstacles to resolving these major family planning problems are seen as a result of the above process. For example:

- Untrained providers are obstacles that are present, most commonly, in low prevalence areas. They are a contributing factor to the underutilization of IUD use, to widespread misuse of oral contraceptives distributed in pharmacies, and they act as a barrier to lowering fertility among sexually active adolescents.

- Lack of knowledge and access to IE&C materials on the part of users also constitutes an obstacle to increasing prevalence and reducing fertility, particularly among culturally or geographically hard-to-reach populations.

- Logistical and physical infrastructure is a third set of obstacles, particularly in the Northeast. Inadequate management information and commodities systems are barriers that must be overcome if contraceptives are to be commonly available in low prevalence areas.

- Attitudes, prejudices, and resistance within important groups in society are a harder to influence set of barriers. These biased attitudes influence legislation, procedures, and implementation capacity, particularly in public sector institutions.

D. Possible Pathfinder Responses to Problems

The Pathfinder strategy must be capable of addressing and, to the extent that resources and institutional capacity permit, overcoming these obstacles to family planning services. Some possible responses that Pathfinder might undertake were delineated by the team as the first step in the development of the five-year strategy. Particular emphasis was placed on Pathfinder's comparative advantage. The "pros" and "cons" of each response were identified and placed in context with all other responses. The result of this process is found in the charts that follow.

How can Pathfinder help overcome the problem of low prevalence in the Northeast and in northeast Minas Gerais?

Response (a): Distribute condoms and IUDs through pharmacies in the Northeast and train counter clerks to provide information on these methods and referrals to doctors.

Pros	Cons
▲ Northeast is a low prevalence area	▲ Potential duplication of SOMARC effort
▲ Potential for high impact (CYPs)	▲ High turnover among drug store employees
▲ Can measure impact	
▲ Success of model in Egypt	
▲ Some Pathfinder experience in this area	

Response (b): Provide incentives and systems for distributors to sell contraceptives to small commercial establishments in the Northeast and to leave them on consignment in private homes in rural villages.

Pros	Cons
▲ Northeast is a low prevalence area	▲ No distribution network in the Northeast
▲ Model shown effective in Colombia	▲ No infrastructure for this model
	▲ Difficult to sustain

Response (c): Support PVOs in promoting IUD insertion along with other temporary methods in municipal health centers in the Northeast.

Pros	Cons
▲ BEMFAM has capacity/willingness to implement	▲ Some political risk connected with the IUD
▲ Great potential for success	
▲ Impact easily measured	
▲ No duplication with other CAs/Pathfinder expertise	
▲ Potential for sustainability	
▲ Encourages public/private collaboration	
▲ Enhances quality by improving method mix	
▲ Less political resistance in smaller municipalities	
▲ Tremendous leverage potential for Pathfinder resources	

Response (d): Support PVOs to implement factory-based distribution programs, particularly among textile and agribusiness firms in the region.

Pros	Cons
▲ Northeast is a low prevelance area	▲ Most industrial production in south
	▲ Doubtful interest of PVOs
	▲ Doubtful interest of Northeast factories

Response (e): Provide IUD insertion services along with other methods in postpartum wards of government hospitals in the Northeast.

Pros	Cons
▲ Northeast is a low prevalence area	▲ Some risks since IUD is a controversial method
▲ Potential for high success rate	
▲ Impact easily measured	
▲ Clients probably low income	
▲ 67% of births in the Northeast are in hospitals	
▲ Pathfinder experience in hospital programs	
▲ Sustainable since government will pick up cost	
▲ Potential synergies with hospital programs for adolescents	

Response (f): Support commodities grants with special emphasis on the Northeast.

Pros	Cons
▲ High impact (CYPs)	
▲ Low cost/CYP	
▲ Impact easily measured	
▲ Technical assistance in logistics to PVOs already begun	
▲ Can target Northeast	
▲ Pathfinder expertise in logistic training	

Response (g): Support addition of family planning services through HMOs

Pros	Cons
▲ High impact	▲ HMOs located throughout country
▲ Strong potential for sustainability	
▲ Tremendous leverage potential for Pathfinder resources	
▲ Reaches poor, employed population	
▲ ABRAMGE has capability/willingness to implement	
▲ Easily replicated	

How can Pathfinder help improve the quality of family planning services?

Response (a): Increase IUD as a component of the method mix by establishing a training center for IUD insertion. Promote a marketing program through the Brazilian manufacturer of IUDs for private doctors.

Pros	Cons
▵ High impact (CYPs) ▵ Synergistic effect with IUD program for govt. hospitals ▵ Sustainable because it is advantageous to local manufacturers ▵ Not duplicative of JHPIEGO or DA because of geographic specificity and marketing component ▵ Addresses "protectionist" attitude of doctors ▵ Pathfinder experience with FEBRASGO in training doctors	▵ Possible risk since IUD is a controversial method

Response (b): Improve quality by promoting an environment responsive to positive changes in INAMPS' policies to include clinical family planning methods (including VSC) as a reimbursable cost.

Pros	Cons
▵ FEBRASGO could collaborate ▵ Pathfinder experience with FEBRASGO ▵ Positive impact on maternal health	▵ Need to change penal code

Response (c): Increase quality by training pharmacy salespeople on use of oral contraceptives, thus reducing misuse.

Pros	Cons
▵ Possibility of funding available ▵ Potential for high impact	▵ Difficult to measure impact ▵ Rapid turnover of pharmacy staff ▵ Duplicative of SOMARC efforts ▵ Pathfinder has little comparative advantage ▵ Implies dilution of efforts

How can Pathfinder address the problem of high adolescent fertility?

Response (a): Establish a hospital-based, postpartum program in the Northeast.

Pros	Cons
▲ Northeast is a low prevelance area ▲ Pathfinder has successful experience and expertise ▲ Would impact high percentage of teenage mothers because most deliveries occur in hospitals ▲ Sustainable since hospital will eventually support ▲ Can be replicated ▲ Reaches high-risk population ▲ Link with hospital program for adult women	▲ Secondary prevention

Response (b): Provide school-based sex education, combined with preparation of training materials and instruction of professors in university schools of education.

Pros	Cons
▲ Some evidence of greater contraceptive use among females receiving sex education in Salvador ▲ Potential leverage and sustainability with Ministry of Education ▲ Sex education the logical place to start ▲ Schools of eduation have autonomy and can introduce sex education without government interference ▲ Particular interest in the state of Paraná for univ. program ▲ Possibility of combining with school-based clinics ▲ Possibility of expansion to schools of agriculture ▲ Experience with training materials production with Odebrecht	▲ Results of efforts (change in behavior) will be very long-term ▲ Half the adolescents already getting sex education ▲ Little evidence that sex education results in changed sexual behavior ▲ Multi-state project difficult to administer ▲ Little experience with school-based clinics

Response (c): Provide family planning services to university students.

Pros	Cons
▲ Easy to reach ▲ Possible to show impact ▲ Can be byproduct of Response (b) ▲ Reaches females beginning sexual activity ▲ Potential multipliers	▲ Population may have alternate sources of contaceptives, e.g. pharmacies ▲ Higher education equals lower fertility ▲ Higher income population in universities

Response (d): Establish a multi-service center for adolescents.

Pros	Cons
▲ Model has been successful in other countries	▲ Investment required and is a costly model ▲ No grantee available ▲ Feasibility questionable

Response (e): Experiment with a peer-to-peer model.

Pros	Cons
▲ Limited success in Mexico	▲ Little known about this idea ▲ Would require technical assistance

Response (f): Establish adolescent clinics in health centers.

Pros	Cons
	▲ Not feasible; discarded

Response (g): Design pharmacy program geared toward adolescents.

Pros	Cons
▲ 66% of adol. in Salvador obtain contraceptives in pharmacies ▲ Reaches all young adults, including those not in school and those not working	▲ Difficult to measure impact

Response (h): Promote family planning through social and youth clubs.

Pros	Cons
▲ An interesting model	▲ No known collaborating youth clubs

Response (i): Explore the feasibility of distributing condoms through commercial channels (small stores) to young adults, accompanied by promotion.

Pros	Cons
▲ An innovative model ▲ AIDS may boost condom use ▲ Reaches all young adults, including those not in school and those not working; primary prevention	▲ Will require much effort

How can Pathfinder improve the institutional capacity of family planning PVOs?

Response (a): Concentrate on BEMFAM through IUD programs in municipal health centers (described as an option to overcome the problem of low prevalance).

Pros	Cons
▵ Pathfinder has strengths and comparative advantage in logistics, MIS, and program evaluation ▵ Can be potentially coordinated with other CAs, Enterprise, MSH/FPMT and DA ▵ Has cost recovery component ▵ Ability to leverage resources ▵ BEMFAM willingness to implement	▵ Risk of promoting controversial method

Response (b): Provide institutional development support to CPAIMC.*

Pros	Cons
	▵ No ability to serve Northeast ▵ Limited impact in service delivery to underserved populations ▵ Focus on training more appropriate for other donors (DA, JHPIEGO, AVSC) ▵ Limited potential for sustainability ▵ Recent underachievement of project goals

Response (c): Provide institutional support to ABEPF.**

Pros	Cons
▵ May contribute to institutional sustainability ▵ Good progress in first year of core support	▵ Not specific to Northeast ▵ Difficult to measure impact

Response (d): Support CEPECS by continuing to work with Enterprise to implement a model sustainable clinic and by providing commodity support to CEPECS' programs. These efforts will be linked to a proposal for a comprehensive MIS program.

Pros	Cons
▵ Geographic focus ▵ Directly related to service provision ▵ Leveraging with municipal governments ▵ Contributes to sustainability ▵ Pathfinder has institutional advantage ▵ Complementary with MSH work in MIS and Enterprise	▵ Management capacity questionable ▵ Limited potential impact

* Pathfinder will continue its commodities project support

** Pathfinder will honor its three year commitment to ABEPF

V. PATHFINDER FIVE-YEAR GOALS FOR BRAZIL

SECTION HIGHLIGHTS

- *Five-year Strategy Goals for Brazil*

Delineation of Pathfinder Goals in Brazil

The next step in the strategic process was the development of goals for Pathfinder's program in Brazil. The goals listed below are a product of the previous problem identification activity as well as the process described in Section VI during which the strategic responses were evaluated according to a set of criterion to determine their order of priority for Pathfinder. Therefore, during the FY 90-94 period, Pathfinder will commit resources and technical assistance to contribute to the following:

1. *Increase Prevalence*

   - Increase contraceptive prevalence by supporting family planning services and dissemination of information in the Northeast region.

2. *Improve Quality*

   - Improve the quality of family planning services through improvements in the method mix by increasing the knowledge and use of the IUD in the Northeast region.
   - Improve the reimbursement policies for family planning clinical procedures.

3. *Decrease Adolescent Fertility Rate*

   - Decrease the fertility rate of women 15 to 24 years of age by providing barrier methods through small commercial outlets and by increasing postpartum family planning services in the Northeast region.

4. *Increase Sustainability*

   - Assist two private voluntary family planning organizations to increase their sustainability by providing technical assistance and institutional support.

VI. PATHFINDER STRATEGY

SECTION HIGHLIGHTS

- *Development of Strategy Criteria*
- *Selection and Analysis of Strategic Options*
- *Pathfinder Strategy for Brazil*

A. Development of Strategy Criteria

The strategy team developed a set of criteria for evaluating the possible responses to the four major problems facing family planning outlined in Section IV. The following list defines, in order of magnitude, the specific criteria based on the four major Pathfinder goals delineated in Section V.

High Priority

1. Impact measured by CYPs
2. Quality services (defined as access to a range of methods)

Medium Priority

3. Service to low prevalence areas
4. Potential for leveraging of Pathfinder resources
5. Contribution to program and institutional sustainability
6. Consistency with Pathfinder comparative advantage

Lower Priority

7. Services to hard-to-reach populations (culturally or demographically)
8. Potential for widespread replicability
9. Avoidance of duplication with other cooperating agencies
10. Measurability of impact
11. Effort required by headquarters and field offices
12. Consistency with expertise of Pathfinder/Brazil

B. Selection of Strategic Options

For the selection of Pathfinder strategic options, only the first three Pathfinder goals delineated in Section V were considered: increasing prevalence, improving quality, and decreasing the adolescent fertility rate. Each of these goals is consistent with the USAID strategy for Brazil.

The strategic options related to goal four, improving the institutional capacity of PVOs, were considered in light of the current commitments to three institutions. Pathfinder will continue its financial and technical support for CPAIMC as a national commodities distribution center; the three-year commitment to ABEPF will be honored; and support to CEPECS will continue for the ongoing project to achieve institutional sustainability. These commitments were all included in the financial projections of the strategy. Continued support for service delivery through financial obligations and technical assistance will assist local PVOs in moving toward sustainability in the future as well.

Travel and training grants, administered through a single "Big TIN" project, will support the implementation of the five-year strategy and were also included in the financial projections for the strategy. These grants will fund short-term national and regional training for family planning providers. Training content will include MIS, evaluation, quality of care, clinical training (especially IUD insertion), contraceptive technology, and other areas relating to the strategy. The following strategic options were those which received the greatest number of "pros" and the fewest "cons" during the problem identification stage.

1. Response to Low Prevalence

- Increase the availability of IUDs in public sector health centers in the Northeast in collaboration with PVOs such as BEMFAM. Furthermore, increase the accessibility to family planning methods, especially IUDs, through HMOs.

- Augment the availability of IUDs to postpartum clients in public hospitals in the Northeast.

- Continue commodity grants and technical assistance in logistics to PVOs.

2. **Response to Inadequate Quality**

- Establish IUD insertion training centers in medical schools for private physicians and market Brazilian-made IUDs to the trained physicians.
- Promote changes in INAMPS reimbursement policies for clinical family planning methods, including female VSC.
- Continue IUD and VSC training for medical students and doctors-in-training.

3. **Response to High Adolescent Fertility**

- Increase postpartum hospital-based services and education to adolescents in the Northeast.
- Support sex education in schools and universities.
- Distribute, through small commercial establishments, barrier methods such as foaming tablets and condoms.

C. Analysis of Strategic Options

The nine strategic options listed above were evaluated using the twelve criteria from Part A which were weighted according to magnitude. The first two criteria were assigned a weight of five; the next four a weight of four; and the last six a weight of three. Each option was attributed a ranking of one, two, or three to represent the extent to which it met the criteria (1 = low; 2 = medium; 3 = high). For example, when option number two, the hospital-based postpartum program, for example, was attributed a value of three and crossed with criterion number two, quality, it received the maximum score.

The results of this analysis may be seen in Table 1. The distribution of IUDs and other methods through health centers, HMOs and postpartum wards ranked the highest in priority, while the pilot project to distribute barrier methods to young adults in small stores ranked lowest.

TABLE 1
RESULTS OF THE EVALUATION OF STRATEGIC OPTIONS

1=Low	Criteria:	1	2	3	4	5	6	7	8	9	10	11	12	
2=Medium														
3=High	Weight:	5	5	4	4	4	4	3	3	3	3	3	3	
QUALITY SERVICES		**ATTRIBUTED VALUES**												**WEIGHTED AVERAGE**
FP in health centers/HMOs		2	3	3	3	3	3	2	3	3	3	3	3	10.33
Postpartum services		3	3	3	3	3	3	1	3	3	3	2	3	10.25
Training in medical schools		2	3	2	3	2	3	2	3	3	1	3	3	9.17
Commodity support & grants		3	1	2			3	2		3	3	3	3	9.11
IUD training for doctors		2	3	3	2	3	3	1		3	1	1	3	8.73
Promotion of reimbursement changes			3	2			2			3	3	1	1	7.86
ADOLESCENTS														
Postpartum services		1		3	2	3	3	2	1	3	3	2	3	8.27
Sex education in univ/schools		1		1	3	2	3	2	3	3	1	3	3	7.82
Small commercial establishments		2		3	1	3	1	3	2	3	2	1	1	7.09
Maximum attributed value and maximum possible score:		3	3	3	3	3	3	3	3	3	3	3	3	11.00

Criteria:

1 Impact in CYPs
2 Quality in terms of method mix
3 Low prevalence area, e.g. northeast region
4 Potential for leveraging resources
5 Contributing to sustainability
6 Pathfinder comparative advantage
7 Hard-to-reach populations
8 Replicability
9 No duplication with other cooperating agencies
10 Possibility of measuring impact
11 Effort required (3=little)
12 Expertise of Pathfinder country office
[] Not applicable

D. Application of Financial Constraints

Although each of the responses was considered to be important, it would be unrealistic to undertake all options due to the limited resources available. Although school and university sex education activities received a lower mid-range score, due to the long-range impact of these programs, Pathfinder will support them exclusively with private funds.

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The distribution and marketing of barrier methods to young adult through commercial establishments was ranked the lowest of all options. However, this option was included under the commodities distribution program as a small, innovative pilot initiative whose feasibility and impact will be tested. In addition, the program was selected as a primary prevention complement to the postpartum secondary prevention program for young adults.

As can be seen in the projections of resources to be allocated in FY 90-94 (Section IX), current commitments consume one-third of the A.I.D. resources available through FY 91. Given these financial commitments, the new strategy will gradually be phased in as current commitments are honored.

E. The Strategy

As current commitments under the CAW are phased out, Pathfinder will adopt a new family planning strategy with five central program emphases for the period FY 90-94:

1. Increase Access to High-Quality Services and Education

Increase the access to temporary family planning methods and information, with emphasis on the IUD, in the Northeast. Programs can be achieved in cooperation with PVOs (such as BEMFAM) and with municipal governments and community organizations. The primary focus will first be upon the larger municipalities and then will gradually extend to smaller, less accessible regions.

2. Continue Expansion of HMO Program

Continue the expansion of family planning services and education with emphasis on clinical methods, including the IUD and female VSC. Efforts should be coordinated through local HMOs in cooperation with ABRAMGE and PROMEDICA. Special attention will be given to promoting services to low-income industrial and agro-industrial workers. ABRAMGE is a national association and consequently the Pathfinder HMO program is national as well. While special focus is given to HMOs in the Northeast, it is essential that HMOs in other areas are included so that they can serve as models for successful replication.

3. Improve Availability of Family Planning to Postpartum Women

Improve the availability of family planning services and education to postpartum patients in public hospitals in the Northeast. The effort will focus on both adult and adolescent women and will offer all temporary methods including the IUD for appropriate clients.

4. Increase Support for Training and Promote Change in Reimbursement Policies

Augment support to the obstetric-gynecological community for family planning through the training of physicians and medical students in IUD insertion and VSC. Train private doctors in IUD insertion and quality of care issues which will possibly be complemented by the marketing of locally-produced IUDs in cooperation with the national manufacturer. Work with FEBRASGO to foster changes in the policies of the Social Security System to include family planning clinical methods, including VSC, as a reimbursable cost.

5. Commodity Distribution and Marketing to Young Adults

Continue support to family planning providers through technical assistance in logistics and management information systems and commodity grants. Couple these efforts with new, pilot initiatives in the marketing and distribution of condoms and foaming tablets to young adults through small shops in the Northeast.

VII. SPECIFIC OBJECTIVES

SECTION HIGHLIGHTS

- *Five-Year Outputs for Fiscal Years 1990-1994*

PATHFINDER'S PROJECTED OUTPUTS FOR FY 90-94

Through implementation of the strategic program areas during FY 90-94, Pathfinder will achieve the following outputs:

- produce 587,420 CYPs through project-related activities
- distribute 844,640 CYPs through commodities grants
- serve 285,172 new family planning users
- train 1,603 health and family planning professionals
- provide fifteen percent of all project-related CYPs and fifty percent of all commodity grant CYPs through the IUD
- provide institutional support to two family planning PVOs

VIII. WORKPLANS FOR FY 90-94

SECTION HIGHLIGHTS

- *In-Depth Analysis of Programs for FY 90-94*
- *Summary of Individual, Ongoing Projects*

A. Analysis of Program Areas for FY 90-94

This section will describe, in greater detail, the five program areas upon which Pathfinder will focus for the next five years. The program areas are: family planning, including IUDs, through Northeast health centers; family planning through HMOs; family planning to postpartum women in the Northeast; physician training and promotion of improved clinical family planning policies; and commodities distribution and marketing to young adults. As explained in Section VI, the strategy will be gradually phased in, as previous commitments are honored.

The workplans include a project summary, potential grantee, target population, geographic focus, funding, output projections (CYPs, trainees, etc.), and implementation issues. The calculations used to determine the output projections are found in Annex II. The second phase of the strategy process will be the development of a plan in December 1989 and January 1990 which will address implementation issues raised during the strategy team discussions and in subsequent meetings with AID/Washington and Brazil. The workplans also include the plans for evaluation and sustainability of each program area as well as technical assistance needs and potential collaboration with other cooperating agencies.

It is hoped that each program area will become a single project which will be implemented or coordinated by one grantee who, in turn, will maximize the efficient management of the strategy. This issue will be explored in greater detail during the preparation of the implementation plan.

Additionally, this workplan section presents an overview of current project commitments, both programmatically and financially. A chronogram of current projects and potential start dates for new programs is included in this section.

Projected program outputs are consistent with Pathfinder's long-term goals for outputs in Latin America. Projected commodity grant CYPs in Brazil will be 1.4 times greater than project-related CYPs. Pathfinder/Brazil will achieve an average of double the new users per year which were achieved in FY 89. Pathfinder, as well, plans to achieve a 20% reduction in trainees in Latin America through FY 96. Pathfinder/Brazil trained 448 people in FY 89 and projecting that through FY 94 would yield a total of 2,240 trainees. The new strategy plans to achieve 1,603 trainees through FY 94, a 28% reduction.

FAMILY PLANNING, INCLUDING IUDs, THROUGH NORTHEAST HEALTH CENTERS
PROGRAM DESCRIPTION

GOALS

- Increase contraceptive prevalence by supporting family planning services and dissemination of information in the Northeast region
- Improve the quality of family planning services through improvements in the method mix by increasing knowledge and use of the IUD in the Northeast region

STRATEGY

Increase access to temporary family planning methods and information, with emphasis on the IUD, in the Northeast. The program will function in cooperation with a PVO (such as BEMFAM) and with municipal governments and community organizations. The primary focus will be first upon the larger municipalities and then will gradually extend to smaller, less accessible regions.

SPECIFIC OBJECTIVES

During FY 90-94, the program will achieve the following outputs:

- 190,689 CYPs
- 114,823 new users
- 300 persons trained
- Increase in IUD use from 0.0% of method mix to 5.8%

DESCRIPTION

Pathfinder will provide support to BEMFAM which will work in collaboration primarily with municipal health services. The focus will be on large municipalities in the Northeast such as Salvador, Natal, Maceis, Recife, and Fortaleza. Presently, family planning services are currently most successfully delivered by collaborative public/private programs working in large municipalities. This achievement is due, in great part, to the quality of infrastucture, large public sector inputs, greater client receptivity, and grassroots support for family plannning both in municipal governments as well as in the population at large. Consequently, this program will be implemented at first in large municipalities where the probability for success is greater.

The program will continue to provide all temporary family planning methods but will begin to promote IUDs to appropriate clients in a number of strategically located health units in each municipality. These units will become referral centers for the insertion of IUDs. When the model is well-established, estimated at the beginning of the year four, services will be gradually implemented in twenty smaller municipalities in order to better reach the under-served rural populations.

Pathfinder will support clinical training in IUD insertion, program administration and supervision, MIS, commodities and evaluation. IE&C materials principally directed at women with low educational levels will be adapted from those already available from PATH. An IE&C and counseling strategy will also be developed which will include an evaluation component.

For the last four years, Pathfinder has supported PVO/public sector collaboration in the Northeast. This experience provides a solid base of expertise with BEMFAM for the implementation of the program. The result of this collaboration will be the leveraging of Pathfinder resources through the public sector for maximum impact. It is expected that the cost per CYP will decrease from $7.65 to $2.96, a 61% decline over the five-year period.

FAMILY PLANNING, INCLUDING IUDs, THROUGH NORTHEAST HEALTH CENTERS
PROGRAM ANALYSIS

FOCUS

Target Population: Phase 1: Poor women of reproductive age (WRA) in large municipalities
Phase 2: Poor WRA in smaller municipalities

Geographic Focus: Northeast

Projected Outputs:

	FY 90-91	FY 92-94	Total Outputs
CYPs	52,495	138,374	190,869
New Users	42,000	72,823	114,823
Trainees	75	225	300

Dates: FY 90-94, beginning in March 1990

Total Funding FY 90-94: $661,000 FY 90-91: $204,000
FY 92-94: $457,000

Grantee: BEMFAM

Alternative Grantee: CEPARH and others to be determined

ANALYSIS

Plan for Sustainability:

Pathfinder will seek collaboration with UNFPA to concentrate on municipalities in the Northeast which are interested in supporting family planning programs. UNFPA could provide support for equipment, training, and other components. Pathfinder, on the other hand, will leverage its investment by linking its support to resources provided by the public sector such as facilities, personnel from all professional levels, and the health network referral system.

Evaluation Component:

Evaluation of the outcome and impact of the project will be based on the collection of baseline data and follow-up evaluation. The data will include the number of users, CYPs, and method mix to measure the increased use of IUDs following service implementation. The project staff will include a person responsible for data collection. Technical assistance in the MIS area will provided by Pathfinder/Brazil and Boston. Information will be collected to determine the user data over time as well as the increase in rural users at the end of the five years.

Technical Assistance Required: (person-months)

Type	Year 1	Year 2	Year 3	Year 4	Year 5
MIS	--	.50	.50	.50	.25
Commodities	.50	.25	.25	.25	--
IE&C	--	1.00	--	--	--
Clinical Management	--	.50	.50	.50	.25
Clinical Training	.25	.25	.25	.25	--
TOTAL	.75	2.50	1.50	1.50	.50

Collaboration with Other Donors: PATH and UNFPA

IMPLEMENTATION ISSUES

- maintaining numbers of projects and grantees at low level
- potential provider bias against IUD
- ensuring sufficient volume of IUD clients for training to meet medical standards
- linking Pathfinder's limited resources with UNFPA or other donors
- providing IUDs through public sector, given the fact that physicians tend to provide method in their private practice
- encouraging MOH/Social Security reimbursement for IUD insertion

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FAMILY PLANNING THROUGH HMOs
PROGRAM DESCRIPTION

GOALS

- Increase contraceptive prevalence by supporting family planning services and the dissemination of information in the Northeast region
- Improve the quality of family planning services through improvements in the method mix by increasing knowledge and use of the IUD in the Northeast region

STRATEGY

Continue the expansion of family planning services and education with special emphasis on clinical methods, including the IUD and female VSC. Efforts should be coordinated through local HMOs in cooperation with ABRAMGE and PROMEDICA. Special attention will be given to expanding services to low-income industrial and agro-industrial workers. While special focus is given to HMOs in the Northeast it is essential that HMOs in other areas are included so that they can serve as important models for successful replication.

SPECIFIC OBJECTIVES

During FY 90-94, the program will achieve the following outputs:

- 194,462 CYPs
- 58,750 new users
- 403 persons trained
- incorporate a total of 48 HMOs into the program
- demonstrate at least a thirty percent decrease in annual cost per HMO

DESCRIPTION

Pathfinder will continue to support the implementation and expansion of family planning services and education among HMOs in the Northeast and nationally. Staff training, supervision, technical assistance, and commodities will be provided. Training will be provided to physicians, nurses, social workers, data specialists, and administrators in the areas of family planning methods, MIS, commodities, and evaluation. Clients will primarily receive clinical methods (IUD and VSC) through HMO services, with a smaller proportion obtaining pills, condoms, and other methods. Special attention will be placed on postpartum clients. This family planning service program was first supported by Pathfinder in eight HMOs in 1988. At the end of the five-year period, the program will incorporate a total of 48 HMOS. Pathfinder will support HMOs for two years, at a lower level during the second year. The HMOs themselves will subsequently cover costs for the services, although it is expected that HMOs in the Northeast will require more financial and technical assistance. In addition to the CYPs provided, the primary purpose of this program is to demonstrate its cost-effectiveness and cost benefits of the program to the HMOs. It is anticipated that the program will be replicated among the HMOs and other sectors as Pathfinder support decreases.

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FAMILY PLANNING THROUGH HMOs
PROGRAM ANALYSIS

FOCUS

Target Population	Poor, working couples who are members of the HMOs		
Geographic Focus:	Northeast and National		
Projected Outputs:	FY 90-91	FY 92-94	Total Outputs
CYPs	66,200	128,262	194,462
New Users	20,000	38,750	58,750
Trainees	88	315	403
Dates:	FY 90-94, second cycle of project began in October 1989		
Total Funding FY 90-94:	$258,000	FY 90-91: $107,000 FY 92-94: $151,000	
Grantee:	ABRAMGE		

ANALYSIS

Plan for Sustainability:

Each HMO will be supported for two years, at lesser amounts the second year as the HMOs absorb a higher percentage of program costs. Increased self-sufficiency will be due to the demonstration of improved institutional cost-effectiveness through the addition of family planning to their ongoing health services. By the end of the five-year period, the average annual cost to the program per HMO will decrease from the current $3,688 to $ 1,890. Cost per CYP to Pathfinder will decline from an initial $1.77 to $.91.

Evaluation Component:

Baseline and follow-up data will be collected from service statistics. Criteria for success will include the number of HMOs participating, the geographic area served, the population covered, method mix, CYPs, and cost-effectiveness. Participating HMOs have already begun to receive technical assistance in the MIS area from Pathfinder headquarters and field offices.

Technical Assistance Required: (person-months)

Type	Year 1	Year 2	Year 3	Year 4	Year 5
MIS	.50	—	—	—	—
Evaluation	.25	.25	.25	.25	.25
Clinical Training	—	.25	.25	.25	—
Total	.75	.50	.50	.50	.25

IMPLEMENTATION ISSUES

- developing plan for MIS and evaluation technical assistance, especially in the service statistics and cost areas
- geographic focus (national with special emphasis on Northeast)

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FAMILY PLANNING TO POSTPARTUM WOMEN IN THE NORTHEAST
PROGRAM DESCRIPTION

GOALS

- Increase contraceptive prevalence by supporting family planning services and dissemination of information in the Northeast region
- Improve the quality of family planning services through improvements in the method mix by increasing knowledge and use of the IUD in the Northeast region
- Decrease the fertility rate of women 15 to 24 years of age by providing postpartum family planning service in the Northeast region

STRATEGY

Improve the availability of family planning services and education to postpartum patients in public hospitals in the Northeast. The effort will focus on both adult and adolescent women and will offer all temporary methods, including the IUD for appropriate clients.

SPECIFIC OBJECTIVES

During FY 90-94, the program will achieve the following objectives:

- 150,037 CYPs
- 111,599 new users, twenty percent of whom are young adults
- 200 persons trained
- 30% of adult method mix attributable to the IUD

DESCRIPTION

Pathfinder will support clinical and other training, educational materials, commodities, improvements in MIS, and other needed technical assistance to participating hospitals in the Northeast. Although all temporary methods will be available to adult and adolescent clients, the program will work to increase the acceptability of the IUD by adult women. Pathfinder has supported a number of public sector hospital-based family planning service programs primarily in the Northeast over the last five years. These programs provided family planning services and education to postpartum women, and to clients in the community, including adolescents. Following the withdrawal of Pathfinder support, many of these hospitals have continued to provide quality services with their own resources. The success of this intervention as well as Pathfinder's acknowledged leadership role in adolescent fertility programs, demonstrates the feasibility of expanding these services to other hospitals.

FAMILY PLANNING TO POSTPARTUM WOMEN IN THE NORTHEAST
PROGRAM ANALYSIS

FOCUS

Target Population: Hospitalized postpartum WRA.

Geographic Focus: Northeast

Projected Outputs:

	FY 90-91	FY 91-92	Total Outputs
CYPs	18,430	131,607	150,037
New Users	14,400	97,199	111,599
Trainees	15	200	

Dates: FY 90-94

Total Funding FY 90-94: $565,000 FY 90-91: $ 91,000
FY 92-94: $474,000

Potential Grantees: To be determined. The selected grantee should have the capability to implement this program in several hospital sites.

ANALYSIS

Plan for Sustainability:

Pathfinder will support each hospital for three years at decreasing levels. Participating hospitals will gradually absorb the total costs by the end of the funding period. Pathfinder will leverage resources by collaborating with hospitals which will contribute their staff, physical facilities, and equipment to the delivery of services and education.

Evaluation Component:

The project will include the collection of baseline data from existing service statistics from the hospitals involved to determine prevalence and method mix. Follow-up evaluation data will be collected to measure change. The primary evaluation indicators are the increase in use of the IUD among adult women and contraceptive use among adolescents as well as CYPs provided.

Technical Assistance Required: (person-months)

Type	Year 1	Year 2	Year 3	Year 4	Year 5
Evaluation	.25	--	--	--	.25
Clinical Management	--	.50	.50	.50	--
Clinical Training	.25	.50	.50	.50	.25
TOTAL	.50	1.00	1.00	1.00	.50

IMPLEMENTATION ISSUES

- maintaining low number of projects and grantees
- identifying grantee capable of managing program in a number of different hospital sites
- identifying states in Northeast for implementation, e.g. Bahia

PHYSICIAN TRAINING AND PROMOTION OF IMPROVED CLINICAL FAMILY PLANNING POLICIES
PROGRAM DESCRIPTION

GOALS

- Increase contraceptive prevalence by supporting family planning services and the dissemination of information in the Northeast region
- Improve the quality of family planning services through improvements in the method mix by increasing knowledge and use of the IUD in the Northeast region
- Improve the reimbursement policies for family planning clinical procedures

STRATEGY

Augment support of the obstetrics-gynecological community for family planning through the training of physicians and medical students in IUD insertion and VSC. Train private doctors in IUD insertion and quality of care issues which will be complemented by the marketing of locally-produced IUDs in cooperation with the national manufacturer. Work with FEBRASGO to foster change in the medical reimbursement policies for clinical family planning methods.

SPECIFIC OBJECTIVES

During FY 90-94, the program will achieve the following outputs:

- 52,052 CYPs
- 630 physicians trained
- document progress toward changes in the reimbursement policy for clinical methods

DESCRIPTION

This program will be made up of three components:

(1) Train selected physicians in the Northeast in IUD insertion. The possible training sites will be the nine medical schools located in the Northeast states. Selection criteria will be established to ensure that the physicians invited will, in fact, utilize their new skills in IUD insertion in their private practices. These criteria will include specialization in Obstetrics-Gynecology or family practice, a significant proportion of WRA as patients, and willingness to pay to attend a one-week training course. The training will be both theoretical and clinical, designed to meet both Brazilian and Pathfinder's medical standards and will also emphasize quality of care issues. This component will be subsequently complemented by possible collaboration with PROMED, the Brazilian IUD manufacturer, to market this method to the newly-trained physicians.

(2) Train medical students and resident physicians to perform IUD insertion and VSC, to disseminate educational materials, and to provide technical assistance, commodities support, and support of national professional meetings. This component is nationally focused and will continue the Pathfinder-supported training activities in medical schools.

(3) Work with FEBRASGO to influence changes in the current system of reimbursement by the Social Security system for family planning clinical methods. This program will be carried out as a part of FEBRASGO's plans to expand its role as an advocate of quality family planning care. Pathfinder's long-standing relationship with the professional society and the location of the new FEBRASGO president in Salvador, Bahia, where the Pathfinder office is also located, will facilitate this process. Activities may include dissemination of information, support for small research studies to document the health risks and economic costs of unecessary caesarian sections for the purpose of tubal ligations and other efforts.

PHYSICIAN TRAINING AND PROMOTION OF IMPROVED CLINICAL FAMILY PLANNING POLICIES
PROGRAM ANALYSIS

FOCUS

Target Population: Components 1 & 2: private doctors, medical students, and doctors-in-training
Component 3: INAMPS

Geographic Focus: Component 1: Northeast
Component 2 & 3: National

Projected Outputs:

	FY 90-91	FY 92-94	Total Outputs
CYPs	1,185	50,867	52,052
Trainees	30	600	630

Dates: FY 91-94

Total Funding FY 90-94: $468,000 FY 90-91: $242,000
FY 92-94: $226,000

Grantee: FEBRASGO

ANALYSIS

Plan for Sustainability:

Component (1) will include a cost-recovery section through charges to physicians for receiving training. IUDs will be be sold to trained physicians by the local manufacturer and training costs have the potential to ultimately be absorbed by the manufacturer.

Evaluation Component:

The FEBGRASGO medical school curriculum implementation and exchange program, which Pathfinder pioneered in Brazil, will be evaluated in year one. Evaluation criteria will include the number of medical schools participating in the exchange program, annual meetings, number of professors trained as trainers, number of medical schools effectively providing family planning training, number of students and residents receiving training, and the number of trainees currently providing family planning services. Pathfinder will work with the Brazilian manufacturer of IUDs to monitor the sales of IUDs to trained physicians in order to calculate the CYPs provided.

Technical Assistance Required: (person-months)

Type	Year 1	Year 2	Year 3	Year 4	Year 5
Marketing	.50	1.00	--	--	--
Evaluation	.25	--	--	--	--
Clinical Training	.50	.50	.50	.25	.25
TOTAL	1.25	1.50	.50	.25	.25

Collaboration: PROMED

IMPLEMENTATION ISSUES

- appropriate selection of doctors to be trained to increase probability of follow-up use of training
- collaboration with PROMED
- phased in program: exchange program, national meeting, selection of training sites in Northeast medical schools
- ensuring sufficient volume of IUD clients for training to meet medical standards
- evaluation of Pathfinder's medical school program

COMMODITIES DISTRIBUTION AND MARKETING TO YOUNG ADULTS PROGRAM DESCRIPTION

GOALS

- Increase contraceptive prevalence by supporting family planning services and dissemination of information in the Northeast region
- Decrease the fertility rate of women 15 to 24 years of age by providing barrier methods through small commercial outlets in the Northeast

STRATEGY

Continue commodity support to family planning providers through technical assistance in logistics and in MIS. Couple these efforts with new, pilot initiatives in the marketing and distribution of commodities to young adults through small shops.

SPECIFIC OBJECTIVES

During FY 90-94, the program will achieve the following objectives:

- 844,640 CYPs through commodities grants
- establishment of commodities distribution centers in the Northeast
- 65 persons trained

DESCRIPTION

This program will be made up of three components:

(1) Pathfinder will continue its provision of commodities to Brazil for warehousing and distribution to family planning providers through the following: a) continuation of CPAIMC as a national distribution center; b) identification of institutions in the Northeast to serve as centers for commodities reception, warehousing, and distribution; and c) continuation of support to institutions which are currently able to receive commodities directly from Pathfinder.

(2) A workshop, planned in early FY 91, will train approximately thirty warehouse storekeepers from family planning organizations in Brazil. Follow-up training will continue throughout the implementation of the program. Technical assistance in organizing and carrying out the workshop will be provided by Pathfinder/Brazil and headquarters staff. This workshop is the follow-up step to the introductory commodities workshop conducted in FY 89 for logistics administrators.

(3) A pilot program will be initiated to market barrier methods (foaming tablets/condoms) to young adults through small commercial establishments in urban areas of the Northeast. Small shops are patronized by even the poorest local communities and, consequently they have the advantage of reaching young adults who are out-of-school and non-working. The increase in condom demand by young adults, due to the publicity about AIDS, should contribute to the program's success. Pathfinder will first organize a needs assessment to determine the feasibility of the program. SOMARC's collaboration will be sought as appropriate. Pathfinder's long-standing support of PROFAMILIA (Colombia's mini-marketing, commercially oriented CBD program) will provide a solid base of experience for launching the program.

COMMODITIES DISTRIBUTION AND MARKETING TO YOUNG ADULTS PROGRAM ANALYSIS

FOCUS

Target Population
Component 1: National, with a Northeast focus
Component 2: National
Component 3: Northeast

Geographic Focus:
Component 1: Family planning providers
Component 2: Family planning providers, logistics area
Component 3: Young adults in the Northeast

Projected Outputs:

	FY 90-91	FY 92-94	Total Outputs
CYPs	284,525	560,115	844,640
Trainees	30	35	65

Dates: FY 90-94

Total Funding FY 90-94: $543,000
FY 90-91: $143,000
FY 92-94: $400,000

Potential Grantees: To be determined, possibly with sub-contract to implement Component (3)

ANALYSIS

Plan for Sustainability:
The grantee agency will generate income from the distribution and marketing of contraceptives. Following a marketing needs assessment of the project, the grantee will generate income through the sales of condoms and foaming tablets to small local shops.

Evaluation Component:
Pathfinder will monitor those storekeepers trained to determine to what extent they use the training received and provide technical assistance as needed. In addition, a system to monitor contraceptive sales in the small shops will also be implemented.

Technical Assistance Required: (person-months)

Type	Year 1	Year 2	Year 3	Year 4	Year 5
Commodities	.50	.50	--	--	--
MIS	.25	.25	.25	.25	--
Marketing	--	2.00	1.00	--	--
Total	.75	2.75	1.25	.25	--

IMPLEMENTATION ISSUES

- feasibility of marketing program to young adults
- collaborating with SOMARC
- identifying of Northeast institutions capable of serving as distribution centers

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B. Ongoing Projects

Sub-section B is a summary of current CAW-funded projects in Brazil. Project information, projected outputs, and project descriptions are included. Some projects will not be renewed while others will become part of the new strategy (ABRAMGE, BEMFAM, FEBRASGO, Big TIN) with modifications in some cases.

Project Information

Project Name:	**Travel and Training Grants for Health Personnel and Key Family Planning Officials**
Grantee:	**Pathfinder/Brazil**
Funding:	**$50,000.00**
Dates:	**November 1, 1989 - October 31, 1990**

Projected Outputs

Persons Trained: 60

Project Summary

This grant will enable Pathfinder/Brazil to continue to support short-term training of health personnel and family planning officials from Brazilian family planning organizations. The training will focus on Pathfinder's long-term strategy and family planning service provision and management in order to improve the quality of services rendered and strengthen selected institutions.

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Project Information

Project #:	**CAW/BRA 025-4**
Project Name:	**Family Planning Services at the Encruzilhada Maternity Hospital**
Grantee:	**Maternidade Encruzilhada**
Funding:	**$34,950.00**
Dates:	**December 1, 1987 - December 31, 1989**

Projected Outputs

New Users:	2,000
Persons Trained:	239
Persons Informed:	5,000

Project Summary

The project supports hospital-based family planning services at the Encruzilhada Maternity Hospital in Recife, Pernambuco. The hospital is the principal health center in the region, serving the low-income population of Recife. The project provides outpatient family planning services to 5,000 postpartum women and clients from the community. The hospital also serves as a training center in family planning service delivery for medical students and physicians-in-training.

Project Information

Project #:	CAW/BRA 059-1
Project Name:	1. CPAIMC Young Adults Family Planning/ Sex Education in Low-Income Neighborhoods 2. Commodities/Supplies Distribution to Brazilian Entities
Grantee:	CPAIMC
Funding:	$135,784.57 (commodities not included)
Dates:	July 1, 1988 - June 30, 1990

Projected Outputs

New Users:	3,240
Persons Informed:	6,210
Other:	3,240 clinic referrals

Project Summary

CPAIMC will strengthen and expand the educational activities implemented during the first project year by working through select schools in twelve poor, peripheral communities of Rio de Janeiro. Talks will be given to young adults, teachers, and parents. Young adults will be referred to CPAIMC clinics.

The second component entails distribution of commodities and supplies to other family planning organizations in order to supply those who would otherwise not have access to contraceptives and to generate income that could be applied to other family planning activities of CPAIMC.

Project Information

Project #:	CAW/BRA 060-2
Project Name:	Family Planning Program with ABRAMGE
Grantee:	ABRAMGE
Funding:	$59,762.00
Dates:	October 1, 1989 - September 30, 1990

Projected Outputs

CYPs:	18,000
New Users:	10,000
Persons Trained:	38
Conferences:	2

Project Summary

Family planning services are being implemented in sixteen ABRAMGE-affiliated health maintenance organizations in geographically diverse regions. Sixteen physicians and sixteen nurses from eight HMOs will join the program in its second year and will be trained in family planning service delivery. The project is designed to demonstrate to HMOs that it is cost-effective for them to provide family planning services. The HMOs involved will serve a large population that otherwise does not have access to family planning services.

A two-day meeting for 24 selected ABRAMGE affiliated HMOs will be held to evaluate and disseminate the program's achievements during the previous year. Additionally, PROMEDICA an ABRAMGE affiliate, will organize a two-day seminar for social workers from major industries in the state of Bahia. The seminar will cover family planning counseling and user perspective.

Project Information

Project #:	CAW/BRA 062-1
Project Name:	FEBRASGO, Medical School Exchange Program
Grantee:	FEBRASGO
Funding:	$49,288.00
Dates:	October 1, 1988 - March 31, 1990

Projected Outputs

New Users:	N/A
CYPs:	N/A
Persons Trained:	Ten exchange visits of professors from ten medical schools

Project Summary

The purpose of this project is to reduce the gap that exists in family planning training among Brazilian medical schools by supporting an exchange program of 46 medical school professors interested in improving training. The exchanges will occur between schools with more developed training programs and those with less developed ones. During the visit, each exchange professor will assess the training. As a separate follow-up project, necessary material and commodities will be distributed to the schools that participated in the program.

Project Information

Project #:	CAW/BRA 063-1
Project Name:	ABEPF Institutional Support
Grantee:	ABEPF
Funding:	$157,847.00
Dates:	January 1, 1989 - June 30, 1990

Projected Outputs

Persons Trained:	200
Other:	Improvements in organizational sustainability

Project Summary

ABEPF is undertaking activities developed in its long-term strategic and financial plan to achieve self-sufficiency. The strategic plan outlines the six program areas that ABEPF will pursue: strengthening institutional infrastructure, training, producing and disseminating of materials, exporting the technical information center, facilitating political dialogue, and increasing technical assistance. This grant covers ABEPF's core support for four of the six program areas.

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Project Information

Project #:	CAW/BRA 065-1
Project Name:	Alagoas and Rio Grande do Norte, Integrated Family Planning Services and Community Health Education, Young Adult Reproductive Health and Sexuality Survey, and Latin American Congress on Family Planning II
Grantee:	BEMFAM
Funding:	$186,213.00
Dates:	March 1, 1989 - February 28, 1990

Projected Outputs

CYPs:	68,797
New Users:	48,000
Conferences:	1
Other:	Survey

Project Summary

Family planning activities have been integrated into maternal child health services provided by the State Secretariats of Health in the states of Alagoas and Rio Grande do Norte. BEMFAM's integrated program consists of an agreement with the secretariats to provide technical assistance, education, IE&C materials and contraceptives. Additionally, BEMFAM provides family planning services and education through agreements with the private sector.

BEMFAM will also carry out a household sample of 7,200 male and female young adults between the ages of 15 and 24 years old. The survey will document knowledge, attitudes, and behavior of young adults on reproductive health, and family planning. It is being conducted in the cities of Rio de Janeiro (Southeast), Curitiba (South), Recife (Northeast). The survey is jointly supported by Pathfinder, UNFPA, PAHO, and CDC.

BEMFAM organized the Latin American Congress on Family Planning II, held August 20-24, 1989 in Rio de Janeiro. An estimated 1,000 professionals participated.

Project Information

Project #:	CAW/BRA 066-1
Project Name:	Institutional Support
Grantee:	CEPECS
Funding:	$55,644.00
Dates:	July 1, 1989 - June 30, 1991

Projected Outputs

CYPs:	13,511
New Users:	27,520

Project Summary

CEPECS is implementing a medical clinic in Belo Horizonte that will generate the necessary income for CEPECS to attain a sustainable level of self-sufficiency while still attending to a poor, needy population throughout the state of Minas Gerais. Enterprise carried out the initial feasibility study and is also funding a portion of project expenses. Other than the funds allotted by Pathfinder for the evaluation, CEPECS will not receive any outside financial assistance after the fourteenth month. By that time, the clinic will begin to generate sufficient income to become self-sustaining and by the end of two years should support CEPECS health network.

Project Information

Project #:	CAW/BRA 068-1
Project Name:	Four Regional Conferences and one National Congress on Young Adult Fertility
Grantee:	Pathfinder/Brazil
Funding:	$47,313.00
Dates:	November 1, 1989 - June 30, 1990

Projected Outputs

Conferences: 5

Project Summary

Pathfinder/Brazil will coordinate regional conferences on Young Adult Fertility in Salvador, Sao Paulo, Rio de Janeiro, and Recife. These meetings will present the results of the household surveys of young adults in these cities in each respective state. The organizations that performed the surveys will be co-coordinators. Public and private sector leaders in family planning, including service providers and researchers, will be invited to discuss the survey results and present recommendations for coordinated actions to be taken.

A National Congress on Young Adult Fertility will be held in April 1990 in Brasilia to compare the four survey results and to bring a national perspective to the issue.

Project Information

Project #:	**CAW/BRA 069-1**
Project Name:	**Family Planning Integrated into Women's Health Care Program in Santarem**
Grantee:	**Fundaçao Esperança**
Funding:	**$64,000.00**
Dates:	**November 1, 1989 - April 30, 1991**

Projected Outputs

CYPs:	**8,000**
New Users:	**4,500**
Persons Trained:	**55**
Persons Informed:	**9,500**

Project Summary

Fundaçao Esperança will continue to provide family planning services and education in its women's health care program at its clinic and eight health posts which serve low-income women in the central portion of the state of Pará in the Amazon region.

C. Chronogram of Current and Planned Project Commitments for FY 90-91

The following chronogram portrays commitment dates and amounts for ongoing projects. Also included are estimated start dates and allocations for new programs developed as part of the strategy for the FY 90-91 period.

TABLE 1
CURRENT AND PROJECTED COMMITMENTS
FY 90-91

I. FY 90-91 Commitments	*FY 90*												*FY 91*											
Project Name	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
ABEPF													129											
CEPECS													27											
PF Young Adult		47																						
TIN					50																			
Esperanca				64																				

II. New Strategy	*FY 90*												*FY 91*											
Project Name	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
BEMFAM									204															
ABRAMGE				59												48								
Postpartum												91												
FEBRASGO										100					142									
CPAIMC													30											
Commodities/YA													113											

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IX. PATHFINDER INPUTS

SECTION HIGHLIGHTS

- *Financial Resources*
- *Technical Assistance and Monitoring Activities*
- *Evaluation*
- *Logistics/Commodities Management Program*

A. Financial Resources

Pathfinder anticipates that the following financial resources from USAID will be available for FY 90-94:

TABLE 1
PATHFINDER FINANCIAL RESOURCES FOR BRAZIL
(THOUSANDS)

Fiscal Year	1990	1991	1992	1993	1994
CAW Allocation	180	300	400	350	250
Add-ons	160	160	250	250	250
Est. Deobligations*	204	100	--	50	101
Total	544	560	650	650	601

*primarily from currency devaluations

These projections were developed based on lower CAW allocations due to the decreased availability of CAW resources for Latin America compared to previous years, as well as the availability of add-on funds. The FY 90 allocation was unusually low due to the potential for significant estimated deobligated funds from exchange gains. The FY 86-89 allocations dropped from $600,000 to $400,000. The FY 91-94 projections, therefore, show a downward trend compared to the FY 86-89 period. These amounts reflect the fact that Pathfinder has designated Brazil a priority country in Latin America and that these financial resources are necessary to demonstrate a measurable positive impact on family planning use in Brazil.

Table 2 describes the projected allocations for each program area. The ordering of the allocations reflects the priority assigned to each of the five program areas based on the criteria developed in Section VI. The health centers in the Northeast program, for example, received the highest ranking and has the largest proportion of funds assigned to it. Commitments already funded in FY 90 and future commitments to ABEPF are included in the table. Slightly over three million dollars is projected for programming over the five-year period.

B. Technical Assistance and Monitoring Activities

The implementation of Brazil's long-term strategy will require technical assistance to grantees in a variety of areas. The majority of technical assistance will be provided by Pathfinder/Brazil supplemented by headquarters staff. Pathfinder will hire external technical assistance when required. Table 3 depicts the amount and type of assistance required per fiscal year and by program area. A total of 22.0 person-months will be given in technical assistance in addition to routine monitoring and supervision visits by Pathfinder/Brazil.

The particular areas of expertise of the Pathfinder/Brazil office are highlighted below to delineate the type of local technical assistance which will be rendered over the next five years. These areas include:

- clinical training
- commodities management
- MIS
- program sustainability and financial management
- clinical management
- hospital-based adolescent and adult programs

Table 2
Funds Allocation for FY 90-94
(Thousands $)

Program Area	FY 90-91	FY 92-94	Total Amount	% of Total
1. Health Centers				
BEMFAM	204	457	661	31%
2. HMOs				
ABRAMGE	107	151	258	
3. Postpartum	91	474	565	19%
4. Commodity Distribution				
Support	85	400	543	18%
CPAIMC	30			
Young Adults/Comm. Est.	28			
5. Physician/Medical School Training				
Training Private Doctors/ Med School/Improved Pols	242	226	468	16%
6. Institutional Development				
ABEPF	129	73	202	7%
TIN	50	120	170	6%
Prior FY 90 Committments				
CEPECS	27		27	5%
Young Adults Survey Conf.	47		47	
Esperanca	64		64	
Total	*1104*	*1901*	*3005*	

TABLE 3
TECHNICAL ASSISTANCE PROVIDED
(NUMBER OF PERSON-MONTHS PER FISCAL YEAR)

Health Centers	1990	1991	1992	1993	1994
MIS	--	.50	.50	.50	.25
Commodities	.50	.25	.25	.25	--
IE&C	--	1.00	--	--	--
Clinical Management	--	.50	.50	.50	.25
Clinical Training	.25	.25	.25	.25	--
Total	.75	2.50	1.50	1.50	0.50

HMOs	1990	1991	1992	1993	1994
MIS	.50	--	--	--	--
Evaluation	.25	.25	.25	.25	.25
Clinical Training	--	.25	.25	.25	--
Total	.75	.50	.50	.50	.25

Postpartum	1990	1991	1992	1993	1994
Clinical Training	.25	.50	.50	.50	.25
Clinical Management	--	.50	.50	.50	--
Evaluation	.25	--	--	--	.25
Total	.50	1.00	1.00	1.00	.50

Training/Policies	1990	1991	1992	1993	1994
Marketing	.50	1.00	--	--	--
Evaluation	.25	--	--	--	--
Clinical Training	.50	.50	.50	.25	.25
Total	1.25	1.50	.50	.25	.25

Commodities	1990	1991	1992	1993	1994
Commodities	.50	.50	--	--	--
MIS	.25	.25	.25	.25	--
Marketing	--	2.00	1.00	--	--
Total	.75	2.75	1.25	.25	--

Total Person Months (By FY)	*4.00*	*8.25*	*4.75*	*3.50*	*1.50*

Monitoring visits often include technical assistance activities. During these visits project performance to date is determined, and technical assistance by Pathfinder is provided to the grantee in order to support any areas which need strengthening. Each of the five new programs will include a technical assistance workplan which will outline

the number of visits, the number of person-months provided by Pathfinder staff (both headquarters and field offices), and the type of technical assistance provided. Technical assistance by external consultants, for example in the IE&C and marketing areas, will be included as well.

Each project developed under the strategy will be visited at least twice yearly by Pathfinder/Brazil staff. The geographic focus on the new projects in the Northeast as well as the limited number of projects in the country portfolio will contribute to the feasibility of more frequent technical assistance visits. This, however, should be viewed in light of the increased size (e.g. more service delivery sites) of individual projects.

C. Evaluation

Evaluation of Programs/Projects

A comprehensive program evaluation system will be developed during the design phase and implemented from the beginning of each new project. Every project will include the collection of baseline data against which to measure performance. Depending on the individual project, the data will be collected from existing service statistics, small area surveys, client interviews, and other sources. This activity will also serve as a measure of the current MIS system of clinical projects and indicate needs for technical assistance. Both ongoing monitoring and end-of-project evaluations will compare current performance against the baseline data. Data collection will be carried out by project staff with technical assistance from Pathfinder, or occasionally, external consultants will be hired.

Evaluation of Country Achievements

A yearly evaluation of the Pathfinder/Brazil strategy will be carried out. At the end of each fiscal year, a document will be prepared which will report on the following indicators:

- Financial and portfolio management indicators such as commitments, disbursements, number of projects committed, and others
- Person-months and nature of technical assistance provided
- Performance of individual projects against the indicators established at the beginning of the project
- Performance of program areas against annual country objectives

- Lessons learned, documented successes, and problems encountered
- Plans for coming fiscal year

In addition, Pathfinder/Brazil and headquarters will carry out an annual update of the country strategy which will accompany the yearly reports.

D. Pathfinder's Logistics/Commodities Management Program

1. Introduction

The logistics infrastructure of Pathfinder consists of a commodities department at headquarters with a staff of four as well as at least one person in each of the sub-regional/country offices (Brazil included). All staff have from two to five years of experience in logistics and commodities management.

Working closely with the Family Planning Logistics Management Project (FPLM) whenever feasible, Pathfinder (Boston and field) prepares annual contraceptive procurement tables and corresponding shipping schedules. Depending on the particular characteristics of a given country and institution within that country, alternate strategies have been developed to ensure timely receipts of shipments.

The commodities program is monitored jointly by the field staff and Pathfinder/Boston. Systematic monitoring is conducted using a comprehensive commodities checklist and approved guidelines. In-depth technical assistance has been provided on several occasions in conjunction with the FPLM staff in Africa and Latin America. These collaborations include the planning and delivery of logistics workshops.

2. Commodities Program in Brazil

Commodities management at Pathfinder/Brazil is handled by the Country Representative and a Program Officer. Due to the increasing size of the program and the establishment of a buffer stock at Pathfinder/Brazil headquarters with an accompanying Off-the-Shelf (OTS) system, the Program Officer dedicates a large part of her time to the commodities program. She must respond to a number of small and/or urgent requests for commodities submitted to Pathfinder/Brazil as well as a number of institutions without duty-free privileges in need of material. The Program Officer must also contend with the number of small back orders still pending.

The Program Officer has been trained in-house by the Commodities Director and staff and has attended the Commodities Management Workshop in Colombia. She has also acted as coordinator and lecturer at the Brazilian Workshop on Logistics and Commodities Management held in Salvador in March 1989 and sponsored by Pathfinder.

3. In-Country Monitoring and Technical Assistance

The Brazil Commodities Program is monitored jointly by the field staff and headquarters staff. The Brazil office is in frequent contact with grantees to ensure smooth scheduling of the commodities distribution schedule. Assistance is often given in obtaining approval from the Ministry of Health. All project-related commodities grants are monitored during project site visits that occur at least twice per project year. Large institutional commodities grants (CINs) are monitored on a yearly basis.

4. Recent Developments

<u>CPAIMC Commodities Distribution Project</u>

A commodities distribution project with CPAIMC is currently underway until June 1990. The project Commodities Manager has attended logistics workshops, most recently the training sponsored by Pathfinder.

The current status and future plans for the distribution center are outlined below:

- The market is divided because CPAIMC manages a parallel project with FPIA.
- CPAIMC management states that their organization cannot afford to receive numerous and sizeable shipments; customs fees which are calculated to be about ten percent of the total value of the shipment are a major cost item.
- The Ministry of Health's approval process is lengthy and may sometimes take up to two months to complete. For example, currently there is a shipment that has had approval pending for over four months.
- Under the new strategy, Pathfinder will continue to provide support and technical assistance to CPAIMC so that it may continue as a national distribution center.

Increase in Requests Submitted

Due to the success of Pathfinder's workshop and the establishment of the buffer stock, the number of requests and the amount of commodities requested have increased substantially over the last three years. Since 1987, requests have increased from 10 to 23 per year.

In the last year, 47 shipments have taken place, nineteen of which were OTS. The IUDs distributed by the buffer stock in 1989 represent more than those distributed by Pathfinder in Brazil from 1986-1988.

5. Commodities Plan for Brazil

The value of commodity assistance provided by Pathfinder to Brazil for FY 89 totalled $262,112. The commodities shipped included in-kind, bulk and IE&C materials. The dollar value represents 43% of Pathfinder's total for Latin America.

Expansion of Operations

All evidence indicates that the increase in requests in 1989 will continue in coming years. As a result of the Pathfinder workshop, new institutions have now begun to request contraceptives and this trend is expected to continue. Many of these institutions are either new recipients of AID-supplied contraceptives or are introducing family planning services for the first time.

The current level of CIN activity compared to past activity shows a marked increase. The following chart presents the projections for the five-year commodities program under the new strategy.

TABLE 4
LOGISTICS/COMMODITIES MANAGEMENT PROGRAM

	1988	1989	1990	1991	1992	1993	1994	TOTAL
Condoms (million)	0.12	1.8	2.6	3	3.5	4	4.5	19.52
IUDs (thous)	1	21.4	24	30	35	40	45	196.4
Foam Tablets (thous)	4.8	34	100	150	200	250	300	1038.8
Foam (thous)	0.4	4	9	11	13	15	17	69.4
Jelly (thous)	4	20	22	25	27	29	31	158
Pills (thous)	40	355	370	380	390	400	410	2345
Diaphragm (thous)	1.1	2.3	5	6	7	8	9	38.4

Note: CIN figures for 1989 include those distributed by CPAIMC and buffer stock. Figures are based on requests. Figures include shipments made and those in the pipeline.

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TABLE 5
PATHFINDER COMMODITY DISTRIBUTION

Northeast		*North-Central-West*		*South and SE*	
Bahia	8	Goais	1	Sao Paulo	7
Paraíba	2	Pará	1	Rio	2
Pernambuco	2	Amazonas	1	Paraná	1
BEMFAM (all regions)	1			E. Santos	1
Minas Gerais	2				
Total	15	Total	3	Total	11

6. Commodities Program under the New Strategy

Workshop II: Logistics and Commodities Management for Storekeepers

The workshop for storekeepers, planned for early FY 91, will train approximately thirty storekeepers from Pathfinder projects and CINs as well as from other family planning organizations throughout Brazil. The workshop will emphasize the concept of maximum and minimum stock as the best mechanism to measure need and schedule projections. The workshop will be organized by and take place at Pathfinder/Brazil.

Contraceptive Distribution Activity

Centers for commodities reception, warehousing, and distribution will be established in the Northeast while CPAIMC will continue to be a national distribution center. The buffer stock at Pathfinder/Brazil will also be restocked on a yearly basis. Table 5 shows the current trend for commodities distribution to the Northeast: of the 29 institutions which have received commodities from Pathfinder since late 1988, 15 are located in the Northeast.

Marketing of Condoms and Foaming Tablets

Pathfinder proposes to provide funding and required technical assistance for marketing condoms and foaming tablets to young adults. Contraceptives will be dispensed through small retail stores located in target urban areas in the Northeast. The program calls for a feasibility study that will be conducted to determine the viability of the program as well as to identify potential grantees. Estimates for this program are included in Table 4 and were based on experiences with similar activities in both Peru and Colombia.

E. Monitoring and Technical Assistance

The monitoring and technical assistance system in place will continue and be strengthened. The centers receiving commodities will be visited on a regular basis by the Commodities Manager at Pathfinder/Brazil. Stock status reports and monthly shipment activity reports will be submitted to Pathfinder/Brazil and headquarters. Technical assistance will be given frequently to these centers to assure adequate commodities management. This support will focus on projections, warehousing, MIS, and distribution.

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ANNEX I

Family Planning Cooperating Agencies/Contractors

Association for Voluntary Surgical Contraception

Development Associates

Family Planning International Assistance

Futures Group

International Planned Parenthood Federation/
Western Hemisphere Region

Johns Hopkins Program for International Education
in Gynecology and Obstetrics

Johns Hopkins University

John Snow, Inc.

Management Sciences for Health

Association for Voluntary Surgical Contraception

Geographic focus:	Rio, São Paulo State, and the ABEPF network
Target population:	Low-income population
# Ongoing projects:	Four
# New projects:	Possibly in 1990, waiting for elections
Grantees:	PRO-PATER, Maternidad de São Paulo and ABEPF, CNBL
Services provided:	Training in VSC, sustainability, technical assistance

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Development Associates

Geographic focus:	Northeast States, Maranhão, Bahia, Rio Grande do Norte, Paraíba, and Pernambuco Periphery of Rio
Target population:	Trainers, nurses, community level workers
Grantees:	ABEPF, BEMFAM, CPAIMC, CAEMI
Technical assistance provided:	Training, training of trainers, management, materials development, management logistics, young adults

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Family Planning International Assistance

Geographic focus:	Londrina, Belo Horizonte, Paraíba, Paraná, Rio, and Minas Gerais
Target population:	Young adults, males, females of reproductive age
# Ongoing projects:	Three A.I.D. funded One phase down (BRA 09)
# New projects:	None
Grantees:	BEMFAM, CPAIMC, CNBL, CEPECS, CLAM
Services provided:	Service agreements with clinics, income generation, IE&C, family planning services, training and institution building

The Futures Group/SOMARC (Social Marketing Program)

Geographic focus:	Pilot project distributing pills in Belo Horizonte and Recife
Target population:	Women of reproductive age
# Ongoing projects:	Two
Grantees:	*O Segundo Brasil*, local pharmacies
Technical assistance provided:	Marketing, KAP survey, policy formulation
Services provided:	Social marketing

International Planned Parenthood Federation/Western Hemisphere Region

Geographic focus:	Primarily Northeast, Rio, and São Paulo
Target population:	Underserved poor adolescents, especially males
Grantees:	BEMFAM
Services provided:	Social marketing, natural family planning, technical assistance, CBD, training, IE&C, clinics

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Johns Hopkins Program for International Education in Gynecology and Obstetrics

Geographic focus:	Rio State, Pernambuco, and Ceará
Target population:	Underserved population
Grantees:	BEMFAM, CPAIMC
# Ongoing projects:	Three
# New projects:	One
Technical assistance provided:	VSC and IUD training, reproductive risk
Services provided:	Curriculum development, training, seminars

Johns Hopkins University/Population Communications Service

Geographic focus:	National
Target population:	Men over 35, urban
# Ongoing projects:	One
Grantees:	PRO-PATER
Services provided:	Mass media

John Snow, Inc./Enterprise

Geographic focus:	Rio de Janeiro, São Paulo, and Ceará
# Ongoing projects:	Four
Grantees:	CPAIMC, PRO-PATER, ABEPF, BEMFAM
Technical assistance provided:	Self-sufficiency, income generation, IE&C, and marketing
Services provided:	Family planning services and IE&C for the for-profit sector

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Management Sciences for Health

Geographic focus:	National
Target population:	Underserved populations
# New projects:	Nine (for period of 10/1/89-12/31/89)
Grantees:	BEMFAM, ABEPF, CPAIMC
Technical assistance provided:	Institutional strengthening, training and technical assistance in management, MIS, cost-recovery, marketing, strategic planning

ANNEX II

Output Projections

Family Planning Through Northeast Health Centers and HMOs

Family Planning To Postpartum Women

Physician Training

Commodities Distribution and Marketing To Young Adults

A. Output Projections

The following section will outline the assumptions underlying the output projections. Also included are the calculations for the projections for CYPs, and method mix, cost per CYP and other data.

1. Family Planning Including IUDs Through Northeast Health Centers

Assumptions

- The FY 90 project assumes a starting base of 20,000 annual users and the current method mix which includes no IUDs. The user number is based on the projections for the current BEMFAM project (CAW/BRA: 065-1) which provides services throughout the public sector in the Northeast states of Alagoas and Rio Grande do Norte and which will end in February 1990. It is anticipated that, during this first year, no significant percentage of IUD users will be seen due to the start-up activities required, such as the training of physicians, nurses, and social workers, implementation of IE&C materials, and other prerequisites.

- A fifty percent continuation rate is assumed from one year to the next.

- The increase in IUD use over the five-year period coincides with the national projections carried out by John Snow, Inc. By the end of the five years, IUD use will increase to 5.8%.

- The projections include a 27% increase in number of users and a corresponding 154% increase in number of CYPs as the IUD becomes a larger percentage of the method mix and continuing users are incorporated.

- The total amount allocated for the five year period is $661,000. For FY 90-91 and FY 92-94, the figures are $204,000 and $457,000 respectively. The new project will begin in March 1990 (FY 90) so the projected cost per CYP is based on $51,000 from FY 90 and $102,000 from eight months of FY 90 activity carried out from the FY 89 commitment.

- Cost per CYP over the five-year period decreases as the public sector picks up more costs, as an increased proportion of the method mix is attributable to the IUD, and as the project becomes more efficient.

TABLE 1
FAMILY PLANNING THROUGH NORTHEAST HEALTH CENTERS
PROJECTIONS

# of Users by Method	1990	%	1991	%	1992	%	1993	%	1994	%	FY 90-94	%
Pills	9,000	45.0	9,570	43.5	9,610	41.6	9,945	41.0	10,442	41.0	48,567	42.3
Condoms	8,000	40.0	8,800	40.0	9,009	39.0	9,435	38.9	9,729	38.2	44,973	39.2
Others	3,000	15.0	3,300	15.0	3,465	15.0	3,638	15.0	3,820	15.0	17,223	15.0
IUDs	0	0.0	330	1.5	1,016	4.4	1,237	5.1	1,477	5.8	4,060	3.5
New Users	20,000		22,000		23,100		24,255		25,468		114,823	
CYPs	20,000		32,495		40,872		46,546		50,957		190,869	
($000)	$153*		$153		$153		$153		$151		$763**	
Cost/CYP	$7.65		$4.71		$3.74		$3.29		$2.96		$4.00	

* $51,000 FY 90, $102,000 for FY 90 activity from FY 89 commitment
** includes $102,000 from FY 89 commitment

2. Family Planning Through HMOs

Assumptions

- Pathfinder currently supports sixteen HMOs in the implementation of family planning services, eight from the FY 89 project and eight from the FY 90 project. The projection of the number of participating HMOs is based on the assumption of an average annual cost of $3,688 per HMO for the current project with an estimated 625 new users per HMO per year.

- The number of new HMOs added each year peaks in FY 91 and FY 92 with twelve added annually. Beginning in the fourth year new HMOs will receive from Pathfinder 80% (FY 93) and 70% (FY 94) of the original start-up costs. This assumes that the HMOs will contribute the difference as the program matures and its cost effectiveness is demonstrated. Over the life of the project (LOP), Pathfinder's support will decrease 30% for the cost of the new HMOs, while the number of new participating HMOs decreases 25%.

- Pathfinder support for HMOs will last two years and the diminishing funding level is seen in the drop from 65% of costs for the "old" HMOs in FY 91 to 40% in FY 94. After two years, it is expected that the HMO itself will assume all costs. The number of "old" HMOs increases from eight each in FY 90 and 91, peaks in FY 92 and 93 and returns to ten.

- A total of 48 new HMOs will be added to the program during the life of the project, with each supported for two years. Total LOP budget is $258,004.

- Due to the fact that IUDs and VSCs account for over ninety percent of CYPs, continuation rates for other supply methods would only have a negligible impact on CYPs. Consequently, continuation rates were not calculated.

- The HMO program has a heavily clinical method focus, with both IUDs and VSCs predominating. These two methods, of course, yield high numbers of CYPs and a resulting lower cost per CYP. The cost per CYP appears low but it should be noted that this is the cost to Pathfinder; the remaining cost is increasingly assumed by the HMOs themselves.

TABLE 2
PARTICIPATION OF HMOs
PROJECTIONS

	FY 90	*FY 91*	*FY 92*	*FY 93*	*FY 94*	*TOTAL*
# of HMOs Active	16	20	24	22	16	
New	$44,100	$44,256	$44,256	$29,504	$15,490	$177,606
"Old"		$19,178	$24,341	$22,128	$14,752	$80,398
# of startups	8	12	12	10	6	48
# of "old" ones	8	8	12	12	10	50
Phased out (-)		8	8	12	12	40
% of PF supp. of "old" HMOs		65%	55%	50%	40%	
% of PF supp. of start-ups		100%	100%	80%	70%	
100% of start up	$3,688					
Annual Costs	$44,100 *	$63,434	$68,597	$51,632	$30,242	$258,004
LOP Aggregate Costs	$44,100	$107,534	$176,130	$227,762	$258,004	

* Note: Includes nine months of activity in FY 90.

TABLE 3
FAMILY PLANNING THROUGH HMOS
PROJECTIONS

# of Users by Method	1990	%	1991	%	1992	%	1993	%	1994	%	FY 90-94	%
Pills	1,500	20.0	2,500	20.0	3,000	20.0	2,750	20.0	2,000	20.0	11,750	20.0
Condoms	750	10.0	1,250	10.0	1,500	10.0	1,375	10.0	1,000	10.0	5,875	10.0
IUDs	3,000	40.0	5,000	40.0	6,000	40.0	5,500	40.0	4,000	40.0	23,500	40.0
VSC	1,350	18.0	2,250	18.0	2,700	18.0	2,475	18.0	1,800	18.0	10,575	18.0
Others	900	12.0	1,500	12.0	1,800	12.0	1,650	12.0	1,200	12.0	7,050	12.0
New Users	7,500 *		12,500		15,000		13,750		10,000		58,750	
CYPs	24,825		41,375		49,650		45,512		33,100		194,462	
($000)	$44.1		$63.4		$68.5		$51.6		$30.2		$257.8	
Cost/CYP	$1.77		$1.53		$1.38		$1.13		$0.91		$1.32	
# of HMOs	16		20		24		22		16			

* nine months of project activity in FY 90

3. Family Planning to Postpartum Women in the Northeast

Assumptions

- Participating hospitals begin with one and increase to twelve by the fifth year. New hospitals receive 100% of Pathfinder support in the amount of $25,000 for one year. Hospitals are supported for a total of three years at gradually decreasing levels as the public hospitals pick up more of the costs themselves.

- It is anticipated that each hospital will have 3,600 users per year, (15 users/day multiplied by 240 days/year), 20% of whom will be adolescents, and 80% will be adults.

- The method mix reflects the use of the IUD and all temporary methods. IUDs will be provided to a small percentage (5-10%) of carefully selected adolescents who meet the criteria for IUD use. Since this is a postpartum program with counseling and IE&C materials available about the IUD and other temporary methods, it is expected that 30% of adult clients will become IUD users by the fifth year.

- Cost per CYP to Pathfinder gradually decreases as increasing portion of costs are absorbed by the hospitals and more are incorporated into the program.

- Due to the likelihood that most women will not return to the hospital for supply methods and that IUD users retain their method for an average of 2.5 years, continuation rates were not calculated as part of CYPs.

TABLE 4
PARTICIPATION OF HOSPITALS
PROJECTIONS

	FY 90	FY 91	FY 92	FY 93	FY 94	TOTAL
# of Hospitals	1	3	6	9	12	
New	$25,000	$50,000	$75,000	$100,000	$112,500	$362,500
"Old"		$16,250	$30,000	$41,250	$55,000	$142,500
"Older"		$0	$10,000	$20,000	$30,000	$60,000
# of startups	1	2	3	4	5	15
# of "old" ones		1	2	3	4	10
# of "older" ones		0	1	2	3	
Phased out (-)			0	1	2	
% of PF supp. of start-ups	100%	100%	100%	100%	90%	
% of PF supp. of "old" Hospitals		65%	60%	55%	55%	
% of PF supp. of "older" Hospitals			40%	40%	40%	
100% of start up	$25,000					
Annual Costs	$25,000	$66,250	$115,000	$161,250	$197,500	$565,000
LOP Aggregate Costs	$25,000	$91,250	$206,250	$367,500	$565,000	

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TABLE 5
FAMILY PLANNING TO POSTPARTUM WOMEN IN THE NORTHEAST
PROJECTIONS

# of Users by Method	1990	%	1991	%	1992	%	1993	%	1994	%	90-94	%
ADULTS												
Pills	1,728	60.0	5,011	58.0	9,850	57.0	14,774	57.0	19,699	57.0	51,062	57.2
Condoms	288	10.0	864	10.0	1,728	10.0	2,592	10.0	3,456	10.0	8,928	10.0
IUDs	576	20.0	1,901	22.0	4,320	25.0	6,998	27.0	10,368	30.0	24,163	27.1
Others	288	10.0	864	10.0	1,382	8.0	1,555	6.0	1,037	3.0	5,126	5.7
New Users	2,880		8,640		17,280		25,919		34,560		89,279	
ADOL.												
Pills	576	80.0	1,663	77.0	3,283	76.0	4,860	75.0	6,480	75.0	16,862	75.5
Condoms	72	10.0	216	10.0	432	10.0	648	10.0	864	10.0	2,232	10.0
IUDs	36	5.0	173	8.0	389	9.0	648	10.0	864	10.0	2,110	9.5
Others	36	5.0	108	5.0	216	5.0	324	5.0	432	5.0	1,116	5.0
New Users	720		2,160		4,320		6,480		8,640		22,320	
Tot New Users	3,600		10,800		21,600		32,399		43,200		111,599	
CYPs	4,518		13,912		27,691		43,868		60,048		150,037	
Cost	$25,000		$66,250		$115,000		$161,250		$197,500		$565,000	
Cost/CYP	$5.53		$4.76		$4.15		$3.68		$3.29		$3.77	
# of Hosp. Active	1		3		6		9		12		31	

4. Physician Training

Assumptions

- The number of training sites will be phased in beginning with three in FY 91 and concluding with nine by FY 94 (Table 7).
- Start-up activities will mean that twenty physicians will be trained the first year at each site. During the subsequent three years thirty doctors will be trained at each site per year. It is expected that a total of 780 doctors will receive training during the four years of the program.
- It is anticipated that each physician will insert five IUDs during the course of the one-week training session.
- During the training itself, 3,150 IUDs will be inserted for a total of 7,875 CYPs.

- To calculate the number of doctors who return to their private practices and actually insert IUDs, a ten percent drop-out rate in the first year was assumed. A five percent drop-out rate was assumed for each subsequent year after training. It is anticipated that careful selection of doctors to be trained will enable the drop-out rate to be kept at these levels.

- Although the number of potential IUD clients varies widely from physician to physician, it was assumed that each trained doctor would insert an average of two IUDs monthly. However, since physicians are trained throughout the year, two IUD's per month for a six month period for each doctor was planned for the first year after training. Therefore, it is projected that 17,671 IUDs will be inserted for a total of 44,177 CYPs following the training.

5. Commodities Distribution and Marketing to Young Adults

- The CYPs in Table 6 include commodities distributed through proposed distribution centers, CPAIMC, Pathfinder buffer stock, and the young adult commercial establishment program. Figures are based on requests and include shipments made and those in the pipeline.

Table 6
Commodities Distribution and Marketing Projections

	FY 90-91	FY 92-94	TOTAL
Condoms	56,000	120,000	176,000
IUDs	135,000	300,000	435,000
Foaming Tabs	2,500	7,500	10,000
Foam	6,667	15,000	21,667
Jelly	15,666	29,000	44,666
Pills	57,692	64,615	122,307
Diaphragm	11,000	24,000	35,000
Total	284,525	560,115	844,640
Cost per CYP	*$0.64*		

TABLE 7
PHYSICIAN TRAINING PROJECTIONS

CYPs	1991	1992	1993	1994	TOTAL
# of Training Sites	3	4	7	9	23
# of Doctors Trained/Site	10	30	30	30	100
Total MDs Trained	30	120	210	270	630
Dropout Rate (10%)	27	108	189	243	567
Dropout Rate (5%)	26	103	180		308
Dropout Rate (5%)	24	97			122
Dropout Rate (5%)	23				1,020
IUDs Inserted During Training					
# of MDs x 5 IUDs	150	600	1,050	1,350	3,150
CYPs	375	1,500	2,625	3,375	7,875
Participating MDs Following Training					
Cohort 1 (Tr. FY 91)	324	616	585	556	2,080
Cohort 2 (Tr. FY 92)		1,296	2,462	2,339	6,098
Cohort 3 (Tr. FY 93)			2,268	4,309	6,577
Cohort 4 (Tr. FY 94)				2,916	2,916
CYPs/Follow-up					
Cohort 1	810	1,539	1,462	1,389	5,200
Cohort 2		3,240	6,156	5,848	15,244
Cohort 3			5,670	10,773	16,443
Cohort 4				7,290	7,290
Total	810	4,779	13,288	25,300	44,177
Total CYPs					
Training	375	1,500	2,625	3,375	7,875
Follow-up	810	4,779	13,288	25,300	44,177
Total					52,052

Cost per MD Trained	$375
Total Costs	$236,250
Cost/CYP	$4.54

ANNEX III

Institutional Overviews

ABEPF

ABRAMGE

BEMFAM

CEPECS

CPAIMC

FEBRASGO

Odebrecht Foundation

A. ABEPF

ABEPF is an association of private family planning providers in Brazil.

Programs and Services

ABEPF provides the following services to its members, which now number approximately 155:

- Consolidation and channeling of grant funding from international donors facilitates the negotiation of donor funding to many small and inexperienced family planning providers.

- Political representation for the family planning sector is one of ABEPF's key functions; however, a March 1988 evaluation conducted by FPMT shows that it only has "scant" relations with government decision-makers.

- The production of educational materials, both for the general public and for more specialized audiences is an area of concentration for ABEPF; their posters, booklets, and folders are used by most family planning providers in Brazil.

- An advisory services and supervision team from ABEPF periodically visits members and makes recommendations regarding quality standards and norms.

- A training of trainers session was conducted by ABEPF in 1988 for a group of thirty trainers from different affiliates; another thirty will be trained this year in contraceptive methodology and utilization of IE&C materials.

- Providing a clipping service. ABEPF reviews all newspaper articles relevant to population, family planning, and related issues; and, when appropriate, sends them to politicians, decision-makers, and family planning institutions.

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Client Groups

ABEPF does not work directly with family planning users, but rather, with service provider organizations. Evidence suggests that the larger and more experienced affiliates view ABEPF as a competitor, rather than as a spokesperson entity. While ABEPF plays a necessary role in linking family planning organizations with international donors, the significance of this role may be diminished as funding resources become scarce, and these organizations gain experience in negotiating grants directly.

Furthermore, to perform the political representation function effectively, ABEPF must have widespread representation in each state. There is some uncertainty as to whether the current coverage is adequate and equal in terms of numbers of members in proportion to the size of the respective client populations that they serve.

Financial Resources

Table 1 shows that ABEPF self-generated 16.5% of its funds in 1988. Although an increase over the 14.5% funds generated in 1987, the 1988 figure included an "administrative rate" (a charge to international donors in the form of overhead) which, if removed, reduces the proportion of self-generated funds to 9%.

TABLE 1
SOURCE OF FUNDS
(PERCENTAGES)

Source	1987	1988
International Donors	85.5	83.5
Self-Generated	14.5	16.5
Self-generated Fund Include		
▵ Annual Dues	16.8	13.4
▵ Donations	12.3	2.7
▵ Sale of Materials	25.3	6.4
▵ Fees for Courses	4.8	2.6
▵ Interest & Dividends	17.0	24.9
▵ Cost Recovery	24.7	5.0
▵ Administrative Rate	45.0	
Total	145.9	55.0

ABEPF has experienced cash flow problems as a result of late payments from international agencies.

Management

The relevant aspects of ABEPF's management systems are described as follows:

- The project focus is on managing individual projects in addition to overseeing annual budgeting and reporting to external agencies.

- A three year plan, intended to move the organization toward long-term objectives and financial self-sufficiency, is the principal management tool now driving the organization. According to projections, self-generated resources will increase from the current levels to 59.1% in the third year (1991). Although these projections show deficits of $158,000 in year one, $129,000 in year two, and $73,000 in year three, Pathfinder's support covers these deficits.

- Change in the organizational culture, to development of a market and entrepreneurial orientation may result from ABEPF's sales of its products to its members, a major implication of the three-year plan.

- An internal control system within ABEPF was developed in response to one project's failure to meet scheduled deadlines by postponing expenditures or not hiring personnel as planned.

- Information systems within ABEPF are reliant upon its members to provide user data; often these data are incomplete.

- The structural organization at ABEPF (a Board of Directors, an Executive Director and General Coordinator, four program areas -- training, IE&C, technical assistance, and marketing) is maintained by ABEPF's ability to locate and hire professional staff with assistance from international donors. Pathfinder has helped hire an administrative financial director.

B. ABRAMGE

Presently, ABRAMGE encompasses approximately 180 of the 400 group medicine practices in Brazil. These, in turn, serve a population of fifteen million (or about a tenth of the Brazilian population) through approximately 200,000 company plans and 20,000 individual or family plans.

HMOs are a growth industry in Brazil. Since 1987, revenues in this industry have increased by twenty percent to approximately one billion dollars per year, a higher rate of growth than was attained even by Brazil's well-known computer industry. It can be explained by the overall rate of industrial growth, the incorporation of the Brazilian population in the workforce, and by the lack of adequate government medical services.

Programs and Services

- Expanding family planning activities among HMO member organizations can be achieved by demonstrating the cost-effectiveness of family planning services. The savings in prenatal care alone are substantial. In turn, businesses that have group medical plans with the HMOs can be shown the cost-effectiveness of family planning through reductions in maternity leave.

- Commodity distribution to PROMEDICA (one of the original and largest members of ABRAMGE) from Pathfinder has continued for years. PROMEDICA is currently, with Pathfinder assistance, acting as project manager and commodities distributor for a program of family planning with sixteen HMOs.

Client Groups

Though ABRAMGE members offer individual and family plans, the vast majority of clients are enrolled through company plans. These clients include low-income urban workers, many of whom live in the *favelas*. Cost of the medical plan may be as low as $5-6 per capita per month.

The method mix offered to clients is inverted according to the findings of the national prevalence study. Unlike national trends, clients more often receive IUDs than other temporary methods.

The geographic focus of ABRAMGE tends to be in the larger cities where the greatest industrial activities take place. For example, over half of the 400 HMOs in Brazil are located in São Paulo. However, it is also very active in the northeast, particularly since PROMEDICA is located in Salvador.

Management

Management of ABRAMGE appears to be sound. Its strategy is to have a broad based membership, provide limited services, and maintain low fixed costs. Consulting services in finance and economics are contracted through a local consulting firm and an external legal advisor. For the most part, ABRAMGE is self-supporting, though it may require external sources of funding for special projects such as conferences.

C. BEMFAM

BEMFAM is the Brazilian IPPF affiliate.

Programs and Services

BEMFAM currently provides the following programs and services:

- Six research projects, including national surveys of family planning users, socio-economic studies, research on the operation of clinical services, and a survey on reproductive health and sexuality among Brazilian adolescents (with support from Pathfinder) have been completed since 1986.

- IE&C materials such as posters, journals, books, films, and slides are produced by BEMFAM.

- *Palestras* (talks) are given by volunteer community leaders trained by BEMFAM at a rate of about 10,000 talks and home visits each per year.

- Training programs have trained approximately 1,600 health promoters, nurses, doctors, and technicians per year since 1973.

- Thirty-five seminars with community and religious leaders, politicians, and health professionals are carried out by BEMFAM annually; these dialogues have significantly contributed to changes in the penal code.

- Clinical services provided by BEMFAM include family planning, gynecological and prenatal consultations, cytologies, and pediatrics. Of the 120 clinics established by 1973, most of them have become independent, formed smaller associations (CEPECS, CLAM) or closed. Presently, BEMFAM's thirteen high-volume clinics receive about eighty thousand new users each year (a 50% increase over new users received by all 120 clinics at the height of BEMFAM's expansion stage). Ten of these clinics are located in the northeast, two serve the *favela* populations of Rio de Janeiro and São Paulo, and one is located in the south.

- BEMFAM's community programs, unlike traditional community based programs (CBD), channel services through public or private health units (77%), municipal governments or community centers (19%), and business enterprises (4%). BEMFAM has approximately 140 agreements with municipal governments in the Northeast to provide contraceptive and educational materials, technical supervision, and follow-up to community and health posts. Institutional priorities include increasing the programs within factories as well as accessing some of the hard-to-reach rural population, which comprises only 27% of the total population.

- Through commodities importation and distribution, BEMFAM supports its clinic and community programs; BEMFAM imports contraceptive methods and other family planning materials (donated by A.I.D. through cooperating agencies including Pathfinder and IPPF) in bulk and distributes them throughout its coverage areas.

Client Groups

BEMFAM's clinic and community services are directed at the lower socio-economic strata that do not have the means to utilize private clinics and commercial channels. Its IE&C and sex education programs place special emphasis on reaching adolescent and pre-adolescent groups.

The large number of condom users in BEMFAM's clinic program (42% of total new users) suggest that males are an important client group. In addition, BEMFAM's personnel report that many of these male condom users are, in fact, adolescents.

Financial Resources

BEMFAM receives approximately three million dollars each year from IPPF, primarily in core support, which constitutes 60% of its total operating budget. Another 8% is provided by other international donors. The remaining 32% is generated locally through the sale of services and materials, clinic fees, and local donations.

In 1988, income from its clinics generated only 22% of clinical costs. BEMFAM can increase cost recovery through more aggressive pricing policies and charging mechanisms for its services. It is essential, though, that it continue to properly serve the low-income client groups and to provide support for extensive community programs. It is unrealistic, therefore, to expect that BEMFAM will become totally financially self-sufficient.

Recent legislation allows BEMFAM, as a registered non-profit organization, to exchange dollars for local currency at the fluctuating market rate (Ncz 10.5=$1 in late

October) instead of the official rate (Ncz 4.3=$1). This practice has substantially reduced the incentive for BEMFAM to enter into debt swaps, since sovereign debt is denominated at the official rate. Moreover, the Brazilian Government has declared a moratorium on the auction of its foreign debt and, given the intense political debate surrounding this issue, it is unlikely that sovereign debt will be available for conversion in the near future.

Management

BEMFAM is headed by an Executive Director and is subdivided into operating departments which include clinical services, IE&C, planning, programming, and special advisory units such as the unit responsible for financial management and "sustainability".

BEMFAM has gained a reputation for efficient program management. It has, however, experienced some difficulty with its MIS for commodities and is currently receiving technical assistance from FPMT to address this issue.

D. CEPECS

CEPECS was founded in the early 1980s as a research center within the Medical School of the Federal University in Minas Gerais.

Programs and Services

CEPECS' principal activity is providing clinical services and supervising community services in family planning.

- Clinical services are provided through a central clinic located in Belo Horizonte and through eleven distribution posts within the Belo Horizonte urban area.

- Community programs established in agreement with municipal health services and community groups distribute family planning supplies and information through 67 posts located throughout the state of Minas Gerais; under these agreements, CEPECS provides contraceptive and educational supplies and assists with health post supervision.

- Publicity campaigns implemented by CEPECS with the support of the SOMARC project have generated demand for clinical and community services as well as created a favorable climate for family planning in the state of Minas Gerais.

- Commodities are distributed to CEPECS from Pathfinder and other donors for use in its own clinic and for distribution to other posts in the region.

Client Groups

The CEPECS clinics serve the poor urban population of Belo Horizonte, and the community programs serve the hard-to-reach poor in the more rural municipalities of Minas Gerais. This removed client group, according to CEPECS personnel, has almost no ability to pay for services, and cost recovery from its clinical operations is minimal.

To increase cost recovery, CEPECS has proposed establishing another clinic serving a middle-class clientele which will offer a full range of obstetric-gynecological services, including ultrasound. CEPECS has not been able to locate a site for this second clinic and will attempt to serve both client groups from the Red Cross facility using different entrances and investing in some remodeling.

Financial Resources

CEPECS relies heavily upon international donors for resources to cover its core budget. If successful, however, the new model clinic could dramatically change its overall financial situation. Financial projections for the project, prepared with the assistance of an Enterprise consultant, indicate that the break-even point for the clinic could be reached within eleven months of its inauguration. It is projected that after 24 months of operation, it will be generating enough revenue to sustain other CEPECS programs and services.

Management

Leadership of CEPECS is provided by a very capable group of medical professors from the Federal University. They recognize that the new focus on cost recovery will require a change in operations and are aware of their limitations in the area of administration and cost control. CEPECS has hired a new administrator to analyze and control costs in addition to marketing the new clinic, which includes negotiating agreements with local companies to provide services for employees.

E. CPAIMC

CPAIMC, located in Rio de Janeiro, is a family planning service and training institution.

Programs and Services

- CPAIMC's clinical services consist of primary health care with integrated maternal-child health and family planning services.
- The training programs offered by CPAIMC include medical and nursing training and a special training program for nursing school professors.
- Commodities importation and distribution to most ABEPF affiliates, private doctors, independent clinics, medical schools, and hospitals is an important CPAIMC component since many small family planning providers are not authorized by the government to import contraceptive materials. CPAIMC is one of the three major recipients of commodities for Pathfinder projects.

Client Groups

CPAIMC focuses its clinic services program on the low-income population in the *favelas* of Rio de Janeiro.

Financial Resources

CPAIMC generates approximately 25% of its total budget through local donations and income generation. The remainder is provided by several international donors, including JHPIEGO and Development Associates (supporting training activities), FPIA (supporting clinic service projects), and Pathfinder (providing commodity support and funding for the adolescent program).

In 1987, CPAIMC received ultrasound equipment for the establishment of a clinic and laboratory services intended to generate 44% of total income. This target, however, has not been reached.

Management

Donor agencies are currently examining CPAIMC's capability to generate income and reviewing its overall organizational management. CPAIMC's role as a national commodities distributor is also under review.

F. FEBRASGO

FEBRASGO is the national professional society for obstetricians-gynecologists.

Programs and Services

FEBRASGO carries out the following activities:

- Publications put out by FEBRASGO include the magazine, *Femina*, and the Brazilian *Journal of Obstetrics and Gynecology*.

- Organization of the National Congress of Obstetrics and Gynecology, a congress held biannually that attracts up to five thousand participants, is the most important event in Brazil for obstetrics-gynecology specialists; participants pay not only a registration fee, but also for enrollment in any course they attend.

- Special events such as seminars, workshops, and continuing education programs throughout the year; companies provide financial support in return for the sponsoring of special events such as the introduction of a new pharmaceutical product or a new technology.

- Among instructional materials prepared by FEBRASGO is a teaching manual for medical students, supported by Pathfinder.

- Approximately fifteen working groups in different areas that relate to obstetrics and gynecology have been organized and coordinated by FEBRASGO.

- Policies and positions on medical issues are reviewed and recommended by special committees within the organization.

Client Groups

The main client group of FEBRASGO is a membership of obstetric-gynecological specialists throughout the country. Most of the members reside in the large urban centers of the southern states, however, FEBRASGO also has important representation in the northeast. The new society president is located in Salvador.

Management

FEBRASGO derives income from conference and seminar activities, grants from pharmaceutical companies, subscriptions, membership fees, and the rental of its facilities. Costs are low and it can be assumed that FEBRASGO is essentially self-supporting. Pathfinder has funded seminars for medical schools and a family planning exchange program among these schools.

FEBRASGO's offices in Rio de Janeiro are headed by the Executive Secretariat and supported by a staff of eight people in charge of program and administrative functions.

G. Odebrecht Foundation

The Odebrecht Foundation is one of Brazil's largest construction companies, with operations around the world. In 1964, it established a foundation to provide social and educational benefits for its growing number of employees. In 1980, the Foundation began extending these services to non-employees. It commenced by sponsoring a series of debates on issues in the area of health and education, and eventually established prizes for the best monographs on these topics.

The Foundation later gained field experience on collaborative projects with the University of Bahia for training health workers and with the State Secretariat of Education to carry out an integrated rural development project. In 1988, a strategic decision was made to focus on programs and services geared for adolescents.

Programs and Services

The Liceo Project is an educational effort intended to provide practical skills to high school students in off-hours (*segundo turno*) and concurrently involve them in programs that include health and family planning. The school has a clinic that will be used to provide family planning information and supplies. This project is unique in that the Odebrecht Foundation is operating in collaboration with fourteen other private, public, and international organizations.

The Odebrecht Foundation has made the strategic decision to channel all of its activities in the health and education area through this ambitious project, which is expected to increase in enrollment.

As part of the Liceo Project, the Odebrecht Foundation has established a clinic (known as "CORA") with Pathfinder private funds to provide information and services in health and family planning and to make referrals. Some commodities, mostly condoms and foaming tablets, have been distributed through this clinic.

The Odebrecht strategy recognizes that field programs in health and education cannot have impact unless a positive policy environment exists. The strategy, therefore, includes, in addition to the Liceo Project, a program of dialogue seminars with various key sectors such as the government, the Church, and the business sector. This program is currently being initiated with the move of the Odebrecht Foundation headquarters to Brasilia.

Client Groups

Odebrecht's client group includes high school students in Salvador as well as all the adolescents that attend the Liceo. Applicants for the Liceo Program are invited to participate in a one-month project that includes education in health and family planning Only about one in five is invited to join the actual workshop on a longer-term basis. No tuition is charged.

Other target groups are national level leaders who are asked to participate in the dialogue seminars.

Financial Resources

Odebrecht is one institution for which financial resources do not present a constraint. First, they have the financial support of the parent company. This financial security can be seen in its investment of $1.5 million in the restoration of the original Liceo. Second, because of their strategic focus and their access to office space in Odebrecht facilities, their fixed costs are low. Third, the Liceo Program is generating income through the sale of locally manufactured desks and chairs to the public school system. Most importantly, international donors are vying for opportunities to become associated with what appears to be a successful grantee.

Management

The general management of the Odebrecht Foundation is the responsibility of Bruno Silveira, Vice-President of the *Conselho* and Executive Director. In line with the new strategic focus, the office in Rio de Janeiro was closed and Mr. Silveira was moved to Brasilia to begin the new dialogue program.

Overall, the Odebrecht Foundation appears to be a strategically managed organization. The Director of the Liceo Program has a clear sense of the project's mission in relation to the larger institutional strategy. It is a classic niche approach, building on strength, and contrasts with an organization like ABEPF that appears to be undertaking too many tasks at once. If there is a weakness, it may be in the amateurish, though creative, quality of some of the publicity and video materials.

ANNEX IV

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TABLE LEGEND

The following are the definitions to the abbreviations that appear throughout the charts in the document:

Abbreviation	Definition
CW	Central-West
NCW	North-Central-West
NE	Northeast
No Educ	No Education
> Prim	Greater than Primary Education
< Prim	Less than Primary Education
Prim	Primary Education
Rio	Rio de Janeiro
SP	São Paulo
S	South
Sterlz	Sterilization
With	Withdrawal

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[1] *Moving Into the Twenty-First Century: Principles for the Nineties* (Washington, D.C.: USAID/Family Planning Services Division, Office of Population, 1989), p. 13.

[2] In A.I.D.'s *Moving Into the Twenty-First Century: Principles for the Nineties*, national family planning programs are categorized in five stages according to the prevalence of modern contraceptive use -- *pre-emergent* (prevalence less than eight percent), *launch* (prevalence between 8 and 15 percent), *growth* (prevalence between 16 and 34 percent), *consolidation* (prevalence between 35 and 44 percent), and *mature* (prevalence of 45 percent and over) stages -- each with its special characteristics and needs.

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[4] *World Population Data Sheet* (Washington, D.C.: Population Reference Bureau, Inc., 1989).

[5] José Maria Arruda, et. al., *Pesquisa Nacional Sobre Saúde Materno-Infantil e Planejamento Familiar Brasil - 1986*, (Rio de Janeiro: BEMFAM Press, 1987), p. 97.

[6] Modern prevalence equals overall prevalence minus rhythm plus withdrawal (Data do not include traditional methods).

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Glossary

Abbreviations

Acronyms

Definitions

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GLOSSARY

ABEPF	*Associação Brasileira de Entidades de Planejamento Familiar*
ABRAMGE	*Associação Brasileira de Medicina de Grupo*
Add-on	Mission monies that are added to the Cooperative Agreement with AID/Washington.
Adolescent	An individual between 15 and 19 years old
A.I.D.	Agency for International Development
AID/S&T/ Planning POP/FPSD	Bureau of Science & Technology, Population, Family Services Division of A.I.D. (See USAID below)
AIDS	Acquired Immune Deficiency Syndrome
ASFR	Age-Specific Fertility Rates - the number of live births per one thousand women within a specific age group[31]
AVSC	Association for Voluntary Surgical Contraception
BEMFAM	*Sociedade Civil Bem Estar Familiar no Brasil*
CAB	Pathfinder's Cooperative Agreement with AID/Brazil
CAEMI	Centro de Assistência Especial Materno Infantil
CAW	Pathfinder's Cooperative Agreement with AID/Washington

CBD	Community-Based-Distribution
CBR	Crude Birth Rate - the number of births per one thousand population in a given year[32]
CDC	Centers for Disease Control
CDR	Crude Death Rate - the number of deaths per one thousand population in a given year[33]
CEPARH	*Centro de Pesquisas e Assistência em Reprodução Humana*
CEPECS	*Centro de Estudos e Pesquisas Clovis Salgado*
CIN	Commodities Identification Number - refers to commodities grants donated by Pathfinder
CLAM	*Conselho Londrinense de Assistência à Mulher*
CNBL	*Centro Nacional Bertha Luz*
Cohort	A group of people sharing a common temporal demographic experience who are observed through time[34]
Commodities	All family planning-related goods such as pills, condoms, IUDs, medical kits, etc.
CPAIMC	*Centro de Pesquisas e Assistência Integrada à Mulher e à Criança*

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CPR	Contraceptive Prevalence Rate - the number of persons using contraception at a given time per population of reproductive age
CYP	Couple-years-of-protection - the amount of contraceptives required to provide contraceptive protection for one couple for one year (CYP is calculated by dividing the quantity of a given contraceptive method by the number of units of that method normally used by a couple during the time period in question.)
DA	Development Associates
Dalkon Shield	A type of intrauterine device no longer distributed
DHS	Demographic Health Survey
FEBRASGO	*Federação Brasileira das Sociedades de Ginecologia e Obsetrícia*
Fertility	The actual reproductive performance of an individual, a couple, a group, or a population[35]
FPIA	Family Planning International Assistance
FPLM	Family Planning Logistics Management Project
FPMT	Family Planning Management Training Project through MSH
FY	Fiscal Year
GATT	General Agreement on Tariffs and Trade

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GDP	Gross Domestic Product
GOB	Government of Brazil
HMO	Health Maintenance Organization
IDB	Inter-American Development Bank
IDRC	International Development Research Center
IE&C	Information, Education, and Communication
IMF	International Monetary Fund
IMR	Infant Mortality Rate - the number of deaths to infants under one year of age per 1,000 live births in a given year[36]
INAMPS	*Instituto Nacional de Assistência Médica e Previdência Social*
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
IUD	Intrauterine Device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JHU	Johns Hopkins University

JOICEFP	Japanese Organization for International Cooperation in Family Planning
JSI	John Snow, Inc.
LAC	Latin America and the Caribbean
Leveraging	Private resources invested for family planning services which are paired with greater public resources to achieve maximum impact on family planning use
Logistics	Support operations dealing with the procurement, transportation, materials management, and other matters related to the handling of details of a projects
LOP	Life of Project
MCH/FP	Maternal and Child Health/Family Planning
Method	A contraceptive method, such as oral contraceptives, IUDs, condoms, etc.
MIS	Management Information Systems
MMR	Maternal Mortality Rate - the number of deaths to women due to pregnancy and childbirth complications per 100,000 live births in a given year[37]
Modern Contraceptive Prevalence	Use of modern contraceptive methods, such as orals, IUDs, condoms, foaming tablets, and VSC, but excluding rhythm and withdrawal

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MOH	Ministry of Health
MSH	Management Sciences for Health
NORPLANT	Registered trademark of the Population Council for contraceptive subdermal implants
OTS	Off-the-Shelf
PAHO	Pan-American Health Organization
PAISM	*Programa de Assistência Integral à Saúde da Mulher*
Parity	The number of children previously born alive to a woman; for example, "two-parity women" are women who have had two children up until now, and "zero-parity women" have had no children up to now[38]
PATH	Program for Appropriate Technology in Health
PIN	Project Identification Number - refers to projects funded by Pathfinder
PROMED	A leading manufacturer of IUDs in Brazil
PROMEDICA	Proteçao Medica a Empresas LTDA
PRO-PATER	Promoçao da Paternidade Responsable
PVO	Private Voluntary Organization

SOMARC	Social Marketing for Change (the Futures Group)
State Secretariat of Health	Highest health authority at the state level in Brazil
Stock-out	Lack of on-hand stock of a particular item at a storage facility
STD	Sexually Transmitted Disease
SUDS	*Sistem Unificado de Saúde* - refers to the decentralization of the Brazilian national health system
SUDESCO	*Superintendência para o Desenvolvimento das Comunidades do Estado de Bahia*
Sustainability	At Pathfinder, this term means joint efforts with grantee agencies geared towards making a family planning program sustainable beyond Pathfinder funding support. This may involve fundraising efforts or charge for services to make the agency self-supporting, integration of private services into public sector services, or assistance in the identification of other potential donors.
TINS	Pathfinder Travel and Training Grants
TFR	Total Fertility Rate - the average number of children that would be born alive to a woman during her lifetime if she were to pass through her childbearing years conforming to the age-specific fertility rates of a given year"
UNFPA	United Nations Fund for Population Activities

Urban	Countries differ widely in their definition of "urban" but essentially this term refers to cities and other densely settled areas
USAID	United States Agency for International Development
VSC	Voluntary Surgical Contraception
WHO	World Health Organization
WRA	Women of Reproductive Age - women aged 15 to 49 years[40]
Young Adult	An individual between 15 and 24 years old

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