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EVALUATION OF THE PROGRAM OF
MOBILIZATION OF COMMUNITY RESOURCES
FOR FAMILY PLANNING IN THE
STATE OF RIO DE JANEIRO

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SUMMARY

At the request of the American Embassy, Brasilia, and the Office of Population, AID/W, Dr. Leo Morris and Dr. Eliane Franco of the Program Evaluation Branch, Division of Reproductive Health, Centers for Disease Control, and Ms. Sharon Epstein, an APHA consultant, traveled to Rio de Janeiro, Brazil, during the period June 16-July 6, 1983, to evaluate the Program of Mobilization of Community Resources for Family Planning in the State of Rio de Janeiro, a project of the Sociedade Civil Bem-Estar Familiar no Brasil (BEMFAM). This project is supported by Family Planning International Assistance (FPIA). During the years 1974-1981, Ms. Epstein was the field coordinator in Bangladesh, the South Pacific Region and Pakistan for the United Nations Fund for Population Activities (UNFPA). In 1981, she also served as an APHA consultant for a management evaluation of FPIA. Dr. Morris is a statistician with specialized training in demography, and Dr. Franco is an obstetrician with training in reproductive health epidemiology.

The State of Rio program has been assisted by FPIA since February 1980 and is scheduled to terminate by the end of September 1983, a total period of 3 years and 8 months. BEMFAM has maintained that the Rio program should continue, but that further external assistance is required. FPIA has cited certain constraints it faces in providing assistance from October 1983. The evaluation findings are expected to be of use to AID and FPIA in deciding upon future project assistance, and to BEMFAM in strengthening family planning services in the State of Rio de Janeiro. The general terms of reference for the evaluation as stated by the Embassy Development Officer and AID/W included (1) the preparation of a detailed narrative description of the project, (2) determination of the coverage and geographic extension, (3) determination of other accomplishments, particularly staff performance and governmental acceptance of family planning at the local level, (4) estimation of the Cost per active user and (5) preparation of recommendations for the future of the project and to suggest ways in which the project could be improved, if extended.

Two-hundred twenty-one (221) community distribution posts, have been established in 61 of the 64 municipios of the State of Rio since February 1980 to date. Whereas in other BEMFAM-assisted programs established through State Governments there are generally three types of distribution posts (health posts, household posts, and community center posts), there is a greater variety of types of posts in the State of Rio program. This has occurred because there is no agreement to date with any State agency in the State of Rio, but there are separate agreements with 61 of the 64 municipios and/or social agencies in those municipios. Thus, in addition to municipio health posts, household posts, and community center posts, there are posts being administered by private institutions, neighborhood associations, unions and rural cooperatives, religious institutions, and industry. For this reason, the State of Rio program is probably more of a "grassroots" community program than programs in other States in Brazil.

BEMFAM's objective of increasing access to family planning information and services by utilizing trained volunteer community workers without a medical background (with the exception of some nurses) led to an obvious emphasis in the State of Rio program, as in the other CBD programs, on distribution of

pills, condoms, and spermicides. Clients are informed about all methods, and if they express interest in clinical contraception they are referred by distributors or educators to other program or nonprogram service points for diaphragms, IUD's and voluntary surgical contraception (VSC). At the current time, family planning services are provided free of charge through about 151 posts, and for a small charge for each type of contraceptives in about 70 posts. In Brazil, this experiment in the subsidized sale of contraceptive is unique to the State of Rio program.

From February 1980 to March 1983, 184,020 new clients accepting a method of contraception were registered in the program, representing 10.6 percent of currently married women (CMW) 15-44 years of age in the State. The condom has gone from less than 1 percent of methods accepted in the first year of the program to 31 percent in the first quarter of 1983. The percentage of new clients accepting pills has decreased from 88 to 60 percent. The program showed steady growth through June 1982 when 75,991, or 4.4 percent, of CMW were active in the program. The percentage active fell to 3.4 percent at the end of 1982 and has been maintained at that level during the first quarter of 1983. The average cost to maintain an active user is only about \$15.00. The great majority of active users are users of the pill (97 percent in March 1983). Only 5.3 percent of active users are condom users compared with the fact that condom users represented 31 percent of new clients in the first quarter of 1983. Another indication of the poor program continuation of condom users is that only 8 percent of condom users are still active in the program.

About 80 to 85 percent of new clients in 1982-83 already use or have used contraception. This is consistent with contraceptive prevalence survey results for Southern Brazil. Also, unpublished data from a CPAIMC operations research household survey in three Rio "favelas" (slum areas) shows that over 60 percent of low-income currently married women were using contraception, and more than half of these women using orals obtained them in the pharmacy. The question remains, "Is BEMFAM serving the poorest of the poor?" Data from the CPAIMC survey show that although the majority of poor women obtain their pills in the pharmacy, there is an inverse correlation between per capita household income and BEMFAM as a source of orals. In other words, the poorer the woman the greater the use of BEMFAM posts. In fact, whereas only 11 to 13 percent of users with at least one minimum salary use BEMFAM posts, the proportion increases to 31 percent for the poorest group of women.

There seems to be a number of misunderstandings in the BEMFAM-FPIA relationship. BEMFAM states that it thought that a project extension beyond the third year of FPIA assistance could be negotiated with FPIA to continue the program in the State of Rio. No other State CBD program initiated by BEMFAM and assisted by any other population donor had become self-supporting in less than 7 years, and there was no cause to think that this program could survive without continued donor support. FPIA Regional Office staff, on their part, in conversations with the Evaluation Team, maintained that the project, had been clearly drafted for 3 years only and that this had been noted on the cover of each subsequent project modification document and reiterated in conversations. Neither BEMFAM nor FPIA could produce for the Evaluation Team an exchange of letters on the future of the State of Rio program, a correspondence which the Evaluation Team would have expected to have taken place, at the latest, by the middle of the third year of project funding.

While BEMFAM may have been far too sanguine in assuming FPIA would continue support in the absence of a written communication and can be faulted for not initiating timely correspondence on the subject itself, in the Evaluation Team's opinion, FPIA had an equal obligation to take into consideration the nature of the program it had assisted and to be clear in writing about the possibilities of support beyond May 1983. In the end, it was left to the Development Officer in the U.S. Embassy in Brasilia to suggest an evaluation to determine the fate of the program, something FPIA itself could usefully have suggested by the middle of the third project year, rather than risk that the program perish in the absence of a source of funding.

The above background and program information is, of course, a brief synopsis of the details included in this report. Four basic summary observations, our principal recommendation and specific recommendations are included in the main report and summarized below. We expect that the reader interested in the detailed data and observations upon which these recommendations are based will read the entire report.

A. SUMMARY OBSERVATIONS

1. Although the State of Rio Program has reached 11 percent of currently married women in the state, only 4 percent are currently active users. However, the program basically serves a "hard core" of poor women who would find it very difficult, if not impossible in the prevailing economic situation in Brazil, to purchase contraceptives at commercial rates from pharmacies and that, from all accounts, those families previously on marginal incomes yet with the ability to purchase from pharmacies are now increasingly impoverished.
2. The BEMFAM organization and the State of Rio program team have worked very hard for about 3 years to build up interest in the program at the local level through what the Evaluation Team perceives as genuinely decentralized and well-placed service outlets, run by recognized community personalities and agencies, which are highly motivated to provide family planning in order to satisfy the demands of neighborhood women.
3. BEMFAM and the State of Rio program team have legitimized the public sector as a source of family planning and have arranged for services to be offered at the administrative/political levels of 61 out of the 64 municipios in the State by negotiating "convenios" (agreements) with mayors and other municipal/county health, education and welfare officials; BEMFAM has done this in the absence to date of any family planning information and service program endorsed by the State or Federal Government.
4. No other State community-based distribution project operated by BEMFAM or any other organization in Brazil and assisted by external donors has become self-supporting in less than 7 years, a period in which donors continued to recognize the need for external assistance. There was misperception and ambiguity regarding the continuation of the program between FPIA and BEMFAM as the third of 3 years of FPIA funding drew to a close.

B. PRINCIPAL RECOMMENDATION

FPIA should be requested by AID to consider extending assistance for the State of Rio program for a period of 2 years, however, on the firm understanding that BEMFAM will initiate discussions concerning the future support of the program with the State Government no later than 6 months into the extension (that is, March 1984), even while it continues all efforts to legitimize the program at the level of municipios, and on the understanding that support for the second year of the extension would be contingent on the continuation of these discussions so that there would be an 18 month period for negotiations and transfer of the program to the State Government. Since the current State Government is in office until the end of 1986, an alternative plan would be support of the project for 3 years with external assistance phased down from 100 percent in the first year to 75 percent in the second year and 50 percent in the third year.

C. RECOMMENDATIONS FOR CONTINUATION, EXPANSION, OR MODIFICATION OF PROGRAM ACTIVITIES

1. Continue to focus on geographical areas and neighborhoods with the greatest concentration of impoverished families in the first year of the extension, and improve or expand the program to bring the number of active users up to the point at which it stood in June 1982.
2. Concentrate on strengthening direct and refresher training of distributors, educators, and supervisors by the State of Rio program team on a decentralized basis within the State especially when there is turnover of staff in the program or in the case of expansion of the physicians' component of the program.
3. Develop more systematic procedures and guidelines for distributors, educators, and supervisors for referral of clients for IUD insertion; BEMFAM should systematically seek out physicians willing to consider offering the service.
4. Consistent with the analysis of service statistics in this report, data on new users and active users could be maintained at the State level and reported to donors on a quarterly rather than monthly basis; A coupon system should be introduced for IUD and VSC referrals so that the referring post can account for such referrals.
5. Routine supervision of distribution posts could be reduced in number to one visit every 2 or 3 months. (Of course, "problem" posts and/or posts with turnover of personnel should be visited more often.)
6. To the greatest extent possible and practical, encourage distributors and educators to follow up clients who fail to return for resupply of pills.
7. Introduce a progesterone-only oral pill into the program for lactating women.

8. Based on an innovation developed by a household distributor participating in the subsidized program, consider encouraging distributors to develop their own networks of subdistributors and consider the training needs of the subdistributors.
9. In view of the training in primary health care and MCH received by distributors, educators, and supervisors, consider whether basic MCH advice and education could not be strengthened at program distribution posts, and consider whether referrals for MCH needs could not be strengthened as well in a closer relationship with local health facilities (i.e., for posts not already located in municipal health facilities).
10. Beyond the initiatives already taken, continue to widen the program focus on men at strategic locations at which they can be easily reached.
11. Implement Patient Flow Analysis studies in the two major clinics that are part of the program.

D. FUNDING RECOMMENDATIONS: THE FOLLOWING ITEMS SHOULD BE CONSIDERED FOR CONTINUED FUNDING:

1. The State of Rio program team (four members full-time, which the Evaluation Team believes would be adequate to cover administrative and technical requirements of the program) and appropriate clerical/logistics support.
2. Physicians and supervisors already employed by the program.
3. National, short-term consultants to assist in training.
4. For the State of Rio program team, for field supervisors and trainees, travel for the purpose of implementing decentralized training throughout the State and for the purpose of supervision.
5. An expanded number of refresher training courses for distributors, educators, supervisors, and physicians already in the program, and new training courses in the case of entry of new personnel into the program.
6. Development and production of materials for training and community education, taking into consideration what has already been developed during the first 3 years of the program.
7. A sample survey once a year of 1 month's new clients to determine previous method and previous source of supply of contraceptives, reasons for switching source and simple socioeconomic data on these clients.

8. Should FPIA consider further support this project, the Evaluation Team recommends that a comprehensive midextension program review be scheduled in the project documentation for joint participation by FPIA Regional Office staff, appropriate BEMFAM staff and the State of Rio program team. In the last year of the extension, BEMFAM and FPIA should, in writing, summarize their views on the status of the program and the need for any further assistance.

E. ADDITIONAL RECOMMENDATIONS

The Evaluation Team has considered certain services beyond what is possible to include under this project and, therefore, makes the following additional recommendations to BEMFAM for its consideration:

1. Additional paid physicians if BEMFAM finds this is necessary to implement the Evaluation Team's recommendation that referrals for IUD insertion be systematically strengthened throughout the program.
2. Expand the Moncorvo Filho Hospital service already offering free voluntary surgical contraception on referral and, if necessary, approach other donors such as the International Program of the Association for Voluntary Sterilization, which has assisted in training to date, for further assistance relating to expansion of the service.
3. Develop a post-partum family planning program at hospitals in the State of Rio in collaboration with hospital and Government health officials.

I. PLACES, DATES, AND PURPOSE OF TRAVEL

At the request of the American Embassy, Brasilia, and the Office of Population, AID/W, Dr. Leo Morris and Dr. Eliane Franco of the Program Evaluation Branch, Division of Reproductive Health, Centers for Disease Control, traveled to Rio de Janeiro, Brazil, during the period June 16-July 6, 1983, to evaluate the Program of Mobilization of Community Resources for Family Planning (PMCR/FP) in the State of Rio de Janeiro, a project of the Sociedade Civil Bem-Estar Familiar no Brasil (BEMFAM). This project, titled Brazil-05, is supported by Family Planning International Assistance (FPIA), an AID grantee agency. The project will be referred to in this report as the State of Rio Program.

At the request of AID/W, Ms. Sharon Epstein, an American Public Health Association (APHA) consultant, was the third member of this evaluation team. During the years 1974-1981, Ms. Epstein was the field coordinator in Bangladesh, the South Pacific Region and Pakistan for the United Nations Fund for Population Activities (UNFPA). In 1981, she also served as an APHA consultant for a management evaluation of FPIA. Dr. Morris is a statistician with specialized training in demography, and Dr. Franco is an obstetrician with training in reproductive health epidemiology.

This travel was in accordance with the CDC-AID/RSSA.

II. PRINCIPAL CONTACTS

A. U.S. Embassy

1. Sam Taylor, Development Attache (in Rio de Janeiro)

B. Family Planning International Assistance (FPIA)

1. Darryl N. Pedersen, Regional Director for Latin America
2. David Skipp, Project Consultant

C. BEMFAM

1. Walter Rodrigues, Executive Secretary
2. Florida Rodrigues, General Program Coordinator
3. Marcio Schiavo, Coordinator, Dept. of Information and Education
4. Marcio Thome, Coordinator, Dept. of Evaluation
5. State of Rio de Janeiro Technical Team
 - a. Ney Costa, State Coordinator (also coordinator, Medical Dept.)
 - b. Silvia Cristina, Evaluation Sector
 - c. Regina Pugliese, Education Sector
 - d. Illydia Gomes, Administrative Sector
 - e. Mario Lucio, Warehouse
 - f. Field Supervisors
 - 1) Tamaragiba
 - 2) Wilma Garcia
 - 3) Rosa
 - 4) Edna Menezes
 - 5) Maria das Gracas Mercês
 - 6) Albanir Fernandes
 - 7) Graca Nascimento
 - 8) Angela do Campos
 - 9) Lusinete de Itaborai
 - g. Community Distributors—See Appendix D

III. EVALUATION TERMS OF REFERENCE

The State of Rio program has been assisted by Family Planning International Assistance (FPIA) since February 1980 and is scheduled to terminate by the end of September 1983, a total period of 3 years and 8 months. BEMFAM has maintained that the Rio program should continue, but that further external assistance is required. FPIA has cited certain constraints it faces in providing assistance from October 1983.

In May, the Development Officer for the U.S. Embassy in Brasilia (Sam Taylor) requested the Office of Population, Agency for International Development (AID), Washington, D.C., to arrange an external evaluation of the Rio program. In turn, AID requested the Division of Reproductive Health, Center for Health Promotion and Education, Centers for Disease Control, Atlanta, Georgia, and the Office of International Health, American Public Health Association, Washington, D.C., to nominate three experienced consultants in population and family planning to carry out the evaluation. The consultants are listed in Section I of this report. The general terms of reference of the consultation were stated by the Embassy Development Officer and AID/Washington as follows:

to prepare a detailed narrative description of the project and specify what groups it is serving;

to determine the cost/effectiveness of the project and future needs for assistance;

to prepare recommendations for the future of the project and to suggest ways in which the project could be improved, if extended.

The evaluation findings are expected to be of use to AID and FPIA in deciding upon future project assistance, and to BEMFAM in strengthening family planning services in the State of Rio de Janeiro.

Leo Morris, Ph.D., M.P.H., and Eliane Franco, M.D., Centers for Disease Control, and Sharon Epstein, M.I.A., M.P.H., consultant to the American Public Health Association, arrived in Rio de Janeiro on June 18, 1983. The in-count component of the evaluation lasted 20 days, inclusive from June 17 through July 4, 1983. A 1-day briefing at the FPIA Regional Office for Latin America in Miami, Florida, on June 16, preceded the evaluation team's arrival in Brazil. Debriefings with BEMFAM in Rio de Janeiro and with AID in Washington were planned to conclude the evaluation.

IV. BACKGROUND DATA: BRAZIL AND THE STATE OF RIO DE JANEIRO*

Brazil, with 3 million square miles of territory, is the largest country in Latin America and the fifth largest country in the world. This vast country has one-third of the population of the Latin American/Caribbean Region. The population of Brazil was estimated at 124.4 million in 1982, with an annual growth rate of 2.2 percent. It is projected that Brazil will have between 18 and 190 million inhabitants by the year 2000.

Brazil is divided into 23 States, 2 territories, and the Federal District of Brasilia. Rio de Janeiro State is in the southeast region of the country. That region, composed of four States, had 43.4 percent of Brazil's population in 1980. Rio de Janeiro State extends over 43,305 kilometers, with an estimated population of 12,035,000 in 1982 and an annual rate of growth of approximately 2.3 percent for the period 1970-1980. Population density was 278 persons per kilometer, compared with population density of 15 persons per kilometer for Brazil as a whole. The State occupies less than 1 percent of the national territory, but it encompassed approximately 10 percent of Brazil's population in 1980.

*Data for Sections IV and V drawn from: The 1980 Brazilian Census discussed in Costa M, Thome M, and Bogue D--Population and Socioeconomic Development in Brazil: A White Paper, Volume I: Demographic Analysis, 1982 (draft); Program Integrado de Planejamento Familiar e Educacao Primaria da Saude e Mobilizacao Comunitaria no Estado do Rio de Janeiro: Historica, BEMFAM; Rio de Janeiro, 1983, (29 pages and annexes); and Rodrigues W. The Evaluation of Family Planning in Brazil, BEMFAM; Rio de Janeiro, February 1980, (70 pages).

Rio de Janeiro State is heavily urban and the City of Rio de Janeiro is the cultural center of the country. Although the national capital was moved to Brasilia in 1960, Rio remains an important center of political and governmental activity. In 1980, 92 percent of the population of the State was living in urban areas. The City of Rio de Janeiro, the surrounding metropolitan area, and 13 other cities, with more than 100,000 population, accounted for 84 percent of the total population of the State. From 1970-1980 the urban population of the State increased at a rate of 5.2 percent in contrast to a decline of -0.4 percent for the rural population. The State receives large numbers of internal migrants from other areas of Brazil. Net migration is +37 per 1,000, composed mainly of persons less than 30 years of age who originate from the northeast of Brazil.

Brazilian fertility has declined since 1965, but the rate of decline slowed between 1970-1980. The total fertility rate for the country in 1980 was estimated as 4.0. In the State of Rio, the total fertility rate in 1970 was estimated at 3.9 and in 1980 at 2.6--a decline of 33 percent in 10 years. The proportion of married women 15-49 years of age increased 2.4 percent between 1970-1980, and the median age at marriage decreased 0.8 years, which may have kept the fertility rate from declining even further. However, during the same period, adolescent fertility (15-19 years) rose from 40 per 1,000 in 1970 to 55 per 1,000 in 1980, an increase of more than 37 percent.

Urban-rural fertility differences are shown below. The decline in fertility was somewhat higher among the rural population.

TOTAL FERTILITY RATE--STATE OF RIO

	1970		1980		% Change	
	Urban	Rural	Urban	Rural	Urban	Rural
TFR	3.06	5.59	2.51	4.39	-18.0	-21.6

In 1980, life expectancy at birth in Brazil was 62.6 years for females and 57.6 years for males. For the State of Rio, life expectancy at birth was 66.9 years for females and 61.6 years for males. Infant mortality in 1978 in Brazil was estimated at 92 per 1,000 live births.

These demographic indicators do not adequately reflect the fact that significant proportions of the urban population in the State of Rio live in poverty. For example, according to the 1978 PNAD* household survey, 31 percent of the urban population of Rio have no running water in the household, 50 percent have no access to a waste disposal system, and 8 percent have no electricity. Fifty-two percent of the economically active population and 25 percent of families in 1980 earned less than two times the minimum wage (Cr 69,552, or about U.S. \$129 at the official rate of exchange prevailing in June 1983),

*PNAD: Pesquisa Nacional de Amostragem de Domicilios (National Sample Household Survey) conducted about every two years by the Brazilian Census.

including people receiving payment in goods only. Representative population based data on health status of these high risk segments of the population--particularly women and children--is not available.

There has not been a national contraceptive prevalence survey (CPS) in Brazil. However, contraceptive prevalence surveys have been conducted in nine States in Brazil between 1979 and 1981 (see Figure 1). Unfortunately, Rio de Janeiro is not included among the States with survey data. As shown in Table 1, with reference to the survey data, there are wide variations in the percentage of married women using contraception. Contraceptive use is highest in the four Southern States of Rio Grande do Sul, Santa Catarina, Parana, and Sao Paulo, with from 62 to 71 percent using contraception, and lowest in the Northeastern States of Bahia (31 percent) and Piaui (31 percent). Contraceptive use is higher in the remaining three Northeastern States of Rio Grande do Norte (47 percent), Paraiba (43 percent), and Pernambuco (41 percent) than it is in Piaui or Bahia, but lower than in the Southern States. At the time of the survey, the States of Rio Grande do Norte, Pernambuco, and Paraiba had community-based contraceptive distribution (CBD) programs that had been in existence for 4 to 6 years. In Piaui, a program had been initiated only 3 months before the survey was carried out, and in Bahia there is no family planning program.

The two most important methods of contraception in all but one State are orals and female sterilization, with these methods accounting for at least two-thirds of total use in each State. Use of sterilization is lowest in Bahia, with only 9.6 percent of women using this method, but varies only in the narrow range of 15.4 to 18.9 percent in the other four Northeastern States. Use of orals was lowest in Piaui and highest in Rio Grande do Sul.

With the exception of the three States in southern Brazil surveyed in 1981 where there are high levels of contraceptive use, unwanted pregnancies are reported by 22 percent to 34 percent of the women interviewed in these surveys (Table 2). These high rates of unwanted pregnancies help define a need for family planning in Brazil.

V. BRIEF HISTORY OF BEMFAM

The Sociedade Civil de Bem-Estar Familiar no Brasil was founded on November 26 1965, as a consequence of concern about the problem of illegally induced abortion expressed by the almost 700 specialists participating in the XVth Brazilian Meeting of Obstetrics and Gynecology held in Rio de Janeiro. At the time of this meeting (and at present), complications caused by abortion constituted a serious medical and social problem in Brazil (Table 3). Family planning was seen as the best solution to alleviate the consequences of abortion and also, by providing the poorest stratum of the Brazilian population with knowledge and access to modern contraceptive methods, to space births in order to reduce health risks to mothers and children. BEMFAM's major objective is to promote and defend the welfare of the Brazilian family.

BEMFAM, in its early years, began a large-scale information and education program on responsible parenthood, contraceptive methods, the socioeconomic benefits of family planning and the need to establish a National Family

Planning Program. This campaign was directed at the general population, the medical establishment and other influential groups, and the political leadership of the country. BEMFAM subsequently established and still supports 60 family planning clinics in urban areas in 10 States, offering free services to those in need. These "demonstrator" clinics served about 52,000 active users of contraception in 1982 and performed pap smears for over 18,000 women.* These clinics established that family planning services were in demand and that they could be offered with few operational problems in the Brazilian context.

At first financed entirely by BEMFAM, expenses for clinic staff and supplies were partially or totally absorbed over time by public State/Municipal or private organizations under signed agreements.

To serve rural areas and smaller cities, BEMFAM established a community-based family planning program in mid-1973 in the State of Rio Grande do Norte in collaboration with the State Health Department. Similar programs followed in the States of Paraiba, Pernambuco, Alagoas, Parana, Piaui, Rio de Janeiro and Ceara, resulting from intense BEMFAM negotiations with respective State Governments and/or individual municipal Governments (municipios) in each State (Table 4). In these programs, nurses and trained, nonprofessional educators and distributors--all of them community volunteers--perform two basic functions:

educational activities in the form of informational and motivational talks within their own respective communities, and

delivery of contraceptive services after interviews with clients to determine any contraindications to contraceptive use and, if contraindications are detected, referral of the client to a physician in the clinical component of the program.

Access to conventional contraceptives--condoms, pills, and spermicides--is made available to the local population at relatively low cost. Local Government and/or community groups provide "distribution post" facilities, and BEMFAM provides contraceptives and other supplies, technical support, training, and supervision. FPIA, the International Planned Parenthood Federation (IPPF), London, England, the Pathfinder Fund, Boston, and Columbia University, New York City, USA, provide funds and/or commodities to BEMFAM under a number of projects so that BEMFAM can support these State programs. These programs provided service to 313,768 active contraceptive users in December 1982.

All BEMFAM activities are carried out through five distinct departments at the BEMFAM central office in the city of Rio de Janeiro, directed by an executive secretary who is assisted by a planning and programming advisory staff and a juridical (legal) advisory staff. The five departments are: Scientific/Medical; Family Planning Programs; Information and Education (I&E);

*In 1975, at the peak of the clinic program, 94 clinics were operating and serving approximately 250,000 active users and since the beginning of the clinic program through 1982, over 960,000 pap smears have been performed.

Evaluation; and Administration. At the level of each State, technical teams, with program, information, education, evaluation and administrative skills, coordinate and supervise activities of the CBD programs. The team for the State of Rio de Janeiro work out of BEMFAM's central office.

VI. STATE OF RIO DE JANEIRO PROGRAM OF MOBILIZATION OF COMMUNITY RESOURCES FOR FAMILY PLANNING

A. Program Description

1. Objectives.

In the State of Rio de Janeiro, as in other BEMFAM programs, major activities include training, education, and service delivery, that is, information and education on family planning methods and distribution of conventional contraceptives (oral pills, condoms, spermicides) by volunteer community educators and distributors who work out of community-based and community-donated distribution posts. The program is intended to improve information on and access to family planning and, thus, to prevent unplanned pregnancies and improve maternal and child health. BEMFAM has, from its inception in 1965, stressed that family planning is an alternative to repeated and poorly spaced or unplanned pregnancies, which often have severe health and socioeconomic consequences, particularly for that part of the Brazilian population at highest risk--those families in lower socioeconomic groups, in urban slums, and in rural areas which have limited access to medical and health care, and especially to medical and health care which must be paid for. The principal goals of the State of Rio program were formulated as follows:

1. To provide to the State population as a whole, I&E on family planning and primary health care;
2. to make family planning methods accessible and available to the largest number of couples;
3. to contribute to the decrease in the maternal and infant mortality rates;
4. to decrease the incidence of induced (illegal) abortion;
5. to improve the quality of life of mothers and children;
6. to decrease the number of abandoned children; and
7. to educate community leaders in the importance and philosophy of family planning and to mobilize and integrate all possible community resources towards providing family planning services.

2. Targets

As in most family planning and health programs, progress in achieving the above objectives is either very difficult to measure (objectives 1, 5, and 7) or would be measurable only with an excellent vital statistics system or periodic household surveys (objectives 3, 4, and 6). Thus, targets have been formulated for program growth (recruitment of personnel), geographic extension and coverage, program users, training courses, and I&E activities. These

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targets and respective accomplishments are shown in Table 5. It is not always clear how the State of Rio program targets were set, even after the Evaluation Team independently discussed them with FPIA and BEMFAM officials. For example, if there were 212 distribution posts established by May 1982, why was the target for the third year only 180, since this appears to represent a cumulative number rather than new posts?

The establishment and expansion of posts is useful as a measure of program growth and data on active users is probably the most useful indication of program achievement. Generally, for all types of targets, targets have been accomplished.

3. Organization

An organization chart of the program staff is provided in an appendix to this report (see Appendix A). The FPIA-assisted project, BR-05, provides for salaries/fringe benefits for the four members of the State level program technical team and for 7 physicians and 13 field supervisors, along with other funding for training and support activities. The four members of the State-level program technical team are responsible for, respectively: administration; medical supervision/technical coordination (an M.D.); education/training; and evaluation.

The paid physicians, and 40 volunteer physicians, are responsible for seeing clients who are referred from distribution posts for medical reasons (contraindications to a method; complaints about and/or side effects of any method; pap smears; health problems) or for provision of clinical contraceptive methods such as the IUD and diaphragm. They also give educational talks in their areas. Five of the seven paid physicians are located in the Rio metropolitan area, and the two other paid physicians are stationed at referral sites elsewhere in the State. All physicians receive their training at the BEMFAM central office and other appropriate sites. Training and supervision are organized by the medical coordinator and the educator/trainer of the State of Rio program team. Paid program physicians are expected to attend a monthly meeting at the BEMFAM central office with the State of Rio medical supervisor/technical coordinator. They are trained in IUD insertion and are equipped at their service site to provide this method. Ten of the 40 volunteer physicians are trained as well, and are visited by respective field supervisors each month for collection of client data.

The 13 field supervisors are the liaison between field and State level staff (distributors/educators/physicians and the State of Rio program team and vice-versa). Each supervisor is responsible for +17 posts, on the average, and covers a variable number of municipios. Each supervisor is required to visit each of his/her posts at least once a month. In the course of a visit, a supervisor discusses the work of the distributor(s) and educator (and backup physicians) with the personnel themselves and with the sponsoring organization (where applicable), and supports and assists this work. The supervisor collects and assesses monthly reports on new and active users and on number and type of educational talks, checks on supplies of contraceptives, and requests additional supplies from the central BEMFAM warehouse; gives additional on-the-job training where necessary and, in general, assists the distributor(s) and educator to solve any particular problems. The supervisor

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also promotes meetings in the community and also gives talks. He/she stays in touch with volunteer physicians and with community leaders. The supervisor attends a monthly meeting at the BEMFAM central office with the State of Rio team, at which observations are made on his/her monthly visits to posts.

Supervisor training consists of a 5-day course with special attention to the objectives and methods of supervision to routine procedures, to supervision of "problem situations," to routine procedures, and to measurements of staff performance. Refresher courses are also scheduled regularly for periods of 3 days.

4. Service Points: Geographic Coverage and Type

Two-hundred twenty-one (221) community distribution posts, staffed by a variable number of distributors and educators, have been established in 61 of the 64 municipios of the State of Rio since February 1980 to date. There were 87 posts established in the 14 municipios of metropolitan Rio and in one other municipio in the first year of the program. This increased to 212 in 49 municipios and 221 posts in 61 municipios in the second and third years of the program, respectively. The distribution of these posts by area and by type are shown in Tables 6 and 7, respectively. About one-third of posts are distributed in each of three areas of the State. A slightly higher proportion of posts covers the lesser populated area of the Interior, because distances there are greater and transportation is limited.

Whereas in other BEMFAM-assisted programs established through State Governments there are generally three types of distribution posts (health posts, household posts, and community center posts), there is a greater variety of types of posts in the State of Rio program, as seen in Table 7. This has occurred because there is no agreement to date with any State agency in the State of Rio, but there are separate agreements with 61 of the 64 municipios and/or social agencies in those municipios. Thus, in addition to municipio health posts, household posts, and community center posts, there are posts being administered by private institutions, neighborhood associations, unions and rural cooperatives, religious institutions and industry. For this reason, the State of Rio program is probably more of a "grassroots" community program than programs in other States in Brazil.

The number of posts in each municipio is shown in Figure 2. At the current time, family planning services are provided free of charge through about 151 posts, and for a small charge for each type of contraceptive in about 70 posts. This experiment in the subsidized sale of contraceptives, unique to the State of Rio program, will be discussed elsewhere in this report. In all posts, I&E on the full range of contraceptive methods, including more permanent methods and natural family planning, is provided without charge to the client. If the client requests an IUD or a sterilization, the client is referred to an appropriate service referral point, either in the BEMFAM network or run by another organization.

One or more program distributors staff each distribution post to serve clients who come in during the day. Each post advertises its own hours. A post can be open all day every day, all day some days, or part-time during the day or week. Educators collaborate with distributors and go out into the community surrounding a distribution post to contact influential individuals and groups

and the public at large, to inform them of the existence of the program and post and to educate them on family planning and contraception through organized "talks." Educators are assigned an area containing a variable number of distribution posts.

5. Program Development

Convenios (agreements) for the establishment of posts are negotiated by the State of Rio program team and by program field supervisors with mayors of municipios and/or municipio health or education officials. When these officials do not want to implement a program, contacts are made with unions and rural cooperatives, community social service organizations, neighborhood associations in lower socioeconomic areas, private institutions, religious groups, and with private individuals who wish to perform some community service out of their own households.

This program was implemented in February 1980 with FPIA assistance. The technical program team and field supervisors received theoretical training in the BEMFAM central office and practical experience in the northeastern States where other BEMFAM CBD programs were in progress. The program emerged in a relatively hostile environment in the State of Rio due to political and religious objections to family planning, heightened by the impending visit of the Pope to Brazil in June 1980. Despite a demand for services on the part of the public, apparent in pharmacy sales of contraceptives, religious objections nevertheless were anticipated by BEMFAM as a result of prior experience with CBD programs in other States of Brazil.* During the first year of the State of Rio program, attempts were made to work with officials in the municipio of Rio. However, some apparently were afraid to be linked to the "controversial" subject of family planning 2 years prior to the first scheduled elections in Brazil in over 20 years. Also, some physicians are said to have resented the fact that the program would operate primarily through nonmedical family planning workers trained specifically for this purpose, who would possibly deprive them of private patients (although it is documented in the nine statewide contraceptive prevalence surveys that most women using pills obtain them from pharmacies without physician-issued prescriptions). There was also a general lack of confidence in the utilization of nonmedical volunteers in a family planning program. Therefore, the first convenios for establishment of distribution posts were made by BEMFAM with housing associations and private individuals (household posts).

*It is interesting to note that, despite the resistance of the Catholic Church in Brazil to family planning (other than natural methods), other popular grassroots religious institutions and "terreiros de umbanda" (spiritualists), have given their support to the program, and some community religious leaders are serving as household post distributors. It is presumed that these neighborhood personalities know that those who consult them on religious and spiritual matters also want access to family planning information and services and they have, therefore, volunteered to help meet this need.

Later on, in other municipios, the mayor's office agreed to collaborate with the program through the municipal secretary of health or education and posts were actually established in or near local Government premises, although most were in municipal health posts. As mentioned previously, where this appeared to be a possibility, BEMFAM gave first priority to collaboration with mayors and municipio officials so that services could be institutionalized. Where such a relationship was not possible, other community institutions were approached. Thus, posts in municipio facilities are most common, household posts are second in number, and other institutions follow. An innovation in the State of Rio program is the incorporation of two universities/medical schools as distribution posts. One of the medical schools subsequently decided to include family planning as a required course for medical students.

6. Community Support and Volunteers

To keep the number of paid professional and technical staff to a minimum, emphasis in this program is put on community support for distributors, educators and other volunteers. A distributor or educator can be a municipio employee, a housing association employee, or an employee of a community social service association, etc. (see types of posts—Table 7), whose salary is paid by the employing organization but whose services are put at the disposal of the family planning program on a full- or part-time basis. The particular employee is interviewed regarding his or her genuine interest in family planning and is selected by the employer in collaboration with one of the program field supervisors. The fact that the salary is paid and the organization lends the time of an employee to this program is a powerful demonstration of community support. Space for the distribution post is also provided, usually within the existing premises of the organization.

Religious/spiritual "consultants" within a community, and housewives, often agree to serve the program as individual volunteers on a full- or part-time basis. The distribution post is, in these cases, located in their homes, without charge to the program.

As stated above, 40 physicians throughout the State also volunteered to see clients on referral from distribution posts, without charge to the program. These are in addition to the seven paid physicians in the program.

By April 1983, BEMFAM had registered 734 community employees and volunteers-- 458 distributors, and 276 educators.

7. Training

The State of Rio program team provides training in primary health care and family planning for physicians, including training in IUD insertion, and the BEMFAM plan is to give refresher courses once a year. Distributors and educators also receive training in maternal-child health and family planning either at the BEMFAM central office or in centrally located cities in the Interior of the State. In addition, field supervisors provide refresher training on the job. Distributors' and educators' training (3 days of small group work) emphasizes the physiology of human reproduction, critical analysis of contraceptive methods, contraindications and side effects, allowing staff to screen out clients for whom a particular method is not recommended or to advise on coping with minor problems; recordkeeping; and community mobilization.

Orientation of women towards prevention of gynecological cancer and orientation of pregnant and lactating women, which may lead to referral for pap smears and prenatal care, respectively, are other important topics. Educators receive exactly the same training as distributors, except for the last class when educators are taught about utilization of educational materials, how to conduct talks and how to make home visits, among other topics.

8. Information, Education, and Communication (IE&C)

A Rio program team member is responsible for community and public information and education activities. Program staff in the field undertake most activities locally. Materials to assist them are produced by BEMFAM and other materials to influence the media, influential groups and the general political scene, are also developed by BEMFAM as needed. BR-05 included a mass media component (radio, TV, etc.) during the second year of the program.

9. Contraceptive Methods

BEMFAM's objective of increasing access to family planning information and services by utilizing trained volunteer community workers without a medical background (with the exception of some nurses) led to an obvious emphasis in the State of Rio program, as in the other CBD programs, on distribution of pills, condoms, and spermicides. Clients are informed about all methods, and if they express interest in clinical contraception they are referred by distributors or educators to other program or nonprogram service points for diaphragms, IUD's, and voluntary surgical contraception (VSC).

Diaphragms and IUD's are provided by BEMFAM clinics and by some volunteer private physicians in the program. VSC is provided at clinics and hospitals of the Ministry of Social Security (INAMPS) and through clinic services established by the Research Center for Integrated Assistance to the Woman and Child (Centro de Pesquisas de Assistencia Integrada a Mulher e a Crianca--CPAIMC) in downtown Rio de Janeiro. BEMFAM has a referral hospital for VSC--Hospital Moncorvo Filho--which has a program funded by the Association for Voluntary Sterilization (AVS), New York, USA, for training of physicians. Surgery is provided free of charge. BEMFAM clients requesting VSC may be referred to any one of these service points. CPAIMC services are free while hospital services at INAMPS are at some cost to the client. VSC, in the absence of other family planning methods, is popular and has been sought by substantial numbers of Brazilian women (see Table 1). In general, importation of IUD's from abroad is restricted and although some supplies are received by BEMFAM and CPAIMC, the service is not widely available outside these service networks. Clinical methods are not part of the State of Rio program established by BEMFAM. Statistics on referrals for diaphragm, IUD, and VSC are not systematically kept at the level of the distribution post and these clients are not followed up to determine if they have actually had the service.

BEMFAM supplies four brands of pills to its distribution posts--Neovlar, Primovlar, Normamor, and Ciclo 21, all manufactured in Brazil. The choice of brands was initially determined as a result of a BEMFAM survey in 1976 which showed that women reported fewer side effects and complications if the brand used had D-Norgestrel as an ingredient. Neovlar and Primovlar were chosen for the program on this basis and, at a later date, the other brands were added. A total of 4 million cycles per year are purchased of all brands to supply BEMFAM programs in 8 States. Because the "pipeline" supply must be

considered, it is difficult to estimate the proportion purchased for the State of Rio alone. However, using the number of clients in a given period of time, State consumption can be calculated at one cycle = U.S. \$.18, which is the converted local purchase price reported by BEMFAM.

The IPPF provides assistance to BEMFAM for local purchase of oral contraceptives in Brazil. The IPPF and the Pathfinder Fund also provide condoms, spermicides, and IUD's purchased abroad and delivered to Brazil. These supplies are utilized by BEMFAM in each State in which it has developed family planning programs, including the State of Rio.

In 1983, BEMFAM expects to receive a shipment of 8 million units of condoms for 8 State programs (half from IPPF and half from Pathfinder). Fifty thousand each of diaphragms and IUD's are also provided by these organizations each year. The only costs BEMFAM sustains regarding contraceptive supplies are customs clearance charges and payment for transportation from port of entry to the BEMFAM warehouse. Spermicides (foam and tablets) are donated by the Government of Japan.

In 1982, for new clients, pills were the overwhelming method of choice in the State of Rio program, followed by condoms, spermicides (foam and tablets), and combined use of condoms and spermicides. For subsequent visits, the order was pills, spermicides, condoms, and combined methods. (See Sections VI-D and VII-D for a more detailed description and analysis, respectively, of service statistics by method.)

Although screening for gynecological cancer is not a stated objective of the program for which targets have been established as in the case of contraceptive methods, pap smears are offered to BEMFAM clients whenever feasible, depending on the availability of physicians and laboratory facilities. In the metropolitan area of Rio, there are three clinics that carry out such screening: the Meier Clinic, the Duque de Caxias Clinic and Hospital Moncorvo Filho.

10. Subsidized Program: Sale of Contraceptives

In April 1982, as an experiment, 10 household and neighborhood association posts in the Rio program were permitted by BEMFAM to sell pills, condoms, and foam at subsidized prices well below what was being charged in local pharmacies (for example, at the time of this evaluation, a cycle of pills reportedly cost from 280 to 380 cruzeiros in pharmacies, depending on the neighborhood). By May 1983, 70 posts were selling contraceptives after reaching a peak of 81 in October 1983 (Table 8). The number of posts vary by month due to post closings, vacations, etc. A monthly supply of pills or foam was 30 cruzeiros during this period, with the value in U.S. dollars declining as the cruzeiro suffered successive devaluations (see note in Table 8). The distribution of income from the sales is as follows: 50 percent is returned to the BEMFAM central office and the general BEMFAM budget; 35 percent is kept at the level of the post as additional income for the distributor or the housing association; and 15 percent is given to the supervisor. All income is reported monthly to the BEMFAM central office. In May, 70 posts generated income in cruzeiros, equivalent to U.S. \$1,203, about \$17.00 per post. In June, the price for a cycle of pills was raised to CR50 (\$US .09) so that an equal amount of sales in June as in May would generate about \$US 1,800.

B. Funding History of Program

The BEMFAM Program of Mobilization of Community Resources for Family Planning in the State of Rio de Janeiro was approved by FPIA for funding for a period of 3 years, from February 1980 through January 1983. FPIA agreed to assist with training, educational activities, supervision, program management and evaluation through budget support for salaries of technical and supervisory program staff; fringe benefits; training consultants; travel; office and audio-visual equipment and supplies; direct costs of production of IE&C materials; computer programming; freight; communications and bank charges; and indirect costs covering the administrative overhead for the State of Rio program team based in the BEMFAM central office. Contraceptives were supplied for the program by IPPF and Pathfinder at no charge to the FPIA budget.

FPIA requested from BEMFAM--and approved--all yearly budgets and subsequent budget modifications in cruzeiros rather than in dollars. Because the Brazilian cruzeiro has been devalued against the U.S. dollar on a monthly basis over the life of the program, and a semi-annual salary increase is required by the Government of Brazil of all employers, including BEMFAM, to offset the effects of inflation on workers' salaries, BEMFAM and FPIA have had to revise the project budget about every 6 to 12 months (see Table 8 for the monthly differences in the exchange rate from April 1982 through May 1983). These have been time-consuming repetitive exercises for BEMFAM staff. Moreover, as exchange rates were apt to change between any one approval and the subsequent expenditure report, the funding history of project approvals and expenditures in cruzeiros and equivalencies in dollars becomes exceedingly difficult to follow from FPIA documents, which sometimes do not even show the prevailing exchange rate. Thus, in order to capture the cost of the project to date, it is necessary to look at the five periodic disbursements that have been made to date by FPIA headquarters in New York into the FPIA project dollar account, amounting to U.S. \$1,369,211. The five disbursements covered reported program expenditures by BEMFAM in cruzeiros. The reimbursement in cruzeiros for funds spent in the previous quarter has been a problem. Because of the 130 percent inflation rate, these funds have only about 60 percent of the value of the money already spent. To our knowledge, FPIA is the only donor agency in Brazil to reimburse in dollars at the value of cruzeiros for a preceding period rather than the cruzeiro equivalency to dollars prevailing at the time of disbursement.

Due to the constant devaluation of the Brazilian currency, it has been possible to allow several "no cost" project extensions since fewer dollars could buy the cruzeiros expended in the previous quarter and dollars were left over. A last "no-cost" project modification in May 1983 intended to extend the Rio program through this evaluation period was approved by FPIA and will carry the program through September 1983. Thus, FPIA funding for what was originally a 3-year project period will then have been stretched to cover 3 years and 8 months. Funds became very tight for BEMFAM towards the end of May and with the last no-cost project extension of 4 months, BEMFAM decided that it had to cut back on expenditures and wind down some activities, particularly in training and community education. For its part, FPIA has cited funding cutbacks as a constraint to future assistance for this project, but this seemed secondary to policy issues, such as the reluctance of FPIA to fund IPPF affiliates and a concern that FPIA funding should lead as quickly as possible to project self-sufficiency. The future of the BEMFAM program in the State of Rio de Janeiro from September 1983 will depend on decisions to be taken on project funding on the basis of the findings of this evaluation.

C. Program Service Statistics

1. Definitions and Reporting System

The Department of Evaluation of BEMFAM has had a relatively streamlined reporting system simplified to an even greater extent in April 1983. A new client ("cliente nova") is defined as a person who has never been to that post, and that person is counted as a subsequent visit ("visita subsequente") on all return visits to the post. With these two pieces of information, along with method, BEMFAM can report new clients and active users each month. Active users are the number of clients estimated to be using program methods at a given point in time. Each pill acceptor receives one cycle at the first visit and three cycles at every subsequent visit. Users of other methods receive 2 months' supply. Thus, active users for any given month are new clients for that month, plus subsequent visits for that month and n previous months, depending on the method used. As mentioned above, there are strict norms on the supply of each contraceptive method given to the client during each subsequent visit, thus, active users can be estimated by method.

New clients and active users are the program indicators required and/or recommended by IPPF and most agencies such as the Agency for International Development (AID), Columbia University, Pathfinder, and the Centers for Disease Control (CDC), Atlanta, Georgia. To our knowledge, FPIA is the only agency that asks for continuing user statistics. A continuing user is defined by FPIA as new users in a funding period, plus return visits in that funding period by new users in previous funding periods. Thus, a woman can come to a clinic in March of one year and never return until October of the following year and be a continuing user in both years, even though she may have been pregnant in between the two visits made 18 months apart.

Not only is this statistic not as valuable as a continuing monthly or quarterly estimation of active users, but it is very time-consuming to match up users from two different calendar or funding periods without an expensive computerized record system. FPIA may have adopted this indicator from the U.S. program where, even with a sophisticated computerized record system, no one has found a way to use the statistic in a meaningful fashion, and the system has been terminated, in part, due to the costs involved in maintaining the master file in the computer to determine continuing users.

Prior to April 1983, a three-part card was filled out in the State of Rio program for every new client (see Appendix B: Part A, with identification information on the client), was filed alphabetically in the distribution post and Part C, with the same information, was given to the client to bring with her on subsequent visits, with the month of return on the reverse side. Part B was submitted monthly to the State of Rio Evaluation Department, with characteristics of the client, including age, number of living children, open interval, and if she was already using a method prior to coming to the distribution post. If she was referred to a physician because of contraindications or any other reason, this was also noted. From February 1980 to October 1982, a monthly 10 percent sample of new clients was conducted to report on their characteristics. This sample was dropped after October 1982 due to the costs involved in maintaining the data at the State level and central office. The Evaluation Team found this sample data very useful (see Section VII-D.). The team will comment later in this report on the possibility of collecting this information one month a year so that trend data on client characteristics can be continued.

In April 1983, the system was simplified so that a client identification card with two parts--one for the post and one for the client--is filled out. The only client characteristics available on this card are age and sex. Individual cards are not sent to the State level and central office, and program data is calculated from listings of new clients and subsequent visits, by method, collected each month by the field supervisor.

2. New Clients

New clients are shown in Table 9 by geographic area and by quarter (3-month periods, with the exception of the first period) from the start of the program in February 1980 to March 1983. During this 38-month period, 184,020 new clients accepting a method of contraception were registered in the program, representing 10.6 percent of currently married women (CMW) 15-44 years of age in the State. The annual percentage of CMW registred in the program increased yearly from 1.3 percent to 3.6 percent to 4.9 percent, reflecting the increase in number of new clients annually from 23,301 in 1980 to 62,519 in 1981 to 85,612 in 1982. Almost two-thirds (62.8 percent) of the cumulative number of new clients went to posts in the Municipio of Rio de Janeiro, followed by 25.1 percent in the surrounding metropolitan area and 12.3 percent in the rest of the State. The program has reached 15.0 percent of CMW in the Municipio of Rio de Janeiro but only 6 to 8 percent in the other two areas.

The quarterly data show 1980 to be a year of fluctuation, followed by substantial and generally consistent growth in the program beginning in the first quarter of 1981 and peaking in the second quarter of 1982. An abrupt drop in new clients was seen at the end of 1982 with some recuperation in the first quarter of 1983, although still at a level only half that of mid-1982. These trends differ slightly by geographic area but follow the same general pattern.

A significant contribution to the rapid increase in total number of new clients in late 1981 and subsequent decline at the end of 1982 is the variation in condom distribution, as seen in Table 10. The condom has gone from less than 1 percent of methods accepted in the first year of the program to 31 percent in the first quarter of 1983. The percentage of new clients accepting pills has decreased from 88 to 60 percent.

3. Active Users

Active users are shown by geographic area and by quarter in Table 11. The program showed steady growth through June 1982 when 75,991, or 4.4 percent, of CMW were active in the program. The percentage active fell to 3.4 percent at the end of 1982 and has been maintained at that level during the first quarter of 1983. In March 1983, almost half (47.6 percent) of active users were reported in the municipio of Rio de Janeiro, with 30 percent and 22 percent in the metropolitan and other areas, respectively.

The percentage of CMW active in each area ranges from only 3.0 percent to 3.6 percent. The "rest of the State" or Interior has retained a greater percentage (56.8 percent) of their cumulative number of new clients, either because the program is newer in these areas, or they do a better job of retaining clients, or a combination of both. Only 24 percent and 38 percent of the cumulative number of new clients are active in the municipio of Rio and the metropolitan area, respectively.

As may be expected, there are more active users per post in the more densely populated Municipio of Rio, with 359 per post falling to 275 per post in the metropolitan area, and 160 per post in the rest of the State. However, approximately 11,000 of the 27,661 active users in the Municipio of Rio are in the Meier Clinic. If this clinic is excluded, there are only 219 active users per post in the Municipio of Rio.

Active users are shown by method in Table 12, and the decline seen at the end of 1982 is a result of declines in both pill and condom users. Active pill users continued to decline in 1983, whereas users of condoms and vaginal methods rose again. The great majority of active users are users of the pill (87 percent in March 1983). Only 5.3 percent of active users are condom users compared with the fact that condom users represented 31 percent of new clients in the first quarter of 1983. Another indication of the poor continuation of condom users is that only 8 percent of condom users are still active in the program.

VII. EVALUATION OF PROGRAM (PMCR/FP)

A. Introduction

The FPIA Regional Office in Miami supplied the Evaluation Team with a full set of project documents prior to arrival in Brazil.

The activities carried out under this evaluation in Brazil can be divided into three parts: (1) briefings by central and State program staff at the BEMFAM central office, (2) a field trip to 20 distribution posts, and (3) data reduction and analysis. The daily agenda is shown in Appendix C. The only addition would be a debriefing with BEMFAM staff on Monday, July 4.

An excellent program briefing book was prepared by BEMFAM for all three consultants, and it was evident that significant staff time was put into its preparation. In addition to the data supplied in the briefing book, several special data requests were made by the Evaluation Team relating to service statistics and the subsidized program. Every request was answered by BEMFAM in a timely manner, and priority was given by BEMFAM staff to the preparation of special tabulations.

The field trip is discussed in the next section. Although the Evaluation Team was together most of the time, each consultant paid special emphasis to his or her technical area. Dr. Morris, a statistician/demographer, was responsible for census data and service statistics analysis; Dr. Franco, an obstetrician/gynecologist, looked at staff performance and clinical issues; and Ms. Epstein, experienced in MCH/FP program management, looked at management and administrative issues. The consultants then systematically exchanged data and observations for further analysis as the evaluation progressed.

B. Field Visits

The team visited 20 of the 221 distribution posts, about 1 of every 11, or 9 percent. The selection of posts was not a completely random process for two reasons: (1) Five of the 16 work days were devoted to field trips, and the posts to be visited had to follow a reasonable geographical ordering following a random start in order to visit all 20 posts in 5 days, including travel time, and (2) a selection of different types of posts was desirable for contrast and completeness.

All the posts visited are listed in Appendix D. This listing includes the post name and number, the date it opened, hours of operation, the number of active users, and the name(s) of the distributor(s). There were seven posts visited in the Município of Rio, four in the metropolitan area, and nine in the Interior. Thus, 35 percent of the posts visited were in Rio, and Rio has 35 percent of the total number of posts. The Interior posts were slightly oversampled--45 percent versus 36 percent of the total--and 20 percent of the posts visited were in the metropolitan area where 29 percent of posts are located (Table 13).

A summary of the types of posts visited in each geographic area is shown below:

<u>Type of Post</u>	<u>Rio</u>	<u>Metro</u>	<u>Interior</u>	<u>TOTAL</u>
County Government	0	3	3	6
Unions/rural coops	0	0	3	3
Clinics	1	1	0	2
Household	2	0	0	2
Housing Association	2	0	0	2
Community Centers	1	0	2	3
Industry	0	0	1	1
Religious Center	1	0	0	1
	<u>7</u>	<u>4</u>	<u>9</u>	<u>20</u>

The administrative regions visited in the município of Rio de Janeiro are shown in Figure 4. The Interior posts visited were in the northern and eastern parts of the State, which are the most rural areas.

C. Staff Performance

In all posts visited, questions were asked of supervisors and distributors to check their knowledge of family planning methods and, for each method, the side effects and contraindications. All supervisors and those distributors trained at the central level had a solid and consistent knowledge on these subjects. The distributors who showed some hesitancy in answering the questions were all staff who were recently trained while on the job. (The recent electoral changes in municipal Governments on March 15, 1983, resulted in a high turnover of personnel assigned by local municipal administrations to work at program distribution posts, increasing the need for training of new personnel at the local level.)

The paid program physicians interviewed by the Evaluation Team are well trained professionals who are very enthusiastic about the program. Whenever there is a contracted (paid) BEMFAM physician in the clinic, he/she examines every new client, discusses appropriate method with the client, inserts IUD's when that method is chosen and examines all those clients with contraindications and side effects from any method. In one clinic visited (Duque de Caxias), the possibility of implementing a post-partum family planning program, together with the hospitals in the area, was discussed. The State of Rio program technical coordinator agrees that this would be useful if funds were available. (A post-partum program has been implemented in the State of Piauí through a BEMFAM-supported family planning project assisted by Pathfinder.)

At all levels of the State of Rio program, personnel are very enthusiastic about being part of the program, and several have made suggestions based on their field observations on how to improve quality of services. The Evaluation Team was particularly impressed by the outspoken and eager comments made by distributors and educators who are all deputed personnel of organizations or volunteers who are obviously very committed to their work in the program.

Although BEMFAM does not have a policy on following up clients who fail to return for resupply, some supervisors and distributors, on their own initiative, try to contact those clients who did not keep to their schedule for a return visit for resupply. This, however, is a local innovation where it is done, depending on the area in which the post is located and the length of time the distributor can dedicate to the program. In rural areas, the contact is generally made by asking a neighbor to give the client the message that she should come back to get a resupply of contraceptives. In urban areas, the distributor can go to the client's house and inquire about the reason she did not come back and encourage her to do so. One of the posts in a neighborhood association uses the association mail system to send letters to these clients. This procedure is more difficult to carry out in posts with a larger number of clients because, at present, there is no systematic way of keeping the records so that the distributor could easily find out who the dropouts are.

The recent change in the design of the client's card left out a space in which the next appointment would be shown. Because that makes it even more difficult to identify dropouts, some distributors took the initiative of marking in pencil on one of the corners of the new card the return visit date, and they communicated the decision to the supervisors who, in turn, brought up the subject in a meeting at the BEMFAM central office.

Contraceptive supplies are well stored at posts, and no problem with stocking/resupply was identified in any of the posts visited by the Evaluation Team.

In CPS's carried out in Brazil, it was found that the majority of women taking pills in southern Brazil and in urban areas in the northeast, used the pharmacy as their source of contraception. Although a rivalry between pharmacies and the program was mentioned by some distributors and supervisors, in some places pharmacists would allow posters to be placed in their stores and would even refer impoverished clients, who could not afford to purchase their contraceptives, to the program.

Distributors and supervisors in municipios visited by the Evaluation Team were well known by local community leaders.

One of the 13 supervisors, a man, is assigned full-time to give lectures on sexually transmitted diseases (STD) and family planning, especially for male audiences, emphasizing the importance of use of condoms. Such audiences are composed mainly of army and police personnel. Clients for treatment of STD or vasectomy are referred to two hospitals, which are funded by the State and municipal Governments. They do not charge for these health services.

Supervisors who were interviewed agreed that the first measure to improve the program is to revitalize the I&E component and step up training. One suggested that a mobile unit should be used to inform, educate and even distribute family planning methods to remote populations.

Overall, the training given to program staff in family planning seems to be effective in preparing them to carry out their assigned functions. The Evaluation Team observes that, based on the program training in primary health care and MCH, distributors, educators, and supervisors could be more active in educating on health at the post level and that simple risk assessment and referrals for appropriate care to health facilities could be stressed to a greater extent at the level of the post.

D. Service Statistics

1. General Observations

The two principal statistics used by BEMFAM--new users (new clients) and active users (active clients)--are in general use throughout Latin America. Data is up-to-date at the State and central level, with final data for April and preliminary data for May available in mid-June. Data for May will be finalized in early July when preliminary data for June is received. During our field trip, current data for June and complementary data for May were available at each post. Each distributor retained organized and accessible files and were able to answer a variety of questions without problem, on the filling out of forms and classification of clients. All data for June appeared to be accurate and consistent with post-specific data available to the team for January through May.

The definition for new users presents no problems, with the exception of the reporting of medical referrals. Totals for new users reported by BEMFAM include referrals to physicians and cytology. (It is our understanding that new clients receiving contraceptives from the physician on the first visit were registered under the method received rather than as a medical referral.) Throughout this report, the team has had to subtract out medical referrals and cytology visits not receiving contraceptives, because these clients did not receive a method at that first visit. Thus, it would be helpful if the number of new users represented only the total number of women (and men, in some cases) receiving contraception at a first visit. The number of women referred to a physician or receiving cytology could be tabulated separately.

It is conceivable that a woman going to more than one post would be counted as a new client more than once. However, this does not appear to be a problem and in this case, the woman would appear as an active user in one post while dropping out as active user in another post, so that she would be counted as only one active user, a more important indicator of program performance.

As long as a standard quantity of supplies is delivered for each method at a first and subsequent visit, active users can be estimated, based on monthly reports of new clients and subsequent visits. This has been the case in all the CBD programs in Brazil. However, a new development in the Rio program is the income generation component in which contraceptives are sold at a subsidized price, and new and subsequent clients do not necessarily "buy" a standard quantity. This will be discussed further in Section VII-F under Income Generation.

A lack of condoms and some brands of oral contraceptives is reported to have contributed to the drop in new clients and active users during the final quarter of 1982. However, during the Evaluation Team's field trip, this problem appeared to have been resolved as no stockouts were found, and ample supplies of each contraceptive was found in each post. In resupplying each post, the supervisor looks at the past 3 months' activity in calculating quantities for resupply for each month.

It may be noted here that although monthly data were available, they were summarized into quarterly figures for trend and other types of analyses. Thus, supervisors, if necessary, could pick up service statistics once every month without much loss in analytical power at the State and central levels. Also, personnel time at the State level could probably be saved if quarterly reports of new clients were reported to donor agencies (the monthly data can be filed if one wanted to refer to them). For active user figures reported at the end of each quarter, new clients would be needed for the final month of the quarter, plus subsequent visits for that quarter and the final month of the previous quarter. Thus, monthly data would still be needed, but it does not have to be collected on a monthly basis.

The recommendation of quarterly reporting brings up another issue. BEMFAM maintains that all donor agencies, with the exception of FPIA, accepts four quarterly reports a year. FPIA requests three 4-month reports, and these reports are tuned to the contract period rather than January-April, May-August, and September-December. BEMFAM would consider instituting quarterly collection and analysis of service statistics to save money but maintains that it has to collect monthly data because of different donor requirements. A recommendation on quarterly reporting is included in Section VIII of this report.

2. Users-Residence and Method of Contraception

An overview of family planning posts and users by area is shown in Table 13. Approximately one-third of the posts is in each geographic area (from 29 to 33 percent). Although most of the population lives in the Municipio of Rio de Janeiro (44 percent), followed by the surrounding metropolitan area (34 percent) and the Interior (22 percent), almost two-thirds of new clients have been registered in the Municipio of Rio with only 12 percent in the Interior. However, 22 percent of active users go to posts in the Interior, compared with 30 percent in the metropolitan area and 48 percent in the Municipio of Rio. As previously shown in Table 9, over half of new clients have been retained in the program in the Interior compared with 38 percent and 24 percent in the metropolitan area and the Municipio of Rio, respectively. Obviously, a greater number of alternative sources of supply are available to women living in Rio and the metropolitan area of Rio. Also, for women who were spacing their children, there is more access to sterilization services in the city when they want to limit childbearing. Since BEMFAM does not provide voluntary surgical contraception (VSC) as part of the program, these women are lost to the program as active users. Many distributors and supervisors spoke about referring women to CPAIMC and INPS for VSC but do not keep records of the number of referrals. A systematic recording of VSC referrals would give some idea of the loss of women to a method the program does not offer. In Northeast Brazil, from 10 to 12 percent of program users have left the CBD programs to obtain VSC (Morris, L., B. Janowitz, W. Rodrigues, et.al.: *Contraceptive Practice and the Impact of Community-Based Distribution Programs in Northeast Brazil*. Submitted to *Studies in Family Planning*).

As shown in Table 10, condoms now account for almost one-third of new client method use, with pills now accounting for 60 percent of new users compared with 88 percent in 1980. However, as shown in Table 11, condom users represent only 5 percent of active users, whereas vaginal methods account for 6 percent, and pills are the primary method of active users at 87 percent. IUD's now represent 1 percent of active users.

Only 8 percent of condom clients are still active in the program. This is consistent with preliminary results of a continuation study in Piauí using the records of 1,736 male and 406 female condom acceptors. About 24 percent of the males and 41 percent of the females continued to 1 year. The continuation of female condom acceptors was equivalent to that of pill acceptors while the continuation of male condom acceptors was substantially less. Because condom acceptors in Rio as in Piauí are predominantly male, the number of active condom users can probably be expected to stabilize very rapidly at a low level. However, the educational value of the condom for young males and the protection it affords for unmarried couples who may be sexually active only sporadically gives the method an importance beyond the number of users it attracts.

These data also support the hypotheses that, in many cases, condoms are used only temporarily by women during breast-feeding before switching to the pill, and that new client figures for condoms are inflated by distribution to male groups who never return as "individuals" for resupply.

3. Characteristics of Users

Data from the 10 percent sample was used to look at trends in characteristics of new clients over time. As discussed in Section VI-C, this monthly sample was discontinued in October 1982. In Table 14, we present data for the first month of the program (February 1980) and every October thereafter. Sample sizes ranged from 171 to 817 for these four periods of time. For the item on previous use of contraception, data was abstracted for every April and October following the first month of the program because of the importance of getting some idea of the dimensions of the substitution effect.

Since October 1980, almost two-thirds of new clients have been less than 30 years of age, with 11 percent teenagers and 55 percent from 20 to 29 years of age in both 1981 and 1982. It is no surprise that a program that provides temporary methods of contraception attracts younger women. In October 1982, only 2.7 percent were over 40 years of age and an additional 12 percent 35-39 years of age (not shown in Table).

The majority of women using the program have one or two living children, and the percentage of new clients with no living children has increased from 3.2 percent to 11.4 percent. The percentage of new clients that have never had a pregnancy has also increased from 3.4 percent to 8.3 percent while another 12 to 13 percent of women who have entered the program do so within 3 months of a pregnancy outcome. The majority of women enter the program more than 1 year following their previous pregnancy.

In the first year of the program, very few of the women registered as new clients were not already using contraception. Thus, when the program was initiated, it essentially supplied a substitute source for women probably buying their contraceptives in the pharmacy. The proportion of new clients already contracepting had declined to 80 percent in October 1982. During the evaluation, some of the old forms were still in use, and a review of 141 new client cards with this information showed that 85 percent of new clients had been contracepting.

It is also interesting to note that virtually all prior use was prior pill use, one of the most effective contraceptive methods available. Therefore, substituting BEMFAM for other sources of contraception does not improve the theoretical effectiveness of the methods employed. However, switching may improve continuation (use effectiveness) because the many BEMFAM posts improve the economic and geographic availability of the contraceptives. In addition, BEMFAM users benefit from screening and instruction on how to use the method, services which are not available from the pharmacies where the contraceptives are otherwise obtained.

The fact that the majority of married women, even low-income women, in Rio de Janeiro are contracepting or have used contraception at some time in the past is no surprise when one considers CPS results from Southern Brazil. Also, unpublished data from a CPAIMC operations research household survey in three Rio "favelas" (slum areas) shows that over 60 percent of currently married women were using contraception, and more than half of these women used oral contraceptives (Table 15). More than half of these women using orals obtained them in the pharmacy. The question remains, "Is BEMFAM serving the poorest of the poor?" Data from the CPAIMC survey show that although the majority of poor women obtain their pills in the pharmacy, there is an inverse correlation between per capita household income and BEMFAM as a source of orals. In other words, the poorer the woman the greater the use of BEMFAM posts. In fact, whereas only 11 to 13 percent of users with at least one minimum salary use BEMFAM posts, the proportion increases to 31 percent for the poorest group of women.

Distributors were asked why they thought that women who were buying pills in the pharmacy were now coming to the program for pills. Almost, without exception, distributors replied that the current economic situation was forcing low-income families to readjust their budgets, and these families could no longer afford the cost of pills in the pharmacy. (Brazil is now in a serious recession with increasing unemployment and under-employment, and the inflation rate is running at 130 percent a year.) In those posts with physicians, distributors said that, in part, the availability of a physician might be an attraction.

The team used information on client characteristics, obtained from the 10 percent sample in this evaluation. Due to the costs of maintaining this monthly sample of new clients, it was discontinued in November 1982. However, it would be useful for the program to continue to obtain information on client characteristics at least once a year—perhaps by registering information on all new clients in 1 given month. Age is already on the new client card and the other characteristics shown in Table 14 could be collected in a special

yearly sample over a 1-month period (except that data on breast-feeding may be more useful than open interval, since breast-feeding may affect use or nonuse of the pill or the dosage of the pill), along with perhaps some data on method switching collected from active users. As a special project in the State of Rio, this could be done for approximately \$2,500 per year (the budget items are available upon request).

4. Cost Per User

As stated above, the FPIA funding documents do not consistently give the exchange rates for cruzeiro budgets. Thus, with an annual inflation rate of 130 percent and a currency that has been devalued by 200 percent in the past year, the cruzeiro budgets are very difficult to interpret when trying to look at cost per user. The Evaluation Team has opted to use the cumulative total of U.S. dollars released to the program through January 1983 to estimate the exogenous cost per new user (annual total) and active user (December of each year), with the total amount released, divided into three equal parts: cost per new and active user is, therefore, estimated as follows:

	<u>1980</u>	<u>1981</u>	<u>1982</u>
New Users	\$19.24	\$7.17	\$5.24
Active Users	\$26.69	\$8.41	\$7.56

Since the largest budget year was the second year because of the mass media line item in that year, it is not entirely correct to divide the money released into three equal parts. However, some of the benefit of the mass media campaign would spill over into the third year. Also, local costs and local contributions in kind have to be taken into account, and we could add about U.S. \$0.20 per contraceptive unit. However, with these caveats in mind, it is possible to get a general order of magnitude.

After a first year with higher start-up costs, the basic cost per new user has fallen to \$5.24 in 1982, and the average cost to maintain an active user was \$7.56. Even if we double these figures for local costs and contraceptive costs, it is not an expensive program--about \$15.00 per active user.

In the Brazilian context, cost-effectiveness may be the most important indicator of family planning program effectiveness. The country is one of the largest in the world with over 120 million people, and costs per unit of service must be kept low if services are to be made available to all women in need of family planning. The estimated cost per active user here in the State of Rio compares favorably to the \$24.71 per couple-years protection calculated recently for the State of Piaui program in Northeast Brazil (Foreit et al).

E. Clinical Issues

Special situations, such as breast-feeding mothers seeking contraceptive services, seem to be well-handled by program personnel in the sense that personnel know that combined oral contraceptives are contraindicated and advise women accordingly. When the women state that they do not want an alternative method of family planning, they are referred to a physician for counseling. The alternative methods of family planning used in the program are condoms, foam, tablets and natural methods, none of them widely accepted by any part of the population. In fact, many distributors reported that breast-feeding women stated their intention to buy orals in the pharmacy rather than use an alternative method.

Since the health status of mothers and children of lower socioeconomic status in the State of Rio de Janeiro is so poor, it is imperative to encourage breast-feeding and birth-spacing, and to give the mother a means of birth-spacing that is acceptable to her and that does not interfere with milk production. One such method is the progestin-only pill which, to this date, is not a part of this program.

Although the State of Rio program does not intend to emphasize clinical methods of family planning (such as the diaphragm, the IUD, and VSC), one of the most important goals of family planning should be to provide the woman/couple with all possible contraceptive alternatives so she/they can choose the one that best suits her/them. Therefore, a stronger referral network should be a goal of this program to serve women in need of clinical methods. One way of establishing a network is to "capture" physicians' interest and participation in IUD insertion, for example, by offering them IUD's free of charge for use in their practices and training on how to insert IUD's, with the understanding that they serve the program's clients without charge whenever clients are referred from distribution points.

F. INCOME GENERATION

As described in Section VI. A.10, ten household and neighborhood association posts, beginning in April 1982, were permitted to sell contraceptives at a subsidized price. This is the first and only program in Brazil in which subsidized sale of contraceptives have been permitted. This was termed and is still considered "an experiment" by BEMFAM. However, as seen in table 8, the number of posts now selling contraceptives varies from 60-78 on a monthly basis (in 1983) and income generation has reached as high as \$US 1,700 in some months. When prices are increased in June 1983 to \$CR 50, an equal amount of sales in June as in May would generate about \$US 1,800 compared with US \$1,203. This amount of money would support the salaries of two to three supervisors if the money were "plowed back" into the program.

We consider the subsidized sales program to be on firm footing and it should no longer be considered an experiment. In fact, this part of the program could continue on an independent basis even if the program is turned over to a State Government agency (The hypothesis is that the State Government would only support the program in State and municipal facilities and would not include household and neighborhood association posts in a government program). At the present time, these posts could be considered self-sufficient at least at the field supervisor level.

Additional posts could be added or hours expanded as income grew. For example, in one housing association post, hours were expanded from three mornings a week in May to every day all day in June. Active users increased from 914 to 1,010 and new users increased from an average of 31 a month in 1983 through May to over 70 during the month of June.

As long as a standard quantity of supplies is delivered for each method at a first and subsequent visit, active users can be estimated, based on monthly reports of new clients and subsequent visits. This has been the case in all the CBD programs in Brazil. However, in the income generation component in the State of Rio, new and subsequent clients do not necessarily "buy" a standard quantity (1 month for new users and 3 months for return visits). If

users were buying more than 1-month supply on an initial visit and more than 3-months' supply at revisits, the active user count would be underestimated using the current definition (and if less than a 3-months' supply was purchased, active users would be overestimated). In the six posts with subsidized sales that were visited, the average number of pill cycles sold were:

<u>Post</u>	<u>New User</u>	<u>Return User</u>
A	2.0	2.4
B	3.0	3.0
C	1.3	2.3
D	2.7	3.0
E	2.7	2.0
F	7.5	8.8

With the exception of post F, new users purchase between one and three cycles and return users purchase between two and three cycles. Thus, active users are being somewhat underestimated when new users are considered and somewhat overestimated when return users are considered. In fact, everything probably balances out. However, Post F changes everything. This post, run by a very dynamic distributor in a household post, has her own network of sub-distributors (similar to an Amway pyramid) and the average number of cycles bought by "new users" and "return users" is 7.5 and 8.8, respectively. In fact, every "new user" and "return user" in her network probably represent two to four women and program statistics will not reflect this. This post officially has about 1,100 active users but the number of active users probably is closer to 2,500. Thus, for the subsidized program, consideration should be given to estimating couple years protection based on sales of contraceptives.

The program should also explore how to introduce the subdistributor concept (with proper training) to other household posts using the dynamic lady in Post F as a shining example.

G. POLITICAL AND LOCAL SUPPORT

Family planning was not an issue of importance for the Brazilian Government until 1974 when representatives attended the Bucharest World Population Conference and supported the idea that couples have the right to choose when they want children and how many children they want. In 1978, a special program was proposed to provide contraception to women at high risk of pregnancy. The program was never implemented, however. In fact, even today, in Brazil, the Federal Government's position on family planning is still ambiguous. The Catholic Church's opposition has contributed to the controversy, since 90 percent of all Brazilians are Catholic (although it is obvious that the majority of better-educated women in the Southern States are contracepting).

Over the last year, an awareness of the need for family planning services in Brazil has been emerging. In March of this year, the President's address to Congress included a statement that one of the reasons for the economic problem seen in Brazil today is its high birth rate, and that some measures for reducing the fertility rate should be implemented. This position was also defended publically by the Chief of the Joint Chiefs of Staff of the Armed Forces in May 1983. He pointed to problems of continuing urban migration and

difficulties in populating less crowded areas in the country such as the Amazon jungle area and the semi-arid Northeast region. In June 1983, family planning was the cover story of ISTO E, a weekly news magazine similar to Time or Newsweek (Figure 5), and major newspapers are carrying stories and editorials on the subject of family planning on almost a daily basis.

However, resistance still exists, notably on the left of the political spectrum and even within the Ministry of Health. The present Minister is reportedly not only against vertical programs of family planning but also defends the policy that contraceptive methods should only be given under a physician's supervision. Although most people believe in the need for family planning services and agree that, at present family planning is still a privilege of well-to-do people but it should be available to the poor, some share the Minister's viewpoint that the absence of direct medical supervision is equal to "indiscriminate" distribution and use of contraceptives. However, the necessity of direct medical supervision would, at this time, eliminate access to family planning services in one-third to one-half of the municipios in the poorest States because of the absence of public health physicians in those areas.

These statements are sometimes made as direct "accusations" against BEMFAM, which uses trained paramedical and nonmedical personnel for education/service with respect to family planning methods. An irony is that CPS data have shown that the major sources of contraceptives are drugstores (temporary methods) and the Federal/State hospitals (permanent methods). Although the Ministry of Health speaks on behalf of family planning only under direct medical supervision, there is no law regulating the sale of any contraceptive method over the counter by pharmacists, a group which, in many instances, has no schooling or training in family planning.

In the State of Rio, the present Secretary of Health has stated off the record that he would like to include family planning services in his primary health care program. This position is an improvement relative to BEMFAM's statewide program, since the past Secretary of Health was totally against family planning. Since the present State Secretary of Health has been in his position for only the past 3 months, there has been no official contact with him by BEMFAM officials. The same applies to many municipios where new mayors were elected and took office in March 1983. However, it is only fair to point out that BEMFAM officials have been hesitant to make contact with new political office-holders due to the uncertainty of continuing FPIA support for the State of Rio program.

At the municipal level, attitudes vary and are fairly independent of political affiliations. Even though it is not always the municipal Governments that enter into convenios with BEMFAM to support the program, the three mayors contacted by the Evaluation Team were very enthusiastic about the program and suggested or proposed ways of improving it. All organizations supporting the program were convinced that it is beneficial to the community and to the individual, and that it is meeting existing needs that could not presently be met in other ways. The attitude at the local level may be persuasive in involving the State Government in offering services, taking local realities into consideration.

One unwritten but important objective of BEMFAM concerning the State of Rio program was to influence the political climate regarding general acceptance of family planning in Brazil. The reason for this unstated objective is that Rio is an influential city in Brazil regarding culture, national behavior, and fashion--if it can be demonstrated that a family planning program can satisfy a significant demand for services in Rio, then the implications would be that this could be done elsewhere in the country too.

H. BEMFAM-FPIA Relationships

The evaluation of relations with representatives of International Donor Agencies can be very subjective. At a minimum, the communication between BEMFAM and International Donors should include submission of quality reports within pre-established deadlines and interim reports on changes in the development of projects. There were some delays in the submission of reports in 1982 which BEMFAM acknowledges as due to the moving of the Central Office.

Specific to this project, there seems to be a number of misunderstandings in the BEMFAM-FPIA relationship. BEMFAM states that it thought that a project extension beyond the third year of FPIA assistance could be negotiated with FPIA to continue the program in the State of Rio. No other State CBD program initiated by BEMFAM and assisted by any other population donor had become self-supporting in less than 7 years, and there was no cause to think that this program could survive without continued donor support. FPIA Regional Office staff, on their part, in conversations with the Evaluation Team, maintained that the project, BR-05, had been clearly drafted for 3 years only and that this had been noted on the cover of each subsequent project modification document and reiterated in conversations (the documents state "first, second, and third year of 3 anticipated years"). Neither BEMFAM nor FPIA could produce for the Evaluation Team an exchange of letters on the future of the State of Rio program, a correspondence which the Evaluation Team would have expected to have taken place, at the latest, by the middle of the third year of project funding.

While BEMFAM may have been far too sanguine in assuming FPIA would continue support in the absence of a written communication and can be faulted for not initiating timely correspondence on the subject itself, in the Evaluation Team's opinion, FPIA had an equal obligation to take into consideration the nature of the program it had assisted and to be clear in writing about the possibilities of support beyond May 1983. In the end, it was left to the Development Officer in the U.S. Embassy in Brasilia to suggest an evaluation to determine the fate of the program, something FPIA itself could usefully have suggested by the middle of the third project year, rather than risk that the program perish in the absence of a source of funding.

There is also some confusion as to whether FPIA has actually adopted a policy precluding FPIA assistance to all IPPF affiliates. An important observation seems to be that BEMFAM is the major organization in Brazil which offers family planning information and services throughout a wide area of the country, and seeks to legitimize family planning in the absence of a Government program and in a climate of political and social indecision about the adoption of an official program. In view of the situation in Brazil, the Evaluation Team feels that FPIA should be sensitive to the merits of further assistance under BR-05 for the State of Rio program, based on observations and recommendations contained in this report.

Regarding the number of cruzeiro readjustments in the budget for BR-05 and the difficulty in following exchange rate fluctuations between the time of project approvals and submission of subsequent project expenditure reports, the Evaluation Team observes that it would save considerable BEMFAM and FPIA staff time and clarify project reporting in the future (assuming any further FPIA assistance is considered) if FPIA could approve yearly budgets and subsequent budget modifications in the dollars equivalency rather than in cruzeiros which, at the moment, is an exceedingly unstable currency.

VIII. RECOMMENDATIONS

A. Summary Observations

1. Although the State of Rio Program has reached 11 percent of current married women in the state, only 4 percent are currently active users. However, the program basically serves a "hard core" of poor women who would find it very difficult, if not impossible in the prevailing economic situation in Brazil, to purchase contraceptives at commercial rates from pharmacies and that, from all accounts, those families previously on marginal incomes yet with the ability to purchase from pharmacies are now increasingly impoverished.
2. The BEMFAM organization and the State of Rio program team have worked very hard for about 3 years to build up interest in the program at the local level through what the Evaluation Team perceives as genuinely decentralized and well-placed service outlets, run by recognized community personalities and agencies, which are highly motivated to provide family planning in order to satisfy the demands of neighborhood women.
3. BEMFAM and the State of Rio program team have legitimized the public sector as a source of family planning and have arranged for services to be offered at the administrative/political levels of 61 out of the 64 municipios in the State by negotiating "convenios" (agreements) with mayors and other municipal/county health, education and welfare officials; BEMFAM has done this in the absence to date of any family planning information and service program endorsed by the State or Federal Government.
4. No other State community-based distribution project operated by BEMFAM or any other organization in Brazil and assisted by external donors has become self-supporting in less than 7 years, a period in which donors continued to recognize the need for external assistance. There was misperception and ambiguity regarding the continuation of the program between FPIA and BEMFAM as the third of 3 years of FPIA funding drew to a close.

B. Principal Recommendation

FPIA should be requested by AID to consider extending assistance for the State of Rio program for a period of 2 years, however, on the firm understanding that BEMFAM will initiate discussions concerning the future support of the program with the State Government no later than 6 months

into the extension (that is, March 1984), even while it continues all efforts to legitimize the program at the level of municipios, and on the understanding that support for the second year of the extension would be contingent on the continuation of these discussions so that there would be an 18 month period for negotiations and transfer of the program to the State Government. Since the current State Government is in office until the end of 1986, an alternative plan would be support of the project for 3 years with external assistance phased down from 100 percent in the first year to 75 percent in the second year and 50 percent in the third year.

C. Recommendations For Continuation, Expansion, or Modification of Program Activities

1. Continue to focus on geographical areas and neighborhoods with the greatest concentration of impoverished families in the first year of the extension, and improve or expand the program to bring the number of active users up to the point at which it stood in June 1982. In the second year of the extension, a reasonable goal would be to increase the number of active users to a level of 7 percent of currently married women.
2. Concentrate on strengthening direct and refresher training of distributors, educators, and supervisors by the State of Rio program team on a decentralized basis within the State--the Evaluation Team places great stress on the need for adequate refresher training of distributors, educators, supervisors, and physicians, and for initial training of newly-recruited distributors, educators, supervisors, and physicians especially when there is turnover of staff in the program or in the case of expansion of the physicians' component of the program.
3. Develop more systematic procedures and guidelines for distributors, educators, and supervisors for referral of clients for IUD insertion; BEMFAM should systematically seek out physicians willing to consider offering the service, offer to train them and supply them with IUD's at no cost for their practices on the understanding that they accept program referrals for insertions at no cost--or minimal cost; develop better recordkeeping by distributors on referrals; and, in any other way, seek to strengthen the referral system.
4. Consistent with the analysis of service statistics in this report, data on new users and active users could be maintained at the State level and reported to donors on a quarterly rather than monthly basis; If data are maintained on a quarterly basis, donors such as FPIA, which have a different requirement, would have to accept quarterly data. A coupon system should be introduced for IUD and VSC referrals so that the referring post can account for such referrals.
5. Routine supervision of distribution posts could be reduced in number to one visit every 2 or 3 months. (Of course, "problem" posts and/or posts with turnover of personnel should be visited more often.)

6. To the greatest extent possible and practical, encourage distributors and educators to follow up clients who fail to return for resupply of pills, i.e., implementation of mailings to those who fail to return (as done in one housing association post). A "tickler file" system for the distribution post with client cards filed by month of return would identify more easily those who are due to return for resupply at any particular time and who may be contacted in some way by the distributor or educator.
 7. Introduce a progesterone-only oral pill into the program for lactating women.
 8. Based on an innovation developed by a household distributor participating in the subsidized program, consider encouraging distributors to develop their own networks of subdistributors and consider the training needs of the subdistributors; expand the sale of contraceptive at distribution posts through subdistributors to the greatest extent possible, except at posts in which other health services are offered free of charge.
 9. In view of the training in primary health care and MCH received by distributors, educators, and supervisors, consider whether basic MCH advice and education could not be strengthened at program distribution posts, and consider whether referrals for MCH needs could not be strengthened as well in a closer relationship with local health facilities (i.e., for posts not already located in municipal health facilities).
 10. Beyond the initiatives already taken, continue to widen the program focus on men at strategic locations at which they can be easily reached.
 11. Implement Patient Flow Analysis studies in the two major clinics that are part of the program.
- D. Funding Recommendations: The Following Items Should Be Considered for Continued Funding:
1. The State of Rio program team (four members full-time, which the Evaluation Team believes would be adequate to cover administrative and technical requirements of the program) and appropriate clerical/logistics support.
 2. Physicians and supervisors already employed by the program and additional hires if BEMFAM finds this is necessary to implement the Evaluation Team's recommendations that referrals for IUD insertion systematically strengthened throughout the community-based program.
 3. National, short-term consultants to assist in training.
 4. For the State of Rio program team, for field supervisors and trainee travel for the purpose of implementing decentralized training throughout the State and for the purpose of supervision--however, as mentioned previously, the Evaluation Team believes that routine supervisory visits could be reduced in number to one every 2 or 3 months.

5. An expanded number of refresher training courses for distributors, educators, supervisors, and physicians already in the program, and new training courses in the case of entry of new personnel into the program.
6. Development and production of materials for training and community education, taking into consideration what has already been developed during the first 3 years of the program.
7. A sample survey once a year of 1 month's new clients to determine previous method and previous source of supply of contraceptives, reasons for switching source and simple socioeconomic data on these clients.
8. Should FPIA consider further support this project, the Evaluation Team recommends that a comprehensive midextension program review be scheduled in the project documentation for joint participation by FPIA Regional Office staff, appropriate BEMFAM staff and the State of Rio program team. In the last year of the extension, BEMFAM and FPIA should, in writing, summarize their views on the status of the program and the need for any further assistance. As indicated in this report, the Evaluation Team hopes that by that time, the State Government will be involved, in collaboration with BEMFAM and other organizations, in a program of family planning activities in Rio de Janeiro.

E. Additional Recommendations

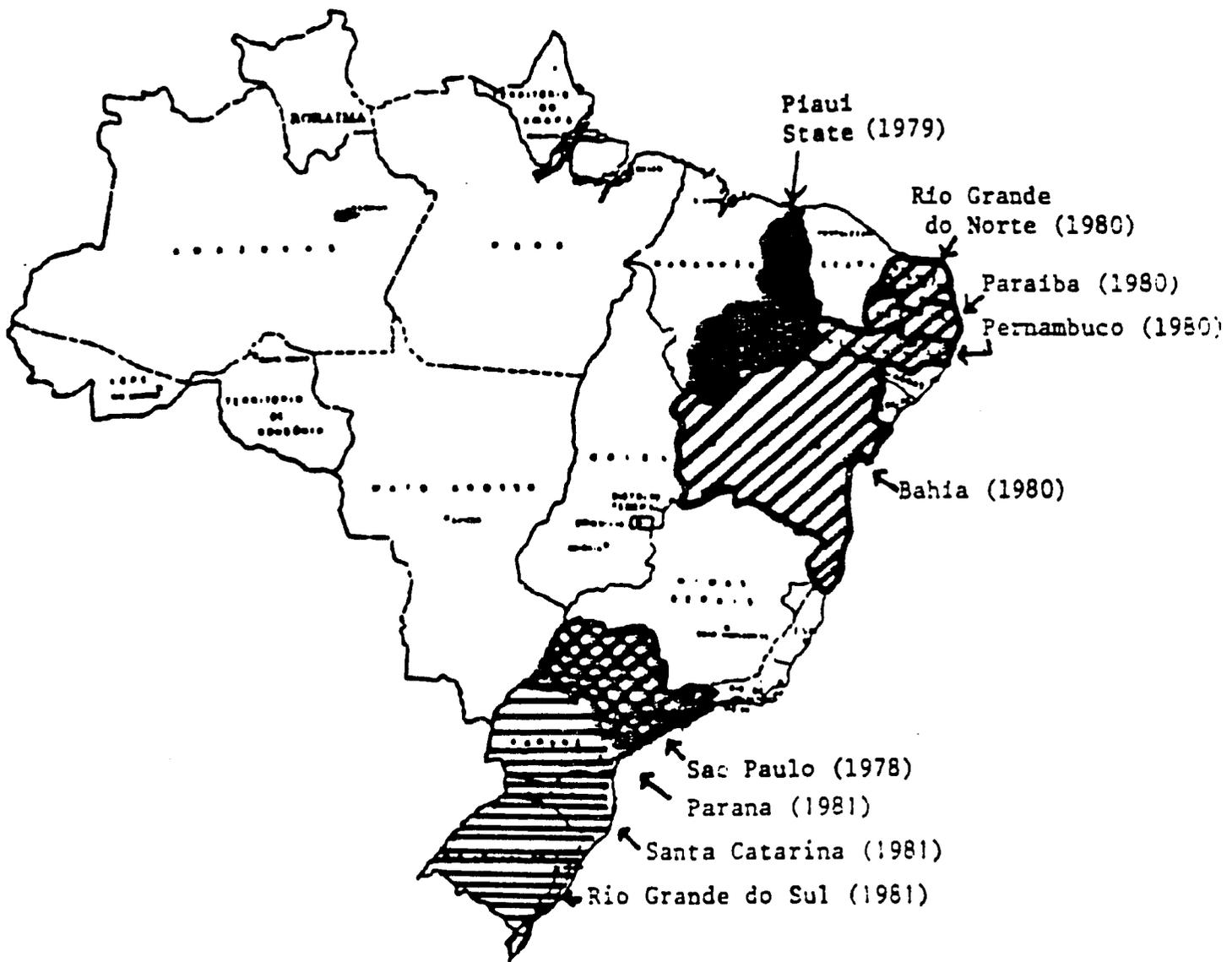
The Evaluation Team has considered certain services beyond what is possible to include under this project and, therefore, makes the following additional recommendations to BEMFAM for its consideration:

1. Additional paid physicians if BEMFAM finds this is necessary to implement the Evaluation Team's recommendation that referrals for IUD insertion be systematically strengthened throughout the program.
2. Expand the Moncorvo Filho Hospital service already offering free voluntary surgical contraception on referral and, if necessary, approach other donors such as the International Program of the Association for Voluntary Sterilization, which has assisted in training to date, for further assistance relating to expansion of the service under a complementary project to BR 05; the Evaluation Team recognizes that there are certain sensitivities involved regarding surgical contraception in Brazil, however, other institutions offer the service (in some cases, at medical risk to the client when linked with unnecessary caesarean sections to ensure physician reimbursement) and a significant number of family planning acceptors do request the service.
3. Develop a post-partum family planning program at hospitals in the State of Rio in collaboration with hospital and Government health officials--the Evaluation Team observes that BEMFAM could approach population donors for assistance under a complementary project to BR-05.

FIGURES

FIGURE 1

Statewide Maternal-Child Health/Family Planning Surveys
Brazil, 1978-1981



Best Available Document

FIGURE 3

New and Active Clients by Quarter
 State of Rio de Janeiro
 February 1980 - March 1983

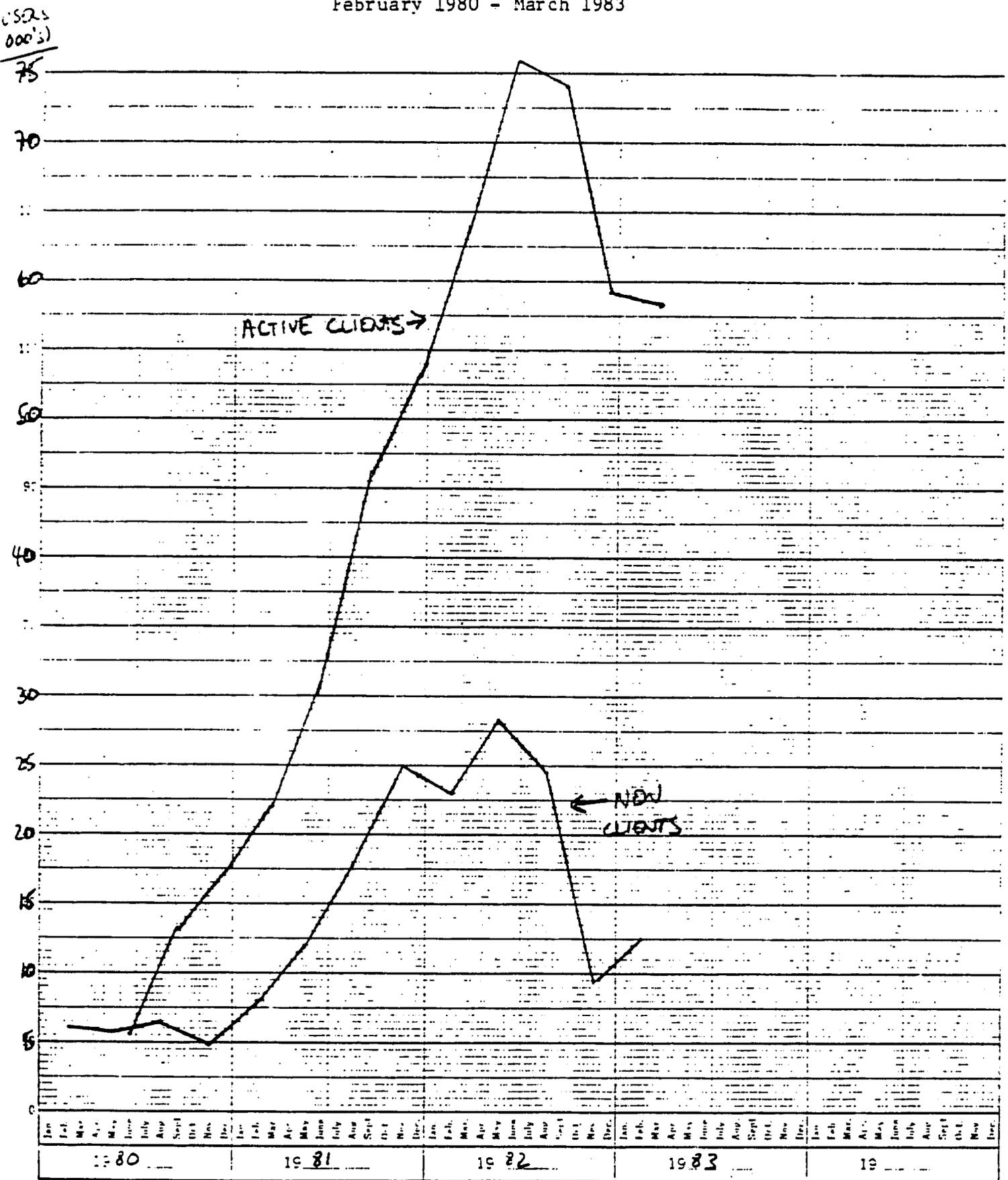
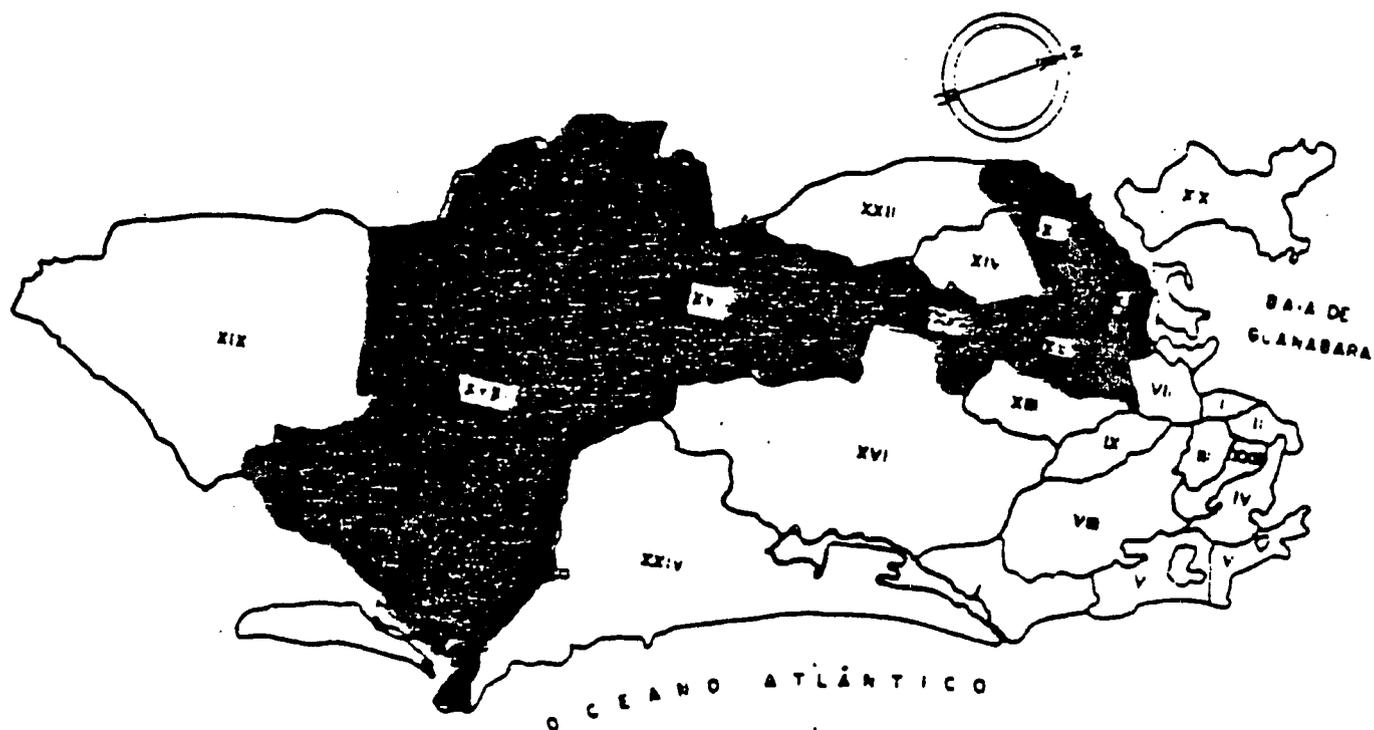


FIGURE -

M A P A
REGIÕES ADMINISTRATIVAS NO MUNICÍPIO DO RIO DE JANEIRO



REGIÕES ADMINISTRATIVAS - RA:

- | | | |
|---------------------|---------------------|-------------------------|
| I - Portuária | IX - Vila Isabel | XVII - Bangu |
| II - Centro | X - Ramos | XVIII - Campo Grande |
| III - Rio Comprido | XI - Penha | XIX - Santa Cruz |
| IV - Botafogo | XII - Méier | XX - Ilha do Governador |
| V - Copacabana | XIII - Engenho Novo | XXI - Paqueta |
| VI - Lapa | XIV - Irajá | XXII - Anchieta |
| VII - São Cristóvão | XV - Madureira | XXIII - Santa Teresinha |
| VIII - Tijuca | XVI - Jacarepaguá | XXIV - Barra de Tijuca |

Best Available Document

Sucessão: Andreazza sobe

ISTO É

Planejamento familiar



A natalidade em debate

TABLES

TABLE 1

Percentage of Currently Married Women Aged 15-44 Currently Using Contraception
by Method, Nine States in Brazil with Survey Data

<u>(Year of Survey)</u>	<u>Rio Grande do Sul (1981)</u>	<u>Santa Catarina (1981)</u>	<u>São Paulo (1978)</u>	<u>Paraná (1981)</u>	<u>Rio Grande do Norte (1980)</u>	<u>Paraíba (1980)</u>	<u>Pernambuco (1980)</u>	<u>Bahia (1980)</u>	<u>Piauí (1979)</u>
Currently Using:	71.3	65.2	63.9	61.6	47.0	43.2	41.4	31.1	30.9
Sterilization	11.3	10.9	16.1	19.7	17.4	15.7	18.9	9.6	15.4
Orals	39.9	33.4	27.8	26.3	17.9	14.3	12.5	11.7	10.0
Withdrawal	7.2	13.8	7.3	8.7	3.4	5.7	3.6	3.2	2.5
Rhythm	6.9	3.9	5.2	3.3	6.0	6.6	3.5	3.6	2.6
Condoms	2.8	2.6	6.6	2.4	0.7	0.2	0.6	1.4	0.1
Other methods*	3.2	0.7	0.9	1.2	1.7	0.6	2.3	1.7	0.3
Not Currently Using	28.7	34.8	36.1	38.4	53.0	56.8	58.6	68.9	69.1
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	1,042	786	1,880	1,076	1,300	1,183	1,259	1,396	1,270

*Includes vaginal methods, IUD's, contraceptive implants (Bahia).

2/6

TABLE 2

Planning Status of Most Recent Pregnancy for Currently Married Women 15-44
 Brazil, 1978-1981
 (Percent Distribution)

<u>State</u>	<u>Year of Survey</u>	<u>Planning Status</u>					<u>No. of Cases</u>
		<u>Total</u>	<u>Planned</u>	<u>Mistimed</u>	<u>Unwanted</u>	<u>Unknown</u>	
Sao Paulo	1978	100.0	64.8	13.2	21.7	0.3	1,736
Piaui	1979	100.0	48.7	15.7	34.4	1.1	1,208
R.G. do Norte	1980	100.0	48.8	23.4	25.9	1.8	1,214
Paraiba	1980	100.0	55.5	18.6	22.8	3.2	1,199
Pernambuco	1980	100.0	50.8	17.0	26.2	6.0	1,184
Bahia	1980	100.0	49.6	12.1	33.4	4.9	1,322
Parana	1981	100.0	70.6	18.3	9.4	1.7	967
S. Catarina	1981	100.0	62.7	24.8	11.7	0.8	706
R.G. do Sul	1981	100.0	68.0	20.1	10.8	0.9	926

TABLE 3

Various Indicators Related to Abortion (Spontaneous and Induced) Data
from Nine Recent Contraceptive Prevalence Surveys in Brazil
1978-1981

<u>State</u>	<u>% of Reported Pregnancies Ending in Abortion</u>	<u>% Married Women With at Least 1 Abortion</u>	<u>% Receiving Medical Attention at Last Abortion</u>	<u>% Hospitalized at Last Abortion</u>
Sao Paulo State, 1978	10.9	21.9	43.1	35.7
Piauí State, 1979	8.5	28.9	50.8	38.9
R.G. do Norte State, 1980	8.7	26.4	24.4	16.8
Paraíba State, 1980	10.5	30.7	53.5	39.0
Pernambuco State, 1980	11.7	33.1	40.4	32.7
Bahia State, 1980	9.9	29.9	33.8	18.5
Paraná State, 1981	9.9	22.3	71.9	49.2
S. Catarina State, 1981	10.2	23.3	72.4	61.1
R.G. do Sul State, 1981	12.6	23.8	71.7	55.7

TABLE 4

States with BEMFAM-Assisted Community-Based
Family Planning Programs

<u>State</u>	<u>Program Start</u>	<u>Date SHD* Took Over</u>	<u>Population (1980-000's)</u>	<u>WCA-000's* (1980)</u>	<u>Donor Agency</u>
R.G. do Norte	08/73	01/83	1,902	457	IPPF
Paraiba	08/75		2,770	646	IPPF
Pernambuco	06/75		6,147	1,485	IPPF/Pathfinder
Alagoas	06/75	06/82	1,990	460	IPPF/Pathfinder
Parana	11/75***	06/81	7,629	1,928	IPPF
Piaui	04/79	****	2,139	495	Columbia/Pathfinder
Rio de Janeiro	02/80		11,301	3,139	FPIA
Ceara	03/82	Part (30%)	5,298	1,276	Pathfinder
			<u>39,175</u>		

<u>State</u>	<u>No. of Posts**</u>	<u>New Users(NU) Thru 12/82**</u>	<u>Active Users (AU) 12/82</u>	<u>% of WCA</u>		<u>% of New Clients Still Active</u>
				<u>NU</u>	<u>AU</u>	
R.G. do Norte	372	235,803	39,023	51.6	8.5	17%
Paraiba	286	212,769	38,885	32.9	6.0	18%
Pernambuco	455	394,224	89,430	26.5	6.0	23%
Alagoas	212	119,128	17,546	25.9	3.8	15%
Parana	105	144,346	11,566	7.5	0.6	8%
Piaui	325	94,035	31,614	19.0	6.4	34%
Rio de Janeiro	224	171,432	59,330	5.5	1.9	35%
Ceara	141	44,972	26,374	3.5	2.1	59%

*SHD: State Health Department; WCA: Women of childbearing age (15-44).

**12/82

***Northern part of State only; extended to entire State in 1981 with transfer of responsibility to State Health Department

****Currently in negotiation.

TABLE 5

State of Rio Program of Mobilization of Community Resources for
Family Planning: Targets for the 3-Year Program, by Year

	2/80 - 1/81		2/81 - 5/82		6/82 - 5/83	
	Target	Accomplishment	Target	Accomplishment	Target	Accomplishment
Component of:						
Distributors	} 240	} 330	200		180	241
Educators			164		224	83
Field Supervisors					15	13
Established						
Centers	90	87	164	212	180	221
Municipios	14	15	64	49	64	61
Total in State)						
Mass Users:						
Users	35,000	36,126 ¹	80,000	112,812	65,057	74,132 ⁴
Subsequent visits	--	30,235	--	178,188	--	162,800 ⁴
Active users	--	16,801 ²	31,118 ³	62,538	45,540 ³	58,068 ⁵
Training Courses: ⁶						
Crises/Attendees	10/204	14/330	14/270	15/328	2/40	2/37
Flash Crses/Att.	--	8/145	8/212	8/145	11/275	
For courses for side orgztns.	--	--	--	--	--	2/-
Objectives: ⁷						
Crises/Attendees	--	368/11,958	2,500/50,000	4,544/99,834	1,080/30,000	--
Messages	--	--	1,620	1,223	--	--
Contacts	--	--	540	442	--	--
Interviews	--	--	26	29	--	--
Boards	--	--	26	--	--	--

figure included clients referred for medical care. Later program reports omit these clients in reporting accomplishments against targets. New users for this year omitting referrals were 26,537.

December 1980

Throughout the program, FPIA asked for data on "continuing users," which is not generally used by any program in Latin America, and BEMFAM reported on subsequent visits and "active users" (see Section VI-C on Program Service Statistics).

1983

1983

Efforts for distributors, educators, supervisors, and physicians.

With the exception of community talks, other I&E activities were part of mass media campaign and not continued beyond program year 2.

TABLE 6

Family Planning Distribution Posts, by Area
State of Rio de Janeiro, Brazil
May 1983

<u>Area</u>	<u>No. of Municipios</u>	<u>Population*</u> <u>(1980)</u>	<u>No. of Posts</u>	<u>% Distribution</u>	
				<u>Population</u>	<u>Posts</u>
Município (Municipality) of Rio de Janeiro	1	5,093,232	77	44.3	34.8
Rio de Janeiro Metropolitan Area**	13	3,925,405	64	34.2	29.0
Rest of State (Interior)	<u>50</u>	<u>2,471,160</u>	<u>80</u>	21.5	36.2
TOTAL	64	11,489,797	221		

*IBGE: Sinopse preliminar do Censo Demografico: Rio de Janeiro, 1980, 1(17), Maio de 1981.

**Includes the municipios of Duque de Caxias, Itaboraí, Itaguaí, Mage, Mangaratiba, Maricá, Nilópolis, Niterói, Nova Iguaçu, Paracambi, Petrópolis, São Gonçalo, and São João de Meriti.

TABLE 7

Family Planning Distribution Posts, by Type of Post
 State of Rio de Janeiro, Brazil .
 May 1983

<u>Type of Post</u>	<u>No. of Posts</u>
Município (municipal) Government*	66
Household	43
Community Centers**	27
Private Institutions	23
Neighborhood Associations	21
Unions/Rural Cooperatives	16
Religious Institutions	8
Industry	7
BEMFAM Clinics	3
University Clinics	2
Others	<u>5</u>
TOTAL	221

*Agreements with municipal Governments establish services in county health posts or municipal educational facilities.

**Social assistance agencies, urban social centers, adolescent protection agencies, community development agencies (i.e., LBA, Fundacao Leao XIII).

TABLE 8

Growth of Subsidized Family Planning Posts
State of Rio de Janeiro

<u>Year</u>	<u>Month</u>	<u>No. of Posts</u>	<u>Income (CR\$)</u>	<u>Exchange Rate*</u>	<u>\$US</u>	<u>\$US Per Post</u>	
1982	April	10	61.345	152	404	40	
	May	11	82.043	165	497	45	
	June	11	129.624	172	754	69	
	July	59	268.577	162	1,476	25	
	August	74	306.711	193	1,589	21	
	September	75	261.249	206	1,268	17	
	October	81	382.051	221	1,729	21	
	November	74	337.771	236	1,431	19	
	December	76	270.066	251	1,076	14	
	1983	January	75	351.396	274	1,282	17
		February	70	282.387	380	743	11
		March	65	456.046	415	1,099	17
April		78	810.700	462	1,755	22	
May		70	590.480	491	1,203	17	

*End of month.

NOTE: A month's supply of either pills or foam was \$CR30 during this period (\$US.20-\$US.06) with the price going up to \$CR50 in June 1983 (\$US.09). A month's supply of condoms was \$CR60 during this period (US\$.40-\$US.12), increasing to \$CR200 in June 1983 (US\$.37).

TABLE 9

New Clients, by Area, by Quarter
State of Rio de Janeiro
February 1980-March 1983

Year	Quarter	Rio de Janeiro	Metropolitan Area	Rest of State	Total	
					Quarter	Annual
1980	Feb.-Mar.	6,133	--	--	6,133	
	Apr.-June	5,209	511	--	5,720	
	July-Sept.	5,209	1,334	--	6,543	
	Oct.-Dec.	3,219	1,366	320	4,905	23,301
1981	Jan.-Mar.	4,420	2,713	893	8,026	
	Apr.-June	6,880	3,964	1,064	11,908	
	July-Sept.	10,795	4,761	2,134	17,690	
	Oct.-Dec.	17,583	4,478	2,834	24,895	62,519
1982	Jan.-Mar.	13,365	6,595	2,989	22,949	
	Apr.-June	16,261	8,235	3,945	28,441	
	July-Sept.	15,322	5,874	3,410	24,606	
	Oct.-Dec.	3,498	3,558	2,560	9,616	85,612
1983	Jan.-Mar.	7,302	2,865	2,421	12,588	
TOTAL		115,556	46,254	22,570	184,020	
% Distribution		(62.8)	(25.1)	(12.3)	(100.0)	
Cumulative No. of New Clients as % of Married Women 15-44 (1980)-						
		<u>15.0%</u>	<u>7.8%</u>	<u>6.1%</u>	<u>10.8%</u>	
Per Year:						
1980		2.6%	0.5%	0.1%	1.3%	
1981		5.2%	2.7%	1.9%	3.6%	
1982		7.6%	4.1%	3.5%	4.9%	

TABLE 10

New Clients, by Method, by Quarter
State of Rio de Janeiro
February 1980-March 1983

<u>Year</u>	<u>Quarter</u>	<u>Pills</u>	<u>Condom</u>	<u>Vaginal Methods*</u>	<u>IUD</u>	<u>Other**</u>	<u>Total</u>
1980	Feb.-Mar.	5,433	--	700	--	--	6,133
	Apr.-June	5,063	3	654	--	--	5,720
	July-Sept.	5,863	36	644	--	--	6,543
	Oct.-Dec.	4,248	3	654	--	--	4,905
1981	Jan.-Mar.	7,102	154	770	--	--	8,026
	Apr.-June	10,467	420	1,021	--	--	11,908
	July-Sept.	14,213	1,513	1,951	13	--	17,690
	Oct.-Dec.	15,782	7,180	1,920	13	--	24,895
1982	Jan.-Mar.	16,437	3,786	2,635	74	17	22,949
	Apr.-June	17,145	8,809	2,407	68	12	28,441
	July-Sept.	12,492	11,022	1,002	66	24	24,606
	Oct.-Dec.	8,472	667	351	67	59	9,616
1983	Jan.-Mar.	7,537	3,929	990	102	30	12,588
	TOTAL	130,254	37,522	15,699	403	142	184,020
	Method Mix (%):						
	1980	88.4	0.2	11.4	0.0	0.0	100.0
	1981	76.1	14.8	9.1	0.0	0.0	100.0
	1982	63.7	28.4	7.5	0.3	0.1	100.0
	1983	59.9	31.2	7.9	0.8	0.2	100.0
	TOTAL	70.8	20.4	8.5	0.1	0.1	100.0

*Foam or tablets with or without condoms.

**Diaphragm and natural method.

TABLE 11

Active Users, by Area, By Quarter
State of Rio de Janeiro
June 1980-March 1983

<u>Year</u>	<u>Month</u>	<u>Rio de Janeiro</u>	<u>Metropolitan Area</u>	<u>Rest of State</u>	<u>TOTAL</u>	<u>% of CMW 15-44 (1980)</u>
1980	June	4,817	395	--	5,212	0.3
	Sept.	11,684	1,647	--	13,331	0.8
	Dec.	13,790	2,756	255	16,801	1.0
1981	Mar.	16,367	5,050	919	22,336	1.3
	June	20,882	7,963	1,859	30,704	1.8
	Sept.	30,430	12,079	3,791	46,300	2.7
	Dec.	33,749	13,845	5,715	53,309	3.1
1982	Mar.	37,354	18,657	7,869	63,880	3.7
	June	39,272	26,205	10,514	75,991	4.4
	Sept.	35,048	27,223	11,885	74,156	4.3
	Dec.	24,626	22,792	11,912	59,330	3.4
1983	Mar.	27,661	17,595	12,812	58,068	3.4
% Distrib.:		47.6	30.3	22.2	100.0	
% of CMW 15-44(1980):						
	Mar. 1983 -	3.6	3.0	3.4	3.4	
	Maximum -	5.1(6/82)	4.6(9/82)	3.4(3/83)	4.4(6/82)	
% of Cumulative No. of New clients:						
		23.9	38.0	56.8	31.6	
Active users per post (Mar. 1983):						
		359	275	160	263	

TABLE 12

Active Users, by Method, by Quarter
 State of Rio de Janeiro
 June 1980-March 1983

<u>Year</u>	<u>Month</u>	<u>Pills</u>	<u>Condom</u>	<u>Vaginal Methods*</u>	<u>IUD</u>	<u>Other**</u>	<u>TOTAL</u>
1980	June	4,471	22	719	0	0	5,212
	Sept.	12,569	35	727	0	0	13,331
	Dec.	15,813	1	987	0	0	16,801
1981	Mar.	21,056	141	1,139	0	0	22,336
	June	28,656	426	1,622	0	0	30,704
	Sept.	41,867	1,690	2,730	13	0	46,300
	Dec.	47,865	2,204	3,214	26	0	53,309
1982	Mar.	58,096	1,957	3,715	108	4	63,880
	June	67,668	4,522	3,598	202	1	75,991
	Sept.	65,543	6,826	1,476	297	14	74,156
	Dec.	56,918	1,175	781	436	20	59,330
1983	Mar.	50,692	3,054	3,704	609	9	58,068
% of Cumulative							
No. of New							
Clients:							
		38.9	8.1	23.6	***	6.3	31.6
Active Users-							
% Distribution:							
	Dec. 1980	94.1	0.0	5.9	0.0	0.0	100.0
	Dec. 1981	89.8	4.1	6.0	0.1	0.0	100.0
	Dec. 1982	95.9	2.0	1.3	0.7	0.0	100.0
	Mar. 1983	87.3	5.3	6.4	1.0	0.0	100.0

*Foam or tablets with or without condoms.

**Diaphragm and natural method.

***This is more than 100 percent because many women are put on a temporary method until an IUD can be inserted during the menstrual period; thus, they are counted as a new client using the temporary method, later switching to the IUD.

TABLE 13

Overview of State of Rio Program, by Area and Selected Indicators

<u>Area</u>	<u>Percent Distribution</u>			
	<u>Population</u>	<u>No. of Posts</u>	<u>Cumulative New Clients*</u>	<u>Active Clients**</u>
Município of Rio de Janeiro	44.3	34.8	62.8	47.6
Metropolitan Area	34.2	29.0	25.1	30.3
Other Areas (Interior)	21.5	36.2	12.3	22.1
TOTAL	100.0	100.0	100.0	100.0

*Until March 1983.

**March 1983.

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TABLE 14

Characteristics of New Clients, State of Rio de Janeiro
Selected Months: 1980-1983

Month Year/	A. Age Group (Percent Distribution)				B. No. of Living Children (Percent Distribution)			
	15-19	20-29	30-39	40 +	0	1-2	3-4	5 +
2/80	1.6	42.9	42.9	11.4	3.2	54.3	27.4	15.1
10/80	8.2	56.7	26.3	8.8	7.6	56.1	28.1	8.2
10/81	11.5	55.0	25.7	7.8	6.7	60.4	22.5	10.3
10/82	11.0	54.8	31.6	2.7	11.4	55.5	22.1	12.0

	C. Open Interval (Percent Distribution)				D. Percent Using Contraception Previously		
	None	0-3 Mos.	4-11 Mos.	1 + Years	Metro Area*	Other	Total
2/80	3.4	0.6	4.5	91.6	99.4	--	99.4
4/80	--	--	--	--	98.7	--	98.7
10/80	6.5	10.7	18.9	63.9	94.2	--	94.2
4/81	--	--	--	--	91.2	85.7	91.0
10/81	6.7	12.7	18.0	62.7	94.4	90.7	93.8 (84.3)**
4/82	--	--	--	--	87.5	83.0	86.6
10/82	8.3	12.5	19.1	60.1	80.0	80.6	80.1

6/83(Evaluation): 85.1

*Including the municipio of Rio de Janeiro.

**During this month it was possible to obtain data for new clients referred to physicians who are more likely not to have previously used contraception.

TABLE 15

Percent of Currently Married Women Aged 15-44
 Currently Using Contraception, by Method Used
 Parque Uniao, Jacarezinho, and Vicente de Carvalho
 Municipio of Rio de Janeiro, 1982

<u>Currently Using</u>	<u>62.9</u>
Orals	38.3
Sterilization	14.6
IUD	3.4
Rhythm	2.0
Withdrawal	1.6
Condom	1.5
Foam/Jelly	1.0
Others	0.5
<u>Not Currently Using</u>	<u>37.1</u>
TOTAL	100.0
No. of Cases	(4,242)

Source: Unpublished data--CPA/IMC
 Operations Research Survey

TABLE 16

Source of Contraception for Current Users of Oral Contraception,
by Monthly Household Per Capita Income
Women Ever-in-Union Aged 15-44
Parque Uniao, Jacarezinho, Vicente de Carvalho
Rio de Janeiro, 1982
(Percent Distribution)

Source of Oral Contraceptives	Total	Monthly Household Per Capita Income (MW)*						
		<1/4 MW	1/4-<1/2 MW	1/2-<3/4 MW	3/4 <1 MW	1-<1-1/4 MW	1-1/4-<1-1/2 MW	1-1/2 or +
Pharmacy	60.7	47.4	54.7	62.0	65.6	76.3	71.2	83.6
BEMFAM	22.9	31.1	26.1	21.2	22.1	12.9	11.0	13.4
CPAIME	14.7	18.8	17.0	15.3	9.7	10.7	17.8	3.0
Gov't. health facility	0.3	0.0	0.4	0.5	0.5	0.0	0.0	0.0
Private physician	0.2	0.0	0.0	0.3	1.0	0.0	0.0	0.0
Others	1.0	2.6	1.5	0.8	1.0	0.0	0.0	0.0
TOTAL	99.8	99.9	99.7	100.1	99.9	99.9	100.0	100.0
No. of Cases	(1,532)**	(196)	(516)	(392)	(195)	(93)	(73)	(67)

*MW = Brazilian Minimum Wage

**198 cases excluded for lack of income and/or source data.

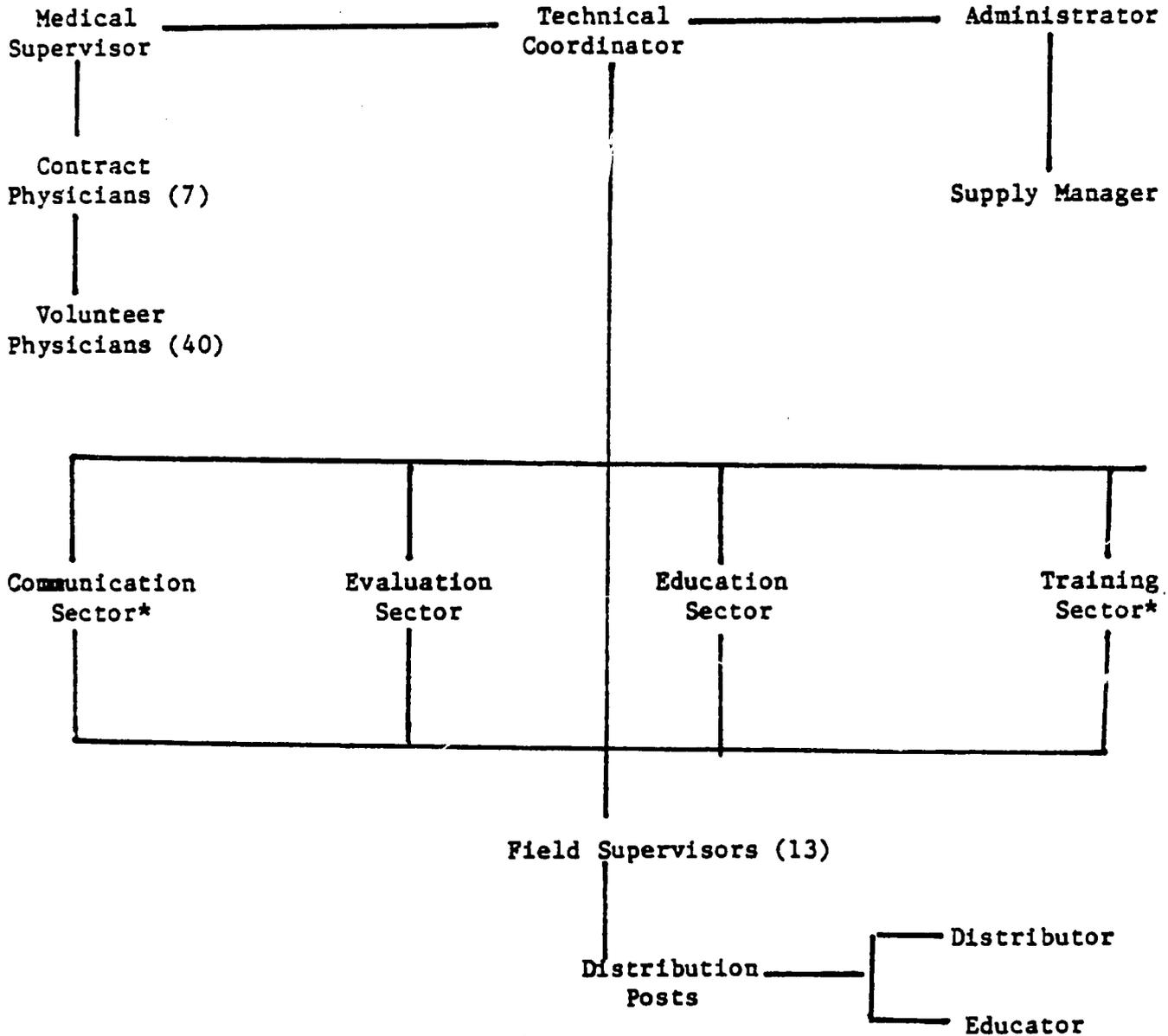
SOURCE: Unpublished data--CPAIME Operations Research Survey.

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APPENDICES

APPENDIX A

ORGANIZATION CHART--STATE OF RIO PROGRAM
OF MOBILIZATION OF COMMUNITY RESOURCES
FOR FAMILY PLANNING



*No longer operating because of budget cuts; the training sector is now combined with the education sector under one staff member, an Educator/Trainer.

AGENDA DE VISITA - ESTADO DO RIO

juiz Visitante: Sharan Epstein, M.P.H.
 Eliane Franco, M.D.
 Leo Morris, Ph.D.

período: 17/06 à 01/07/83

DIA	DATA	ATIVIDADE	RESPONSÁVEL
6a.	17	TRPDE: Entrevista com o Secretário-Executivo	Dr. Walter Rodrigues
2a.	20	MANHÃ: a) Análise da programação a ser desenvolvida b) Reunião com coordenação geral de programas TRPDE: a) Sharan/Eliane - Reunião com coordenação Depto de Avaliação e I e E b) Leo - Trabalhar com estatísticas dos postos a ser visitados.	Schiavo, Flórida Ney/ Thomé. Flórida Thomé/Schiavo
3a.	21	MANHÃ: Visita à clínica do Meier (03) TRPDE: Reunião com coordenação técnica do Programa do Rio	Ney Ney/Silvia Regina Illydia Maria
4a.	22	Viagem - Itaboraí: Prefeitura Municipal (41) Posto de Saúde Pacheco (254) Roc Bonito: Posto de Saúde (67) Casemiro de Abreu: Fundação Leão XIII (281) Pernoitar - Campos	
5a.	23	Campos: Sindicato da CEDAE (143) USINA SANTA CRUZ Campos: Centro Social Urbano da Perua (144) Conceição de Macabu - Posto da Farmácia da Prefeitura (155) Macaé - Fundação Leão XII (247) Pernoitar - Macaé	

APPENDIX C (Cont.)

DIA	DATA	ATIVIDADE	RESPONSÁVEL
6a.	24	São Pedro da Aldeia - Inst. Proteção à Criança (57) São Pedro da Aldeia - Sindicato dos Trabalhadores Rurais (169) São Pedro da Aldeia - Posto de Saúde Ana Nery (238) Sapucaia - STR (153)	
2a.	27	Visita à Postos Religiosos e Municipais - Ten Espírita Morada de Oxalá (221) Secretaria Municipal de Saúde de Nova Iguaçu (54) Visita à clínica de Cavias	Dr. Ney Costa e equipe
3a.	28	MANHÃ: Visita a Postos de Associação de Moradores e Domiciliares Associação de Moradores da Favela da Maré (28); Associação de Moradores de Nova Brasília (19). Associação de Moradores da Vila Proletária da Penha (17); Posto Domiciliar Vila Aliança (40) e Domiciliar de Campo Grande (56) TARDE: Reunião com supervisores de campo.	Dr. Ney Costa e equipe Dr. Ney Costa e equipe
a. e a.	29-30	Relatório	
6a.	01	MANHÃ: Relatório TARDE: Reunião com o Secretário-Executivo e Staff.	

Best Available Document

APPENDIX D

LIST OF POSTS VISITED

Rio de Janeiro Municipio

<u>Name</u>	<u>Post No.</u>	<u>Date Opened</u>	<u>Hours</u>	<u>No. of Active Users (5/83)</u>	<u>Distributor(s)</u>
ier Clinic	3	2/80	9 AM-5 PM	10,783	Doris Martins Rosangela Felixi Rosangela Amara
ousing Assn. of la Proletaria Penha	17	8/80	9 AM-5 PM	914	Luzinete Mendes and Eliana Franco
ommunity Post-- la Kennedy	26	8/80	5 PM-6 PM (Thursdays)	123	Milzete Bastos
ousing Assn. of vela da Mare	28	8/80	9 AM-4 PM	539	Maria de Penha Silva
ousehold Post-- la Alianca	40	10/80	9 AM-11 AM	2,224	Maria Isis Oliveira
ousehold Post-- mpo Grande	56	1/81	2 PM-4 PM	646	Sonia Nascimento
anda Espirita rada de Oxala	221	1/82	8 AM-6 PM	56	Lyz Wilma Alneida

Metropolitan Area

<u>Municipio</u>	<u>Post Name</u>	<u>Post No.</u>	<u>Date Opened</u>	<u>Hours</u>	<u>No. of Active Users (5/83)</u>	<u>Distributor(s)</u>
ique de Caxias	Clinica de Caxias	226	1/82	8 AM-5 PM	2,346	Maria Aparecida
aboari	County Health Post (Downtown)	41	12/80	8 AM-11:30 AM 1 PM-5 PM	1,224	Anilda de Souza Silva and Katia Regina Silva
aboari	County Health Post (Pacheco District)	254	8/82	8 AM-11 AM (Wednesdays)	61	Sandra Maria de Freitas
ova Iguacu	County Health Post	36		8 AM-5 PM	757	Nilda

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APPENDIX D (Cont.)

C. Interior

<u>Município</u>	<u>Post Name</u>	<u>No.</u>	<u>Date Opened</u>	<u>Hours</u>	<u>No. of Active Users (5/83)</u>	<u>Distributor(s)</u>
Campos	Sindicato da Cedae (Union)	143	8/81	9 AM-5 PM	109	Sergio Souza Terra
Campos	Usina Santa Cruz	144	7/81	8 AM-6 PM	118	Terezinha Amar Alves
Rio Bonito	County Health Post	67	11/80	9 AM-5 PM	674	Corina Mendonc
Conceicao de Macabu	County Pharmacy	155	9/81	11 AM-5 PM	77	Delizete Garcí
Macaé	Community Center (Leao XIII)	247	6/82	9 AM-6 PM	75	Marcia Franco
Squarema	Rural Workers Union	153	8/81	9 AM-5 PM	191	Rita Cassia
S. P. D'Aloeia	Rural Workers Union	169	8/81	9 AM-5 PM	56	Leda Pinheiro and Elinemlda
S. P. D'Aldeia	Ana Nery Health Post	238	3/82	8 AM-11:30 AM	185	Oswaldo Santos
S. P. D'Aldeia	Child Protection Institute (IPAC)	57	12/80	9 AM-6 PM	176	Bernadete